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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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Jolles, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-11394
April 3, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of Referee St. Martin's order which set aside its denial of claimant's aggravation claim for a right knee injury. On review, the employer contends claimant failed to establish that her condition worsened. We agree and reverse.

Claimant was 41 years of age at the time of hearing. In March 1980 her right knee buckled while she was pulling green chain. Since her compensable injury, claimant has undergone three surgeries. In April 1980 Dr. German, orthopedist, performed a medial meniscectomy. In November 1980 Dr. German performed further surgery, excising a retained posterior horn of the medial meniscus and trimming the lateral meniscus. In April 1981 claimant underwent a "chondroplasty patella and lateral retinacular release," which was performed by Dr. North, orthopedist.

In October 1981 Dr. Pasquesi, orthopedist, conducted an independent medical examination. Recommending claim closure, Dr. Pasquesi opined that claimant's total impairment was 25%. The doctor advised that claimant should perform work which required her to be on her feet no more than four hours per day and which allowed her to sit and stand when necessary. Dr. Pasquesi further recommended that claimant refrain from climbing, kneeling or walking over uneven ground. Dr. North concurred with Dr. Pasquesi's report. Dr. German concluded that claimant had a permanent mild instability which would cause her intermittent discomfort, as well as further discomfort when standing or twisting on the knee on a consistent basis.

A Determination Order issued November 10, 1981, awarding claimant 20% permanent right leg (knee) disability. The award was subsequently affirmed by a Referee's August 1982 order.

Claimant continued to receive treatment for her swelling, pain and grating complaints. To increase her muscle strength, a Cybex program was prescribed. In May 1982 Dr. German noted that claimant's strength was "markedly improved." The doctor opined that claimant would continue to have symptoms of knee pain on occasion "no matter what she does." Dr. German concluded that it was "probably to her best advantage not to be doing heavy laboring such as mill work, log cutting, etc." However, the doctor did not place further restrictions upon claimant other than to avoid heavy laboring.

In May 1982 claimant also sought treatment from Dr. Rudd, orthopedist. The doctor reported that claimant was making slow, steady progress in building her quadriceps strength and was becoming more tolerant of her pain. Dr. Rudd concluded that claimant's permanent impairment was 15%.

In August 1982 Dr. Hutson, orthopedist, performed an independent medical examination. Dr. Hutson reported that claimant's problems were resolving well. The doctor recommended that claimant continue her muscle strengthening exercises, but saw no reason why claimant could not return to her former employment without restrictions.

Claimant returned to work as a utility worker on the green chain in August 1982. Her duties were basically the same as those she performed before her injury. Claimant continued to engage in her prescribed exercises, but not on a scheduled basis. Her pain soon reappeared and ultimately forced claimant to seek further medical treatment. She returned to Dr. Rudd in May 1983. Diagnosing an abnormal patellofemoral mechanism, Dr. Rudd recommended realignment surgery.

Claimant was reexamined by Dr. Hutson, who disagreed with Dr. Rudd's surgery recommendation. The doctor reported that there was no evidence that claimant's knee was objectively worse than when last seen in August 1982. Dr. Hutson felt the very best thing for claimant would be to secure a lighter type of employment.

Dr. German conceded that claimant was not without symptoms. However, the doctor felt these symptoms had objectively been compatible with her employment. Dr. German continued to opine that claimant was medically stationary, with no restrictions. Soon after issuing this opinion, Dr. German reported that due to claimant's unhappiness with her treatment, she would be seeking treatment from another physician.

In October 1983 claimant was reexamined by Dr. Rudd. The doctor felt "fairly definitely" that claimant's symptoms were greater in March and that her heavy physical work had aggravated her condition. Hoping to avoid further surgery and rehabilitation, Dr. Rudd recommended lighter work.

In February 1984 claimant was examined by Dr. Kopp, orthopedist. The doctor foresaw the possibility of a repeat arthroscopy to further investigate the cause of claimant's symptoms. However, citing his relationship with Dr. German in the local community, Dr. Kopp advised claimant that he would be "less than a purely objective observer in your case considering the animosity you have had for him in the past."

In March 1984 claimant was again examined by Dr. Rudd. In Dr. Rudd's opinion there had been no essential change in claimant's condition over the past 18 months. Dr. Rudd concluded that claimant was stable and that her impairment was the same as had been previously issued. The doctor erroneously reported that claimant had received 30% right leg disability.

Following the hearing Dr. Rudd was deposed. Dr. Rudd testified that the aggravation claimant experienced was an increase in her pain. The doctor agreed that the knee's internal derangement remained the same. In Dr. Rudd's opinion a 30% impairment rating approximately doubled his rating of claimant's impairment. He had changed his May 1983 recommendation for surgery after discussing with claimant her emotional, medication and personal problems. These problems also prompted Dr. Rudd to be "very cautious in taking literally" claimant's reports of pain.

Claimant testified that at the time of her August 1982 hearing she could walk around her 20-acre property without stopping, as well as walk up and down winding stairs to the beach. She was also able to ride horses and pedal her bicycle. Once she returned to work, her pain and swelling returned. The knee progressively weakened until she was forced to terminate her

employment. Since leaving her work the knee has not improved, although the pain is not as incessant. Her medication consists of Motrin as well as an antidepressant. Due to her pain claimant has curtailed her recreational activities. For example, the one time claimant had ridden a horse that year she experienced pain and swelling in the knee.

The Referee found that claimant had established a compensable aggravation claim. The Referee reasoned that Dr. Rudd's recent opinions, as well as Dr. Kopp's opinion, had been tainted by loyalty to their peer, Dr. German. Finding claimant to be an honest and credible witness, the Referee concluded that her testimony coupled with Dr. Rudd's initial opinion established a compensable aggravation. The Referee cited Garbutt v. SAIF, 297 Or 148 (1984).

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. ORS 656.273(1). A physician's report is not indispensable to a workers' compensation claim. Garbutt, supra, at 151. The worker's or other lay testimony may or may not carry the worker's burden of proof. In some cases a symptomatic worsening will be found sufficient to warrant claim reopening under the aggravation statute, while in other cases it will not. Billy Joe Jones, 36 Van Natta 1230, 1235 (1984).

We find that claimant has not carried her burden of proving a worsening of her condition. In reaching our decision we are persuaded by the opinions of Dr. German, the former treating orthopedist, and Dr. Hutson. Both physicians had seen claimant before and after her alleged worsening and were of the opinion that claimant's condition had not objectively worsened. Dr. German conceded that claimant was not without symptoms, but concluded this recurrence was compatible with her employment. Furthermore, based on Dr. German's prior opinion, intermittent episodes of symptomology were to be expected. Given claimant's disability award and her proclivity for subsequent exacerbations, we do not consider it particularly noteworthy that claimant would periodically experience an increase in her right knee symptoms upon exertion. See, Kenneth L. Elliott, 36 Van Natta 1141 (1984).

We also find Dr. Rudd's opinion, as the recent treating orthopedist, informative. Dr. Rudd concluded that there was no essential change in claimant's condition over the past 18 months. Although he stated claimant experienced an aggravation in terms of her pain, Dr. Rudd opined that claimant's internal derangement remained the same. Moreover, upon learning of claimant's emotional and personal problems, Dr. Rudd had revised his prior recommendation of surgery and became wary of claimant's pain complaints. Finally, although we agree with the Referee that Dr. Kopp's opinion is of no probative value, we do not agree that Dr. Rudd's opinion has likewise been tainted by claimant's differences with Dr. German. Not only is there no evidence to suggest Dr. Rudd's opinion was tainted, but the doctor provided a perfectly cogent and reasonable explanation for why he modified his prior recommendation for surgery.

Considering the extensive medical history of claimant's right knee, the complex nature of her current condition, and the virtual unanimity of the medical opinions, we do not find that claimant's

honest and credible testimony is sufficient to establish the compensability of her claim for aggravation.

The employer further requests permission to offset time loss benefits which have allegedly been paid during this period of reopening. Since neither party has had an opportunity to litigate the merits of this overpayment issue, we leave the matter to the employer, to assert in the proper manner at the relevant time to the appropriate forum. Milton O. Burson, 36 Van Natta 282, 284 (1984).

ORDER

The Referee's order dated September 14, 1984 is reversed. The self-insured employer's denial dated November 2, 1983 is reinstated and affirmed.

MICHAEL R. HARMAN, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-02979 & 82-03232
April 3, 1985
Order on Remand

This case is before the Board on remand from the Court of Appeals. Harman v. SAIF, 71 Or App 724 (1985). The Board has been instructed to award claimant permanent total disability and to determine an allowance of attorney fees to claimant's attorney. The mandate does not specify the effective date of claimant's permanent total disability award, and the court's written opinion provides no assistance in that regard. We, therefore, look to the record.

Claimant's treating physician declared claimant medically stationary as of January 12, 1981. On January 13, 1981 claimant returned to work for the employer under the terms of work station modification and wage subsidy agreements between the employer and the Workers' Compensation Department. Claimant worked full time continuously at the modified work until he was laid off for economic reasons on December 4, 1981. Claimant was terminated by the employer on April 1, 1982. The hearing in this case was convened December 14, 1982.

The standard for determining the effective date of a retroactive permanent total disability award is "the earliest date that claimant's permanent total disability is proved to have existed." Morris v. Denny's, 53 Or App 863, 867 (1981). See also Wilke v. SAIF, 49 Or App 427, 431 (1980). Although that date is frequently found to be the date on which a claimant was declared to be medically stationary, see, e.g., William B. Johnson, 36 Van Natta 98, 104 (1984), there is no rule of law to that effect, see Albert D. Richey, 36 Van Natta 1580, 1583 (1984), and a finding of an appropriate effective date is based upon all of the relevant medical, social and vocational factors, Morris v. Denny's, supra.

In Albert D. Richey, supra, we fixed the effective date of a permanent total disability award as the medically stationary date with special emphasis upon our finding of fact that there was no change in claimant's medical or vocational situation after the medically stationary date. In this case, there was a significant change in claimant's vocational situation, beginning the day after he was found to be medically stationary, that is, he returned to full time gainful employment. We believe that claimant's full time employment precludes his being found permanently and totally

disabled as of his medically stationary date, particularly due to the fact that claimant's treating physician did not view claimant as being permanently and totally disabled from a medical standpoint alone.

We find that the earliest date that all relevant factors combined to permit the legal conclusion that claimant was permanently and totally disabled was the date upon which he was laid off from his employment, December 14, 1981. Claimant is, therefore, awarded permanent total disability as of December 14, 1981.

On the issue of attorney fees, claimant's attorney is awarded 25% of the increased compensation awarded by this order, not to exceed $3,000, payable out of and not in addition to claimant's compensation. See ORS 656.386(2); OAR 438-47-045; Morris v. Denny's, 53 Or App 863, 866 (1981); Zoi Sarantis, 36 Van Natta 1634 (1984).

IT IS SO ORDERED.

PETER R. WARNER, Claimant
Harrang, et al., Claimant's Attorneys
Flinn, et al., Defense Attorneys

WCB TP-85004
April 3, 1985
Third Party Distribution Order

Claimant has petitioned the Board for an order distributing the proceeds of a third party recovery obtained by settlement of his civil action against an allegedly negligent third party. Claimant sustained a severe injury to his left arm while working for Emerald Forest Products, Inc., whose workers' compensation insurance is provided by the SAIF Corporation. The employer leased a plywood veneer lay-up machine from BPS Associates. This machine apparently did not comply with the requirements of the Oregon safety code. Claimant sustained the injury in question while he was cleaning part of the machinery, when his left hand and forearm were caught in and drawn into the machine.

Claimant initiated a civil action against BPS Associates as the owner of the machinery, alleging negligence in various particulars. During the trial, while the jury was deliberating, claimant settled his third party action for the sum of $40,000. SAIF granted its approval of this settlement, indicating that it would seek a distribution in accordance with the statutory formula. See ORS 656.593(1)(c).

In his petition claimant explains that he entered into a settlement of his third party action in anticipation of a possible determination by the jury that the third party was not negligent, and that claimant was injured solely as a result of the negligence of claimant's employer. Claimant maintains that, in fact, the employer was negligent, and that its negligence proximately caused his injury. Claimant's petition asserts that the employer and SAIF have an arrangement whereby the employer is directly responsible for payment of claim costs "once a threshold level of $100,000 has been reached." Claimant maintains that the costs of his claim have exceeded $100,000, and, thus, that the sum payable to SAIF as the paying agency will be credited, "dollar for dollar," to the allegedly negligent employer. Claimant contends

that, in order to effectuate a "just and proper distribution" under these circumstances, SAIF should not receive any portion of the settlement proceeds.

In its response to claimant's petition, SAIF states that its current claim costs amount to approximately $48,700. The balance of the settlement proceeds remaining after partial distribution pursuant to ORS 656.593(1)(a) and (b) equals approximately $13,350. Thus, SAIF will recover less than 30% of its actual claim costs according to the statutory distribution formula.

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), generally applies to the distribution of a third party recovery obtained by settlement. Marvin Thornton, 34 Van Natta 998 (1982). On a rare occasion, circumstances might justify a departure from the statutory distribution formula. Thus, in Robert T. Gerlach, 36 Van Natta 293 (1984), we ordered that the paying agency's lien be reduced by an amount equal to 15% of its actual expenditures for compensation in an effort to, ". . . in effect, reconstruct an agreement the parties substantially entered into, but which subsequently fell apart primarily due to an unfortunate failure of communication." Id. at 296.

Even assuming that the employer was negligent, no degree of negligence could expose it to any liability other than that provided by the Workers' Compensation Law. ORS 656.018. This limited liability extends to the employer's industrial insurer. ORS 656.018(3). The statutes governing distribution of the proceeds of a third party recovery draw no distinction between an innocent employer and one whose alleged negligence is partly, or even solely, the cause of a worker's injury. The distribution proposed by claimant is in derogation of the exclusive remedy provisions of the Workers' Compensation Law. Therefore, we do not find claimant's argument persuasive.

The proceeds of claimant's third party recovery shall be distributed according to the formula provided by ORS 656.593(1).

IT IS SO ORDERED.

LEIGHTON J. BOWMAN, Claimant
Thomas Flaherty, Claimant's Attorney
Edward Olson, Defense Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-09931
April 8, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of those portions of Referee Thye's order which: (1) set aside its de facto denial of responsibility for claimant's medical services claim for a low back condition; and (2) upheld North Pacific Insurance Company's denial of claimant's "new injury" claim. On review, SAIF contends claimant's current low back condition is related to a new injury, for which North Pacific is the responsible party.

Following our de novo review of the medical and lay evidence, we agree with the Referee that the preponderance of the persuasive evidence establishes that claimant's current low back condition is attributable to his 1972 compensable injury, for which SAIF is

responsible for medical treatment pursuant to ORS 656.245. Accordingly, we affirm the order of the Referee.

Claimant submitted a brief thoroughly detailing the pertinent facts of this case, as well as outlining the present state of responsibility law. However, he concluded that either insurer was responsible, dependent upon an aggravation or new injury theory. Moreover, his primary argument that claimant suffered a new injury did not prevail on Board review. Under these circumstances, claimant is not entitled to an attorney's fee. See, William H. O'Bryan, 36 Van Natta 1272 (1984); Robert Heilman, 34 Van Natta 1487 (1982). Finally, although claimant urged the Board to affirm that portion of the Referee's order which awarded him interim compensation and assessed North Pacific penalties and accompanying attorney fees, North Pacific did not contest that portion of the Referee's order. Inasmuch as this issue was neither raised nor contested by North Pacific on Board review, claimant is not entitled to attorney fees.

ORDER

The Referee's order dated July 10, 1984 is affirmed.

BUD E. WILLIAMS, Claimant
Ernest W. Kissling, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-09788
April 8, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Leahy's order which upheld a Determination Order awarding temporary disability from March 11, 1982 through September 9, 1983, but excluding the period from March 4, 1983 through August 31, 1983 inclusive, plus 7.5° for 5% scheduled disability for loss of use of the right leg and 22.5° for 15% scheduled disability for loss of use of the left leg. On review claimant contends that he is permanently and totally disabled or, in the alternative, that he is entitled to an unscheduled award. He also contends that he was entitled to temporary disability continuously from March into September 1983.

We affirm that portion of the Referee's order relating to claimant's entitlement to temporary disability compensation.

On March 11, 1982 claimant, an illiterate and borderline retarded 62-year-old male, was shot at work. He underwent an exploratory laparotomy. Dr. Bachulis discovered a laceration of the transverse colon for which he performed a colostomy. Dr. Carr extensively dissected the hip joint to remove shell fragments. In addition, a bullet lodged in the lumbar back near the L3 right nerve root, causing considerable destruction to the adjacent posterior back muscles, was removed.

While hospitalized a history of preexisting high blood pressure and heart problems was obtained. Before the injury claimant was experiencing angina attacks once or twice weekly and using nitroglycerin occasionally.

Claimant was discharged from the hospital on March 24, 1982. Dr. Carr reported on April 22, 1982 that claimant's chief complaint was numbness, burning and tingling in the area of the right thigh corresponding to the third lumbar nerve root. Dr. Carr felt that claimant had contused the nerve root or was

developing scarring around it from the injury, but believed that it should clear up with time. Claimant also reported experiencing weakness in the left hip.

Claimant was rehospitalized on June 9, 1982 for closure of the colostomy. Dr. Bachulis released claimant to return to full work on August 22, 1982. Claimant's job required very heavy lifting. The abdominal incision tore out almost immediately upon his resumption of this activity. Although the incisional hernia was surgically repaired on January 18, 1983, it tore out again in the spring of 1983. At hearing, claimant had a lump about the size of an egg. He testified that his doctor had told him that if he avoided lifting, the hernia would not spread and that he could thereby avoid another surgery. In light of these experiences and claimant's overall physical condition, we find his reluctance to submit to this further surgery not unreasonable.

Dr. Gilbert reported on May 26, 1983 that the recurrent ventral hernia was not disabling.

On April 26, 1983 Dr. Carr reexamined claimant. Claimant complained of pain with ambulation. The previously reported numbness continued. Sensation was decreased over the entire right side of the right leg. Lumbar x-rays showed rather severe degenerative changes. Dr. Carr stated that claimant's condition had not changed a great deal since April 1982. He stated that claimant's antalgic gait may be permanent and that he did not think claimant would ever be able to go back to work.

Dr. Carr's report of June 28, 1983 described claimant's major problems as persistent pain and numbness in the right leg as a direct result of the gunshot wounds. He said that damage to the nerve roots caused the marked antalgic gait and an inability to stand for any length of time. Taking into account age, education and disability, he opined that claimant was unable to go back to any type of work. Dr. Carr's October 25, 1983 report further clarified that although some of claimant's discomfort could come from degenerative disc disease, most of the problems he manifested primarily in the right leg were directly referrable to the gunshot injury.

Dr. Skelley, Callahan Center medical examiner, thoroughly evaluated claimant on September 2, 1983. Claimant's complaints included constant aching in the low back, right leg and left thigh. Sitting, standing, walking or driving 20 minutes worsened the pain and made the back and right leg pain sharp. Twisting, bending or going up stairs caused an immediate worsening. Once or twice a day claimant was experiencing pain and aching in the neck shooting up from the low back. Claimant also reported occasional pain at the hernia sight and angina.

Dr. Skelley stated claimant's limitations as follows:

> "This patient would be between the sedentary and light work range. He has to avoid sitting, standing, walking over 20 minutes. He is unable to climb stairs. He is unable to do any repetitive bending or twisting. It is my opinion that this patient would be unable to work for two hours.

"I also feel that this patient is totally disabled from his physical disabilities. That associated with his atherosclerotic heart disease and ventral hernia would certainly make him a poor candidate for entering the work force in any capacity."

The Callahan Center's psychologist, Dr. Means, rated claimant's full scale IQ at 73, placing him in the fourth percentile according to an age appropriate norm group. She noted that claimant had functioned occupationally through the years by doing a variety of tasks which required heavy work, but could no longer handle work in that capacity. She found it questionable that claimant would be able to adapt to anything in the light sedentary range, terming the prognosis for return to work as poor.

From about the spring of 1983 through about January 1984, claimant cared for six horses in exchange for room and vegetables from a garden. The job mainly involved feeding hay with a pitchfork, cleaning stalls and currying animals. He was fired because he could not handle heavier activities. He subsequently made two unsuccessful contacts in an effort to obtain work as a butcher. Claimant credibly testified, however, that he was no longer physically capable of meat packing work.

ORS 656.206(1) provides that a claimant is permanently and totally disabled if permanently incapacitated from regularly performing work at a gainful occupation 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. ORS 656.206(3) places upon the claimant the burden of proving permanent total diability status, claimant's willingness to seek regular gainful employment and that claimant has made reasonable efforts to obtain such employment. Efforts to seek employment are not required, however, where it is clear that such efforts would be in vain. Butcher v. SAIF, 45 Or App 313 (1980).

The medical evidence as a whole and Dr. Skelley's report in particular persuades us that claimant is permanently and totally disabled from his physical impairments. Claimant's age, intelligence level and illiteracy further preclude employability. Claimant has nonetheless attempted to return to his former employment, attempted to earn at least his room through the care of horses and attemped to find work as a butcher. His willingness to work is well demonstrated. Accordingly, we award claimant permanent total disability.

ORDER

The Referee's order dated May 24, 1984 is affirmed in part and modified in part. Claimant is awarded permanent total disability effective as of September 9, 1983 in lieu of the awards of 5% scheduled permanent partial disability for injury to the right leg and 15% scheduled permanent partial disability for injury to the left leg made by the Determination Order dated October 4, 1983. Claimant's attorney is awarded 25% of the additional compensation granted by this order, total fees at hearing and on Board review not to exceed $3,000, as a reasonable attorney's fee. The Referee's order is affirmed in all other respects.

JAMES R. DELLINGER, Claimant
David Force, Claimant's Attorney
Starr & Vinson, Attorneys
Cummins, et al., Defense Attorneys

WCB 84-03454
April 9, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of Referee McCullough's order which set aside its denial of compensability of claimant's epididymal orchitis condition. We reverse.

Claimant underwent a non-work-related vasectomy on September 17, 1983. He worked without difficulty related to the vasectomy until October 27, 1983, when he noticed sudden pain and swelling of his left testicle while at work. He was offbearing one-tenth inch thickness veneer from a dryer at the time he noticed the first pain and swelling. The pain and swelling increased and he consulted the physician who performed the vasectomy. Conservative management failed to relieve claimant's symptoms and surgery was performed on November 21, 1983 to remove an inflamed and swollen epididymis.

Claimant's theory, supported by the attending physician, a urologist, was that the straining done at work was a traumatic injury which caused the infection of the left epididymis. The theory is that infectious organisms were forced to the epididymis by the pressure exerted in the abdomen when claimant lifted the veneer off the dryer belt.

Two urologists reviewed the evidence for the employer. They opined that a man could not acquire an infection in his epididymis as a result of straining unless his vas deferens were unobstructed between the prostate and the epididymis. Therefore, in their opinion, it was unlikely that claimant, a vasectomized man with a history of prostate infection, could acquire an infection in his epididymis by straining. They opined that he had infectious organisms in his vas deferens at the time of the vasectomy which eventually caused the inflammation and swelling of the vas and epididymis and that it was coincidental and unrelated to his work activity that claimant first noticed painful symptoms while at work.

The Referee found claimant and his wife were credible and that their testimony showed that the first awareness of symptoms of infection occurred at work. Claimant's attending physician treated claimant for the prostate infection, performed the vasectomy and the epididymectomy, and opined that the epididymal infection was related to claimant's work.

When it is a question of appropriate medical treatment, we customarily defer to the attending physician, but when the issue before us is a complex question of medical causation, the attending physician's opinion is entitled to no more weight than any other similarly qualified professional's opinion. Hammons v. Perini, 43 Or App 299 (1979). Claimant's attending physician's opinion is couched in terms of possibility rather than probability and does not persuade us that his theory of causation is more likely than not. See Gormley v. SAIF, 52 Or App 1055 (1981). On the contrary, each opinion of the two similarly qualified consulting physicians is more persuasive that claimant's infection was not causally related to straining at work, and we find that claimant has not carried his burden of persuasion. Therefore, we reverse the

Referee's order and find the epididymal orchitis condition was not compensable.

ORDER

The Referee's order dated October 12, 1984 is reversed and the self-insured employer's denial dated January 31, 1984 is reinstated.

NONDA G. HENDERSON, Claimant
Evohl F. Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 84-05908
April 9, 1985
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated March 26, 1985. The Board's order modified the amount of overpaid temporary disability benefits the self-insured employer was entitled to offset against future permanent disability awards. Claimant contends he is entitled to an attorney fee award pursuant to ORS 656.386 for "increasing" claimant's compensation by "presumably reducing the alleged overpayment."

The Supreme Court has held to the contrary, concluding that ORS 656.386(1) applies to subsequent reversals of denied claims for compensation. See Forney v. Western States Plywood, 297 Or 628 (1984). The Forney court reasoned that where the employer erroneously unilaterally offset an overpayment, the worker's entitlement to an award of attorney's fees for prevailing on the offset issue was restricted to a statutory remedy, for which none was presently available. This case presents an analogous situation which is governed by the same statutory restrictions. Moreover, we conclude that a modification of the amount of the employer's future offset is not equivalent to an award of additional temporary disability. Consequently, claimant is not entitled to an attorney's fee pursuant to OAR 438-47-030.

Accordingly, claimant's request is granted. On reconsideration, with the above supplementation, the Board adheres to and republishes its former order.

IT IS SO ORDERED.

TREVA K. HUBBARD, Claimant
Doblie & McSwain, Claimant's Attorneys
David Horne, Defense Attorney

WCB 83-12018
April 9, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Pferdner's order which: (1) affirmed a Determination Order dated April 10, 1984 in all respects; (2) upheld the insurer's denial of claim reopening for a worsened condition; (3) declined to order the insurer to authorize more than two chiropractic treatments per month, as requested by claimant's treating chiropractor; and (4) declined to impose penalties and associated attorney fees.

The issues on review are: (1) whether the Determination Order prematurely closed this claim; (2) in the alternative, whether claimant is entitled to claim reopening for a worsened condition; (3) in the alternative, whether claimant is entitled to any permanent disability in addition to the 16° for 5% unscheduled

disability for injury to her right shoulder; (4) whether Dr. Won, claimant's treating chiropractor, should be authorized to treat claimant at least twice a week as requested; and (5) whether penalties/attorney fees are warranted.

The Referee concluded that claimant failed to sustain her burden of proving entitlement to any of the relief claimed. We agree with this conclusion. Therefore, we affirm the Referee's order and make the following comments concerning the frequency of treatment issue.

Claimant was injured in August of 1983. In March of 1984 the insurer requested that Dr. Won justify claimant's need for more than two chiropractic treatments per month. The insurer relied upon OAR 436-69-201(2)(a). On the date of claimant's injury, that rule provided:

> "Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 24 office visits by any and all attending physicians in the first 60 days from first date of treatment and four visits a month thereafter. This statement of fact does not constitute authority for an arbitrary limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. * * * *"

That rule was amended, effective January 16, 1984, to allow two office visits per month, rather than four, after 60 days from the first date of treatment. WCD Admin. Order 1-1984.

Claimant argues that the rule in effect on the date of her injury governs her entitlement to medical services and defines the allowable number of treatments. ORS 656.202(2). But see Barrett v. Union Oil Distributors, 60 Or App 483 (1982); Lindsey v. SAIF, 60 Or App 361, 364 (1982).

We need not decide whether the version of the rule in effect on the date of claimant's injury, as opposed to the version of the rule in effect at the time of the "claim" for medical services, is controlling. As both versions of the rule state, the rule is nothing more than a guideline. Neither rule defines a maximum number of treatments that a claimant may receive, as suggested in claimant's brief. See Kemp v. Workers' Comp. Dept., 65 Or App 659, 663 (1983); Lloyd C. Dykstra, 36 Van Natta 26, 35 (1984). The insurer has authorized two chiropractic treatments per month. Claimant contends that she is entitled to more frequent treatment. The issue is whether the treatment claimant seeks is reasonable and necessary. SAIF v. Belcher, 71 Or App 502, 505 (1984); Milbradt v. SAIF, 62 Or App 530 (1983). Claimant currently is receiving two chiropractic treatments per month, for which the insurer is paying. Claimant has failed to satisfy her burden of proving that any additional treatment is either reasonable or necessary as a result of her industrial injury.

ORDER

The Referee's order dated July 20, 1984 is affirmed.

LYN A. HULSLANDER, Claimant
Evohl F. Malagon, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 84-02564
April 12, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests, and claimant cross-requests, review of Referee Michael Johnson's order which directed the insurer to pay claimant compensation for temporary total disability from February 17, 1984, until the claim was closed or claimant's entitlement otherwise ended; and declined to impose penalties/attorney fees for alleged unreasonable claims processing. The insurer contends that claimant is not entitled to temporary total disability as ordered by the Referee because her employment was terminated for reasons unrelated to her industrial injury. Claimant contends that the Referee's order should be affirmed insofar as it requires the insurer to continue payment of temporary disability pending claim closure, but that the order should be reversed insofar as it fails to impose penalties/attorney fees.

We agree with the Referee's conclusion that claimant is entitled to continuing temporary disability benefits as of February 17, 1984; however, we reach this conclusion based upon different reasoning.

The insurer contends that it is not obligated to pay any temporary disability benefits beyond February 16, 1984, because on that date claimant's employment was terminated for excessive absenteeism. Claimant had worked for the employer for approximately two and a half years prior to her termination. In 1982 she had been given a verbal warning concerning her unsatisfactory attendance. In 1983 she had been given a written warning, and in early 1983 she had been suspended for five days as a result of her excessive absenteeism. None of these absences had anything to do with claimant's industrial claim, which is for an upper extremity condition recently diagnosed as thoracic outlet syndrome. Claimant's absences in 1982 and 1983 apparently resulted from a chronic bronchitis condition. Some of these absences were medically excused.

Claimant's industrial problem began in September or October of 1983, when she began to experience pain and numbness in her arms. Claimant had worked as a grader in the employer's plywood mill for approximately one year. When her physician indicated that she needed a job with less arm motion, she was given lighter duty as a dryer feeder. Claimant performed her job as a dryer feeder until she was taken off work for two weeks in mid January of 1984. On January 17, 1984, Dr. Schwartz, claimant's attending physician, had reported that in view of claimant's persistent complaints, he believed claimant's condition represented a true thoracic outlet syndrome, and that "the first approach" would be to cease her work activity to determine whether there was any change in "the pattern of her aching." Thus, claimant remained off work until February 1, 1984 when Dr. Melson, another physician in Dr. Schwartz's office, released claimant to return to work and "continue light duty."

Claimant returned to work as a dryer feeder and worked from the first until the thirteenth of February. On February 14 she called in sick, stating that she had a recurrence of her bronchitis condition, or the flu. Claimant worked her regular shift on February 15. She came to work on February 16, and after working approximately one-half of her shift, she was called into the personnel office, and her employment was terminated for excessive absenteeism.

Claimant returned to Dr. Schwartz the following day, February 17, 1984. His office note of that day indicates that since her return to work, claimant had increasing difficulty with numbness and tingling in both upper extremities. Dr. Schwartz's office note continues:

> "I have explained to the patient that her symptoms do correspond to thoracic outlet syndrome and appear to be aggravated by the type of repetitive arm movement she is performing in her work. The symptoms seem to improve when she is not working at this job. I discussed with her the alternatives of referring her to a thoracic surgeon for possible surgical correction versus changing her job activities."

Claimant informed Dr. Schwartz on this date that her employment had been terminated "because of her continuing medical problems."

On or about April 10, 1984 Dr. Schwartz completed a physical limitations checklist indicating that claimant was capable of performing light work which did not require repetitive arm movement. He also indicated that claimant was capable of returning to work with the restrictions noted, and that the estimated medically stationary date was February 17, 1984, the date of his preceding examination.

On April 30, 1984, however, in response to claimant's attorney's inquiry, Dr. Schwartz reported, "I do feel that at the time of her examination on February 17, 1984, the patient was unable to return to work and should be authorized to receive lost compensation as of February 17, 1984." He explained that claimant had two alternatives to resolution of her medical problem. Since claimant appeared to be without symptoms when she was not working, he stated that one approach would simply be not to perform the job which had caused the condition to become symptomatic. Alternatively, claimant could submit to surgery, which involved removal of the first rib on both sides.

By letter of April 29, 1984 the insurer attempted to obtain Dr. Schwartz's clarification as to whether claimant was actually released to return to her job as a dryer feeder, or if the repetitive arm movements involved in that work were excessive. In a postscript, the claim representative inquired, "In the absence of surgery would you consider this worker to be medically stationary? If so, as of what date?" The record contains no response to this inquiry.

The insurer scheduled claimant for an independent medical examination with Dr. Tearse. He was asked to state his opinion concerning the diagnosis of thoracic outlet syndrome, the nature

and extent of permanent work restrictions, and whether claimant should be considered medically stationary in the absence of surgery. Although Dr. Tearse had examined claimant as of the hearing, there is no report of his examination in the record.

The hearing was held on May 15, 1984. Other than her recent examination by Dr. Tearse, claimant had not seen a physician since her last appointment with Dr. Schwartz on February 17, 1984. Nor was she scheduled to see him in the near future. The Referee found that claimant initially rejected the surgical option proposed by Dr. Schwartz, but that she is presently willing to submit to surgery. We believe claimant's testimony reflects that she remains undecided as to whether surgery is the best option to pursue.

The Referee analyzed this case by referring to our decisions in Gloria J. Bas, 36 Van Natta 175 (1984), and Thomas C. Harrell, 34 Van Natta 589 (1982). In those cases we utilized OAR 436-54-222, the administrative rule governing payment of temporary partial disability, to determine the respective claimants' entitlement to temporary disability benefits. In Harrell we held that the claimant was entitled to no temporary disability benefits after his employment was terminated based upon our conclusion that his behavior on a particular date constituted "'violation of normal employment standards' and that the employer was justified in terminating claimant's employment." 34 Van Natta at 591. See OAR 436-54-222(6)(b). In that case, the claimant had returned to modified work and was being paid a wage equal to his regular wage. Thus, that claimant's temporary partial disability rate was zero. See OAR 436-54-222(2).

In Bas we further analyzed the provisions of the administrative rule in light of SAIF's contention that subsections (3) and (4) applied, rather than subsections (5) and (6), to determine claimant's entitlement to temporary partial disability versus temporary total disability. In that case, the claimant had returned to part time work; therefore, she was receiving a portion of her regular wage, which was supplemented by temporary partial disability. Her employment was terminated as a result of a misunderstanding between her and one of her supervisors. We concluded that claimant had not been discharged as a result of her "violation of normal employment standards"; that the offer of part time employment had been withdrawn within the meaning of OAR 436-54-222(6)(b); and that, therefore, claimant was entitled to reinstatement of her temporary total disability benefits, rather than continued temporary partial disability. 36 Van Natta at 180.

These cases (Harrell and Bas) address the issue of a claimant's entitlement to temporary disability when the claimant returns to gainful employment during a period that he or she is not medically stationary and, for reasons not related to the industrial injury, the claimant's employment is terminated. Gloria J. Bas, supra, 36 Van Natta at 179. The distinguishing feature of this case is that claimant's injury-related condition became exacerbated as a result of her two week period of work activity. This is confirmed by claimant's testimony, as well as Dr. Schwartz's reports on and after February 17, 1984. Indeed, Dr. Schwartz indicated that claimant's condition was such that she was not capable of performing repetitive arm movements, and that she was unable to return to her employment as a dryer feeder at the time of her examination on February 17, 1984.

This case, therefore, is very different from Bas and Harrell, in which there was no evidence of a change in the claimants' injury-related medical condition as a result of their return to modified employment. For this reason, we find the analysis employed in those cases of little assistance in resolving the present dispute.

Instead, we find our decision in David Cheney, 35 Van Natta 21, 35 Van Natta 109 (1983), helpful. In that case, claimant was released to return to work after an extended period of recovery from his industrial injury. Claimant returned to work for a new employer and continued working for approximately five weeks, when he quit because of continuing physical problems. He returned to his attending physician, who subsequently verified that claimant was no longer able to continue working as a result of his compensable injuries, and that claimant was in need of further medical services. Claimant's physician also stated that claimant was entitled to temporary disability benefits. All of this occurred before the insurer was able to process the claim to closure through the Evaluation Division. The parties and the Referee apparently regarded claimant's request for time loss as a claim for reopening based upon a worsening of claimant's condition. We concluded it was more appropriate to characterize the issue as involving a request for reinstatement of temporary total disability benefits, which previously had been properly terminated when claimant returned to work. We held:

> "In this kind of situation, we think the better rule is: where there is a subsequent request for temporary disability arising from the same injury prior to claim closure, it is unnecessary for the claimant to prove a worsening of the compensable condition; it is sufficient to show that the circumstances that justified prior termination of time loss benefits (a release to return to regular work and/or actual return to work) no longer exist due in material part to the effects of the injury." 35 Van Natta at 22. (Emphasis in original.)

In this case, claimant had been taken off work for two weeks as a result of her chronic arm problems. During the period after she was released to return to work, and in fact did so, these problems recurred. Her physician indicated she could expect this to occur if she continued to engage in this type of work activity, and he subsequently reported that claimant was not capable of performing her work as a dryer feeder. Thus, although claimant had been released to return to light duty as a dryer feeder, her physician subsequently indicated that she was not capable of performing this work activity. While it is true that claimant's employment was terminated on February 16, 1984, for reasons unrelated to her industrial injury, it is equally true that her physician verified her inability to continue working in her modified capacity as of the following date. There is no evidence to contradict claimant's testimony, or the statements of her attending physician.

Admittedly, Dr. Schwartz's reports, particularly when read

together, are not a model of clarity; which is why we are in complete agreement with the Referee's refusal to impose a penalty/attorney's fee for alleged unreasonable claims processing. We find the insurer's conduct eminently reasonable. Cf. David Cheney, supra, 35 Van Natta at 24-25. Claimant asserts that the insurer's only options were to submit the claim for closure or continue payment of temporary total disability. This is simply wrong. See ORS 656.268(2); Jackson v. SAIF, 7 Or App 109 (1971). Claimant had been released to return to her work as a dryer feeder, and, in fact, had performed this work up until the date she was terminated for reasons unrelated to her injury. Dr. Schwartz's February 17, 1984 office note cannot be considered as reasonable notice to the insurer that the doctor was verifying claimant's inability to perform her work as a dryer feeder. The information he subsequently provided in the physical limitations checklist would only serve to confirm the insurer's reasonable belief that claimant's inability to continue working was due to the fact that she had been terminated, as opposed to reasons associated with her industrial condition. Finally, there is not a shred of evidence indicating that the insurer ever received Dr. Schwartz's April 30, 1984 letter to claimant's attorney. It is this report which constitutes the first arguably clear statement of claimant's inability to continue working as a dryer feeder, and it is this report which has formed the basis of our conclusion that claimant is entitled to reinstatement of temporary total disability as of February 17, 1984. In the absence of evidence indicating that the insurer received this report, we do not believe that any claim for imposition of penalties/attorney fees is justified.

ORDER

The Referee's order dated July 11, 1984 is affirmed. Claimant's attorney is awarded $400 for services on Board review in connection with the temporary disability issue, to be paid by the insurer.

BOBBIE L. MACKI, Claimant
Kenneth D. Peterson, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 82-10850
April 12, 1985
Order on Reconsideration

Claimant has requested that the Board reconsider its Order on Remand. The order granted claimant interim compensation from September 8, 1982 through November 5, 1982, assessed a penalty of 15% of the interim compensation due and not paid and awarded an insurer-paid attorney fee of $250. Claimant maintains that the insurer-paid attorney fee is inadequate.

Attorney fees, if appropriate, ORS 656.382(1), are awarded based upon the effort expended and the results obtained. OAR 438-47-010(2); Stephen L. Rennels, 36 Van Natta 1360 (1984). While we do not doubt that claimant's attorney expended considerable effort toward resolution of claimant's case overall, overall claimant lost. The only result obtained for claimant was approximately two months of interim compensation and a modest penalty. As we noted in our Order on Remand, because of the timing of the Supreme Court's decision in Bono v. SAIF, 298 Or 405 (1984), claimant's entitlement to interim compensation and a penalty in this case occurred more as a result of inaction by the insurer than action by the claimant or her attorney.

The request for reconsideration is granted. After reconsideration, we adhere to and republish our Order on Remand dated March 18, 1985.

IT IS SO ORDERED.

COY F. BOWEN, Claimant
Kilpatrick & Pope, Claimant's Attorneys
Keith Skelton, Defense Attorney

WCB 83-11642
April 16, 1985
Interim Order of Remand

Claimant has moved the Board for an order correcting the transcript of the hearing. We have reviewed claimant's request and find that the requested correction may be material to the outcome of our review. We are, however, without jurisdiction to rule upon claimant's motion. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 (1983); Muffett v. SAIF, 58 Or App 684 (1982). We, therefore, remand this case to Referee Howell to consider and rule upon claimant's motion. The Board retains jurisdiction over the request for review. The Referee is directed to complete his consideration and ruling upon the motion with 30 days. Upon issuance of the Referee's ruling, this case shall be returned to the Board for completion of the review process.

IT IS SO ORDERED.

KENNETH R. KASHUBA, Claimant
Doblie & McSwain, Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 84-06918
April 16, 1985
Order Denying Motion to Dismiss

The employer and its insurer have moved the Board for an order dismissing claimant's request for review of Referee Pferdner's order on the ground that the request was not timely served upon the insurer. The Referee's order was mailed January 25, 1985. On February 22, 1985 the request for review was delivered to the Board. Attached to it was a certificate stating that a true copy of the request had been mailed to the attorney of record for the employer and its insurer. No argument is made that the attorney did not receive the request or that the insurer has in any way been prejudiced. The motion to dismiss is denied.

IT IS SO ORDERED.

LaJUAN D. ALLEN, Claimant
Robert H. Grant, Attorney
Cowling, et al., Defense Attorneys

WCB 82-02652
April 18, 1985
Order on Remand

This case is before the Board on remand from the Court of Appeals. Allen v. Fireman's Fund Ins. Co., 71 Or App 40 (1984). The Board has been instructed to award the deceased claimant permanent total disability and an attorney fee for having obtained increased compensation and to calculate a penalty and attorney fee for suspension of payment of a 1975 permanent partial disability award.

The mandate does not specify the effective date of the deceased claimant's permanent total disability award, and the court's written opinion provides little assistance in that regard. We, therefore, look to the record.

The standard for determining the effective date of a

retroactive permanent total disability award is "the earliest date that claimant's permanent total disability is proved to have existed." Morris v. Denny's, 53 Or App 863, 867 (1981). See also Wilke v. SAIF, 49 Or App 427, 431 (1980). We find that the earliest date that all relevant medical, social and vocational factors combined to permit the legal conclusion that claimant was permanently and totally disabled was January 29, 1982. On that date claimant was examined by Southern Oregon Medical Consultants, who opined that it was doubtful that claimant would return to work due to the combination of his physical and psychological conditions. We find that there was no change in claimant's medical or vocational status between January 29, 1982 and the date of the hearing. That January 29, 1982 was the date claimant was declared medically stationary is only one element of our determination. See Albert D. Richey, 36 Van Natta 1580, 1583 (1984). Claimant is awarded permanent total disability as of January 29, 1982.

On the issue of attorney fees for increased compensation, claimant's attorney is awarded 25% of the increased compensation awarded by this order, not to exceed $3,000, payable out of and not in addition to claimant's compensation. See ORS 656.386(2); OAR 438-47-045; Morris v. Denny's, 53 Or App 863, 866; Zoi Sarantis, 36 Van Natta 1634 (1984).

The court has instructed us to award a penalty and associated attorney fee on account of the insurer's failure to pay the balance due on a permanent partial disability award granted by a June 17, 1975 Determination Order. That balance is $4,687.98 and was due and unpaid at the time of the hearing. See EBI Companies v. Thomas, 66 Or App 105, 111 (1983). The delay in payment was approximately seven years as of the hearing; however, the suspension in payment was pursuant to a then-existing standard practice in the industry which was not declared to be unreasonable until the Court of Appeals decision in Taylor v. SAIF, 40 Or App 437 (1979).

At the hearing in this case the Referee awarded a 10% penalty for a similar suspension in permanent partial disability benefits awarded by a 1977 Determination Order. That penalty was affirmed by the Board and the Court of Appeals. Although we are not bound by that percentage under the terms of the mandate, we note that claimant urged that the penalty be affirmed, and we take it as a benchmark. Claimant is awarded a penalty of 10% of the unpaid benefits due under the terms of the 1975 Determination Order. Claimant's attorney is awarded a fee of $400 in association with the penalty, to be paid by the insurer in addition to compensation.

IT IS SO ORDERED.

JUAN ALONZO, Claimant
Allen, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 81-09123
April 18, 1985
Order on Reconsideration

The employer has requested reconsideration of our Order on Review issued January 25, 1985. The request is granted. On reconsideration the Board adheres to and hereby republishes its previous order.

IT IS SO ORDERED.

THOMAS H. BOWEN, Claimant (Deceased) WCB 81-08859
Pozzi, et al., Claimant's Attorneys April 18, 1985
David Horne, Defense Attorney Order on Review
Reviewed by Board Members Ferris and Lewis.

The insurer requests review of that portion of Referee Leahy's order which awarded an attorney's fee in addition to compensation. Claimant's award for permanent total disability and claimant's widow's entitlement to benefits are not at issue on review. The issue on review is whether the attorney's fee should be paid out of compensation or in addition to compensation.

Claimant was compensably injured on September 24, 1969. He was granted an award for permanent total disability by Determination Order on April 3, 1975. This award became final by operation of law without a request for hearing by either party.

The insurer submitted a periodic report on claimant pursuant to ORS 656.325(3) and a Determination Order awarded 80° for 25% permanent partial disability on August 24, 1981. See OAR 436-65-200(2). Claimant requested a hearing on the extent of his permanent disability. The first hearing was held on May 11, 1982. The record was held open pending resolution of a motion by the insurer to obtain authorization to take depositions to perpetuate testimony of out of state witnesses. On August 13, 1982 the Presiding Referee entered an order denying authorization for the depositions. Before the hearing could be resumed, claimant died on February 14, 1983, of a brain tumor unrelated to his industrial injury. Claimant's widow filed a claim on February 24, 1983, and advised by attached letter that "under the statute she is now substituted for [claimant] in the current Request for Hearing and automatically would be entitled to widow's benefits under 656.208." The insurer denied the widow's benefits claim by letter of March 4, 1983, because claimant was not declared permanently totally disabled at the time of his death. On March 14, 1983 claimant's wife's request for hearing on the denial was received by the Board with a letter asking that the matter be consolidated with claimant's claim. The Presiding Referee held a telephone conference with the parties and on March 23 wrote the following letter under the claim number used for claimant:

> "It's my understanding [claimant] has passed away, and that [claimant's widow] has made a widow's claim that has been denied. Pursuant to our telephone conference of March 21, 1983, [claimant's widow] will be included as a party to this matter, and the case will be set for hearing in regular course."

Claimant's widow amended her hearing request to include her husband's claim number on her hearing request. On March 14, 1984 the insurer submitted divorce and property settlement documents to show that claimant's widow was not entitled to widow's benefits.

The hearing resumed on March 29, 1984 and the record was closed on May 3, 1984. The issues before the Referee were the extent of claimant's permanent disability and the status of claimant's widow. Although claimant had requested the hearing, the procedural burden was on the insurer to show that there had

been a change in circumstances since the award for permanent total disability because it was a redetermination of extent of disability. Harris v. SAIF, 292 Or 683 (1982), Bentley v. SAIF, 38 Or App 473 (1979), Allan Kytola, 37 Van Natta 15 (1985). Claimant's widow was substituted for her husband in the proceeding and was able to take advantage of this procedural burden and prevail on the issue of the extent of claimant's permanent disability for that reason alone. By statute and administrative rule, when claimant requests a hearing on the extent of permanent disability and prevails by obtaining additional compensation, claimant's attorney is allowed a fee out of the additional compensation awarded. Claimant's attorney should have been allowed 25% of the increased compensation payable to claimant subject to a maximum of $2,000, out of the additional compensation awarded. ORS 656.386(2); OAR 438-47-025; cf. ORS 656.382(2).

On the issue of the marital status of claimant's wife at the time of claimant's death, claimant's widow's attorney should not have been awarded a fee. While the issue of her marital status was an element of her claim, and claimant's widow had to prevail in each and every element of her claim, she does not thereby become entitled to an insurer paid fee for each element in which she prevails. An attorney's fee award is for prevailing on the claim, not for prevailing on an element of the claim. The insurer did not deny that claimant's widow was the wife at the time of death, although it did present evidence to cast doubt on that finding. There was no denial that claimant's widow was the wife at the time of death, the insurer merely insisted that claimant's widow prove her case. That is not a denial whose overturning entitled claimant's attorney to a fee. Claimant's widow had to prove her status as the wife at the time of death regardless of the underlying claim of right.

Claimant's widow argues that her right to compensation is independent of her husband's claim and cites Fossum v. SAIF, 289 Or 777 (1980) and Mikolich v. State Ind. Acc. Com., 212 Or 36 (1957). Fossum was a surviving spouse's death benefits claim under ORS 656.807 for the death of a worker due to occupational disease. The court found that a surviving spouse has an independent right to compensation in the context of death of a worker due to asbestos-related disease. Mikolich was a surviving spouse's claim for benefits under ORS 656.208 after the worker's death while permanently totally disabled before a determination of any permanent disability had been made. The court held that the surviving spouse had the same right as claimant to obtain an adjudication of extent of permanent disability and that the surviving spouse's right was independent of claimant's.

We find that claimant's widow pursued a right to compensation under two claims of right: (1) by taking her husband's place in his litigation, and (2) by making her own claim for benefits. She did prevail on her husband's claim and therefore her attorney's fee award should have been made out of the additional compensation awarded by the Referee. She did not prevail on her independent claim for benefits and thus did not overturn the insurer's denial and is therefore not entitled to an insurer paid attorney's fee on that theory. If she had a right to and did pursue her own independent claim, then the burden would have been on her as the claimant to prove that her husband was permanently totally disabled at the time of death. Mikolich, supra; accord, Bradley

v. SAIF, 38 Or App 559, rev. den. 287 Or 123 (1979); cf. Mayes v. Boise Cascade Corp., 46 Or App 333, rev. den. 289 Or 373 (1980); Charlie W. Owen, 36 Van Natta 1216 (1984).

Claimant's widow argues that an attorney's fee award in addition to compensation is required by the decision in Teel v. Weyerhaeuser, 294 Or 588 (1983). In that case, the court held that "the party responsible for bringing the issue before the court . . . initiated the appeal within the meaning of ORS 656.382(2)." In this case, claimant brought the issue of extent of permanent disability before the Referee by requesting a hearing on a Determination Order. There is no evidence that the insurer initiated the hearing request or raised any issue except the marital status of claimant's wife at the time of claimant's death. No fee should have been awarded for prevailing on the issue of claimant's wife's marital status, and the fee award for increasing claimant's award from 80° for 25% unscheduled permanent disability to permanent total disability should have been limited to 25% of the increased compensation awarded up to a maximum of $2,000.

ORDER

The Referee's orders dated May 17, 1984 and June 20, 1984 are reversed in part, modified in part, and affirmed in part. The insurer's denial of March 4, 1984 is affirmed. Claimant's widow's attorney is allowed 25% of the additional compensation granted by the Referee's order, not to exceed $2,000, to be paid out of compensation and not in addition to compensation. The remainder of the orders are affirmed.

MICHAEL R. EWING, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 82-05440
April 18, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Seymour's order which: (1) awarded an additional 32° (10%) unscheduled disability on review of Determination Orders dated June 14, 1982 and March 19, 1984, which awarded 32° (10%) and 48° (15%) unscheduled disability respectively, thereby granting a total unscheduled award of 112° (35%) for injury to claimant's low back; (2) awarded 30° scheduled disability for 20% loss of use or function of the right forearm; and (3) declined to award any temporary disability in addition to that awarded by the above-mentioned Determination Orders.

Claimant contends that he is entitled to additional permanent partial disability, scheduled and unscheduled, as well as additional temporary total disability.

Claimant appears to advance a premature closure theory in support of his time loss claim vis-a-vis the June 14, 1982 Determination Order. The insurer objects, asserting that claimant did not argue premature closure before the Referee. See EBI Companies v. Thomas, 66 Or App 105 (1983); Mavis v. SAIF, 45 Or App 1059 (1980); Richard Pick, 34 Van Natta 957 (1982). Even if we were to consider the time loss question as a premature closure issue -- whether claimant's condition was other than medically stationary at the time of claim closure -- we would hold that

claimant has failed to establish his burden of proof in this regard. As to the related question of claimant's entitlement to additional temporary total disability beyond the termination date established by the Determination Order, we affirm and adopt the relevant portions of the Referee's order.

With regard to the remaining issues of additional temporary total disbility in connection with the March 19, 1984 Determination Order, scheduled and unscheduled disability, we affirm the Referee's order.

ORDER

The Referee's order dated September 24, 1984 is affirmed.

STEPHANIE A. GRIMSLEY-BRUNI, Claimant
Evohl F. Malagon, Claimant
SAIF Corp Legal, Defense Attorney

WCB 83-03880
April 18, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Baker's order which set aside its denial of claimant's request for authorization of a proposed laminectomy and diskectomy under ORS 656.245. Claimant cross-requests review of the attorney fee award. The issues on review are the compensability of proposed surgery and the amount of the attorney's fee.

Claimant compensably injured her back on September 14, 1981. She entered into a disputed claim stipulation, signed by Referee Foster on June 7, 1982, and her claim was closed by Determination Order of July 7, 1982, with no award of permanent disability. She continued to obtain treatment and evaluations under ORS 656.245 and entered into another disputed claim settlement for payment of those bills which was signed by Referee McCullough on January 19, 1983. By this time, claimant had been examined by at least ten doctors, including radiologists, who had all agreed that claimant's back problem was muscular not neurological. Drs. Mundall and Serbu specifically opposed myelography as contra-indicated by claimant's symptomatology and functional overlay. A CT scan was performed on December 16, 1981 and the radiologist's report, in its entirety, stated:

> "Transverse images from L3 through S1 with additional images of the L4-5 and L5-S1 disc level show 1+ to 2+ posterior midline bulging of the lumbosacral disc without significant impingement on the thecal sac or adjacent nerve roots. Although a small herniation might produce this appearance, I can't see any objective evidence that this is a clinically significant lesion. The rest of the study looks quite normal.
>
> "IMPRESSION: Mild midline bulge of the lumbosacral disc of equivocal clinical significance."

We adopt the following findings of the Referee:

> "On December 21, 1982 Dr. Matz referred claimant to Dr. Donald T. Smith, a neurological surgeon, for evaluation including a myelogram requested by SAIF.

"Dr. Smith first examined claimant on January 23, 1983. He interpreted the CT scan of December 16, 1981 as showing a very distinctive central disc protrusion at the L5-S1 level. He recommended a myelogram, and perhaps a discogram, because he believed the correct diagnosis was probable central disc protrusion associated with the work injury of September 14, 1981. Claimant was hospitalized by Dr. Smith for a myelogram on Feburary 8, 1983. Myelography demonstrated inadequate filling of the S1 and S2 roots on the left as compared to the right, which was consistent with the claimant's pain problem and the fact that she might have a central type discal protrusion. The radiologist concluded that the myelogram showed changes compatible with a lateral herniated nucleus pulposus at L5-S1 on the left. On February 9, 1983, Dr. Smith did a diskogram which showed a posterior extravasation pattern consistent with a central type diskal protrusion/herniation. Dr. Smith felt this was a very positive diskogram, with reduplicated pain elaboration as well as the extravasation of the contrast medium in a central manner. The radiologist concluded that there was a posterior escape of the contrast compatible with an abnormal disc. In the discharge summary Dr. Smith stated at one point that the myelogram was considered to be probably a negative study, although there was considerable space between the posterior aspect of the vertebral bodies and the caudal sac. He noted that the diskogram showed posterior extravasation of the contrast material. The final diagnosis on discharge was lumbar herniated disc at L5-S1.

"On February 21, 1983 claimant was hospitalized by Dr. Matz after she slipped and exacerbated her back. His assessment was documented herniated disc at the L5-S1 level, now increasingly symptomatic."

Dr. Smith scheduled claimant for L5-S1 laminectomy and diskectomy. SAIF invoked the provisions of OAR 436-69-501 and requested an independent medical evaluation by Dr. Rosenbaum. Dr. Rosenbaum reviewed the medical records, examined claimant and recommended against surgery. SAIF asked Dr. Smith to arrange with Dr. Rosenbaum for a third opinion. Dr. Smith suggested five doctors, one of whom was Dr. Mason. Dr. Mason reviewed the medical records, examined claimant, and recommended against surgery. Dr. Smith disagreed with both recommendations and again requested authorization for surgery. Dr. Rosenbaum reviewed Dr. Mason's report and concurred with his recommendation against surgery. SAIF apparently denied authorization for the surgery.

Claimant then requested a hearing. Claimant was the only witness at the hearing. Her testimony was consistent with the statements in the documentary record. There is no later evidence in the file. There has been no motion to remand to the Hearings Division for submission of newly developed evidence. Claimant's motion to include additional evidence in the record on review was denied by Board order on October 11, 1984, under ORS 656.295(5).

Under ORS 656.245, the insurer is required to provide "medical services for conditions resulting from the injury for such period as the nature of the injury or the process of recovery requires. . . ." Medical services must be reasonable and necessary, and the necessity must result from the compensable injury. Poole v. SAIF, 69 Or App 503 (1984); McGarry v. SAIF, 24 Or App 883 (1976); see Bowser v. Evans Product Company, 270 Or 841 (1974); Wait v. Montgomery Ward, 10 Or App 333 (1972). Claimant is free to choose to go ahead in the face of overwhelming opinion that the proposed course of treatment is not necessary, but the insurer is not liable for payment for medically unnecessary services. McGarry v. SAIF, supra. The Referee held that the worker's right of free choice in treating physician "includes the right to the treatment prescribed by that doctor except in the most unusual circumstances."

We previously discussed the issue of the necessity of proposed back surgery in James L. Saleen, 35 Van Natta 621 (1983). There is a striking similarity in the facts and the legal issue:

> "The determination of this issue turns on whether surgery in relation to claimant's protruding disc at L4-5 will decrease his headaches, neck pain and low back pain. Claimant's present treating physician believes it might, but numerous other physicians who have examined or treated claimant believe that the proposed surgery will do nothing for claimant."

In denying compensability of the proposed surgery, the Board concluded:

> "While we generally defer to the treating physician where the issue is the propriety of a proposed course of treatment, ... the medical evidence in this case greatly preponderates in favor of a conclusion that claimant's residual discomfort from the injury will not be reduced by the proposed surgery." (Citation omitted.)

We decline to oppose the overwhelming weight of medical opinion on this record. Therefore, that portion of the May 30, 1984 order of the Referee that ordered the SAIF Corporation to provide the back surgery prescribed by Dr. Smith is reversed.

Because we reverse the finding of compensability of the proposed surgery, and reinstate the insurer's denial, there is no entitlement to an attorney's fee, and that portion of the Referee's order is also reversed.

ORDER

The Referee's order dated May 30, 1984, is reversed and the SAIF Corporation's denial of compensability of the proposed surgery is reinstated.

DENNIS L. HANKINS, Claimant
David Force, Claimant's Attorney
Schwenn, et al., Defense Attorneys

WCB 83-10401
April 18, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Fink's order which set aside its denial of claimant's aggravation claim for a low back injury. On review, the insurer contends the claim is not compensable. We agree and reverse.

Claimant was 38 years of age at the time of hearing. In May 1983 he sustained a compensable injury when he slipped, twisting his back. Claimant sought immediate treatment from Dr. Bachhuber, orthopedist, who diagnosed lumbar strain. Dr. Bachhuber noted left lumbar pain and S1 tenderness, as well as questionable right calf muscle tenderness and questionable left hypesthesia. X-rays were normal.

For the following two months claimant received conservative treatment from Dr. Bachhuber on approximately five occasions. The doctor's chart notes indicate that claimant complained that his legs felt weak and numb. One chart note states that claimant had some left leg complaints, but no major complaints. The claim was closed by Notice of Closure with approximately two weeks of time loss and no permanent impairment.

Claimant had suffered a previous low back injury in December 1977. Dr. Kai, osteopath, had diagnosed lumbar and lumbosacral strain and administered conservative treatment on an intermittent basis from December 1977 through April 1980. In February 1978 and August 1978 chart notes, claimant complained of left lumbar spasms. In a March 1979 chart note claimant's right leg felt "tingling like it is asleep." An April 1980 chart note states as follows: "I'm about 100% better still have to use crutches cause I can be going on and suddenly my legs just go out from under me." From April 1980 until claimant's May 1983 injury claimant sought no medical treatment for his low back.

In June 1983 claimant returned to his pre-injury employment as a vinyl applicator for a manufacturing company. He was laid off in July 1983. Claimant, his wife, his father-in-law and his neighbor testified that during this time claimant exhibited right leg symptoms. Claimant characterized his symptoms as weakness and numbness. He dragged the leg and had to lift it with his hands in order to climb stairs. These symptoms caused claimant's relatives to attempt to dissuade him from driving to Alaska in search of employment. However, in August 1983 claimant traveled to Alaska, riding in a car driven by his nephew.

In Alaska claimant worked for approximately five weeks. The first three weeks he was assigned work as a framer. Initially the work was relatively light. After working "probably four days," claimant experienced a "throbbing charlie-horse type feeling" in

his mid-back. The pain gradually spread into his right leg. However, claimant continued to work until his lifting requirements increased his pain to the point he was unable to perform his duties as a framer. For the final two weeks claimant performed lighter work as a finish carpenter. His right leg pain continued, prompting his return to Oregon in mid-October 1983. Claimant testified that while in Alaska he did not experience any incident, episode or accident which precipitated these increased pain complaints.

Claimant returned to Dr. Bachhuber, who noted that claimant's right leg pain began while claimant was working in Alaska. Dr. Bachhuber further noted that, "Since patient initially went to VA hospital it would seem that he did not think this was related to his prior industrial injury at the time." A CT scan revealed a disc protrusion at L5-S1, centrally and to the right, and a central disc bulge at L4-5.

In November 1983 claimant sought treatment from Dr. Smith, neurosurgeon, who performed a discectomy. Dr. Smith testified via deposition that claimant's October-November 1983 condition was related to his May 1983 injury. From Dr. Bachhuber's records, Dr. Smith concluded that claimant did experience right-sided complaints at the time of the May 1983 injury. Moreover, Dr. Smith felt that it was not necessarily significant that claimant had no right side complaints initially. The chronology of claimant's symptoms suggested to Dr. Smith that claimant was initially experiencing left-side symptoms which were indicative of the lumbar strain-sprain pattern and, as those symptoms subsided, claimant's right side symptoms increased, indicating the progression of the nerve root problem caused by the central disc protrusion. Dr. Smith conceded that a central disc problem is less common, but he professed that a shift in symptoms was a "fairly frequent situation," particularly in central disc herniations. Based on the medical history preceding claimant's May 1983 injury, it was Dr. Smith's opinion that claimant "very well would have ended up . . . with some back disease and discal disease." However, the doctor concluded that the May 1983 injury was a material contributing factor in causing claimant's herniated disc.

Dr. Bachhuber issued a report and testified via deposition. In Dr. Bachhuber's opinion claimant's right lower lumbar condition was not related to claimant's May 1983 injury. The primary basis for the doctor's opinion rested on the change of claimant's symptoms. At the time of the May 1983 injury claimant's symptoms were on the left, but while claimant was in Alaska, the symptoms became right-sided. Dr. Bachhuber conceded that, on an infrequent basis, he had seen in disc herniation cases a change of symptoms from one side to the other. However, the doctor concluded that claimant's initial left side complaints could not have been caused by the large, central disc herniation due to the anatomy in the L5-S1 area. If the herniation had caused left side symptoms in May 1983 other physiological symptoms would also have been expected. These other symptoms had not appeared.

Claimant testified that he has experienced lower back pain since the May 1983 injury. He still has numbness in the right leg, all the way to the foot. His left leg is getting better. Claimant's symptoms from his 1977 injury were different in that

they were located in his mid-back area. Claimant and his wife testified that he never experienced radiation, pain nor numbness in his legs following the 1977 injury. Claimant contended that his use of crutches in 1980 was not prescribed treatment for his back or leg problem. Claimant recalled that Dr. Bachhuber gave him a pain shot over the right hip during claimant's initial examination in May 1983. Dr. Bachhuber disagreed, testifying that he recalled administering the injection on the left-side, below the belt line at the sacroiliac joint.

Having "no reason whatsoever to question his credibility," the Referee concluded claimant was a credible witness. The Referee further noted that Dr. Smith had stated that claimant was a very straightforward historian. Concluding that Dr. Smith's opinion was more persuasive than Dr. Bachhuber's, the Referee found the aggravation claim compensable.

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. ORS 656.273(1). In order to sustain his burden of proof, claimant must establish by a preponderance of evidence that his condition is worse and that the worsening is causally related to his compensable injury. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984).

We are not persuaded that claimant's herniated disc condition was related to his compensable low back injury. Consequently, we find that claimant has failed to establish the compensability of his aggravation claim.

Contrary to the Referee's conclusion, we do not find Dr. Smith's explanation to be more persuasive than that of Dr. Bachhuber's. Both opinions provide equally cogent, reasonable and plausible explanations for the relationship between the compensable injury and the herniated disc. With the opinions on this complex medical issue in equipoise, it follows that claimant has failed to meet his burden of proof. See Eugene R. Jones, 36 Van Natta 1517 (1984). Moreover, we tend to accord slightly greater weight to the opinion of Dr. Bachhuber, the physician who had observed claimant at both pertinent dates, May 1983 and October 1983. See Faye L. Ballweber, 36 Van Natta 303, 304 (1984). When claimant's prior back and leg complaints are also considered, along with the physical duties of his intervening employment in Alaska, the lay evidence, particularly claimant's credible testimony, is insufficient to establish the compensability of his claim for aggravation.

ORDER

The Referee's order dated September 18, 1984 is reversed. The insurer's denial dated November 9, 1983 is reinstated and affirmed.

SANDRA J. HUBBARD, Claimant
Cummins, et al., Claimant's Attorneys
Alice Bartelt, Defense Attorney
Lindsay, et al., Defense Attorneys

WCB 82-04524 & 82-01681
April 18, 1985
Order on Remand

This case is before the Board on remand from the Supreme Court. Hubbard v. Imperial Fabrics, 298 Or 552 (1985)(Per Curiam). The Board has been instructed to reconsider the case in light of Bono v. SAIF, 298 Or 405 (1984). The Court of Appeals had reversed the Board in part and remanded for an award of interim compensation, penalty and attorney fees under its Bono case.

In Bono v. SAIF, supra, the Supreme Court held that an injured worker is entitled to temporary total disability as interim compensation if the worker "left work as that phrase is used in ORS 656.210(3)." 298 Or at 410. We look to the record to determine whether claimant lost time from work due to her alleged injury.

Claimant testified, "I think I missed around five days." The Court of Appeals noted after its review of the record, "Although the evidence is inconclusive, it appears that claimant may have missed five days of work, but not consecutively, between December 7, 1981, and January 15, 1982, when she was terminated." Hubbard v. Imperial Fabrics, 69 Or App 687, 691 n.3 (1984) (Emphasis added). We view these statements as too speculative upon which to base an award of compensation under Bono v. SAIF, supra. We also find that claimant was terminated on January 19, 1982, not January 15, 1982.

We do not read the Supreme Court's mandate as requiring us to reconsider any other issues addressed in our prior order. See Sandra J. Hubbard, 35 Van Natta 1566 (1983).

ORDER

Upon reconsideration we adhere to and republish our Order on Review dated October 13, 1983.

PETER G. JAYROE, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-01895
April 18, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee T. Lavere Johnson's order which awarded claimant 30% (96°) unscheduled permanent disability for a left shoulder and back injury. An April 9, 1984 Determination Order had awarded no permanent disability. On review, SAIF contends the permanent disability award should be reduced. We agree and modify the Referee's order.

Claimant was 30 years of age at the time of hearing. In May 1983, while working as a "chaser" for a logging company, claimant slipped and fell, landing on his left hip and shoulder. His treating chiropractor, Dr. Kelley, diagnosed his condition as "moderate lumbar sprain/strain with muscle spasms. Severe anterior shoulder girdle muscle strain with acromioclavicular joint disfunction [sic]." Dr. Kelley subsequently noted that

claimant experienced a shoulder dislocation, as well as joint instability resulting from the injury.

In May 1983 claimant was examined by Dr. Blake, orthopedist, on referral from Dr. Kelley. Dr. Blake diagnosed acute subacromial bursitis of the left shoulder and mild cervical strain. The doctor noted that claimant had full range of motion and painless subacromial popping. Dr. Blake opined that claimant could return to work in approximately two weeks with no restrictions.

Claimant returned to Dr. Blake in December 1983. Noting that there had been no change in claimant's condition over the past six months, Dr. Blake concluded that claimant's condition was medically stationary. Dr. Blake amended his previous opinion, stating that claimant could not return to his job as a logger, but could engage in modified work.

In December 1983 Dr. Kelley rated claimant's permanent "residuals." Based on claimant's reduced range of motion findings for his left shoulder, the doctor concluded that claimant's upper extremity disability equalled 17%. When the left shoulder's joint instability and claimant's low back stiffness and pain were considered, Dr. Kelley opined that claimant's total amount of "permanent disability" approximated 25%. Dr. Kelley recommended that claimant refrain from returning to the woods or to his previous occupation. In the hopes of improving the left shoulder's stability, Dr. Kelley referred claimant to Dr. Keizer, an orthopedist.

For the following two months, claimant apparently received various modes of conservative treatment from Dr. Keizer and a licensed physical therapist. In March 1984 Dr. Keizer reported that claimant was medically stationary and released him to regular work. In Dr. Keizer's opinion, claimant suffered no permanent impairment.

In March 1984 claimant was examined by the Orthopaedic Consultants. Claimant's range of motion in the left shoulder was full except for a 10° decrease for external rotation. The Consultants noted mild tenderness in the shoulder and some crepitation with abduction. Palpation about the neck and upper back elicited some tenderness in the left suboccipital area. However, the Consultants noted no cervical spine tenderness nor muscle spasms. In the Consultants' opinion claimant suffered no residual neck impairment and minimal left shoulder impairment.

In April 1984 a Determination Order issued. Claimant was awarded no permanent disability.

At Dr. Kelley's request, claimant was examined by Dr. Poulson, an orthopedist. Noting "obvious crepitus and crunching" when moving the left shoulder, Dr. Poulson proposed surgery to remedy claimant's repeated dislocations. In May 1984 Dr. Poulson opined that the surgery was needed before claimant could return to work.

Dr. Blake reviewed the reports of Orthopaedic Consultants and Dr. Poulson. Dr. Blake advised that he was "in total agreement" with the Consultant's report. Stating there was "absolutely no indication" of shoulder instability, Dr. Blake disagreed with Dr. Poulson's recommendation for surgery. Dr. Blake continued to feel

that claimant's condition was medically stationary and that he should return to the job market.

In July 1984 Dr. Kelley reported that claimant could not be considered medically stationary as long as the proposed surgery was not performed. Considering claimant's present status, Dr. Kelley restricted claimant to light to medium work and a 35- to 50-pound weight limitation.

The matter proceeded to hearing. The sole issue contested at hearing was the extent of permanent disability.

Claimant credibly testified that, since his compensable injury, he has experienced chronic symptoms which include neck and upper back pain, with periodic muscle spasms and restrictions of motion. He suffers from left shoulder pain, weakness and instability, which restricts the motion of both his shoulder and arm. Claimant also experiences left hip and leg pain, as well as periodic headaches. These symptoms fluctuate, depending upon the amount of claimant's activity. Claimant is limited in his ability to engage in activities which involve heavy lifting, the overhead use of his left arm and shoulder, ascending or descending rough terrain, and prolonged walking. Since the injury claimant has also curtailed his recreational activities, such as boxing, swimming and competitive motocross racing.

At the time of hearing claimant had recently returned to work for another employer as a timber faller and bucker. Claimant testified that his return to the woods was contrary to Dr. Kelley's advice, but that his financial situation necessitated his decision. Claimant has a tenth grade education and no GED. He is right-handed. His past work experiences have all involved physical labor. In addition to his experience in the lumber industry, claimant has worked as a mechanic/motorcycle assembler and as an installer of trailer house awnings. He has also operated logging equipment.

We are persuaded that claimant has suffered permanent impairment and a permanent loss of earning capacity due to the compensable injury. Consequently, he is entitled to an award of unscheduled permanent disability. However, we find the Referee's award of 30% 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 disabling pain, in rating the extent of claimant's disability. After completing our de novo review, including claimant's credible testimony regarding his pain and physical limitations, and considering the above guidelines, we conclude that an award of 10% unscheduled permanent disability would more appropriately compensate claimant.

ORDER

The Referee's order dated August 21, 1984 is modified. In lieu of the Referee's award, claimant is awarded 10% (32°) unscheduled permanent disability, which represents the total award for his compensable injury. Claimant's attorney's fee shall be adjusted accordingly.

WILLIAM D. LEWIS, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-11679
April 18, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Seymour's order which set aside its denial of claimant's aggravation claim and awarded temporary disability compensation. SAIF contends that claimant's compensable condition has not worsened since the last arrangement of compensation. It further contends that interim compensation benefits are not due because claimant had permanently left work due to his noncompensable heart condition before the alleged aggravation.

Claimant, a truck driver, was compensably injured on October 20, 1981 when he slipped on a battery case that he was using as a step to clean the windshield on his truck and landed on his right heel. Claimant had had a myocardial infarction in 1964. He had experienced shortness of breath and chest pain with exertion since, but felt that this had never really bothered him on his job. At the time of the injury he had worked with the same employer over 20 years.

Dr. Degge examined claimant on September 27, 1982. Claimant then complained of fairly constant low back aching, with radiation to the right leg after being up over fifteen minutes. Claimant reported numbness and tingling in the right thigh, calf and two toes, with periodic calf cramps. He also noted recurrent urinary and rectal incontinence. Dr. Degge stated that a cardiologist, Dr. Hawn, had recently declared claimant totally disabled from any gainful employment due to his cardiac status. Dr. Degge opined that claimant was stationary, rating loss of lower back function due to the injury as moderate, but overall low back impairment as moderately severe due to congenital defects and exogenous obesity.

In September 1982 the employer asked Dr. Degge's opinion as to whether claimant could perform a special light duty job that it intended to create for claimant. The job was to have required that claimant sit or stand in a heated, furnished, spacious office, observe yard traffic, make reports by phone and keep a log book. The office was to be equipped with a comfortable chair and bed. No stooping, twisting, lifting, prolonged standing, sitting or walking was to be required. Claimant was to be free to take breaks as needed and work as few hours as necessitated by his physical status. The employer offered to make any modifications Dr. Degge felt necessary. Dr. Degge responded on October 14, 1982 as follows:

> "Patient could return to such duties as far as his back problem is concerned, however, it appears that his heart condition would preclude any type of employment at this time."

The last arrangement of compensation was a May 17, 1983 stipulated order bringing claimant's total award to 240° for 75% unscheduled disability.

Claimant's treating doctor, Dr. Floyd, wrote on November 16, 1983 that on September 12, 1983 claimant reported increased back pain and leg numbness. The doctor diagnosed an exacerbation of claimant's chronic low back strain and prescribed medication, heat and rest. Claimant was subjectively only a little better on September 26, 1983. Dr. Floyd reported that claimant was asked to call in three weeks regarding his progress. Because he had not heard from claimant, he assumed that claimant was the same or better. Dr. Floyd assumed that the worsening was related to the compensable incident based on the fact that claimant had no significant back problems before the incident.

Dr. Degge reexamined claimant on February 28, 1984. He opined that objectively and subjectively claimant was no worse since February 1982. He explained that claimant has spondylolysis, which produces variations in symptoms with activity. Dr. Degge could not recall asking claimant if he felt he was worse. The doctor stated, however, that dependence on subjective complaints in this case would probably be inaccurate due to claimant's dependent personality disorder.

Based on Scheidemantel v. SAIF, 68 Or App 822 (1984) and Oakley v. SAIF, 63 Or App 433 (1983), SAIF contends that claimant has failed to prove an aggravation because he has not shown by medical evidence a worsening of his underlying condition. SAIF's reliance on Scheidemantel is misplaced, see Scheidemantel v. SAIF, 70 Or App 552 (1984), and the Oakley requirement of medical evidence has been expressly rejected by the Supreme Court, Garbutt v. SAIF, 297 Or 148, 151 (1984).

We find Dr. Degge persuasive that claimant has not worsened since the last arrangement of compensation. Claimant has been awarded 75% unscheduled disability. When a person receives a substantial disability award, it is generally to be expected that that person will have pain in the injured portion of the body. See Kenneth L. Elliott, 36 Van Natta 1141 (1984). The symptomatic fluctuations claimant has experienced were also to be expected and do not require reopening of the claim. See Russell Hildebrandt, 34 Van Natta 510 (1982).

We next consider whether claimant should have received interim compensation. Interim compensation is appropriate only where a claimant leaves work as a result of the allegedly compensable condition. Bono v. SAIF, 298 Or 405 (1984). SAIF received the aggravation claim on or about December 12, 1983, but did not issue its denial until February 16, 1984. Since well before the alleged aggravation, however, claimant was totally disabled from employment as a result of his preexisting noncompensable heart condition. Because claimant was already totally disabled, no further loss of work was possible. Accordingly, no interim compensation was due.

ORDER

The Referee's order dated September 17, 1984 is reversed. The SAIF Corporation's February 16, 1984 denial is reinstated and affirmed.

RONALD D. McCARTY, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-01350
April 18, 1985
Order Denying Dismissal

Claimant has moved the Board for an order dismissing the employer's request for review of Referee Galton's order on the ground that post-hearing publicity involving claimant's case has prejudiced claimant's ability to obtain impartial review of his claim. We find that such publicity as there was did not involve, was not directed at, and had no effect upon any person charged with making a decision on the merits of claimant's request for review. The motion is denied.

IT IS SO ORDERED.

GARY A. SPRAGUE, Claimant
Evohl F. Malagon, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 84-08039
April 18, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of that portion of Referee Seymour's order which upheld the insurer's denial of compensability of his ischiorectal abscess condition. The insurer cross-requests review of that portion of the order which found claimant's coccygeal pain was compensable. The issues on review are compensability of claimant's coccygeal pain and ischiorectal abscess.

Claimant was driving his employer's truck on May 22, 1984 when he stopped to tighten the load. In the process of tightening the binders, he claims he slipped and fell, hitting his tailbone on the trailer. He continued on his trip, stopped overnight at home, then picked up his employer on May 23 and they continued to the unloading stop. Claimant alleges that he reported the fall to his employer at that time. On May 24, 1984 claimant consulted his family doctor about a sore tailbone. The doctor diagnosed acute coccydynia and recorded there was no evidence of an abscess. Analgesics and sitz baths were prescribed. Claimant consulted the doctor approximately weekly for a month, did not seem to improve and then told the doctor he was going to consult a chiropractor. There is no evidence that claimant did consult a chiropractor, but he was eventually referred to a surgeon who diagnosed an abscess and performed surgery in July 1984.

Claimant's family doctor reported his finding of acute coccydynia and related it by claimant's history to the fall on the truck. He also opined that it was more likely than not the fall and subsequent pain led directly to the formation of the abscess. The physician who performed the surgery opined that claimant's abscess was unrelated to any trauma and specially commented in both his pre-surgical workup and his later opinion that the alleged fall in May was non-contributory. We agree with the Referee that claimant has not proven by a preponderance of the evidence that the abscess was a compensable result of a compensable injury.

The Referee also found that claimant suffered a compensable injury to his tailbone. The evidence in favor of that finding was claimant's testimony. The evidence against that finding was an inconsistent driver's time log, testimony of a fellow employe, testimony of the employer and inconsistencies in the evidence when

compared with claimant's testimony. The inconsistencies in the log are not persuasive. The fellow employe was found not credible based on demeanor at hearing, and we are not inclined to disturb that finding. Miller v. Granite Construction Co., 28 Or App 473 (1977).

The Referee made no credibility finding on the testimony of the employer and claimant; therefore, we must weigh their testimony based on the record alone. See, Davies v. Hanel Lbr. Co., 67 Or App 35 (1984). Claimant testified that he fell while tightening his load binders and hit his tailbone on the edge of the trailer as he fell to the ground. He continued driving from the California border to Eugene, stopped overnight, then picked up his employer and continued on to Brownsville where they unloaded the trailer, then returned to Eugene where claimant worked on the truck. The employer denied that claimant told him about the fall at that time. Claimant was aware that this trip completed his work for this employer. The next day claimant went to his doctor. Given the alleged mechanism of injury, the interim activities of driving to Brownsville, unloading the truck after the alleged fall and the return trip to Eugene, we are not persuaded that claimant was injured by a fall in the course of his employment. Therefore, we reverse the Referee's finding that claimant suffered a compensable traumatic injury to his tailbone.

ORDER

The Referee's order dated October 22, 1984, is affirmed in part and reversed in part. That part of the order which set aside the insurer's denial of the coccydynia claim and awarded an associated attorney's fee is reversed. The remainder of the order is affirmed.

ANNA M. ADSITT, Claimant
Francesconi & Cash, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-02227
April 23, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The employer and the SAIF Corporation request review of Referee Galton's order which set aside SAIF's denial of claimant's occupational disease claim for adult situational stress reaction characterized by situational depression. SAIF also cites as error the Referee's failure to order the treating psychologist to release his chartnotes generated before January 1984. Because of our decision in this case, other issues raised by SAIF and the employer on review are not discussed in this order. The issues on review are compensability and SAIF's entitlement to medical records.

Claimant was hired by the employer, a municipal public utility, in 1979 as a billing clerk. She worked in an office with the office manager and the supervisor of operations of the utility. Other employes passed through the office and customers occasionally came to the office, but claimant worked primarily with the office manager and the supervisor. Claimant quit her job on August 16 effective August 26, 1983. By order of the Employment Appeals Board dated December 21, 1983, claimant was found to have quit her job without good cause. Sometime during December 1983, claimant's husband was injured at work and was disabled. In January 1984 claimant began treatment with a psychologist, Dr. Cooley, and filed her occupational disease claim.

Claimant's treating psychologist had treated claimant's family for problems relating to her son and his school from 1981 through March 1983. Claimant refused to release the records of that period of treatment based on a privilege asserted on behalf of the son who was the focus of treatment at that time and the Referee was persuaded by claimant at hearing to exclude those records. SAIF asserted that the privilege was waived on three grounds: (1) by making the claim; (2) the records were not privileged because it did not seek the records of treatment of a non-party but only those admissions made by claimant who was not the patient; and (3) that the statements it sought were not made within the privileged doctor-patient relationship because they were made before a group of people who had no privileged relationship with claimant. We infer from the positions of the parties that claimant considers the records unnecessary to carry her burdens of proof and persuasion. We find that the Referee acted within his discretion in this case and that the record is sufficiently and appropriately developed. See ORS 656.295(5). Decisions regarding release of medical records in occupational disease claims for work-related stress conditions, in which statements made in group therapy sessions for conditions or patients not related to a claimant's work are sought for admission as evidence, will have to be made on a case by case basis with the burden of persuasion of proving compensability of the condition remaining with claimants.

The contribution of claimant's work-related stress to her condition requiring treatment is a complex question of medical causation in which expert medical opinion is necessary. Three doctors have examined claimant and provided opinions. Claimant's treating psychologist had the benefit of his prior association with claimant in the treatment of claimant's son. His next contact with claimant was in January 1984, five months after claimant quit her job. He treated claimant for grief due to her loss of her job. His opinion was that conflicting demands and frequent unrealistic criticism at work were the major contributing cause of claimant's situational stress reaction in August 1983, although he also testified that claimant had "a certain emotional disability, at times a certain lack perhaps of insight regarding her reaction to situations." He opined that the central issue in claimant's reaction was her perception that conflict with the office manager had become intolerable and that the supervisor was not acting to make the office function as claimant wished.

After reviewing claimant's medical records and examining claimant, a psychiatrist, Dr. Turco, opined that it was very difficult to determine the major contributing cause of claimant's situational stress reaction because there were so many factors involved and that the employment factors contributed to the intensification of claimant's problems. He noted that claimant blamed the office manager for the problems claimant had on the job and that claimant denied problems with alcoholism before this employment. He testified that claimant's work-related problems were the proverbial final straw when added to claimant's other problems with her family, her husband's injury and disability, and her alcoholism, and that claimant was not able to competently analyze interpersonal relationships.

Claimant's family physician, Dr. Rasor, agreed with Dr. Turco's report, then opined that the stressful work situation was the major contributing factor to claimant's depression, and then admitted that "major causation" was a question of semantics because work was only one of many problems in a complex situation. He testified that claimant's condition did not worsen because her depression, anxiety, emotional instability and alcoholism had been longstanding problems before this employment. He first learned that claimant had problems at work in August 1983 when he recommended that she begin participation in a community-based outpatient alcoholic rehabilitation program. It was his opinion that claimant's work problems reached a crisis point in August 1983 and that that was the most important factor in her need to obtain treatment at that time. He did not recommend to claimant that she leave her job.

The doctors relied heavily on claimant's history in forming their opinions. Although the Referee found that claimant's testimony was credible and relied on it to find that there were objective stressful factors at her work, we also note that claimant admitted alcoholic blackouts at a rate of one or two per week during the period for which she claimed work-related stress was exacerbating her underlying condition. We also note that claimant did not seek psychological counselling for work-related stress at the time she claimed the stress was at its worst, but rather that she entered the alcoholic rehabilitation program, and denied at that time that her job was the most significant cause of her problems. Dr. Cooley's opinion in January 1984 that his treatment was needed to help claimant deal with the loss of her job contradicts Dr. Rasor's report of claimant's apparent euphoria at being free of her job and is difficult to reconcile with the long interim between loss of the job and commencement of treatment. Conditions leading to loss of a job can be stressful and lead to compensable occupational disease, but the actual loss of the job is not an event causing compensable consequences. Elwood v. SAIF, 298 Or 429 (1985). We find that claimant has failed to prove that work-related factors were the probable major contributing cause of her disease or that they were the probable major contributing cause of a worsening of her underlying preexisting condition. Wheeler v. Boise Cascade, 298 Or 452 (1985); SAIF v. Gygi, 55 Or App 570 (1982); see also Terese L. Panecaldo, 36 Van Natta 1353 (1984) (personality conflicts based on non-work related factors and misconduct not within scope of employment). The Referee's order is reversed.

ORDER

The Referee's order dated June 19, 1984, is reversed and the SAIF Corporation's denial is reinstated.

RICK W. CHARLEY, Claimant
Emmons, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 83-08948
April 23, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee T. Lavere Johnson's order which awarded 20.25° for 15% scheduled permanent partial disability in addition to a Determination Order award of 27° for 20% scheduled disability of the right foot. The issue on review is extent of scheduled permanent partial disability.

Claimant was injured on April 29, 1982, when a large block of metal fell on his right foot. Multiple surgeries were performed and claimant has lost the fourth toe at the metatarsophalangeal joint and the fifth toe has been syndactylized into the area of the base of the missing fourth toe. Claimant requires a special insert in his work boots to maintain comfort and balance. Cold weather and prolonged standing make claimant's foot sore.

Claimant has returned to work full time. He is limited to no more than six hours per week of overtime. He is to avoid use of ladders and should not perform work requiring balancing and standing on tiptoes. Claimant has a lifting, squatting, and bending limit based on lower extremity injuries sustained in a non-compensable motor vehicle accident.

Considering the guidelines set forth at OAR 436-65-536, 548, and 555, we find that claimant was adequately compensated by the Determination Order award of 27° for 20% scheduled permanent disability for the work-related injuries. See Jeffrey D. Ganieany, 36 Van Natta 166 (1984).

ORDER

The Referee's order dated September 28, 1984 is reversed. The Determination Order dated August 2, 1983 which awarded 27° for 20% scheduled right foot disability is reinstated.

ROBERT L. DELEPINE, Claimant
Richardson & Murphy, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-08797
April 23, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Braverman's order which upheld the SAIF Corporation's partial denial of his current cervical condition, diagnosed as cervical spondylosis. Claimant contends that SAIF is estopped from denying the compensability of his cervical condition by virtue of SAIF's alleged acceptance of his "claim" for compensation relative to that condition. Although it is not entirely clear, we assume claimant maintains alternatively that the record establishes the requisite causal nexus between his accepted 1979 low back injury and his present cervical condition.

Assuming arguendo that SAIF did, in fact "accept" a cervical problem in connection with claimant's original injury, this fact alone does not dictate the conclusion that SAIF is not at liberty to deny the compensability of claimant's current cervical condition. Clyde C. Wyant, 36 Van Natta 1067 (1984); John E. Russell, 36 Van Natta 678 (1984); see also Roller v. Weyerhaeuser Co., 67 Or App 583-587 (1984) (discussion of insurer's post-closure right to deny claims for specific medical treatment or aggravation on the ground that it does not result from the injury).

There being no procedural bar to SAIF's partial denial, we are in complete agreement with the Referee's finding that the

evidence fails to establish, by a preponderance, that claimant's current neck condition is causally related to his 1979 injury. Therefore, we affirm the relevant portions of the Referee's order.

ORDER

The Referee's order dated July 19, 1984 is affirmed.

LIZ A. DESTAEL, Claimant
Lawrence Wobbrock, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 83-04946 & 83-04947
April 23, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of those portions of Referee Pferdner's order which set aside its denial of further treatment of claimant's low back condition and awarded 16° for 5% unscheduled permanent partial disability in addition to the 16° for 5% disability awarded by Determination Order. The issues on review are compensability and extent of unscheduled permanent partial disability.

Claimant was first injured on September 22, 1980. She strained her neck and upper back and was treated by Dr. Mayer, chiropractor. The doctor released claimant to return to work on March 27, 1981 but stated that she would not be medically stationary for two more months. He later reported exacerbations of claimant's condition in March and August 1981.

On October 26, 1981 claimant was working as a resaw operator when a sharply pointed sliver of wood was ejected by the saw into her upper right abdominal quadrant. Claimant remained standing and was at first unaware that her skin had been pierced. The wood pierced skin and muscle tissue but did not pierce the peritoneum. The sliver did not exit but pressed against the skin on claimant's side. The sliver was removed surgically. The attending surgeon released claimant to return to her regular work on January 18, 1982 and the claim was closed by Determination Order on March 1, 1982 with an award of time loss only.

On April 21, 1982 Dr. Mayer reported that claimant's October 1981 injury had worsened her spine condition and that further treatment was needed. On July 29, 1982 Dr. Mayer first reported that claimant had a problem with her lumbar spine in addition to the thoracic and cervical spine problems for which he had been treating her. The doctor also opined that claimant had some permanent impairment of her back due to the 1981 injury. At this time, two independent medical examiners, Dr. Gatterman, chiropractor, and Dr. Howell, osteopath, found claimant had no impairment of her low back.

In October 1982 claimant began treating with Dr. Gritzka, orthopedic surgeon. Dr. Gritzka asked claimant to stop having her low back manipulated by the chiropractor and prescribed a corset, exercises, and medication, and ordered laboratory tests to try to diagnose the source of claimant's long-standing back problems. Dr. Carr, orthopedic surgeon, examined claimant and reported the presence of a "bat-wing" deformity in which claimant's left lateral transverse process of the L5 vertebra formed a false joint with her ilium. Dr. Carr noted that claimant's pain was localized to the area where the false joint was located and suggested that a

lumbar fusion might be appropriate for claimant. Dr. Gritzka decided to proceed with a local injection of an anesthetic and a corticosteroid.

Dr. Robinson, orthopedic surgeon, examined claimant for the insurer and opined that claimant had no permanent impairment related to her industrial injuries but had a mild impairment related to her congenital spinal condition. Dr. Gritzka agreed with the report. Dr. Mayer strongly disagreed with all of the independent medical examiners' evaluations and Dr. Gritzka's treatment program. A Determination Order issued on May 5, 1983, closing the 1980 injury with an award of time loss from April 13 through May 2, 1982 and awarding 16° for 5% unscheduled permanent partial disability of claimant's low back.

Between the date of the Determination Order and the date of the hearing in March 1984, claimant received two injections into her painful low back area, obtained a home traction device on Dr. Gritzka's prescription, and was reexamined by Drs. Howell and Robinson. The independent examiners continued to relate claimant's back impairment to her congenital L5 anomaly, although Dr. Gritzka opined that the October 1981 abdominal injury had contributed to claimant's need for medical services for her low back and that the injury had made the previously non-disabling condition symptomatic. On the tenth day before hearing, the insurer issued a letter denying responsibility for further medical treatment or disability for back pain because medical evidence indicated that claimant's "current back pain is attributable to a preexisting congenital deformity of an articulating transverse process of the fifth lumbar segment and is no longer related to either" industrial injury or employment. At hearing, the parties stipulated that the date of injury on the Determination Order of May 5, 1983 should have been October 26, 1981, rather than September 22, 1980 and this stipulation was recorded by the Referee in the Opinion and Order.

The Referee found the claimant was credible on the issue of the onset of her low back symptoms very shortly after the October 26, 1981 injury.

This is a complicated question of causation for which expert medical analysis is required. See Hammons v. Perini, 43 Or App 299 (1979). After reviewing the opinions of the various health practitioners in this case, we are more persuaded by the opinions of Drs. Gatterman, Howell, and Robinson that claimant suffered no injury nor impairment to her low back as a result of the October 26, 1981 injury. Dr. Gritzka once agreed with Dr. Robinson's assessment, then opined that the mechanism of the abdominal injury could have caused instability of the ligament holding the congenital deformity. Dr. Mayer's opinion of causation is a conclusory restatement of claimant's theory of causation. We find that claimant has not carried her burden of persuasion that the abdominal injury resulted in any back injury or impairment.

Payment for medical services pending acceptance or denial of a claim does not prejudice the insurer's right to deny responsibility for or compensability of a condition. ORS 656.262(9). The insurer denied compensability of the low back condition but continues to be responsible for treatment of conditions compensably related to the 1980 and 1981 injuries. See

Safstrom v. Riedel International, Inc., 65 Or App 728 (1983); Aquillon v. CNA Insurance, 60 Or App 231 (1982). We find that the insurer properly denied compensability of claimant's low back condition. See Joji Kobayashi, 36 Van Natta 1558 (1984).

Because we find that the claim for low back impairment is not compensable, the issue of extent of disability is moot. But if we were to consider the claimant's extent of disability, we would be persuaded again by the opinions of Drs. Gatterman, Howell, and Robinson that claimant's disability is due solely to the congenital deformity and not to the work-related injuries of 1980 or 1981. Therefore, there should have been no award for disability. Barrett v. D & H Drywall, 73 Or App 134 (CA-A29349, April 10, 1985).

ORDER

The Referee's order dated September 5, 1984 is reversed in part and affirmed in part. That portion of the order which set aside the insurer's denial is reversed and the insurer's denial of further treatment is reinstated. That portion of the order which awarded 32° for 10% unscheduled permanent partial disability of claimant's low back is reversed and the May 5, 1983 Determination Order award of 16° for 5% unscheduled disability of claimant's low back is set aside. The attorney fees associated with the denial and the extent of disability are reversed. That portion of the order which upheld the denial of work-related causation of claimant's low back condition is affirmed.

MARY A. DOWNEY, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-01911
April 23, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Siefert's orders that upheld the SAIF Corporation's denial of her occupational disease claim for rhinosinusitis allegedly caused by exposure to cigarette smoke in her workplace. The issue is compensability.

Claimant is employed as a proofreader with an agency of the State of Oregon. She has a medical history of sinus trouble dating back to at least 1968, including surgery to her sinuses. Claimant also has had a host of other medical problems over the years. Claimant testified that in the course of her work history since about 1972 she has actively avoided areas where there was a concentration of cigarette smoke, as she also has done while off the job. The evidence establishes that claimant's off-the-job exposure to cigarette smoke is minimal. Claimant has never smoked and does not live with anyone who smokes.

In 1981 claimant's state agency moved into a new building. In this building claimant worked in an open area along with several cigarette smokers. Claimant and four of her coworkers testified that at times concentrations of cigarette smoke in the area was very high. Claimant related that when she is exposed to the smoke, she exhibits symptoms of burning and itching eyes and nasal passages, a cough and nasal discharge. When she is away from the smoke, as in over the weekend, her symptoms diminish. Effective July 1, 1984 claimant's agency adopted a no smoking policy in the building. At the hearing, claimant testified that her symptoms have improved dramatically.

Claimant's treating physician, Dr. Parosa, reported and testified that, in his opinion, claimant has irritative rhinosinusitis caused by exposure to tobacco smoke. Dr. Parosa also opined that claimant's reaction to the smoke is not allergic, but irritative. While there is some evidence to the contrary, we find from the weight of the persuasive medical evidence that claimant is not allergic to tobacco smoke.

Dr. Parosa's testimony was that claimant has an exquisite sensitivity to cigarette smoke, which is a variant of a normal state, rather than a condition or disease. Because of this preexisting hypersensitivity, exposure to cigarette smoke causes an expression of the sensitivity in the form of rhinosinusitis. When the rhinosinusitis syndrome thus expresses itself, according to Dr. Parosa, claimant has a true medical condition, rhinosinusitis, induced by the smoke. The doctor also testified that repeated exposure to cigarette smoke has caused the sensitivity itself to worsen, and that claimant is now more sensitive than before.

Dr. John Girod reviewed claimant's medical file for SAIF. He also opined that there was no evidence through which to conclude that claimant's reaction was allergic. He concluded, "In the final analysis, I would attribute [claimant's] upper respiratory tract symptoms to her job if it is felt that there is exposure to significant amounts of cigarette smoke in the air."

Dr. Carl Lawyer also rendered an opinion on claimant's condition. He stated that in his opinion there probably was a relationship between exposure to cigarette smoke and claimant's upper respiratory problems. He concluded, "In my opinion, passive cigarette smoke inhalation would probably be producing temporary exacerbations of a preexisting condition. [Claimant] would probably have episodes of exacerbation of her sinusitis, even without passive cigarette smoke inhalation, but they might well be less frequent and less severe."

The Referee properly recognized that the decision in this case is guided by the line of cases beginning with Weller v. Union Carbide, 288 Or 27 (1979) and most recently rounded out by Wheeler v. Boise Cascade, 298 Or 452 (1985). The "Weller test" was stated by the court as:

> "[I]n order to prevail claimant would have to prove by a preponderance of evidence that (1) his work activity and conditions (2) caused a worsening of his underlying disease (3) resulting in an increase in his pain (4) to the extent that it produces disability or requires medical services."

Weller v. Union Carbide, supra, 288 Or at 35.

Claimant's principal contention on review is that she has no underlying "condition" to worsen in the Weller sense. Rather, claimant contends that her preexisting sensitivity to cigarette smoke only results in what could be called a "condition" after exposure to smoke. Thus, when there is no exposure, there is no "condition." In support of her contention, claimant points to the Board's decision in Irvin L. Slater, 35 Van Natta 1368 (1983), in which it was stated, "We do not believe that this enhanced

sensitivity qualifies as a 'preexisting condition.'" Slater, however, was an industrial injury case where previous back injuries had made the claimant more susceptible to future injury, and his new injury did not involve a "worsening" of anything.

We are persuaded by the evidence that, whether it is called a "disease," "heightened sensitivity," or "condition," claimant had a preexisting hypersensitivity to cigarette smoke and preexisting underlying rhinosinusitis. The question is whether the evidence establishes to the requisite level of persuasion that this "condition" became worse because of claimant's employment. As the Supreme Court has recently held, it does not matter whether a condition is symptomatic or asymptomatic at the time of employment. Wheeler v. Boise Cascade, supra, 298 Or at 457-58. The evidence strongly suggests, and we find, that claimant was symptomatic at the time of employment and for several years prior. There is also evidence from all three physicians who rendered opinions that, at the very least, claimant has underlying rhinosinusitis, the symptoms of which became worse as a result of on-the-job exposure to cigarette smoke.

In Hutcheson v. Weyerhaeuser, 288 Or 51 (1979), the court found compensable a temporary, work related worsening of claimant's chronic obstructive pulmonary disease, sinusitis and bronchitis. We believe that Hutcheson is most closely on point. In Wheeler, the court said of Hutcheson:

> "The points of Hutcheson were that (1) to be compensable, an occupational disease or injury does not have to permanently worsen the condition, (2) the level of proof necessary to substantiate a claim is by a preponderance of evidence and (3) the record in Hutcheson was strong enough to conclude that the preexisting condition was exacerbated, thus satisfying the Weller criteria." (Emphasis the court's.) 298 Or at 457.

We conclude that claimant has carried her burden of proving that her sensitivity to cigarette smoke has worsened as a result of her employment and that her underlying rhinosinusitis condition has also worsened, even if only temporarily. Under Hutcheson, claimant's occupational disease claim is compensable.

On review, claimant also claims entitlement to "interim compensation" commencing the fifteenth day after her claim was presented. Under Bono v. SAIF, 298 Or 405, 410 (1984), claimant is entitled to temporary total disability benefits as interim compensation if she "left work as that phrase is used in ORS 656.210(3)." There is insufficient evidence in the record for us to determine whether claimant so "left work." Because we find claimant's claim compensable and remand for further processing by SAIF, claimant's entitlement to temporary disability benefits is a claims processing matter.

Claimant also seeks a penalty and attorney fees for failure to pay interim compensation. Under the circumstances, we do not believe a penalty is warranted.

ORDER

The Referee's orders dated August 22, 1984 and September 18,

1984 are reversed. The SAIF Corporation's denial dated January 19, 1983 is set aside and claimant's claim is remanded to the SAIF Corporation for processing and closure according to law. Claimant's attorney is awarded $1,250 for services at hearing and an additional $650 for services on Board review for obtaining a reversal of the denial, to be paid by the SAIF Corporation.

DAVID R. DREILING, Claimant
Allen & Vick, Claimant's Attorneys
Stoel, et al., Defense Attorneys

WCB 84-01130
April 23, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denial of claimant's occupational disease claim for mental stress and stress-induced labile hypertension. The issue is compensability.

The Board affirms and adopts the order of the Referee, with the following comments. In this occupational disease claim for mental stress, claimant has the burden of establishing both legal and medical causation. See Hutcheson v. Weyerhaeuser, 288 Or 52, 55 (1979); Coday v. Willamette Tug & Barge, 250 Or 39, 49 (1968). Expert medical evidence is required to establish medical causation. Uris v. Compensation Department, 247 Or 420 (1967).

The record does not contain a narrative report, or any other reasoned explanation, from claimant's treating psychiatrist. See OAR 438-07-005(2). Although the treating psychiatrist apparently believes that there is some kind of relationship between claimant's psychiatric condition and his employment, the evidence falls far short of that required to satisfy a fact finder that claimant's employment more likely than not was the major contributing cause of his condition. See Dethlefs v. Hyster Company, 294 Or 298 (1983).

ORDER

The Referee's order dated August 27, 1984 is affirmed.

KATHLEEN M. GOULD, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 84-05208
April 23, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Howell's order which: (1) awarded interim compensation from April 17 through April 24, 1984, and from May 5 through July 12, 1984; and (2) awarded penalties and attorney's fees for unreasonable delay in paying compensation and unreasonable delay in accepting the claim. The issues on review are temporary total disability compensation and penalties and attorney's fees for unreasonable delay.

Claimant was working full-time from the date of injury until April 24, 1984. She was off work due to her injury beginning on April 25 until May 4. She returned to work full-time on May 5, 1984. Claimant was paid temporary total disability compensation on June 7, 1984, for the period she was off work. Claimant's medical service costs were paid.

Claimant is not entitled to "interim" compensation for the

period during which she was working full-time. Bono v. SAIF, 298 Or 405 (1984).

For the 29 day delay in paying the time loss due claimant for the period during which she was disabled, claimant should have been awarded a penalty of 15% of the compensation then due. See Zelda M. Bahler, 33 Van Natta 478 (1981), rev'd in part on other grounds, 60 Or App 90 (1982).

With respect to penalties and attorney's fees for prevailing on the claims of unreasonable delay in accepting the claim, there are no amounts then due, all compensation to which claimant was entitled having been paid, therefore, no penalties or attorney's fees should be awarded. EBI Companies v. Thomas, 66 Or App 105 (1983).

ORDER

The Referee's order dated October 31, 1984 is modified in part and reversed in part. The award of penalties for late payment of temporary total disability compensation is modified to award 15% of the amount of the compensation. The remainder of the Referee's order is reversed.

CLAUDIO E. GRANDJEAN, Claimant
Peter E. Baer, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-07033
April 23, 1985
Order on Reconsideration

Claimant requests reconsideration of the Board's Order on Review dated March 26, 1985, which affirmed and adopted the Referee's order and cited for comparison Ford v. SAIF, 71 Or App 825 (1985), and Guse v. Adminco, 70 Or App 376 (1984). Claimant states that these cases are factually indistinguishable from his case because: (1) his hearing loss was greater than expected for his age; (2) he was exposed to loud noise at work; and (3) there was no evidence that claimant was exposed to abnormal noise off the job.

We find the cases cited distinguishable. In Ford, the Court of Appeals found that 28 years of continuous exposure to the noise of mill machinery, and an eight-hour weighted-average noise exposure of 90 decibels after noise reduction measures were instituted by the employer, together with the employer's failure to offer evidence of its noise level testing and equivocal evidence of medical causation, was sufficient for claimant to carry his burden of persuasion that the work-related noise exposure was the major contributing cause of his hearing loss. In Guse, the Court of Appeals found that close exposure to a police siren, 15 years of intermittent close indoor exposure to large caliber pistol firing, and medical evidence that claimant's hearing loss was not due to the aging process, was sufficient to prove that claimant's work exposure was the major contributing cause of his hearing loss and tinnitus.

Claimant maintained swimming pools for a school district and had to work around swimming pool machinery. Noise level testing by an industrial hygienist showed maximum momentary noise level exposure was 81 decibels with the constant noise range between 67 and 77 decibels. Claimant personally performed his own noise level testing a year later and found noise levels above 130 decibels. Claimant moonlighted for many years maintaining home swimming pools and a private club pool. He testified that the

other pools' machinery was not as noisy as that of the school district, but no noise level test results were introduced. The medical evidence indicated that claimant's hearing loss was not consistent with noise exposure but that it was consistent with aging, prior infection or heredity, and that claimant's school-district-work related noise exposure was only one of many contributing sources to claimant's hearing loss and tinnitus.

Claimant argues that the mere fact that his hearing loss is greater than usual for a person of his age is sufficient to show some work-related causation, and he claims there is no evidence that he was exposed to dangerous levels of noise away from the school district. When a claimant wishes to rely on a temporal relationship to show causation, as here where claimant suffered a hearing loss during years when he was working around machinery, the burden of persuasion is on claimant to rule out other causes of his condition. See Bradshaw v. SAIF, 69 Or App 587 (1984).

As did the Referee, we find that claimant failed to sustain his burden of proof that his work-related noise exposure was the major contributing cause of his tinnitus and hearing loss. See James v. SAIF, 290 Or 343 (1981); SAIF v. Gygi, 55 Or App 570 (1982).

ORDER

Claimant's request for reconsideration is granted. On reconsideration, the Board adheres to and republishes its Order on Review dated March 26, 1985.

DELBERT LAWSON, Claimant
Steven Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Brian L. Pocock, Defense Attorney
Miller, et al., Defense Attorneys

WCB 82-10501 & 82-11235
April 23, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Argonaut Insurance Company, insurer for Davidson's Industries, Inc. (hereinafter "Davidson's"), requests review of Referee Betty Browne's order which set aside its denial of claimant's aggravation claim based upon her findings that claimant's worsened condition in September of 1982 was compensable and the responsibility of Argonaut in connection with claimant's June 1980 neck injury. Argonaut contends that the SAIF Corporation, as insurer for one of claimant's more recent employers, Timber Cutters, is responsible for payment of claimant's compensation. The only pertinent substantive issue on review is employer/insurer responsibility for claimant's worsened neck condition.

There is a threshold issue concerning which documents comprise the record of exhibits in this proceeding. Because of some confusion in this regard, by an interim order dated September 26, 1984, we remanded this case to the Presiding Referee for a determination as to "what exhibits constitute the record on review . . . . " 36 Van Natta 1320 (1984). Pursuant to our order, the Presiding Referee entered his "Determinations on Remand." Thereafter, the briefing was completed, and this case is once again before us for review of the responsibility question. The puzzle concerning the exhibits, however, remains to be pieced together.

The hearing was held on March 24, 1983. A great deal of activity occurred thereafter, however, partly as a result of the fact that the record remained open for taking three physicians' depositions, and partly as a result of the fact that after the hearing another of claimant's employers, International Paper Company, was joined as a necessary party to the proceeding. See former OAR 436-83-280 (since renumbered as OAR 438-06-065, eff. May 1, 1984). After the Referee's order of joinder issued, claimant filed a claim with International Paper, and the claim was formally denied on or about September 8, 1983.

All the parties, including International Paper, were represented by counsel at an October 3, 1983 deposition of Dr. Abel, claimant's family physician. The depositions of the two other doctors, Hockey and Mundall, never were taken, or if they were, they were not transcribed and submitted for inclusion in the record. However, additional written reports were solicited from Drs. Hockey and Mundall and submitted to the Referee. A letter from Dr. Mundall dated November 9, 1983, addressed to counsel for Argonaut, was submitted to the Referee by SAIF under cover of a December 14, 1983 letter. The cover letter and doctor's report appear in the record as Exhibit 44; however, it appears that the Referee did not intend to admit this particular exhibit. A November 23, 1983 letter from Dr. Hockey, addressed to counsel for Argonaut, appears in the record as Exhibit 43. This exhibit was forwarded to the Referee under cover of Argonaut's counsel's letter of December 5, 1983; however, counsel's cover letter does not appear in the record as an exhibit. Although Dr. Hockey's report appears in the record, it would appear that the Referee did not intend to admit it as an exhibit. Another report from Dr. Hockey, dated December 16, 1983 and addressed to counsel for SAIF, was submitted to the Referee under cover of a December 20, 1983 letter from SAIF's attorney. However, neither the cover letter nor Dr. Hockey's report appear anywhere in the record.

On or about July 27, 1983 counsel for SAIF submitted three pages of Dr. Abel's chart notes covering the period March 3, 1982 through February 9, 1983. Although SAIF's cover letter does not appear in the record, the three pages of chart notes are included as Exhibit 12, pages 1 through 3. Although it is far from clear, it appears that the Referee may not have considered these chart notes, since they were submitted after the March 24, 1983 hearing.

Finally, under cover of a November 9, 1983 letter to the Referee, counsel for Argonaut submitted an October 14, 1983 letter from claimant's original attending chiropractic physician, indicating the nature and extent of treatment claimant initially received after his June 1980 neck injury. An additional document included as part of this submission was an October 17, 1983 letter addressed to the chiropractor, Dr. Hebert, in which counsel for Argonaut requested verification of Dr. Hebert's statement that claimant was symptom free at the time of his last treatment on December 4, 1980. This document contains a handwritten notation from Dr. Hebert verifying this statement.

By letter dated January 12, 1984 the Referee advised the parties that the record was closed and that they should submit written argument. She invited argument on the question of the admissibility of proposed exhibits submitted subsequent to the date of hearing. Apparently there was written argument submitted,

as evidenced by the copy of International Paper's argument which has been appended to its respondent's brief on review. However, the record of the proceedings before the Referee does not contain any written argument. In any event, it appears as though whatever written argument was received did not address the issue of the admissibility of the post-hearing exhibits. In her order, the Referee referred to three sets of exhibits: those in the "Davidson's case," numbered A-1 through A-27; those in the "Timber Cutters case," numbered B-1 through B-12; and those submitted by International Paper, numbered C-1 and C-2. The Referee's order then states, "Other gratuitous submissions were forwarded by the parties after the hearing and have not been admitted to the record nor considered by the Referee."

There is a document titled "Amended Index of Documents" itemizing Exhibits A and 1 through 44. Many of these are duplications of the exhibits contained in the three above-mentioned sets (i.e. sets A, B and C relative to the three respective employers). Apparently, after the hearing, one of the parties organized the previously submitted exhibits in the preferred chronological order for submitting exhibits and composed an amended index. Some of the documents included were not previously submitted. In this regard, it is noteworthy that in colloquy at the beginning of the hearing the Referee specifically inquired of SAIF's attorney whether there were any other medical or vocational reports in its file, "which are not now part of the record?" In response, counsel for SAIF indicated his willingness to peruse SAIF's file, and in the event additional documents, particularly medical reports, were identified, submit those.

All of the documents presently appearing in this record, including sets A, B and C, and all of the documents identified in the "Amended Index of Documents" are admissible. We have considered them in our review of this case, and they are properly included as exhibits. In addition, the documents which apparently were submitted but not included and, therefore, obviously not admitted in and to the record as exhibits certainly should have been included whether or not the Referee found them admissible. See Edward Morgan, 34 Van Natta 1590, 1591 (1982). Furthermore, we hold that all of the documents which were submitted after the hearing should have been admitted as exhibits, with one exception noted below.

The record was left open for the depositions of three doctors in an effort to generate additional medical opinion evidence on the difficult responsibility issue presented in this case. Only one deposition was taken, that of Dr. Abel. However, additional written reports were obtained from the other two physicians, Mundall and Hockey. Under these circumstances, we believe the post-hearing reports submitted while the record remained opened should have been admitted and considered by the Referee. In addition, counsel for Argonaut obtained additional information from claimant's initial treating physician, Dr. Hebert, including his statement that when he discharged claimant from treatment, claimant was "symptom free." This is relevant and material evidence bearing on the ultimate issue in this case -- employer/insurer responsibility; therefore, we believe that these additional documents should also have been admitted and considered by the Referee. Michael Cochran, 35 Van Natta 1726, 1727 (1983); Edward Morgan, supra, 34 Van Natta at 1591.

A December 20, 1983 copy of a chart note from Dr. Mundall was

submitted by Argonaut's attorney under cover of a February 1, 1984 letter. Because this proposed exhibit was submitted well after the Referee advised that the record was closed by her letter of January 12, 1984, we do not deem it appropriate that this document be admitted as an exhibit. It remains with the file, however, as a proposed exhibit.

One other proposed exhibit needs to be addressed. It is a November 22, 1982 report from Dr. Wong. It was provided to counsel for Argonaut after the hearing, apparently under cover of a letter from SAIF dated March 28, 1983. Three days later, under cover of a separate letter, SAIF provided Argonaut's attorney with four additional exhibits. All of these exhibits (a total of 11) are included as part of the exhibits admitted and considered by the Referee, either in set A or set B. Considering the confusion that has prevailed in compiling the record to this point, and the fact that there are obviously documents which were submitted to the Referee but not included in the record, it is a logical inference that this November 1982 report likewise was submitted but somehow omitted when the record was compiled. Therefore, based upon this inference, we deem it appropriate to admit this document as an exhibit.

In sum, and to state it in the simplest possible terms, the documents which comprise the record on review are those exhibits which are numbered A-1 through A-27, B-1 through B-12, C1 and C2, and those additional exhibits identified in the "Amended Index of Documents." Furthermore, all additional exhibits referred to in the November 6, 1984 letter from counsel for Argonaut to the Presiding Referee are admitted as exhibits, with the exception of Dr. Mundall's December 20, 1983 chart note and counsel's February 1, 1984 cover letter to the Referee which accompanied that chart note. These two documents, however, shall remain in the record as proposed, but not admitted, exhibits.

Having now defined the record on review, ORS 656.295(3), (5), we turn to the merits of this case. On the issue of employer/insurer responsibility, we disagree with the Referee's finding that claimant's worsened neck condition is the responsibility of Argonaut in connection with his June 1980 injury. Instead, we find and hold that claimant's work activity during his most recent employment with Timber Cutters materially and independently contributed to his neck condition, diagnosed as acute and chronic cervical strain. See Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Bill B. Dameron, 36 Van Natta 592 (1984).

Claimant's June 25, 1980 neck injury occurred while he was wedging a tree. He slipped while working in an awkward position and felt a pain in his neck. Claimant did not see a physician until he visited Dr. Hebert, a chiropractor, on July 16, 1980. Dr. Hebert diagnosed acute cervical sprain and administered chiropractic manipulation. Claimant received four treatments one week, two treatments the following week, one treatment per week for the next two weeks, one treatment every other week for the following six weeks, and then one treatment a month over the next two months. On December 4, 1980, the date of Dr. Hebert's last treatment, claimant was discharged from treatment. According to Dr. Hebert, claimant was without symptoms at that time.

Claimant never missed any work, although he avoided wedging,

which caused neck pain. Claimant continued to work for Davidson's through 1980 and 1981, missing little time at all and apparently no time on account of his neck condition. Claimant testified, however, that he continued to be symptomatic. He was treated by Dr. Tracy, another chiropractic physician, in August of 1981. Complaints noted at that time were neck stiffness, difficulty in turning the head, and low back pain. Dr. Tracy diagnosed subluxation at various levels of the cervical spine, as well as pelvic and sacral subluxations. In addition, x-rays disclosed disc degeneration at the C-5 and C-6 levels.

Claimant terminated his employment with Davidson's in October of 1981. He then went to work for Timber Cutters on October 21, 1981. Timber Cutters is jointly owned by claimant's sister and her husband. Claimant worked for Timber Cutters through and including February 9, 1982, on which date claimant sustained an apparently severe burn injury. This injury disabled claimant for approximately six weeks, at the end of which (in March 1982) claimant went to work for International Paper, where he was employed until July 30, 1982. On August 2, 1982 claimant resumed his employment with Timber Cutters, where he continued to work until September 8, 1982, when he quit because his neck ". . . got to hurting so [he] couldn't even work."

No doubt claimant was experiencing some residuals of his 1980 neck sprain/strain. Alternatively, claimant was experiencing symptoms associated with the degenerative condition of his cervical spine. In any event, the level of symptoms that claimant experienced did not significantly interfere with his ability to work as a timber cutter on a continuing basis up to and including the date that he terminated his employment with Timber Cutters.

Claimant began to experience increasing neck pain during his employment with International Paper, as evidenced by his visit and initiation of treatment with Dr. Abel on July 22, 1982. Dr. Abel testified that the physical therapy prescribed for and received by claimant helped to alleviate this symptomatology, but that the symptoms returned as claimant continued to work in the woods. Thus, although claimant became increasingly symptomatic during the latter part of his employment with International Paper, these symptoms subsided with treatment but then resurfaced to such an extent that claimant was forced to stop working in early September of 1982.

In order to "shift liability" from Davidson's/Argonaut to one of claimant's more recent employers in this factual context (where claimant has become disabled during more recent employment but there is no discrete incident or episode which can be identified as an "injury"), the evidence must establish more than the mere recurrence or exacerbation of symptoms of claimant's original neck injury. Persuasive evidence of a worsening of claimant's "underlying condition" is required. Bill B. Dameron, supra, 36 Van Natta at 598. Although circumstantial evidence, including claimant's credible testimony, may tend to shed light on this difficult question, the answer, for the most part, depends upon competent medical evidence. We understand Drs. Abel, Hockey and Mundall to be of the opinion that claimant's recent work activity, particularly his work for Timber Cutters, materially and independently contributed to his preexisting neck condition, thereby causing the increase in symptoms which disabled claimant

and forced him to stop working. Given this conclusion, we find and hold the SAIF Corporation, as insurer for Timber Cutters, claimant's last employer, responsible for payment of claimant's compensation.

ORDER

The Referee's order dated May 16, 1984 is reversed in part. That portion of the order which set aside Argonaut Insurance Company's November 5, 1982 aggravation claim denial, issued in behalf of Davidson's Industries, Inc., is reversed, and that denial is reinstated and affirmed. That portion of the order which upheld the SAIF Corporation's December 8, 1982 denial, issued in behalf of Timber Cutters, is reversed. SAIF's denial is set aside, and this claim is remanded to SAIF for acceptance and processing in accordance with law. The remainder of the Referee's order is affirmed. SAIF shall reimburse Argonaut for all compensation and attorney fees payable under the terms of the Referee's order to the extent that such amounts have been paid by Argonaut during the pendency of this proceeding.

LARRY C. LONG, Claimant
Doblie & McSwain, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-06154
April 23, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of that portion of Referee Peterson's order that denied claimant's request for increased unscheduled permanent partial disability. The issue is extent of disability upon reclosure of a claim due to aggravation of a compensable injury.

Claimant's entire argument on review is premised on his assertion that he is entitled to have his extent of disability totally redetermined upon claim reclosure. Claimant's entitlement, however, is circumscribed by ORS 656.273(1), which provides:

> "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." (Emphasis added.)

On review claimant does not address the Referee's specific finding that the evidence fails to establish that claimant's permanent loss of earning capacity is any greater now than it was in November 1982. Claimant argues only that his testimony should have been given greater weight. The Referee considered claimant's credible testimony in reaching his decision, but found the medical question sufficiently complex that claimant's testimony alone was insufficient to prove his case. We agree. See Garbutt v. SAIF, 297 Or 148, 151 (1984).

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated August 30, 1984 is affirmed.

RAY MOORE, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-01005
April 23, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's denial of claimant's bilateral carpal tunnel syndrome and refused to impose penalties/attorney fees for various alleged claims processing violations, including unreasonable delay in referring claimant for vocational assistance. Claimant seeks an order remanding his "occupational disease claim" to SAIF for processing, as well as imposition of penalties/attorney fees on various grounds.

Although we agree with the Referee's ultimate conclusion, which is that claimant is not entitled to any of the relief requested, we reach that decision by different reasoning.

Claimant sustained a compensable back injury on March 10, 1976. Later that same year bilateral carpal tunnel syndrome was diagnosed, and surgery was performed to alleviate claimant's symptoms. Apparently in early 1978, some medical bills associated with this carpal tunnel surgery (apparently bills for hospitalization) were forwarded to SAIF. By a speed letter dated April 15, 1977, SAIF returned these billings to the medical provider indicating its responsibility for a "back condition only," and suggesting that the medical provider directly bill claimant or his private health insurer. There is an inference that claimant's private health insurer received and paid for all medical billings associated with his carpal tunnel condition.

The issue of the work-relatedness of claimant's bilateral carpal tunnel syndrome apparently was not raised by claimant (or by counsel in his behalf) until claimant's present attorney's letter to SAIF dated December 1, 1983, essentially requesting that SAIF process a separate claim for benefits relative to claimant's bilateral carpal tunnel syndrome. SAIF thereafter requested an opinion from its neurological consultant concerning a relationship between claimant's bilateral carpal tunnel problems and his original 1976 back injury. Dr. Brown, the consultant, reported his opinion that there was no relationship. SAIF thereafter formally denied, that is, partially denied, the compensability of claimant's bilateral carpal tunnel syndrome. This denial was issued under the same claim number as claimant's accepted low back injury, and is obviously intended to be a denial of claimant's carpal tunnel syndrome as an alleged consequence of the accepted back injury. It is not a denial of a separate occupational disease claim.

In a March 30, 1984 letter to SAIF's legal examiner, claimant's attorney requested, among other things, that SAIF process a separate occupational disease claim for bilateral carpal tunnel syndrome, originating with the 1976 medical billings related to that condition. When the hearing convened, claimant and SAIF outlined the issues presented for resolution. Claimant contested SAIF's denial and also requested an order remanding the "occupational disease claim" to SAIF for proper processing. In addition, claimant requested an award of interim compensation and

the impositon of penalties/attorney fees for SAIF's failure to process, in any manner (either as a separate occupational disease claim or as a potentially compensable consequence of the accepted back injury), his claim for benefits in connection with the carpal tunnel syndrome. In addition, claimant alleged an improper reduction of his temporary total disability benefits, for which he sought the imposition of penalties/attorney fees; and further alleged unreasonable delay in referring him for vocational assistance and also entitlement to penalties/attorney fees for the delay.

At the close of the hearing, counsel for SAIF amended the written denial to include a denial of an occupational disease claim for carpal tunnel syndrome. Claimant's attorney objected, stating, "I think that claimant should have an opportunity to file a request for hearing on that denial and respond to it."

In his order upholding SAIF's denial, the Referee referred to this case as one involving "a carpal tunnel occupational disease." Apparently as a consequence of that characterization of the issue, and notwithstanding the fact that he upheld SAIF's partial denial of claimant's carpal tunnel syndrome (issued in connection with the low back claim), he refused to consider any of the remaining issues raised by claimant, with one exception discussed below. The Referee concluded that such questions were more appropriately considered in connection with "a low back claim file."

In addition to upholding SAIF's partial denial, the Referee declined to impose a penalty/attorney's fee for SAIF's failure to process a claim for carpal tunnel syndrome in a timely fashion. Although it is unclear from his written order, it appears as though he considered stipulations entered into in February 1979 and March 1983 as having some preclusive effect upon the present claim and the related issues of penalties/attorney fees. In addition, he found no "medicals," as referenced in counsel's March 20, 1984 letter to SAIF, "to support claimant's occupational disease claim." We understand this portion of the Referee's order to mean that claimant failed to establish that SAIF ever received a claim for benefits in association with his carpal tunnel syndrome in 1976 or 1977.

It is apparent that SAIF received some medical billings related to claimant's 1976 carpal tunnel surgery. It is equally apparent that these billings were returned by SAIF to the medical provider, who, in turn, submitted them to claimant's private health insurer who then paid the bills.

It is equally apparent that claimant's carpal tunnel syndrome was not work-related, and was never considered work-related by his physicians, either at the time surgery was performed or presently. The physicians' billings were forwarded directly to claimant's private health insurer. It apparently was the hospital's billings that were forwarded to SAIF and then returned by SAIF. There is no evidence to indicate what form these billings took and what information they contained. Thus, we have no basis for concluding that SAIF had reasonable notice that the hospital intended to make a claim in claimant's behalf. It is more likely than not that a clerical error was made, and these billings mistakenly were submitted to the industrial insurer, rather than claimant's private health insurer. Therefore, we find insufficient evidence to conclude that the hospital billings

obviously received by SAIF constituted a "claim" within the meaning of ORS 656.005(7) and our decision in Billy J. Eubanks, 35 Van Natta 131 (1983).

Claimant's attorney's December 1, 1983 letter to SAIF was the first reasonable notice that claimant was seeking compensation in connection with his carpal tunnel condition. Less than two weeks before, a stipulation had been approved whereby SAIF accepted claimant's aggravation claim and initiated temporary total disability payments as of October 14, 1982. The record indicates that the claim was reclosed on July 17, 1984. Presumably, claimant was in receipt of all temporary disability benefits to which he was entitled when he made this "claim" for carpal tunnel syndrome. Therefore, claimant would not have been entitled to "interim compensation" in connection with his "carpal tunnel claim," even if there had been evidence to indicate that, at the time the claim was made, he was disabled by this condition. Carl R. Osborn, 36 Van Natta 1648 (1984); see Bono v. SAIF, 298 Or 405 (1984). Because SAIF formally denied, within 60 days of notice of the claim, the compensability of claimant's carpal tunnel syndrome, at least as a potentially compensable consequence of his back injury, we find no basis for imposition of penalties/attorney fees on any other grounds.

Claimant appears to suggest that he is entitled to another hearing on the issue of the compensability of his carpal tunnel syndrome, not as an allegedly compensable consequence of his back injury, but as a separate occupational disease. See ORS 656.802(1). Prior to and at the hearing claimant was contending that his carpal tunnel syndrome was compensable as an occupational disease, although prior to the hearing, SAIF obviously was proceeding on the assumption that claimant was contending his carpal tunnel condition arose out of his accepted back injury. Considering the fact that claimant was asserting the occupational disease theory prior to and at the hearing, we find no basis for his objection to SAIF's oral amendment to its denial at the time of hearing. In addition, claimant's apparent contention that he is entitled to another hearing on the "occupational disease claim" is without any foundation. See Million v. SAIF, 45 Or App 1097 (1980); cf. Thomas v. SAIF, 64 Or App 193 (1983)..

We find and hold that the "carpal tunnel claim" fails for lack of proof on either theory. The evidence fails to establish that claimant's 1976 injury involved his upper extremities or otherwise materially contributed to the onset of his carpal tunnel syndrome. Likewise, the record fails to establish that claimant's work activity for the employer was the major contributing cause of this condition. Indeed, the medical evidence bearing on this issue is completely to the contrary.

The remaining issues involve claimant's contention that penalties and attorney fees are warranted for unreasonable reduction in claimant's temporary total disability benefits and for SAIF's unreasonable delay in referring claimant for vocational assistance. With regard to these issues, it appears that a hearing convened subsequent to the July 30, 1984 hearing before Referee Leahy in this proceeding. Appended to its respondent's brief, SAIF has submitted a copy of Referee Mulder's order in WCB Case No. 84-08065, which was issued January 7, 1985 (the hearing was held December 10, 1984). That proceeding was primarily concerned with claimant's request that a July 17, 1984 Determination Order which reclosed his claim be modified to award

additional temporary and permanent disability. However, claimant raised the same penalty/attorney fee issues that he previously asserted before Referee Leahy. Unlike Referee Leahy, Referee Mulder decided the questions presented by imposing a penalty and associated attorney's fee for improper reduction of temporary total disability; and with regard to the vocational assistance issue decided that the issue was "not ripe," and that claimant had failed to prove entitlement to an authorized training program.

In his reply brief in this proceeding, claimant has objected to SAIF's submission of Referee Mulder's order. Claimant asserts that this amounts to a request that the record be reopened for the submission of new evidence. See generally ORS 656.295(5). Referee Mulder's order is an official order of this agency, and we have authority to take administrative notice of its contents. Dennis Fraser, 35 Van Natta 271 (1983). Claimant has had the opportunity to respond and, in fact, has responded to this document, which we officially note.

Having failed to obtain a ruling from one Referee, claimant proceeded to relitigate the same issues before Referee Mulder. Claimant obtained a decision on what is certainly the exact issue presented on review with respect to the penalty/attorney's fee for reduction of temporary total disability. Referee Mulder's decision is not presently subject to review, as our agency records indicate that his order now has become final by operation of law. Considering these circumstances, we refuse to give further consideration to this issue.

Arguably the question decided by Referee Mulder (entitlement to vocational assistance, to-wit an authorized training program) is different from the question apparently raised before Referee Leahy and now the Board -- SAIF's alleged unreasonable delay in referring claimant for vocational assistance. Assuming that the unreasonable delay issue has not already been decided, and that the decision has not already become final by operation of law, we nevertheless conclude that the issue is not properly before the Board. If an insurer unreasonably delays referring an injured worker for vocational assistance, the Director of the Workers' Compensation Department, not this Board, is authorized to impose a penalty for violation of the insurer's statutory obligations. Joel I. Harris, 36 Van Natta 829, 840 (1984), aff'd mem, 72 Or App 591 (1985); see ORS 656.745, OAR 436-61-981; see also ORS 656.728(1) (eff. July 1, 1984). Thus, we lack jurisdiction to grant the relief requested.

ORDER

The Referee's order dated August 24, 1984, as clarified herein, is affirmed.

HILARY RUSSELL, Claimant
Doblie & McSwain, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-03213
April 23, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The City of Portland, direct responsibility employer, requests review of Referee Peterson's order that set aside its denial of the compensability of continuing palliative chiropractic treatment for the alleged residuals of a 1978 low back injury.

On April 20, 1978 claimant injured her low back while attempting to move a 30-gallon can two-thirds full of wet dirt. She initially received chiropractic treatment; however, the record does not develop in any detail the early course of claimant's treatment. In August of 1978 Dr. Gripekoven, orthopedist, opined that claimant might have a herniated L5-S1 disc; however, there is no evidence in the record that Dr. Gripekoven's suspicion was ever confirmed by anyone.

On January 5, 1979 claimant was examined by a panel of the Orthopaedic Consultants, who opined that claimant was medically stationary and that her impairment as a result of her injury was minimal. They further recommended that claimant receive no further chiropractic treatment. Claimant's claim was closed by a Determination Order dated February 7, 1979 which awarded claimant 16° for 5% permanent partial disability for her low back injury. The Determination Order was not appealed.

Claimant was treated by Dr. Daugherty, chiropractor, between March and September of 1979. Dr. Daugherty opined that claimant had developed chronic low back pain. His recommended therapy included swimming and bicycle riding. On September 4, 1979 Dr. Daugherty ceased treating claimant, noting that she still had back pain but was not improving under his care.

Claimant was again examined by Orthopaedic Consultants on January 25, 1980. This panel recorded that claimant reported low back pain about 20% of the time and that chiropractic treatments gave her relief from symptoms. After their examination the Consultants stated that there were no objective signs of impairment and that claimant had improved since the previous Orthopaedic Consultants' examination. X-rays available to the panel, however, revealed a slight narrowing at L5-S1. The Consultants recommended that claimant continue her chiropractic treatments for as long as they provided relief from pain.

The record contains no direct evidence of claimant's treatment between the January 1980 examination by Orthopaedic Consultants and the next subsequent Orthopaedic Consultants' examination on February 1, 1983. This panel, of which Dr. Gripekoven was a member, noted that claimant began chiropractic treatment with Dr. Beeson in March of 1980. Initially claimant saw Dr. Beeson three times weekly. By February of 1983 claimant was seeing Dr. Beeson about every three weeks. The panel opined that claimant had a chronic lumbosacral strain, by history. The doctors further stated that continuing chiropractic treatment was not indicated.

The employer issued the denial at issue in this case on

March 8, 1984. On May 9, 1984 Dr. Tilden conducted a chiropractic examination at the employer's request. In connection with his examination, Dr. Tilden obtained x-rays taken of claimant at the Western States Chiropractic Clinic approximately three weeks after her 1978 injury. On the basis of his interpretation of these x-rays, Dr. Tilden concluded that claimant had a degenerative L5-S1 disc compromise that preexisted the 1978 injury. He opined that any pain claimant was experiencing in 1984 was due to the degenerative disc disease and was unrelated to the 1978 industrial injury. Dr. Tilden opined that no further chiropractic treatment was indicated due to the industrial injury and that one of the exercises claimant was doing was contraindicated.

Both Dr. Beeson and Dr. Tilden testified at the hearing. Dr. Beeson testified that he had never seen the 1978 x-rays of claimant. On cross-examination Dr. Beeson stated that claimant has a Grade I (the least severe) "retrolysthesis" of L5-S1 and that that condition could be compatible with degenerative disc disease. Dr. Beeson confirmed that, to his knowledge, claimant had never had a CT scan or a myelogram and that claimant had no radiculopathy.

Dr. Tilden testified that, in his opinion, claimant's symptoms were not related to her 1978 injury. His reasoning was based upon his examination finding of no presently measurable impairment from the injury and the 1978 x-rays, which were consistent with more recent x-rays showing the progression of claimant's degenerative disc disease. None of the x-rays examined by Dr. Tilden revealed, in his opinion, evidence of severe injury to claimant's spine. Although Dr. Tilden stated on cross-examination that it would be his opinion that claimant's current symptoms were related to the injury if it was assumed that claimant had a permanent impairment from a chronic lumbar strain, he stated that if one were to add to the assumption that claimant had preexisting degenerative disc disease, claimant's current symptoms would not be attributable to the 1978 incident.

Claimant testified that she has had low back pain continuously since her injury. At the time of the hearing, she was seeing Dr. Beeson once or twice per month. His treatments resulted in relief from pain for one or two weeks.

The Referee rendered his decision verbally at the conclusion of the hearing. He discussed at some length his views on the applicable burden of proof in this case, which he felt should be borne by the insurer. He went on to state, however, that because the claimant had not advanced this theory of the burden of proof, he would find that claimant had met her burden of proof. There is no doubt that claimant has the burden of proof in this case. In Poole v. SAIF, 69 Or App 503, 505-06 (1984), the court stated:

> "As with compensability in general, claimant has the burden of proving that the condition for which he receives medical services was caused by his compensable injury and that the treatment is reasonable and necessary. SAIF v. Forrest, 68 Or App 312 . . . (1984); see also McGarry v. SAIF, 24 Or App 883 . . . (1976)."

Poole v. SAIF, supra, involved a factual situation we find to

be nearly indistinguishable from the facts of this case. The claimant in Poole was denied further chiropractic treatment for his low back on the ground that his symptoms were as a result of degenerative disc disease unrelated to his compensable low back injury. The medical testimony came from chiropractors with differing views of the cause of claimant's symptoms, one feeling that further treatment was compensable and two others opining that it was not. The court affirmed our finding that further treatment was not compensable.

In this case, the very best claimant has done is advance two arguably equally probable explanations for her low back pain. "When the evidence presented reflects two explanations for a claimant's condition that are equally plausible to the factfinder, and one is noncompensable, the claimant has failed to sustain the burden of proof." Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 460 (1984). The Referee's order was erroneous.

ORDER

The Referee's order is reversed. The City of Portland's denial dated March 4, 1984 is reinstated and affirmed.

BETTY L. SEINER, Claimant
Velure & Bruce, Claimant's Attorneys
Lindsay, et al., Defense Attorneys
Daniel Brown, Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-00691
April 23, 1985
Order of Dismissal

The SAIF Corporation has moved the Board for an order dismissing claimant's request for review of Referee Quillinan's order that dismissed claimant's request for hearing. SAIF's request specifically asks that the request for review be dismissed as to it and the parties it represents, which are the noncomplying employer and the Workers' Compensation Department Administrative Fund. See ORS 656.054. For the reasons that follow, we dismiss claimant's request for Board review in its entirety.

On January 18, 1984 claimant, through her attorney, submitted an aggravation claim for bilateral carpal tunnel disease to Farmers Insurance Group, insurer of European Engine Products in whose employ claimant had sustained a compensable 1981 industrial injury. Farmers denied the claim on medical grounds May 31, 1984. In August 1984 Farmers received information that led it to believe that claimant's condition was the responsibility of Fairfield Home for the Aged, a.k.a. Fairfield Adult Foster Home (Fairfield). Fairfield had been adjudicated to be a noncomplying employer during the relevant period in May 1984 in an unrelated claim.

Farmers approached the Compliance Division regarding contacting Fairfield to determine whether one of the two should be designated a paying agent pursuant to ORS 656.307. The SAIF Corporation, on behalf of the Workers' Compensation Department and the Administrative Fund issued a denial of responsibility in September 1984. On September 20, 1984, on motion of Farmers, the Referee joined Fairfield as a party to the hearing. Although the question is not squarely before us, we question the propriety of Fairfield having been joined, since the record does not disclose that a claim was ever filed with Fairfield and SAIF represents

that one has not been filed. See Thomas L. Runft, 36 Van Natta 1660, 1661-62 (1984) (Pursuant to Board policy motions by one employer to join another employer against whom no claim has been filed consistently denied).

A hearing convened October 24, 1984. Claimant was not present at the hearing, however her attorney was present. Also present were the noncomplying employer and his attorney, the attorney for SAIF and the attorney for Farmers. The Referee's order was issued November 5, 1984. On November 14, 1984 claimant filed her request for Board review. The request certifies that copies of it were mailed to Farmers, its insured and its attorney and to the noncomplying employer and its attorney. Nowhere does there appear evidence that a copy of the request was mailed to SAIF or the Workers Compensation Department. SAIF has represented that it did not receive a copy of the request for review, a copy of the Board's acknowledgement of the request, the transcript of the hearing or a copy of the claimant's brief. Claimant's brief was received by the Board January 25, 1985. SAIF filed its motion to dismiss on February 14, 1985. More than sixty days after filing of the SAIF motion have passed and claimant has submitted no response.

We find the facts to be as represented by SAIF's attorney and agreed to by the attorney for the noncomplying employer. We note that Farmers' attorney specifically states that Farmers has no position with regard to SAIF's motion.

We find that neither SAIF nor the Department received a copy of claimant's request for review or actual knowledge thereof within thirty days after the Referee's order was issued. ORS 656.295(2) provides: "The requests for review shall be mailed to all parties to the proceeding before the referee." (Emphasis added.) SAIF was a party to the proceeding before the Referee and was present by counsel at the hearing. We believe that claimant's failure to mail copies of the request for review to SAIF is fatal to the request. As we read Argonaut Insurance v. King, 63 Or App 847, 852 (1983), the invalidity of claimant's request for review as to SAIF renders it invalid as to all parties. See also Junior L. Weatherford, 36 Van Natta 1705 (1984). Accordingly, claimant's request for review must be dismissed.

ORDER

Claimant's November 14, 1984 request for Board review of the Referee's order is dismissed. The Referee's order dated November 5, 1984 is final by operation of law.

DAVID F. BRAINERD, Claimant
Steven C. Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 82-08311 & 82-07045
April 26, 1985
Order on Reconsideration

EBI Companies has requested reconsideration of the Board's Order on Review dated March 29, 1985. In our previous order, we affirmed those portions of the Referee's order which found EBI responsible for claimant's left knee and low back conditions. However, we reversed that portion of the Referee's order which had set aside EBI's partial denial of responsibility for claimant's right knee condition. EBI contends we neglected to modify the Referee's award of attorney fees concerning this issue.

The Referee awarded $1500 for "services in reversal of the denial." At hearing the sole issue regarding claimant's left knee condition was responsibility. However, both responsibility and compensability of claimant's right knee and low back conditions were contested. Consequently, the attorney's fee award was apparently intended for prevailing on the issue of compensability for these latter two conditions.

Since we have found claimant's right knee condition noncompensable, it follows that a portion of claimant's award of attorney fees should be eliminated. Therefore, considering the efforts expended and the results obtained, we conclude that claimant's attorney fee award for services rendered at hearing should be reduced to $750. See OAR 438-47-010(1)(2).

Accordingly, EBI's request is granted. On reconsideration, with the above modification, the Board adheres to and republishes its former order.

IT IS SO ORDERED.

WALTER F. BRUNDAGE, Claimant
Pozzi, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 83-12217
April 26, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Neal's order which awarded no temporary total disability compensation on a claim of aggravation of a low back injury after claimant retired from employment for reasons unrelated to his injury and disabling condition. The issue on review is whether a retired worker is entitled to time loss compensation when his condition worsens such that if he were employed he would have to stop working.

The Board affirms and adopts the order of the Referee. See Stiennon v. SAIF, 68 Or App 735, rev. denied (1984).

ORDER

The Referee's order dated July 30, 1984, is affirmed.

MARVIN G. CHAPIN, Claimant
Allen & Vick, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-11921
April 26, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Leahy's order which affirmed the insurer's partial denial of chiropractic treatment for injuries to the low back. Claimant also seeks an insurer-paid attorney's fee for reducing the scope of the insurer's denial.

The Board affirms and adopts the order of the Referee. See Poole v. SAIF, 69 Or App 503 (1984); Hilary Russell, 37 Van Natta 470 (April 23, 1985); Clyde C. Wyant, 36 Van Natta 1067 (1984).

Claimant takes the position on review that the denial attempted to foreclose forever claimant's entitlement to treatment of his low back condition as it might worsen due to the compensable injury and that the Referee's order only upheld that portion of the denial that denied treatment in November 1983. We find the denial was based on medical opinions that the treatment was not required due to claimant's compensable injury and that claimant has not shown an aggravation of his compensable condition. ORS 656.245, 656.273. Therefore, the partial denial was not reduced by the Referee's order and claimant did not prevail on the denial issue and is not entitled to an attorney's fee award.

ORDER

The Referee's order dated August 24, 1984, is affirmed.

GEORGE M. GURLEY, Claimant
Steven C. Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-00079
April 26, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Danner's order which upheld the SAIF Corporation's February 17, 1984 denial of his back condition. Claimant also contends that the Referee erred in denying him access to certain of SAIF's investigative materials and that SAIF's refusal to provide these materials was unreasonable. SAIF cross-requests review of those portions of the Referee's order which awarded a 25% penalty and a $700 attorney fee for SAIF's alleged failure to pay temporary total disability compensation in a timely manner and alleged failure to furnish claims information in a timely manner pursuant to former OAR 436-83-460 (superceded 1984).

We first consider claimant's contention that he was wrongfully denied access to certain investigative reports. He contends:

> "The SAIF Corporation was in possession of some investigative materials which they provided to various physicians. These materials were alluded to in one of the physician's reports. As a result of this mention in the medical reports, claimant took the position that any alleged privilege was waived. He then requested that the materials be disclosed. The SAIF Corporation (on the morning of hearing) refused to provide the materials and withdrew the medical report that made reference to it. The SAIF Corporation took the position that this cured any lack of discovery and that claimant was not entitled to be provided with the materials that had been provided to the doctor, unless the report was admitted into evidence."

SAIF's responsibility to provide claims information in this

case is governed by former OAR 436-83-460 (superceded 1984). It in part provided:

> "Upon demand of any claimant requesting a hearing, the DRE/SAIF and its representatives shall within 15 days of mailing said demand furnish to claimant or his representative, without cost, copies of all medical and vocational reports and other documents relevant and material to the claim which are then or come to be in the possession of the DRE/SAIF or its representatives, except that evidence offered solely for impeachment need not be disclosed." (Emphasis added)

Claimant's January 4, 1984 request for hearing contained a request for copies from SAIF of all present and future medical documents and other information related to the claim. Although the Referee's order does not address claimant's entitlement to additional documents, and although neither the disputed documents nor the medical report allegedly referring to them are included in the record for our review, the materials that we do have suggest that the Referee, without directly reviewing the disputed materials, denied claimant's request on the basis that the impeachment exception of former OAR 436-83-460 excused their nondisclosure.

The disputed documents were not offered at hearing. Two witnesses did testify, however, that claimant had cut wood since the alleged injury, notwithstanding claimant's testimony to the contrary. These witnesses also testified that someone from SAIF had come to their shop to investigate. We surmise that the disputed materials relate at least in part to this investigation.

Former OAR 436-83-460 did not require pre-hearing disclosure of relevant and material documents so long as their use at hearing was limited to impeachment. It was the nature of their use, not the character of the documents with reference to the claim, that was and is determinative. As the record before us does not demonstrate that claimant was denied documents relating to evidence used at hearing for other than impeachment purposes, there is no basis to conclude that additional materials should have been provided.

The Board affirms and adopts the order of the Referee as it relates to compensability.

Finally, we consider the Referee's award of penalties and attorney fees for SAIF's alleged failure to pay temporary total disability compensation in a timely manner and alleged failure to furnish claims information in a timely manner. We find no proof that compensation was not timely paid. Absent such proof, the award of penalties and attorney fees was improper. See Darrel W. Carr, 36 Van Natta 16, modified, 36 Van Natta 164 (1984); ORS 656.262(10).

ORDER

The Referee's order dated August 6, 1984 is affirmed in part and reversed in part. Those portions of the Referee's order

awarding a 25% penalty and a $700 attorney fee for the carrier's alleged failure to pay temporary total disability and comply with OAR 436-83-460 in a timely manner are reversed. The Referee's order is affirmed in all other respects.

ROY M. HOKE, Claimant
Burt, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 83-07945
April 26, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Seymour's order which directed it to resume payment of permanent total disability compensation awarded by a Determination Order dated September 2, 1983, and imposed a penalty and associated attorney's fee based upon the permanent total disability benefits which were unpaid as of the date of the hearing. The broad issue is the propriety of the insurer's cessation of permanent total disability benefits. The narrow issue concerns the precise effect of another Referee's order in a prior proceeding.

Claimant sustained a compensable low back injury in September of 1979. The claim was initially closed by Determination Order in June of 1981, which awarded temporary disability and 80° (25%) unscheduled disability. In December of 1981 a stipulation was approved whereby the parties agreed that the claim should be reopened and temporary total disability paid as of March 31, 1981. Thereafter, on April 21, 1982, another Determination Order issued withdrawing the previous Determination Order and closing the claim with an award for temporary total disability and 160° (50%) unscheduled disability.

In September of 1982 the employer, through its service agency at the time, issued a formal denial of claim reopening for an allegedly worsened condition. In early December of that year claimant was admitted to the hospital with increased low back pain. Claimant was hospitalized for almost three weeks. On December 21, 1982 the employer issued another formal denial of claim reopening stating that there had been no worsening of claimant's injury-related condition.

On February 22, 1983 a hearing convened before Referee Daron in WCB Case No. 82-09021. The issues were claim reopening for a worsened condition pursuant to ORS 656.273, payment of medical services in connection with claimant's December 1982 hospitalization, pursuant to ORS 656.245, and penalties/attorney fees for unreasonable resistance to the payment of compensation. The record of that hearing was closed that same date.

On February 18, 1983, four days before the hearing before Referee Daron, claimant had been examined by Dr. Raaf, a neurosurgeon, apparently on referral by Dr. Burr, claimant's attending orthopedic physician. In a report dated March 3, 1983, addressed to Dr. Burr and copied to the employer's service agency, Dr. Raaf stated that claimant was presently incapacitated for any kind of work. He recommended reexploration and decompression of the nerve root between L4 and L5 on the left. The employer processed Dr. Raaf's report as another aggravation claim. After conferring with Dr. Buza, claimant's attending neurosurgeon, the employer formally denied the request for claim reopening on the

basis that claimant's condition had not "clinically" materially worsened. This denial was dated March 22, 1983.

On March 28, 1983 Referee Daron issued his order in WCB Case No. 82-09021. Among other things, he ordered that the employer accept and process a December 1982 aggravation claim, including payment of medical services and temporary total disability as of December 2, 1982. Because of its outstanding March 22 denial, the employer failed or refused to pay compensation or further process the claim as ordered by Referee Daron.

The employer requested Board review of Referee Daron's order.

Claimant requested a hearing contesting the employer's March 22, 1983 denial. A hearing convened before Referee Wilson in WCB Case No. 83-02989. Referee Wilson issued an order on May 23, 1983. The outcome of the present proceeding is determined by the effect given to this Referee's order, which became final by operation of law.

The record before Referee Wilson consisted of all documentary evidence made of record in the Daron proceeding. In addition, twelve other exhibits were admitted, including the March 3, 1983 Raaf report and the March 28, 1983 Daron order. Referee Wilson concluded that at the time of the employer's March 22 denial Referee Daron had jurisdiction of the proceeding, and that, "It was his [Daron's] responsibility to determine whether claimant's condition had worsened and whether an aggravation had occurred." Referee Wilson stated that the denial was "ill-advised," reasoning that it would have been preferable for the employer to request that Referee Daron reopen the evidentiary record upon receipt of the Raaf report. He also commented, however, that, "The documents received in this interim [after the Daron hearing and before issuance of the Daron order] would have added nothing to [the] case, even if admitted at a reconvened hearing." Referee Wilson found the employer's denial improper. He also concluded that the insurer's action, or non-action, constituted unreasonable resistance to the payment of compensation. His order concluded:

> "IT IS THEREFORE ORDERED that the denial issued on March 22, 1983 is disapproved and set aside.
>
> "IT IS FURTHER ORDERED that the employer pay all sums ordered by [Referee Daron] in his Opinion and Order of March 28, 1983, and employer is ordered to pay, as additional compensation in the form of penalty, an amount equal to 25 percent of the benefits payable to claimant from the date of cessation of those benefits to the date upon which such benefits are again resumed.
>
> " * * * * "

Referee Wilson also imposed an employer-paid attorney's fee pursuant to the provisions of ORS 656.382(1).

After issuance of Referee Wilson's order the employer paid compensation as previously ordered by Referee Daron. The claim

was processed to closure pursuant to ORS 656.268. On September 2, 1983 a Determination Order awarded claimant additional temporary total disability and permanent total disability effective July 19, 1983. The employer began payment of permanent total disability as ordered by the Determination Order.

On December 8, 1983 the Board entered its Order on Review in WCB Case No. 82-09021, the proceeding in which Referee Daron found that claimant had sustained a compensable aggravation as of December 1982. Roy M. Hoke, 35 Van Natta 1756 (1983). The Board reversed that portion of Referee Daron's order which set aside the employer's December 1982 aggravation claim denial. That denial was reinstated and affirmed. (The Court of Appeals has recently affirmed the Board's order insofar as it determined that there was no compensable aggravation. Hoke v. Libby, McNeil & Libby, 73 Or App 44 (1985)).

After receiving the Board's order, the employer terminated claimant's permanent total disability payments. In addition, the employer advised claimant of an overpayment of temporary total and permanent total disability benefits in excess of $14,000.

Claimant requested a hearing challenging the employer's termination of benefits and requesting penalties/attorney fees. A hearing convened before Referee Seymour on April 5, 1984, which resulted in the order presently on review. The sum and substance of Referee Seymour's rationale is that the employer was not justified in terminating claimant's permanent total disability payments because the September 2, 1983 Determination Order awarding permanent total disability was entered pursuant to Referee Wilson's order, which had become final by operation of law. Referee Seymour's order states in pertinent part:

> "The Workers' Compensation Board, by its Order on Review, found that there was no medical evidence of a worsening of claimant's condition from the June 24, 1981 Determination Order, to the December 21, 1982 denial letter. Obviously, in order for the Evaluation Division to have made the finding it did when it found the claimant to be permanently and totally disabled, there must have been evidence of a worsening after the December 21, 1982 denial. The worsening found by the Evaluation Division could easily have been based upon the worsening of pain found by Dr. Raaf in his March 3, 1983 letter, which was the subject of the insurer's March 22, 1983 denial, which denial was overturned by Referee Wilson's Opinion and Order, which Opinion and Order was not appealed."

Unlike Referee Seymour, we do not view Referee Wilson's order as "overturning" the employer's March 22, 1983 denial, in the usual sense. That is, we do not consider Referee Wilson's order as a ruling on the merits of an aggravation claim. As we read Referee Wilson's order, he found the denial procedurally improper and set it aside on that basis. Referee Wilson's order merely enforced the terms of Referee Daron's order and imposed a penalty/attorney's fee for the employer's failure to process the

claim. Referee Wilson ordered the employer to "pay all sums ordered by the Referee [Daron] in his Opinion and Order of March 28, 1983 . . . ." Referee Wilson made no independent findings concerning a possible worsening of claimant's condition, which would necessarily form the basis of a ruling on the merits of the employer's aggravation claim denial. Whether Referee Wilson correctly ruled that the procedures employed by the employer were proper is not a question before us.

Because of our conclusion that Referee Wilson's order did nothing more than enforce the terms of Referee Daron's order, it necessarily follows that the Determination Order which awarded permanent total disability (in addition to awarding temporary total disability "per Opinion and Order of March 28, 1983" -- the Daron order) was entered pursuant to Referee Daron's order reopening the claim as of December 2, 1982. The remaining question is the propriety of the employer's termination of permanent total disability upon issuance of the Board's Order on Review.

The issue of whether the employer was obligated to continue paying permanent total disability benefits after issuance of the Board's Order on Review rises and falls with the question of the effect to be given Referee Wilson's order. Claimant does not contend that the employer was obligated to continue payment of permanent total disability in the absence of a finding that Referee Wilson's order independently invested the Determination Order with some legal force or effect, nor would such an argument be persuasive. Once the Board issued its order reversing Referee Daron's order and reinstating the insurer's denial, the Board order became the "law of the case" with respect to all matters decided. The aggravation claim was then in denied status. Therefore, the September 2, 1983 Determination Order, which reclosed the claim pursuant to Referee Daron's order that the claim be reopened and processed to closure, was rendered a nullity. The employer was not thereafter required to pay any further compensation under the terms of the Determination Order. Accordingly, there was no resistance or refusal to pay compensation within the meaning of ORS 656.262(10) or 656.382(1), and no penalties or attorney fees are warranted.

ORDER

The Referee's order dated April 13, 1984 is reversed in its entirety.

JOHN P. KEEBLE, Claimant
Carney, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-11875 & 84-01661
April 26, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee Leahy's order which found that claimant was entitled to temporary disability benefits based on the wages he received at the time of his original compensable injury rather than the wages he received when he sustained a subsequent injury, while participating in a wage subsidy program. On review, SAIF contends claimant's temporary disability benefits should be based on the wages he received while participating in the wage subsidy program.

The Board affirms the order of the Referee with the following comment. We perceive no persuasive reason to distinguish an injury suffered while participating in a wage subsidy program from an injury suffered while participating in a nonremunerative authorized training program. The rationale is the same. The subsequent injury occurred during reasonable activities of vocational retraining which flow as a direct and natural consequence from the primary injury. See Firkus v. Alder Creek Lumber, 48 Or App 251 (1980), rev den, 292 Or 302 (1982); Wood v. SAIF, 30 Or App 1103, rev den, 282 Or 189 (1978). To conclude otherwise would serve as a disincentive to injured workers contemplating vocational rehabilitation through wage subsidy agreements and would be contrary to the general objective of the Workers' Compensation system to restore the injured worker to productive employment.

ORDER

The Referee's order dated June 29, 1984 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

CURTIS M. LYON, Claimant
Myrick, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04398
April 26, 1985
Order on Remand (Remanding)

This case is before the Board on remand from the Court of Appeals. The court has instructed us to remand this matter to a Referee for the purpose of considering additional evidence submitted by claimant directly to the court. ORS 656.289(6).

NOW, THEREFORE, this matter is hereby remanded to Referee Phillip A. Mongrain for further proceedings in accordance with the court's Order Remanding for Taking Additional Evidence, entered April 22, 1985.

IT IS SO ORDERED.

OLIN D. MONKS, Claimant
David C. Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-00464
April 26, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee T. Lavere Johnson's order which: (1) set aside the SAIF Corporation's denial of medical services and awarded a $250 attorney's fee for prevailing on the denial; (2) affirmed a Determination Order dated July 12, 1983, which awarded 144° for 45% unscheduled disability for injury to claimant's left shoulder; and (3) declined to impose a penalty/attorney's fee. Claimant contends that he should be awarded an additional attorney's fee for prevailing on SAIF's denial; that he is entitled to an additional unscheduled award; and that penalties and attorney fees are appropriate for SAIF's allegedly unreasonable denial. In its respondent's brief, SAIF challenges the Referee's conclusion that the denied medical services are compensable.

We affirm the Referee's order in its entirety. Claimant contends that, in the absence of a cross-request for review, SAIF

may not challenge that portion of the Referee's order setting aside its denial. We disagree. Jimmie Parkerson, 35 Van Natta 1247 (1983). Claimant's attorney would have been entitled to an insurer-paid fee on Board review had he addressed the merits of this additional issue raised in SAIF's respondent's brief. Judy M. Friedrich, 36 Van Natta 1210, 1211 (1984); see Teel v. Weyerhaeuser Co., 294 Or 588 (1983). Claimant's reply brief, however, has not addressed the merits of the issue raised by SAIF; therefore, no attorney's fee is warranted.

ORDER

The Referee's order dated February 27, 1984 is affirmed.

GREGORY N. MOONEY, Claimant
James W. Powers, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Stoel, et al., Defense Attorneys

WCB 84-00855 & 84-00568
April 26, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Les Schwab, a self-insured employer, requests review of Referee Podnar's order which set aside its denial of claimant's low back injury aggravation claim and which upheld the SAIF Corporation's denial of claimant's low back injury claim on behalf of its insured, Consolidated Pine, Inc., for an incident on October 24, 1983. Les Schwab additionally cites as error the Referee's exclusion of four exhibits. Claimant requests an increase in the attorney fee awarded.

Claimant's first industrial injury was May 7, 1982, while employed by Les Schwab, after which claimant returned to work for the same employer and suffered occasional exacerbations of his symptoms. His treating doctor increased his lifting limit to one hundred pounds in February 1983. Claimant moved and began working for SAIF's insured in September 1983. He testified that he felt stiff and sore from the work on the planer chain, but he had been able to handle it. On October 24, 1983 claimant lifted and twisted a four foot long 4x12 and felt an immediate sharp pain. He continued to work for a day and a half, but then was in too much pain to continue working and sought medical help.

We find that the incident on October 24, 1983 was a new injury. Claimant's treating physician, Dr. Atkins, opined that claimant had suffered a new injury which was aggravated by the prior injuries. After reviewing all of claimant's records, Dr. Atkins still believed that the new injury made an independent contribution to claimant's condition, although he opined that the problem would currently be less if there had not been the earlier injuries. It was the type of sudden traumatic event capable of causing this type of injury and which, in fact, did cause claimant to require medical treatment and to lose time from work, which transfers responsibility from the earlier employer to the later employer. See Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Sylvia J. Roberts, 36 Van Natta 613 (1984).

Because we find that responsibility for claimant's condition lies with the SAIF Corporation as the insurer on the risk at the time of the later injury, the award of an attorney's fee against Les Schwab is also reversed. It appears from the record that claimant retained his attorney after the order under ORS 656.307 was issued. Claimant took no position at hearing and on review as

to which employer is responsible; therefore, there will be no attorney fee award. Wilfred Pultz, 35 Van Natta 684 (1983); Robert Heilman, 34 Van Natta 1487 (1982).

In view of the disposition of the responsibility issue, the propriety of the Referee's exclusion of exhibits is moot.

ORDER

The Referee's order dated June 15, 1984 is reversed. The denial of Les Schwab of January 19, 1984 is reinstated and the award of attorney fees against it is vacated. The denial of the SAIF Corporation of December 23, 1983, as amended January 4, 1984, is set aside and the claim is remanded to SAIF for processing according to law. SAIF shall reimburse Les Schwab for all claim costs paid pursuant to the Referee's order.

CLIFFORD L. PIERPOINT, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-09140
April 26, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of that portion of Referee Quillinan's order which upheld the SAIF Corporation's denial of his aggravation claim for a low back injury. On review, claimant contends that his compensable condition has worsened. SAIF cross-requests review of that portion of the Referee's order which assessed penalties and accompanying attorney fees for failing to properly deny medical bills.

We affirm that portion of the Referee's order which found that claimant had failed to establish a compensable aggravation. We also affirm that portion of the Referee's order which assessed SAIF a penalty for an improper denial of claimant's medical bills. However, we modify the Referee's attorney fee award of $800. Attorney fee awards are based on efforts expended and results obtained. OAR 438-47-010(2). Generally, "results obtained" in the form of medical services are considered to be rather modest. Derry D. Blouin, 35 Van Natta 570 (1983). Considering the efforts expended and the results obtained by claimant's attorney in establishing not only SAIF's unreasonable conduct in issuing an improper denial, but also in securing payment for medical treatments pursuant to ORS 656.245, we conclude that an attorney's fee of $600 would be more appropriate.

ORDER

The Referee's order dated August 9, 1984 is affirmed in part and modified in part. Claimant's attorney is awarded $600 for prevailing at hearing on the medical treatment issue and the penalty issue. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $150 for services rendered on Board review relating to the penalty issue, to be paid by the SAIF Corporation.

ROBERT E. PITTMAN, Claimant (Deceased)
Joel B. Reeder, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Ass't. Attorney General
Reviewed by Board Members Ferris and Lewis.

WCB 83-01462 & 83-01463
April 26, 1985
Order on Review

Claimant requests review of that portion of Referee Mongrain's order which upheld the SAIF Corporation's partial denial of responsibility for his low back medical treatment. On review, claimant contends his current low back treatment was causally related to his 1975 compensable injury.

The Board affirms the order of the Referee with the following comment. The parties have advised us that subsequent to the Referee's order claimant died from injuries sustained in an automobile accident. SAIF has moved for dismissal, contending the Board lacks jurisdiction because the identity of claimant's beneficiaries, if any, is unclear. We deny SAIF's motion. If a worker has filed a request for hearing and death occurs prior to the final disposition of the request, the worker's surviving spouse or children under the age of 18 shall be entitled to pursue the matter to final determination of all issues presented by the request for hearing. See ORS 656.218(3), (5); ORS 656.204. Our de novo review of the record reveals that although claimant apparently was divorced, he is survived by a daughter who meets these statutory requirements. Consequently, claimant's surviving child is entitled to pursue this matter to final determination.

ORDER

The Referee's order dated July 31, 1984 is affirmed.

KATHY I. SMITH, Claimant
Steven C. Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Marcus K. Ward, Defense Attorney
Reviewed by Board Members McMurdo and Ferris.

WCB 83-03432 & 83-06838
April 26, 1985
Order on Review

The SAIF Corporation requests and cross-requests review of Referee Howell's order. In its capacity as the insurer for Family Counseling Service of Lane County, SAIF requests review of that portion of the Referee's order which set aside its denial of the compensability of claimant's 1983 back condition and found it responsible for payment of compensation to claimant. In its capacity as insurer for Central Oregon Council on Aging, Inc. (COCA), SAIF cross-requests review of that portion of the Referee's order which found claimant's current back condition compensable. The Referee upheld COCA/SAIF's aggravation claim denial based upon his determination that Family Counseling is liable for payment of claimant's compensation. The issues on review are compensability of claimant's back condition beginning in early 1983; and, assuming it is compensable, which employer is responsible for payment of claimant's compensation.

On our de novo review, we conclude that claimant has failed to establish by a preponderance of the persuasive evidence that her current condition is compensable, either as an aggravation of her compensable 1982 injury (COCA/SAIF) or as a new industrial exposure while working for Family Counseling during the latter months of 1982. Therefore, we reverse the Referee's order.

Claimant had no back problems until May 26, 1982. On that date, while she was working as a homemaker performing housework for one of COCA's elderly clients, she experienced the immediate onset of back pain while lifting a vacuum cleaner. Claimant was treated by Dr. Lang, a chiropractic physician, who noted claimant's complaints of left, mid back pain. He diagnosed left intercostal strain at the T8 to 10 levels. Chiropractic manipulation with physiotherapy was administered. Claimant was released to regular work on June 17, 1982, and she returned to work. Dr. Lang released claimant from his care on July 7, 1982; however, she returned to his office on July 12, apparently having experienced an exacerbation of her back condition. Dr. Lang anticipated that claimant's condition would become stable within two to three weeks. Claimant apparently was dissatisfied with the treatment provided by Dr. Lang. This prompted her consultation with Dr. Newby, a neurosurgeon. Dr. Newby examined claimant on August 13, 1982. He diagnosed thoracic strain. The complaints recorded in his office notes are described as pain immediately below the tip of the left shoulder blade, occasionally radiating into the left leg, left arm and left temporal region of the scalp. Dr. Newby found no paraspinal muscle spasm. He prescribed Clinoril, an anti-inflammatory medication, exercise and swim therapy. He indicated that claimant was to continue working. He scheduled claimant for a return visit during the first part of September for a repeat evaluation. Claimant never returned to Dr. Newby, apparently as a result of her move from the Bend area to the Eugene/Springfield area in September of 1982. At that time claimant was essentially free of any back complaints.

Although the claim was initially closed by a Determination Order on August 24, 1982, that Determination order was rescinded in view of claimant's July exacerbation. The claim was officially closed on October 27, 1982 with an award for temporary total and temporary partial disability only.

In September of 1982 claimant began working part time for Family Counseling. Her job duties required her to care for a paraplegic woman (also referred to as a quadraplegic woman in various portions of the record) and her son in their home. Claimant's job duties included moving the woman into and out of her waterbed and wheelchair. Claimant was uncertain of the woman's weight, but believed that she weighed more than 100 pounds, possibly 135 pounds. Although claimant did not testify to or otherwise relate this fact, her most recent attending chiropractic physician, Dr. Carlstrom, testified that the history in his office notes reflected that claimant moved this woman "with another's help."

Claimant began to experience neck, shoulder, upper back, mid back and, apparently, low back pain sometime during November of 1982. She continued to work until January of 1983, when she had to quit because of the pain. In early January of 1983, she came under the care of Dr. Carlstrom. The 829 form (Change of Attending Physician) completed by Dr. Carlstrom describes claimant's complaints as, "mid back pain, high back pain, neck pain, headaches, leg pain, low energy, more irritable, more nervous, loss of sleep." The form also notes, "pain and tenderness in the neck, pain and tenderness in the high back, pain and tenderness in the mid back, pain and tenderness in the low back." (Dr. Carlstrom testified at the hearing and stated that

claimant did not express any complaints of low back pain during her initial visit, according to his office notes.) Dr. Carlstrom's x-ray findings were, "multiple misalignments of the cervical-dorsal, lumbo-sacral areas." He diagnosed, "chronic cervical and dorsal sprain-strain with muscle spasm, myositis and radiculalgia with associated reoccurring headaches." Chiropractic manipulative therapy was administered, and Dr. Carlstrom estimated that claimant would require two to three months of treatment. Dr. Carlstrom's office verified claimant's inability to work as of January 10, 1983.

Claimant was examined by Dr. Degge, an orthopedic surgeon, at SAIF's request on or about March 1, 1983. At that time claimant had no complaints concerning her "upper back." She was experiencing neck and low back symptoms, however. He described claimant as ". . . an obese 32 year old female five foot one and three quarter inches in height weighing 198 pounds." Dr. Degge found no visible or palpable paracervical muscle spasm in either the cervical or dorsal lumbar areas of claimant's spine. There was full range of motion of the cervical and dorsal lumbar spine, and all motions were accomplished without pain. X-rays of the cervical and lumbar spine disclosed a spine that was in "good alignment." Dr. Degge commented that there was no evidence of subluxations, dislocations or malalignments. Nor was there any evidence of skeletal injury. He diagnosed a strain of the dorsal spine, "by history," resolved; postural low back pain; muscle tension headaches; functional overlay; and exogenous obesity. He commented that, as reported by earlier examiners, claimant had sustained a strain of her dorsal spine as a result of her May 1982 injury, but that she did not develop pain in her neck or lower back until this was reported by Dr. Carlstrom in January of 1983, eight months following the injury. He considered claimant as suffering from tension-type headaches secondary to a functional overlay. He stated that claimant's postural low back complaints were aggravated by her obesity, and that, "There is very little in the way of clinical or x-ray findings to support the degree of disability this workman is alleging." He considered claimant's symptoms to be largely functional in origin. He found claimant's work related dorsal spine injury stationary, stating that claimant could return to the same occupation with limitations in bending and lifting due to her postural low back complaints. Dr. Degge found "no evidence whatsoever of aggravation of injuries growing out of the accident of May 26, 1982."

On March 14, 1983 SAIF issued a denial of claimant's aggravation claim in connection with her May 1982 COCA injury.

On or about June 15, 1983 claimant filed a claim with Family Counseling. The claim was initially deferred by SAIF.

On June 24, 1983 Dr. Carlstrom reported that claimant had improved to the point of being medically stationary as of June 7, 1983. He stated that she had responded to treatments, but that she was subject to aggravation. He anticipated a need for one to two treatments per month for the "immediate future." His examination of June 7, 1983 reflected ranges of motion of the thoracolumbar and cervical spine that were within normal limits. Claimant experienced only minimal pain with digital pressure to the spine.

Claimant was examined by Dr. Fechtel, a chiropractic physician, on or about July 15, 1983, at SAIF's request in

connection with the Family Counseling claim. The history that he took with regard to the May 1982 injury was that, "[Claimant] noted severe pain in the left lower back which occurred as she lifted, the[n] got worse during the course of that day." (Emphasis added.) The complaints described by claimant included neck, shoulder and low back discomfort, characterized primarily as "pressure." Dr. Fechtel's physical examination was limited to the lumbosacral spine. He found full and unrestricted lumbar range of motion. He examined the x-rays available from Dr. Degge's office consisting of multiple projections of the cervical and lumbar spine. He agreed with Dr. Degge's assessment of good general alignment without pathology or fracture at any level, although he interpreted the lateral projection of the lumbar spine as demonstrating a slightly reduced lordosis. Dr. Fechtel diagnosed thoracic strain, "consistent with mechanism of accident, per the 1982 on-the-job incident," which was resolved; thoracolumbar strain, by history, and marked obesity. He found no evidence of permanent impairment of the lumbosacral spine.

Dr. Fechtel obviously took some time to discuss with claimant her personal and medical history. He formed the impression that claimant had recently been widowed. He also concluded that claimant was experiencing "significant musculoskeletal stress due to rapid weight loss and gain. His report states:

> "In history taking, this patient reports that she has been subjected to significant emotional distress. * * * [claimant] indicates that prior to her accident in 1982, she weighed 165 which represented a 75 pound weight loss. Then after her husband died, she gained back to 210. She has lost at this exam approximately 10 pounds and is doing this through proper eating practice. It is believed that these two factors set the stage for the discomfort this patient reports occurring over the November, December, and January, 1983 period. I must agree with Dr. Degge that there appears to be no aggravation of the 1982 incident. The 1983 discomfort is separate and distinct."

In view of the "emotional and physical milieu" that he considered claimant to be undergoing during late 1982/early 1983, and in the absence of any particular incident that could be identified as an onset of claimant's pain, he concluded that claimant's work activities for Family Counseling had very little to do with the onset of her problems. He considered it likely that her back pain would have occurred with any duty at home or at work.

Claimant apparently indicated that she felt she was incapable of continuing to work in her present condition. Dr. Fechtel considered this inconsistent with his objective findings on examination. He recommended that claimant continue an appropriate weight loss program and significant exercise therapy in order to alleviate her discomfort. He also informed claimant that she was capable of returning to whatever work she desired without limitations. On the basis of his physical examination and review of the medical reports, he stated his concurrence with the conclusions stated in Dr. Degge's report.

On July 18, 1983 SAIF formally denied claimant's claim with Family Counseling.

The parties deposed Dr. Fechtel prior to the hearing. He indicated that the emotional stress he perceived claimant undergoing would, in and of itself, account for claimant's physical or musculoskeletal discomfort. He also indicated that the fluctuation in claimant's weight, as he understood it, would have been a material contributing cause to the onset and continuation of her back problems. He clarified that his examination disclosed no significant orthopedic problem.

At the hearing claimant testified that as a result of her May 1982 injury she initially experienced mid and upper back pain. She had no pain in her lower back until she returned to work approximately one month after her injury. The symptoms that prompted her return to Dr. Lang in July of 1982 included not only mid and upper back pain, but low back pain as well. Thus, her testimony is somewhat at odds with the history reflected by contemporaneous medical reports, which report complaints of mid back pain, as opposed to upper and low back pain, in May and August of 1982. This portion of the record supports the conclusion that claimant developed multifarious back complaints after she completely recovered from her May 1982 injury and her claim was closed, not sometime prior thereto as her testimony suggests.

Dr. Carlstrom testified at the hearing. It was his opinion that claimant's condition resulted from a combination of her May 1982 back injury and her work activities for Family Counseling. He testified:

> "I felt that . . . the vacuum incident was . . . the area that was -- that gave rise to the mid-back . . . mid to upper back and the beginnings of the lower back, and the second one had the . . . effect of making . . . the condition worse, and making it more widespread."

The Referee discounted Dr. Degge's opinion based upon his conclusion that Dr. Degge "erroneously understood that claimant had no low back or neck symptoms until January 1983." He also found it significant that Dr. Degge's report contains no reference to claimant's job duties with Family Counseling involving the moving and lifting of claimant's disabled client. We have already noted that claimant's testimony is at odds with the history reflected by contemporaneous medical records. The records, in fact, do support Dr. Degge's conclusions concerning the localized complaints associated with claimant's initial injury and the later onset of more widespread complaints. We are uncertain whether Dr. Degge's failure to note claimant's more recent employment is due to his failure to take an accurate history or claimant's failure to relate activities she deemed significant in the onset of her increasing problems.

There is at least an inference that the fault lies with claimant. When claimant was examined by Dr. Degge, she had not yet filed a claim with Family Counseling. It is possible that, at that point in time, she did not consider her more recent

employment significant in the onset of her back complaints. In addition, when claimant was examined by Dr. Fechtel after she filed the claim with Family Counseling, although she described her work activity involving caring for and moving a disabled patient, she failed to inform Dr. Fechtel that she was assisted in moving her patient, a fact she shared with Dr. Carlstrom only. Since she failed to inform Dr. Fechtel of this seemingly significant fact, it is plausible that she failed to inform Dr. Degge of her specific work activities for Family Counseling. In any event, Dr. Degge was aware of the fact that claimant had been employed in patient care as recently as early January of 1983. Furthermore, he was concerned primarily with the possible connection between claimant's May 1982 injury and her complaints at the time of his examination in early 1983.

Dr. Fechtel was aware of claimant's work activities with Family Counseling, and he concurred with Dr. Degge's conclusions. In addition, Dr. Fechtel believed that claimant's current low back complaints were more a product of recent fluctuations in her weight, and emotional stress associated with the loss of her husband. Dr. Fechtel was mistaken in his belief that claimant was recently widowed; however, in fact, claimant did suffer the loss of a brother in September of 1982. Although claimant testified that she was not under "any particular stress" as a result of her brother's death, she also testified that she felt "both grief and relief" upon his passing.

It is claimant's burden to prove the compensability of her claim. This claim is compensable either as an aggravation of claimant's May 1982 injury with COCA, or as a new exposure with Family Counseling. We believe that if the claim with Family Counseling is compensable at all, it is compensable as an occupational disease, as opposed to an industrial injury. O'Neal v. Sisters of Providence, 22 Or App 9 (1975); White v. SIAC, 227 Or 306, 322 (1961); see also Donald Drake Co. v. Lundmark, 63 Or App 261 (1983); Valtinson v. SAIF, 56 Or App 184 (1982); Clarice Banks, 34 Van Natta 689, 692-96 (1982), affirmed United Pac. Reliance, Inc. v. Banks, 64 Or App 644, 648-49 (1983). Therefore, in order for claimant to establish the compensability of her claim with Family Counseling, she must establish that her work activity for that employer constituted the major contributing cause of her condition. Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570 (1982).

Considering the circumstances of this case, including the fact that claimant apparently recovered from the effects of her May 1982 injury, returned to work for a period of time, and then gradually began to experience the onset of symptoms, not only in the area of her original injury, but throughout her entire spine, we believe that it is incumbent upon claimant to produce persuasive medical evidence of a causal connection between her original 1982 injury and her condition in January of 1983 and thereafter. See Uris v. Compensation Department, 247 Or 420, 424 (1967); see also William C. Myers, 36 Van Natta 851, 855 (1984). We believe that the same holds true of claimant's occupational disease claim with Family Counseling. In either case, claimant can satisfy her burden of proof only if we find that the medical/chiropractic opinion evidence preponderates in favor of her claim.

Weighing the respective medical opinions in the light most favorable to claimant, and considering those opinions in the context of the facts and circumstances concerning claimant's back and associated problems, we find and hold that claimant has failed to establish the compensability of her claim by a preponderance of the persuasive evidence. There is no medical opinion even suggesting that claimant's work activities for Family Counseling constituted the major contributing cause of her 1983 back condition. Although there may have been some contribution, we find that it certainly does not amount to major causation. There are two professionals who hold the opinion that claimant's recent back problems are not causally related to her 1982 COCA injury. The circumstantial factors in this case, as partly established by claimant's testimony, tend to support the conclusion that these opinions lie closer to the truth than the contrary opinion of claimant's attending chiropractic physician.

Claimant has failed to establish the compensability of her current condition as an aggravation of her May 1982 COCA injury. Claimant also has failed to establish the compensability of her new claim with Family Counseling. Therefore, the denials issued in behalf of both employers should have been upheld, and we modify the Referee's order accordingly.

ORDER

The Referee's order dated May 31, 1984 is reversed in part and modified in part. That portion of the Referee's order which set aside the SAIF Corporation's July 18, 1983 denial is reversed, and that denial, issued in behalf of Family Counseling, is reinstated and affirmed. To the extent that the Referee intended to partially set aside the SAIF Corporation's March 14, 1983 aggravation claim denial, issued in behalf of COCA, insofar as the denial is a denial of compensability, the Referee's order is modified, and that denial is upheld in its entirety.

ROSALIE L. TOPE, Claimant
Galton, et al., Claimant's Attorneys
Tooze, et al., Defense Attorneys

WCB 84-02526
April 26, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Braverman's order that upheld the insurer's denial of claimant's claim for aggravation of her accepted psychiatric condition. The issue is compensability.

The Board affirms and adopts the order of the Referee. We would only add that claimant's attorney's opening remarks at hearing to the effect that claimant's condition represents "peaks and valleys" to be expected considering the extent of her disability is exactly what was contemplated by her already substantial award of permanent partial disability. No suggestion is made that claimant is not entitled to medical services under ORS 656.245, if required.

ORDER

The Referee's order dated June 29, 1984 is affirmed.

KARL J. WILD, Claimant
Tamblyn & Bush, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Rankin, et al., Defense Attorneys

WCB 83-06997 & 84-02862
April 26, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Peterson's order that set aside its denial of responsibility for claimant's low back condition and ordered it to reimburse Argonaut Insurance Company for temporary disability benefits paid to claimant pending Argonaut's denial of claimant's aggravation claim. The issue is responsibility.

We address first the question whether claimant's low back condition was conceded by the insurers to be compensable. At the hearing, there was a colloquy among counsel and the Referee which, we find, distills down to a stipulation by counsel for Argonaut and SAIF that there was no dispute that claimant's compensable condition had worsened, and that the question to be resolved was industrial causation. In simpler terms, the issue is whether claimant suffered an aggravation of his 1981 injury for which Argonaut is responsible or a new injury or disease for which SAIF would be responsible.

In June of 1981 claimant sustained what was diagnosed as an acute back strain while he was employed by Argonaut's insured. His symptoms included low back pain with radiating pain into his right buttock and right leg, occasionally down to the foot. Claimant was treated conservatively by Dr. Schuler, an orthopedist, and ultimately his claim was closed by a Determination Order issued March 30, 1982 that awarded no permanent disability. The record contains evidence that claimant continued to exhibit symptoms after claim closure and that claimant sought treatment on occasion.

On April 1, 1983 claimant returned to Dr. Schuler complaining of a resumption of low back pain with pain radiating into his right leg. Dr. Schuler characterized claimant's pain as an exacerbation of the same pain claimant was treated for about one year previously. At this time claimant was employed by SAIF's insured. Dr. Schuler authorized time loss as of April 18, 1983.

On April 26, 1983 claimant consulted Dr. Vessely, an orthopedic surgeon. Dr. Vessely also characterized claimant's symptoms as an ongoing exacerbation of low back pain and gave his clinical impression of a herniated lumbar disc. Dr. Mason, a neurosurgeon, examined claimant on May 4, 1983 and noted that claimant's range of motion was markedly limited and that claimant exhibited a positive straight leg raising at 10° on the right. A myelogram performed on May 10, 1983 showed a herniated nucleus pulposus on the right at L5-S1. On May 23, 1983 Dr. Mason performed a lumbar laminectomy during which he found and removed a disc fragment that had extruded into the spinal canal. Claimant recovered uneventfully and no longer has symptoms of radiculopathy.

On July 11, 1983 Argonaut denied claimant's aggravation claim. At the time, Argonaut's theory appeared to be that claimant's condition and surgery were caused by one or both of two intervening, nonemployment-related incidents, a motor vehicle accident and/or a furniture lifting incident.

Dr. Schuler, who was no longer treating claimant, when informed of the motor vehicle accident and shown photographs of the wrecked vehicle, changed his opinion and concluded that claimant's condition was probably due to the accident. Dr. Mason opined on November 1, 1983, "It is my feeling that the patient's current lumbar problem had its origin with his initial injuries, and I do not feel that this is a new secondary process that has occurred more recently." When he rendered that opinion, Dr. Mason did not know about the motor vehicle accident. When he was informed about the accident, Dr. Mason noted that claimant had never mentioned it to him. He went on to state that if the 1981 injury was benign and claimant required treatment after the accident, that he would conclude that the accident contributed significantly to claimant's overall back problem. Dr. Mason concluded by stating that Dr. Schuler, as the treating physician at the time, would be in a better position to evaluate causation.

On January 9, 1984, after discussing the motor vehicle accident with claimant, Dr. Mason opined that, if claimant's description of the accident was accurate, claimant's back problem was, in his opinion, secondary to his industrial injury. Claimant and his brother, who was also in the accident, both testified that the accident involved the car hitting a tree at about ten miles per hour and that neither claimant nor his brother were injured.

On January 23, 1984 Dr. Mason wrote that claimant's employment at SAIF's insured was the cause of claimant's back problems. Dr. Mason's opinion is conclusory in the extreme, and there is no indication in the record that Dr. Mason had any knowledge of what claimant did for SAIF's insured, whether claimant suffered a discrete new injury, or why the doctor concluded as he did. On February 12, 1984 claimant submitted a Form 801 in which it was claimed that claimant had injured his low back while loading a semitrailer for SAIF's insured on March 27, 1983. SAIF denied this claim on March 9, 1984. At the hearing, claimant specifically denied that there was any discrete incident of injury while employed by SAIF's insured. Claimant's counsel agreed that in order for the Referee to hold SAIF responsible for claimant's condition, claimant would have to prove an occupational disease.

The Referee's findings and opinion were entered on the record at the close of the hearing. As we read the Referee's findings, he attributed claimant's ultimate need for surgery to work exposure at SAIF's insured, although he referred to the result of that exposure as both an occupational disease and a new injury. We disagree.

We find that the preponderance of the medical evidence is persuasive that claimant had a disc herniation from 1981 on. There is no persuasive medical evidence tending to link claimant's employment at SAIF's insured to any portion of claimant's back problem, either as a new injury or an occupational disease. Dr. Mason's opinion that SAIF's insured is responsible is one of three differing opinions he rendered as to the etiology of claimant's back problem, and that opinion is totally without foundation. We assign it little weight. See Moe v. Ceiling Systems, 44 Or App 429 (1980). See also OAR 438-07-005(2) (form and content of medical reports as evidence).

Argonaut relies upon Industrial Indemnity v. Kearns, 70 Or App 583, 587 (1984), for the proposition that SAIF in this case must overcome a rebuttable presumption that it is responsible for claimant's condition. We find that Kearns is distinguishable from this case. In Kearns, claimant had a documented injury at the second employment. To, in effect, shift the burden to the second employer under those facts was consistent with Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984). However, where, as in this case, there is no evidence whatsoever of a second injury, and where claimant expressly disavows such an injury, Kearns has no application.

In his findings, the Referee referred to Garbutt v. SAIF, 297 Or 148 (1984), in support of his finding that a claimant's claim could be made out on his testimony alone. While that proposition may be true in the abstract under the Garbutt holding, Garbutt itself recognizes the reality that lay testimony may not carry the burden of proof. 297 Or at 151. Where complex issues of medical causation are involved, expert medical evidence is usually required. Uris v. Compensation Department, 247 Or 420, 424 (1967). In the final analysis, Garbutt v. SAIF, supra, does not establish a rule of the sufficiency of proof, merely a jurisdictional threshold. 297 Or at 152 (Peterson, C.J., dissenting).

We find that the question whether claimant's employment at SAIF's insured was a factor in claimant's need for back surgery is a complex medical question, requiring expert medical evidence for its resolution. Claimant's testimony is insufficient to persuade us that his work at SAIF's insured caused or actually contributed to his herniated disc. See Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984); SAIF v. Brewer, 62 Or App 124, 129 (1983); Smith v. Ed's Pancake House, 27 Or App 361, 365 (1978). We find that claimant "is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury." ORS 656.273(1).

Because of our decision on insurer responsibility, we find it unnecessary to discuss SAIF's further contentions regarding attorney fees and reimbursement for temporary disability benefits.

We note that claimant's attorney's participation on Board review was directed in large part at the issue of whether nonemployment-related incidents were the major cause of claimant's need for surgery. This was an argument as to compensability, not responsibility, and neither insurer argued on review that claimant's back surgery was not compensable. Claimant's attorney's participation on review was, thus, not meaningful, in the sense that it did not contribute to the review process. Cf. OAR 438-47-090. No attorney fee will be awarded on Board review.

ORDER

The Referee's order dated July 16, 1984 is reversed. The SAIF Corporation's denial dated March 9, 1984 is reinstated and affirmed. Argonaut Insurance Company's denial dated July 11, 1983 is set aside and claimant's claim is remanded to Argonaut Insurance Company for further processing and closure pursuant to ORS 656.268. The attorney fee for services at hearing ordered paid to claimant's attorney by the SAIF Corporation shall be paid by Argonaut Insurance Company.

ROBERT D. CRAIG, Claimant
Roger D. Wallingford, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 82-11435
April 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requested review of Referee Mulder's order dated July 6, 1983 which upheld the insurer's backup denial of his cervical condition and set aside the Determination Order dated April 22, 1982. At the time of the Referee's decision, justification for issuing a backup denial was set out by the decision in Bauman v. SAIF, 62 Or App 232 (1983). In the interim between the Referee's decision and our review, the Supreme Court reviewed Bauman v. SAIF, 295 Or 788 (1983), and we remanded to the Referee, ORS 656.295(5), to develop the case further on the issue of fraud or misrepresentation. Robert D. Craig, 36 Van Natta 355 (1984). A hearing was held and the Referee issued his Opinion and Order finding that the insurer had sufficient justification to issue its backup denial. Claimant requests review of Referee Mulder's order after hearing on remand. The issues on review are the sufficiency of the insurer's basis for issuing a backup denial and compensability.

We reviewed the relevant facts in our original Order on Review (Remanding). Robert D. Craig, supra. One addition must be made to that recital to complete the findings of fact. Claimant made a claim for aggravation on October 25, 1982, through his attending physician, Dr. Markham. As a result of that claim, the insurer obtained an independent medical examination by Dr. Rosenbaum.

Claimant was the only witness at the second hearing. He stated he now believes that the "all consuming" pain incident at the curb probably happened in April 1981, before he discontinued his karate discipline, rather than in January 1982, as he told Dr. Podemski in February 1982 and Dr. Markham in March 1982. He is sure that he told both doctors about the sudden onset of severe "all consuming" pain. He responded to the physicians' questions and elaborated where he could on specific points, but the doctors did not ask him if there were intervening accidents or injuries between January 1980 and February 1982. He testified that when Dr. Rosenbaum interviewed him in December 1982, claimant described the progression of his symptoms, including an over-dramatized account of the curb incident which at that time he felt happened in January 1982.

The Referee found claimant testified credibly at both hearings. That claimant was credible at hearing does not explain inconsistencies in the histories recorded by the various doctors in this case nor claimant's inability to provide a reasonably clear date when his neck and arm pain became "all consuming." It is incredible that this claimant who testified that he felt this "all consuming" pain in April 1981 continued to participate in his karate discipline for two months and then waited seven more months before seeking definitive medical care of the condition. It is far more probable that he sought appropriate care for his neck and arm conditions almost immediately, in January 1982, and that is in accord with the histories recorded by the all the doctors in spite of claimant's current assertion that their histories are incorrect. Equally difficult to reconcile is the lessening

difference between the alleged date of injury and onset of symptoms. Dr. Podemski reported that claimant said he had intermittent neck pain since a 1959 motor vehicle accident and chronic neck and left arm pain began December 1981. Dr. Markham reported that claimant said his left shoulder pain began three or four months after the January 1980 incident. Dr. Rosenbaum reported that claimant said the pain began within one month of the January 1980 incident. Claimant testified that the pain began within three weeks of the undated January 1980 incident. Although claimant testified credibly, his unreliability as a historian makes his theory of causation implausible and irreconcilable with his prior statements. Cf. Randal R. Senner, 36 Van Natta 1126 (1984).

Taking the development of the record at the time the insurer first accepted the claim and processed it to closure by Determination Order, the insurer reasonably relied on claimant and his treating doctors to accept the claim as work-related. There was no indication in the record that the attending physican had considered the effect of the curb incident in arriving at his opinion of relation to the industrial injury, even though claimant testified that he had told the doctor about it. The first evidence that the original injury was not compensable came about as the result of a referral for a second opinion before surgery on a claim for aggravation.

Claimant argues on review that his failure to disclose that the "all consuming" pain incident was a result of stepping off a curb was not misrepresentation because he was not under a duty to disclose it. He distinguishes his duty to disclose from that articulated in Skinner v. SAIF, 66 Or App 467 (1984), because Skinner was directly asked about previous injuries and failed to relate all previous injuries while in this case claimant alleges that the doctors did not directly ask him about intervening injuries and that if they did he did not consider the curb incident in which he suffered sudden "all consuming" pain to be either an accident or injury. In the context of determining whether there has been sufficient misrepresentation to justify a backup denial, we think claimant's duty to disclose information is that he must disclose relevant information about symptoms of pain or distress, regardless of his perception of the cause, and allow his doctor to consider what is relevant and irrelevant. Opinions of medical causation are best left to experienced professionals in complex situations and the more reliable and accurate information that is considered the greater the probability of arriving at a logically sound and correct conclusion. See Uris v. Compensation Department, 247 Or 420 (1967); Moe v. Ceiling Systems, 44 Or App 429 (1980); Charlene Devereaux, 36 Van Natta 911 (1984).

We find that claimant's failure to disclose the sudden onset of "all consuming" pain due to stepping off a curb was a material misrepresentation which entitled the insurer to raise the issue of underlying compensability of the claim by issuing a backup denial. See Skinner v. SAIF, supra; Carolle J. Tucker, 36 Van Natta 1374 (1984); Thomas D. Parker, 36 Van Natta 1165 (1984). Thus having raised the issue of compensability of the claim, it was claimant's burden to prove by a preponderance of the evidence that the claim was compensable in spite of the allegation and proof of misrepresentation. Skinner, supra; cf. Parker v. D. R. Johnson Lumber Co., 70 Or App 683 (1984).

The Referee relied on the opinion of Dr. Rosenbaum that claimant's condition was due to unrelated underlying preexisting

cervical arthritis and that the trauma of stepping off a curb was the probable cause of the onset of pain and numbness symptoms. Dr. Rosenbaum's opinion is persuasive because it contains the most complete version of claimant's history and relates the x-ray findings of advanced cervical osteoarthritis to claimant's increasing symptomatology. The opinions of the other physicians rely on partial histories and fail to account for the x-ray findings, therefore, their opinions are not persuasive on the issue of causation. We find that claimant has not carried his burden of persuasion that his condition is related to an industrial injury. See Charlene Devereaux, supra; see also Laura Jones, 34 Van Natta 196 (1982) (Issue of causation depends on analysis of reasons given in support of expert medical opinions).

ORDER

The Referee's orders dated August 17, 1984 and July 6, 1983 are affirmed.

ERWIN R. MUSTOE, Claimant
Emmons, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 76-00610 & 78-04474
April 30, 1985
Order on Reconsideration

The insurer requested reconsideration of the Board's Order on Review dated February 21, 1985. In order to allow sufficient time to permit claimant the opportunity to respond and to fully consider the insurer's request, we abated our order on March 22, 1985.

The request for reconsideration is granted. On reconsideration the insurer contends that our order awarding permanent total disability effective August 22, 1977, less an adjustment for permanent partial disability paid pursuant to the Referee's order should be modified to also allow an offset for temporary disability benefits paid for periods after August 22, 1977. Claimant has responded that he does not object to allowing the insurer to offset time loss payable for periods subsequent to the effective date of the permanent total disability award.

We hold that such an offset is appropriate and modify our prior order accordingly. See Carlos Iglesias, 36 Van Natta 751 (1984).

ORDER

On reconsideration of the Board's Order on Review dated February 21, 1985 the Board modifies its former order to allow temporary disability payments made for periods after August 22, 1977 to be offset against the permanent total disability award. The Board adheres to its former order in all other respects and hereby republishes it as modified herein.

ROBERT E. NEAL, Claimant
Lawrence Wobbrock, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-05167
April 30, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee St. Martin's order which awarded an additional 96° (30%) unscheduled disability on review of a Determination Order which awarded 64° (20%) unscheduled

disability, thereby granting claimant a total award of 160° (50%) unscheduled disability for injury to the neck, mid and low back. Claimant contends that he is entitled to an additional award for unscheduled disability.

The Referee found that claimant unreasonably failed to cooperate with his vocational consultant by failing to contact or otherwise make himself available to the vocational assistance provider. Claimant assigns this as error, as a matter of fact. Claimant also maintains, however, that his alleged failure to participate in vocational assistance is not an appropriate factor to take into consideration in awarding compensation for unscheduled permanent partial disability. But see ORS 656.325(3) and (4).

If we were to agree with claimant that he did not, in fact, unreasonably fail to cooperate with the vocational consultant, we nevertheless would find the Referee's award of unscheduled disability adequate in compensating claimant for the loss of earning capacity attributable to his industrial injury. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated September 28, 1984 is affirmed.

JAMES C. PERSHALL, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 83-06904
April 30, 1985
Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing the employer's request for Board review of Referee Nichols' order issued January 24, 1985 and amended January 25, 1985. As we understand claimant's argument, claimant asserts that the employer is precluded from Board review because it did not specifically state in its January 30, 1985 request for review that it sought review of the Amended Opinion and Order.

The January 24 Opinion and Order granted claimant an award of permanent total disability and ordered an attorney fee paid in addition to compensation. The January 25 Amended Opinion and Order altered the attorney fee award to make it payable out of compensation. The Amended Opinion and Order concluded: "The remainder of the Order remains in full force and effect." The January 24 order was not abated. The employer requested review well within thirty days from both orders.

We believe that the employer's request for Board review more than adequately gives notice of the order appealed from. Claimant does not suggest any other deficiency in the request for review. Cf. Argonaut Insurance v. King, 63 Or App 847, 852 (1983); Gerardo V. Soto, Jr., 35 Van Natta 1801, 1803 (1983). The motion is denied.

IT IS SO ORDERED.

JAMES E. SUMMERS, Claimant
Galton, et al., Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 83-08369
April 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Podnar's order that set aside its denial of claimant's back, arm and hand condition as related to injuries of May 18 and June 17, 1983, awarded penalties and attorney fees and denied its request to rate claimant's extent of disability. The issues are: (1) compensability of the conditions denied; (2) penalties and attorney fees; and (3) rating extent of disability.

On May 18, 1983 claimant was shoveling metal slag when his back began to hurt. Claimant initiated a claim by submitting a Form 801 on or about June 2, 1983. Dr. McIntosh, claimant's treating chiropractor, submitted a Form 827 on June 8, 1983 relating the same mechanics of injury.

On June 20, 1983 claimant submitted another Form 801 making claim for an injury occurring June 17, 1983 when he jumped to avoid being splattered with molten zinc and struck his back on a torch carrier, sustaining a contusion. In a letter report written June 24, 1983 Dr. McIntosh discussed both injuries and authorized time loss effective June 20, 1983.

On July 11, 1983 the insurer filed a Form 1502. From this point forward the claim resembles what the Referee described as a "shell and pea game." The 1502 referred only to the injury date of May 18, 1983, which it noted was accepted as a disabling original injury. The form went on to recite that time loss payments were made effective June 18, 1983 and that time loss payments were not timely paid. Between the acceptance and August 19, 1983 claimant was examined by Dr. Miller and Dr. Schuler, both medical doctors. The histories taken by each of the doctors are consistent with each other, Dr. McIntosh's history and claimant's account of the mechanics of the two injuries.

On August 19, 1983 the insurer issued a denial. The record contains two versions of the denial. We find that the following denial was the one received by claimant:

> "Re: Employee: James Summers
> Employer: T.V.T. Die Casting
> D/Injury: May 18, 1983 & June 17, 1983
> Claim No: L04-14300
>
> "Dear Mr. Summers:
>
> "On or about June 20, 1983, you submitted a claim for Worker's [sic] Compensation benefits to your employer . . . for complaints regarding your low back due to an injury on June 17, 1983, as well as an incident on May 18, 1983, after which you claim injuries involving numbness to your arms, hands and strain to your upper spine. Your claim was deferred for investigation and temporary total disability paid in the interim.

"Our investigation has determined that the medical and factual evidence does not adequately confirm that your complaints regarding your back, arms, and hands are related to your employment . . . . Further, the alleged incidents of May 18, 1983, and June 17, 1983, did not cause the injuries for which you have made claim with the exception of a possible contusion to your low back which is medically stationary.

"Therefore, on behalf of T.V.T. Die Casting and their worker's [sic] compensation insurer . . . we must respectfully deny any and all responsibility for your complaints regarding your arms, hands, and strain to your upper and lower spine arising out of and in the course and scope of your employment . . . . We will continue to provide benefits for the contusion to your back which is medically stationary and all medical expenses received prior to the date of this denial have been paid. You will find enclosed a Form 1503 requesting a Determination Order for the contusion to your back and an Order should be forthcoming in the near future."

[Statement of appeal rights omitted.]

The 1503 referred to in the insurer's denial letter was not prepared until August 30, 1983. It recites an injury date of May 18, 1983. In the remarks section the form states: "Accepted contusion to low back only." We find that the contusion occurred on June 17, not May 18. Also on August 30, 1983 the insurer filed another Form 1502 transmitting its denial letter. The Form recites an injury date of May 18, 1983 and notes that the status of the claim at the time of filing was an accepted disabling injury.

A Determination Order was issued on September 12, 1983. It awarded time loss only and stated that, "This is not a Department Determination of any condition denied by the insurer's letter dated August 19, 1983." The Determination Order recites the date of injury as May 18, 1983.

Claimant timely requested a hearing on the denial. The hearing was convened on December 8, 1983. Due to the number of witnesses scheduled to testify, the hearing could not be completed in the time allotted and the matter was continued for further proceedings. On February 17, 1984, before further proceedings were held, the insurer issued a notice of claim closure reciting an injury date of May 18, 1983 and containing language identical to the September 12, 1983 Determination Order. The second session of the hearing was held February 24, 1984 and the third and final session June 8, 1984. In the interval between the second and third hearing sessions, the Workers' Compensation Department refused claimant's request for review of the insurer's notice of closure on the ground that the matter was pending before the Hearings Division. It appears from the record that the insurer ceased paying temporary disablity benefits as of August 22, 1983.

Against this background, the insurer states its position:

> "It is the position of the [insurer] that the claims processing, and benefits paid were proper in that there was acceptance of a May 18, 1983 'medical only' claim involving a strain and contusion resulting from the June 17, 1983 incident, but that all other claimed conditions/disabilities were properly denied and rated by the . . . notice of closure and Determination Order."

The insurer's position is bewildering, at best. We find it inconceivable that a claim could be accepted, denied and rated as to disability. On our de novo review, we find the following facts:

1. Claimant did not lose any time from work due to the May 18, 1983 industrial injury;

2. Claimant left work on June 20, 1983 due to the June 17, 1983 industrial injury;

3. Both injuries occurred as described by claimant;

4. The insurer received both of claimant's Forms 801 prior to July 11, 1983;

5. On July 11, 1983 the insurer accepted claimant's then-existing condition, based upon both injuries, as a compensable disabling condition;

6. On August 19, 1983, more than sixty days after the latter of the two injuries, the insurer attempted to deny responsiblity for claimant's condition;

7. The denial was issued prior to any action by the Evaluation Division, while the claim was in accepted, open status.

On the basis of these facts, the denial is in direct contravention of Safstrom v. Riedel International, Inc., 65 Or App 728 (1983); Roller v. Weyerhaeuser Co., 67 Or App 583 (1984); and Maddocks v. Hyster Corporation, 68 Or App 372 (1984), and it cannot stand. Cf. Bauman v. SAIF, 295 Or 788 (1983). We adopt the Referee's comment that, "Any confusion generated as a result of lumping two separate claims together and then attempting to carve out certain portions of each to accept cannot possibly be resolved in favor of the [insurer]."

The insurer argues in its brief that Safstrom, Roller and Maddocks were all decided subsequent to the issuance of the denial in this case. We do not interpret the insurer's argument as standing for the proposition that, because they were decided subsequent to the denial in this case, those cases do not apply. If that argument is made, we reject it. Rather, the insurer appears to be arguing that (1) these subsequent decisions by the Court of Appeals go to the reasonableness of its conduct and, therefore, to the penalty issue and (2) that these subsequent decisions would allow the Referee to rate claimant's extent of disability at the hearing, which he refused to do.

The Referee imposed two penalties. The first was 10% of the interim compensation between June 18, 1983 and July 11, 1983, which was paid approximately eight days late. The insurer does not

discuss this penalty on review. It will be affirmed. The second penalty was 25% of the compensation due and unpaid between August 19, 1983, the date of the denial, and August 15, 1984, the date of the Referee's order.

The insurer argues that it denied based on the medical reports indicating that claimant was minimally or not at all disabled. That reliance was wide of the mark. None of the medical evidence available to the insurer at the time the denial was issued suggested that claimant's two injuries were not compensable. An insurer should be charged with knowing the difference between evidence relating to compensability and evidence relating to extent of disability. An otherwise compensable claim may not be denied on the basis of the latter type of evidence. We do not find it necessary to address the insurer's argument regarding the effect of the Safstrom, Roller and Maddocks cases because we find that the claims processing in itself was sufficiently unreasonable to warrant a maximum penalty.

Finally, the insurer urges that the Referee erred in not evaluating claimant's extent of disability. The Referee was correct. OAR 438-06-040 provides that the Board will not rate extent of disability, either at hearing or on Board review, unless either the Evaluation Division or the insurer has once considered the question. The insurer argues that the September 12, 1983 Determination Order and the February 17, 1984 insurer notice of claim closure satisfy that requirement. We disagree. As discussed above, the request for determination was so confusing that it would have been next to impossible to evaluate claimant's disability in any sort of a meaningful manner. We further find the insurer notice of closure to have been of no effect because of the earlier Determination Order purporting to "close" the same claim. Because the September 12, 1983 Determination Order was procured under circumstances that make it meaningless, we set it aside. This is consistent with that portion of the Referee's order, which we affirm, that orders the insurer to assign separate claim numbers to the two injuries.

ORDER

The Referee's order dated August 15, 1984 is modified to set aside the Determination Order dated September 12, 1983. As modified, the Referee's order is affirmed. Claimant's attorney is awarded $950 for services on Board review, to be paid by the insurer.

JOSEPH N. THOMAS, Claimant
Peter O. Hansen, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 84-00523
April 30, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests, and claimant cross-requests, of Referee Shebley's orders which set aside the employer's denial and remanded claimant's injury claim for acceptance and processing, and declined to impose a penalty and associated attorney's fee for unreasonable denial. The issues on review are whether claimant, in fact, was a subject worker as opposed to an independent contractor at the time of his injury; whether ORS 656.029 applies to the City of Portland as a governmental entity; and whether the employer's denial was unreasonable.

We agree with and adopt as our own the Referee's findings of fact. We affirm the Referee's order with the following additional comments.

The employer denied claimant's injury claim for the stated reason that claimant was an independent contractor and not an employe of the City. The Referee concluded that, as a matter of fact, claimant was an independent contractor. He further concluded, however, that by operation of ORS 656.029(2), and the absence of a declaration stating that claimant's services were rendered as those of an independent contractor, claimant was deemed to be the employer's subject worker and, therefore, entitled to benefits under the Act. At hearing the employer argued that ORS 656.029 was inapplicable in view of the fact that claimant's contract of hire with the City preceded the enactment of the statute. The Referee rejected the employer's argument and applied the statute. See also Robert E. Becker, 36 Van Natta 782 (1984).

On review the employer has abandoned the argument advanced before the Referee and, instead, argues the inapplicability of the statute based upon its status as a governmental entity. We reject the employer's statutory constructon argument and hold that, as a subject employer within the meaning of ORS 656.005(14) and (25), the City is subject to the operative effect of the statute. Claimant suggests that, by its failure to argue this defense before the Referee, the City has waived it and should be precluded from raising this "new issue" for the first time on review. We do not regard the employer's argument as a "new issue"; rather, we consider it as an alternative argument in support of the same legal issue presented to the Referee: The applicability of ORS 656.029. See Anita A. Bade, 36 Van Natta 1093 (1984), aff'd mem. 73 Or App 344 (1985).

The cornerstone of the employer's statutory construction argument is an informal September 7, 1983 Attorney General's opinion which concludes that ORS 656.029 does not apply to any unit of state or local government. Opinions of the Attorney General are entitled to "earnest consideration"; however, they are not binding. Alexander v. Gladden, 205 Or 375, 383 (1955); see Burlington Northern v. Dept. of Rev., 291 Or 729, 762 (1981) (Tongue, J., specially concurring).

The basic premise of the opinion, as stated at page four, is that the State is not a "'person' within the Workers' Compensation Law." In stating this conclusion, the opinion relies upon an earlier, formal opinion concerning the scope of a different statute, ORS 656.556. 39 Op. Atty. Gen. 583 (1979). That statute is concerned with enforcement of workers' compensation insurance premium payments.

We do not take issue with the Attorney General's construction of ORS 656.556 because that statute is not relevant in this proceeding. We do believe, however, that the 1983 informal opinion does not adequately consider the purposes underlying the enactment of ORS 656.029 in construing the phrase "person letting the contract." In determining legislative intent, we must consider the object to be accomplished. James v. Carnation Co., 278 Or 65, 72 (1977).

> "It is a rule of statutory interpretation, having paramount importance, that courts seek legislative intent from the whole of the statute and not from isolated words and phrases, divorced from their context, and from the spirit and purpose of the enactment." City of Portland v. Duntley, 185 Or 365, 380 (1949).

We thoroughly reviewed the legislative history of ORS 656.029 in order to ascertain its proper application in Richard F. Erzen, 36 Van Natta 218 (1984), affirmed EBI Companies v. Erzen, 73 Or App 256 (1985); Richard O. Hampton, 36 Van Natta 230, 36 Van Natta 626 (1984) and Dennis P. Cummings, 36 Van Natta 260, 36 Van Natta 590 (1984). Those cases all involved 1981 injuries, whereas this case involves a 1983 injury. The statute has been amended in the interim; however, the amendments do not appear to alter the findings and conclusions we previously reached concerning the purpose and intent of the statute. We found the primary purpose of ORS 656.029 to be the establishment of a simple test for determining who was an independent contractor and who was a subject worker. The mechanism provided is the joint declaration of status as an independent contractor. See OAR 436-51-054. The legislature apparently intended that if the declaration was filed, there would be no question of the status of the independent contractor as such. In the absence of filing the independent contractor would be deemed to be the subject worker of the other contracting party. This result obtains under subsection (2) of the statute, when the "person to whom the contract is let" performs the work "without the assistance of others."

A second result anticipated by the legislature was that independent contractors would find it necessary to have or secure workers' compensation insurance in their own right. This would be the natural product of the employer's desire to avoid having another subject worker, which could impact the employer's premium and create potential liability for a work-related loss. Richard F. Erzen, supra, 36 Van Natta at 221-22. In this sense, the legislature intended to impose a policing function upon employers that enter into subcontract agreements and are in the position of a "prime contractor." See Robert E. Becker, supra, 36 Van Natta at 786.

Our review of the legislative record did not disclose any intent on the part of the legislature to exempt the State or its political subdivisions from the operation of the statute. The fact that Senator Kulongoski requested the 1979 Attorney General's opinion concerning ORS 656.556, and that he indicated to the Senate committee considering SB 476 (the 1979 bill that ultimately was enacted and codified as ORS 656.029) his intention that "the definition of 'person' would include the statutory definition," is a slim reed upon which to base a conclusion concerning legislative intent. See Minutes, Senate Committee on Labor, Consumer and Business Affairs, April 24, 1979, p. 8.

The Workers' Compensation Law deals with practical matters and should receive a practical construction. Kosmecki v. Portland Stevedoring Company, 190 Or 85, 94 (1950). Rather than relying on a specific provision, the statutes must be read as a whole with a view toward effecting the overall policy they are intended to promote. Wimer v. Miller, 235 Or 25, 30 (1963); Rosell v. SIAC,

164 Or 173, 182 (1940). It has previously been noted that in construing the Workers' Compensation Law, the court should not "lug in at one door what the legislature industriously put out at another." Baker v. SIAC, 128 Or 369, 383-84 (1929). These principles of statutory construction are certainly as applicable to ORS 656.029 as the principles employed by the Attorney General.

The Workers' Compensation Law universally applies to the State and its political subdivisions in their capacity as subject employers. ORS 656.005(14). ORS 656.029 is intended to provide a simple means for defining the relationship between contracting parties. It is also intended to encourage the purchase of workers' compensation insurance by entities that might otherwise attempt to avoid this business cost. There is no question that we would be "lugging in one door" exactly what the legislature has recently "escorted out" another were we to agree with the employer that, as a political subdivision of the State, it is not subject to ORS 656.029. Such a conclusion would be entirely inconsistent with the policies and goals that are apparent from our review of the legislative history of the statute, as well as the general policies of the Workers' Compensation Law. Considering the statute in this context, we believe that the State and its political subdivisions fall within the ambit of the statute by "necessary implication." See 39 Op. Atty. Gen., supra at 584.

Claimant's cross-request for review raises the issues of whether, in fact, claimant was an employe, as opposed to an independent contractor, and whether penalties/attorney fees are warranted for unreasonable denial. As did the Referee, we find that the City and claimant did not have an employer-employe relationship, and that claimant performed services for the City as an independent contractor. It is only by operation of ORS 656.029 that claimant is deemed to be the employer's subject worker and, therefore, entitled to benefits under the law. Contrary to claimant's assertion, we do not believe that the employer's defense is based upon "legal theories dreamed up by counsel as a rationalization for the denial." To the contrary, we believe that the employer had a reasonable basis for doubting its liability for claimant's injury; therefore, the Referee correctly declined to impose a penalty/attorney's fee.

Finally, there is an additional issue which merits brief comment. Attached to its appellant's brief as appendices, the employer has submitted copies of the above-referenced 1983 and 1979 opinions of the Attorney General and portions of the legislative record for Senate Bill 476. Claimant objects to this tender of "additional evidence" on review. This material has not been submitted as "evidence," and we have not considered it as such. These materials are relied upon by the employer in support of its legal defense, as one would rely upon a statute, a judicial or administrative decision, or any other authority presented as binding or persuasive. Claimant's objection, therefore, is without merit.

ORDER

The Referee's orders dated May 22, 1984 and May 31, 1984 are affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the self-insured employer.

LOIS BROWN, Claimant
Peter Hansen, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 83-11056
May 2, 1985
Order of Dismissal

The Claimant has requested review of the Referee's order dated January 21, 1985. The request for review was filed with Board on February 21, 1985, 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.

STEPHEN C. DOOLEY, Claimant
David C. Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 84-0245M
May 6, 1985
Own Motion Order Referring for Hearing

Claimant has requested that the Board exercise its jurisdiction pursuant to ORS 656.278 and award claimant additional compensation for his April 23, 1971 back injury. Claimant's aggravation rights have expired. Claimant has also moved the Board to exercise its own motion jurisdiction in the absence of a reply from the SAIF Corporation to his petition and the evidence submitted therewith and three subsequent motions. See OAR 438-12-005(1)(c). Claimant asserts that he is entitled to the equivalent of a "default judgment" on account of SAIF's failure to respond. We disagree. There is no absolute right to additional compensation under ORS 656.278. See ORS 656.278(1), (3).

The evidence upon which we base our decision is, however, another matter. SAIF's failure to respond to claimant's requests is unexplained, and no evidence contrary to that forwarded by claimant has been forthcoming. We would, we believe, be justified in deciding this case solely on the evidence now before us, were it not for the fact that we perceive a duty to the parties and reviewing courts to decide own motion cases in the light of all available evidence. This Board is charged by statute with resolving disputes involving the distribution of third-party settlements and judgments, which we find to be somewhat analogous to own motion matters in that we are given wide latitude by statute in establishing procedures and exercising our discretion on the amount and nature of evidence upon which to base a decision. The Court of Appeals has stated that, "[P]roceedings that culminate in a third party distribution order must produce a record adequate for our review . . . ." Blackman v. SAIF, 60 Or App 446, 448 (1982). We are of the opinion that in deciding own motion cases we should assure that the record is adequately developed for the purposes of review, to the extent that own motion cases are subject to further review. See ORS 656.278(3).

We do not believe this case is sufficiently developed that we may decide the issues raised by claimant, or that our decision, if reviewable, could adequately be reviewed by a court. Accordingly, we hearby refer this matter to the Hearings Division pursuant to OAR 438-12-010(1)-(3) for a fact-finding hearing. The issues at the hearing shall be those issues raised by claimant's August 15, 1984 Own Motion Application. Claimant's November 15, 1984 Motion for Relief by Default is denied. The Referee shall rule on

claimant's Motion for Appointment of Medical Expert, filed December 3, 1984 prior to the hearing. The Hearings Division is ordered to conduct the hearing as a Hardship Case pursuant to OAR 438-06-010. 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 regard to the resolution of claimant's application.

IT IS SO ORDERED.

TOMMIE D. CALLAHAN, Claimant
Mitchell, et al., Attorneys

WCB 84-00721
May 7, 1985
Order Denying Motion to Dismiss

The employer has moved the Board for an order dismissing claimant's request for review on the grounds: (1) that the request for review was not timely filed; and (2) that claimant has failed to file and serve a brief within the time specified by OAR 438-11-010(3).

The Referee's order was issued November 28, 1984. The request for Board review was mailed December 26, 1984. The request was timely. OAR 438-05-040(4)(c); OAR 438-11-005(2).

The employer has also requested an order dismissing claimant's request for Board review on the ground that claimant has not filed an appellant's brief.

There is nothing in the workers' compensation law or the Board rules which requires that a brief must be filed by an 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 a ground for dismissal of a request for review. The request for dismissal is denied.

The employer is granted twenty days from the date of this order to file a brief, if it so elects.

IT IS SO ORDERED.

DAVID B. COLLISON, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-08229
May 7, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Neal's order which awarded 30% (45°) scheduled permanent disability for loss of use of his right leg (knee), whereas a July 2, 1984 Determination Order had awarded 20% (30°) left leg (knee) scheduled disability. On review, claimant contends his right leg (knee) permanent disability award should be increased and that he is entitled to a permanent disability award for his left leg (knee).

The insurer contends claimant's right leg permanent disability does not exceed 20%. We have authority to consider the insurer's contention notwithstanding its failure to cross-request review. Jimmie Parkerson, 35 Van Natta 1247, 1249-50. Moreover, the insurer's contention does not raise a new issue. See Gleason W. Rippey, 36 Van Natta 778 (1984).

Following our de novo review of the medical and lay evidence, including claimant's credible testimony concerning his residuals and physical limitations, we conclude that claimant has failed to establish his entitlement to a scheduled permanent disability award for loss of use of his left leg (knee) as a causal result of his compensable right leg (knee) injury. Furthermore, we agree with the Referee's conclusion that the Determination Order erroneously awarded permanent disability for the left leg (knee) rather than the right leg (knee) and should be amended. See Lesley Robbins, 31 Van Natta 208 (1981); David Hunter, 32 Van Natta 273 (1981). Consequently, we affirm that portion of the Referee's order which found that claimant was not entitled to left leg (knee) disability.

We modify that portion of the Referee's order which awarded claimant 30% permanent right leg (knee) disability.

Claimant was 29 years of age at the time of hearing. While working as a forester, he stepped off a log, twisting his right leg and dislocating his right knee. An arthroscopy confirmed the initial diagnosis of medial collateral ligament tear. Following conservative treatment, another arthroscopy was subsequently performed in which cartilaginous defects were removed from the knee.

Dr. Rusch, claimant's treating orthopedist, opined that claimant suffered a mild recurrent right knee disability. The doctor noted that future degenerative osteoarthritis and increasing disability would be expected. While demonstrating a full range of knee motion, claimant exhibited tenderness and pain. Claimant's right leg quadricep strength was 7% weaker than his left leg, while the hamstring strength of his right leg was 10% - 15% weaker.

In Dr. Rusch's opinion claimant could walk no more than one hour in an eight hour day. The doctor reported that claimant experienced pain almost immediately when walking on uneven ground, but had no "giving way" sensations when performing these activities. However, these sensations of instability, as well as increasing pain, occurred when claimant walked downhill or descended stairs. Claimant described swelling in the knee following two to four hours of increased activities, such as landscaping or cutting firewood. Dr. Rusch further reported that claimant was unable to squat or kneel, but had no difficulty with sitting for prolonged periods. This inability to squat or kneel had prompted Dr. Rusch to advise claimant to seek a more sedentary job.

Claimant returned to work for his former employer performing desk work and eventually, limited field work. However, his knee could not accommodate the field work and claimant was ultimately terminated. At the time of hearing claimant had secured temporary employment as a county planner which was basically a sedentary job. Due to his physical limitations he did not believe he could perform the tasks required of a forester, a vocation for which he was well trained and educated.

Claimant's credible testimony echoed Dr. Rusch's description of claimant's pain, weakness, swelling, instability and physical limitations. Prior to his compensable injury claimant had never experienced knee problems. Since the injury claimant has

developed a limp, avoids turning on his knee, and has been forced to alter the manner in which he sits and rises from a chair. Due to the injury he has significantly curtailed, if not eliminated, recreational activities such as backpacking, camping, jogging, softball, volleyball, and basketball. He periodically takes medication in order to relieve pain and swelling.

Compensation for permanent injury to claimant's right leg shall be assessed as loss of use. ORS 656.214(a). The extent of loss of use does not necessarily correlate to the extent of mechanical impairment, although the latter is usually a relevant consideration. Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980).

After completing our review of the medical and lay evidence, including claimant's credible testimony concerning his disabling symptoms and physical limitations, and considering the guidelines as set forth in OAR 436-65-550 and 555, we conclude that a scheduled disability award of 20% is appropriate.

ORDER

The Referee's order dated September 27, 1984 is affirmed in part and modified in part. In lieu of all prior awards, claimant is awarded 20% (30°) scheduled permanent disability for loss of use of his right leg (knee). Claimant's attorney's fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed.

ERNEST B. GAMBINO, Claimant
Carney, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-05692
May 7, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests, and claimant cross-requests, review of Referee Knapp's order which set aside SAIF's aggravation claim denial, awarded claimant interim compensation, and imposed a penalty as a percentage of the unpaid interim compensation found to be "then due." The issues raised by SAIF are the causal connection between claimant's December 5, 1982 right leg injury and claimant's leg condition on and after March 23, 1983; and the period for which interim compensation was awarded. Claimant's cross-request for review assigns as error the Referee's failure to award an attorney's fee in association with the penalty.

Claimant sustained an injury to his right leg on December 5, 1982 while working for Good Samaritan Hospital. Claimant scraped his leg on some fiberglass insulation and thereafter developed a rash and swelling. He was initially seen in Good Samaritan's emergency room, where he was examined by Dr. Bosker. Dr. Bosker diagnosed allergic contact dermatitis secondary to fiberglass particles. Claimant was sent to the Primary Care Clinic for examination by Dr. Santa, who is an internist and apparently works with or for the hospital. Dr. Santa first examined claimant on December 7, and he diagnosed contact dermatitis with a secondary infection. Claimant was treated with topical steroids and antibiotics. His claim was accepted as a disabling injury claim.

In an 828 form dated December 28, 1982, Dr. Santa reported that claimant was released to return to regular work on December 13, 1982; that his condition was medically stationary as

of that date; and that there would be no permanent impairment as a result of his injury. The claim was closed by notice of closure dated January 10, 1983, with an award for three days of temporary total disability in December of 1982. See ORS 656.268(3).

Dr. Santa treated claimant through December of 1982 and January of 1983. The rash on claimant's leg dissipated, but the swelling continued, although it improved. On February 21, 1983, Dr. Santa recorded in his progress record, "right leg edema, mild chronic edema," which no longer needed to be followed, and "borderline blood pressure" which needed to be rechecked in one month.

On March 23, 1983, claimant was seen by Dr. Morgan at Good Samaritan Hospital with a recurrence of right leg swelling, warmth and tenderness. He was again treated with antibiotics, and again the rash resolved. Claimant continued to have problems with edema of the right leg.

In April of 1983 claimant began treatment with physicians at Kaiser Permanente. He initially was examined by Dr. Herring, who diagnosed post-inflammatory lymphedema, related to claimant's industrial exposure/injury. A later diagnosis by Dr. Herring was lymphedema status post trauma and cellulitis. Claimant was referred to Dr. Duckler for further evaluation. Dr. Duckler examined claimant on or about May 12, 1983. He diagnosed "lymphedema, etiology obscure with postphlebitis, ligament, right leg."

Claimant was again examined by Dr. Santa on May 10, 1983. In a report to SAIF following this examination, he described the events of claimant's original injury, his (Dr. Santa's) course of treatment, and his findings on that examination. He noted that claimant's pre-employment examination in November of 1979 reflected that claimant had a history of a chronic psoriasis-like rash on his legs, in addition to having borderline hypertension. Dr. Santa also noted that the venogram taken by the Kaiser physicians disclosed normal deep venous system of the leg and thigh. Claimant's left leg also was found mildly edematous at that time. Dr. Santa's report concludes:

> "The persistent nature of [claimant's] edema, the fact that the edema is present in both legs, and his persistent abnormal blood pressure all suggest to me that there may be other reasons for this edema forming state. I strongly emphasized to [claimant] . . . that he be evaluated for other causes of swelling of his legs. I suspect that the exposure he received while working here in December, 1982 led to a worsening of whatever underlying condition is causing his edema. My feeling is that whatever worsening the event in December may have caused is now resolved. The evidence strongly supports the idea that [claimant's] edema may be on [some] basis other than one related to his on-the-job injury."

SAIF had Dr. Girod, its medical consultant in internal medicine, review claimant's medical file for an opinion concerning

claimant's current symptoms and his December 1982 industrial injury. He noted that an April 2, 1983 medical chart note disclosed a tender, right inguinal lymph node in addition to marked swelling of the right leg. He ruled out the diagnosis of thrombophlebitis or post-phlebitic syndrome. He formed the impression that claimant apparently developed a lymphatic obstruction as a result of the infection which followed his original right leg injury.

> "It appears that the claimant developed infection in the leg as a result of a burn or abrasion. This subsequently led to lymphangitis with swelling of lymph nodes in the right groin. Because of the obstruction of lymphatic vessels, he has developed swelling of the right leg which has been somewhat persistent."

Dr. Duckler referred claimant for examination by Dr. Feldman. Dr. Feldman agreed with Dr. Duckler's tentative diagnosis of a probable lymphedema. He found the "exact pathogenesis" conjectural, but he stated it was possible that claimant had developed a severe cellulitis subsequent to his injury which had left him with lymphedema. In a medical information form completed at or about the time of his June 6, 1983 examination of claimant, Dr. Feldman stated a diagnosis of lymphedema of the right leg, etiology obscure.

Dr. Trautman also examined claimant during June of 1983. In the medical information form he completed, he indicated that it was undetermined whether claimant's lymphedema was the result of his industrial exposure or injury.

By letter dated June 13, 1983, SAIF formally denied claim reopening, for the stated reason that there was insufficient medical information relating claimant's current right leg condition to his December 5, 1982 injury, "which was diagnosed as a rash."

Claimant continued to treat with Dr. Duckler at Kaiser Permanente. A medical information form dated June 22, 1983, completed by Dr. Duckler, states, "I cannot account for lymphedema [of the right] leg."

SAIF referred claimant for examination by Dr. Porter, Professor of Surgery and head of the Division of Vascular Surgery at the Oregon Health Sciences University School of Medicine. He examined claimant in early August of 1983. His diagnoses ("impression") were bilateral leg swelling, chronic; a possible history of contact dermatitis of the right lower leg; chronic psoriasis; and untreated hypertension. He believed that, although it remained indefinite, it appeared as though claimant did have a contact dermatitis involving his right lower leg at the time of his original injury. He stated, however, "I am unaware of any contact dermatitis that smolders along in an active fashion for six months and indeed the patient shows no evidence of activity at the present time." He expressed uncertainty concerning how much of the "rash" of the right leg may have been related to claimant's underlying chronic psoriasis. Dr. Porter stated that claimant "certainly ha[d]" mild edema of both lower extremities at the time of his examination. He believed that this edema could just as well be related to claimant's chronic hypertension as to any other

etiology. He ordered a venous vascular laboratory examination in order to determine whether claimant's mild leg swelling resulted from any venous insufficiency. After obtaining a report of the venous examination, Dr. Porter reported that the examination was totally normal, thereby ruling out any venous insufficiency. He doubted that claimant's mild ankle edema was related to lymphedema, stating that it might be related to hypertension. He also indicated that claimant had "obvious psoriasis" and that, "perhaps flare-ups of the dermatologic condition he has had in his right lower extremity may have been excoriatic eruption." He concluded by stating that he found no causal relationship between claimant's present complaints and his work history.

SAIF apparently provided Dr. Porter's report to Dr. Duckler, as indicated by Dr. Duckler's letter of September 8, 1983. In that letter, he stated that Dr. Porter's report would be "of great value in helping [to] manage this rather difficult case." In a medical information form dated September 19, 1983, Dr. Duckler stated diagnoses of cellulitis of the right leg, psoriasis and hypertension.

In an October 25, 1983 report to claimant's attorney, Dr. Bosker, who initially examined claimant in the emergency room, reported his impression that the most likely explanation for the persistent swelling of claimant's right lower leg was lymphedema, and that the persistent swelling was clearly caused by claimant's injury. He formed this conclusion on the basis of various factors: Claimant's apparent good health prior to his injury; the absence of any known allergies, no history of leg edema venous "incapitance" or lymphatic obstruction prior to this episode; and the fact that claimant was taking no medication before his injury. Dr. Bosker also stated that, although claimant had been found to have mild idiopathic hypertension, in the absence of congestive heart failure, it would be highly unlikely that a "unilateral right leg swelling" could be explained on the basis of hypertension. Dr. Bosker, who had the benefit of examining claimant initially after his exposure, felt that claimant had a severe allergic reaction, which was characterized by severe swelling, erythema and intense inflammation. He explained that the lymphedema was caused by obstruction of the lymphatic channels due to fibrosis and contracture, resulting from the intense inflammatory response and recurrent infections in the involved extremity. Thus, these factors led to a compromise in lymphatic return from the right lower extremity. He felt there was no other condition which could have resulted in the right lower leg swelling and persistent pain. He found no evidence of congenital lymphatic obstruction of any kind. Due to the intensity and severity of claimant's initial exposure and reaction, he felt claimant's exposure to "fiberglass particles and/or other chemicals" was certainly the "sole etiology of his subsequent course."

In a follow-up report, Dr. Bosker further addressed the medical opinions that claimant's right leg swelling resulted from his hypertensive disease. These opinions, as noted by Dr. Bosker, were based upon the finding that claimant had "very slight left leg swelling," in addition to his chronic right leg swelling. Dr. Bosker stated that the left leg swelling noted was "nowhere near as severe or dramatic as the right leg pathology." He also stated that if hypertension was the cause of the right leg

swelling, he would expect the swelling to be uniform bilaterally and in a similar temporal sequence, which did not appear to be the case. He reiterated that hypertension rarely is responsible for lower extremity swelling, unless venous insufficiency or right-sided congestive heart failure is present. He concluded that the left and right leg swelling were unrelated, and that the right leg pathology resulted entirely from claimant's industrial injury.

In a final report dated February 24, 1984, Dr. Santa clarified that when he examined claimant on February 21, 1983, there was only a trace of edema, which he felt did not require further followup. In his judgment:

> "* * * [W]hatever exposure had occurred at work, whether it was from direct trauma causing his cellulitis in December, or some type of contact dermatitis causing the rash and subsequent cellulitis, by this date his leg had returned to its pre-existent state. No matter what the etiology of his occupational exposure, by February 21, 1983, the process had run its course."

He also stated that when he reexamined claimant on May 10, 1983, all of claimant's acute problems had resolved. At that time, claimant had swelling in both legs, which to Dr. Santa, strongly suggested that the leg swelling was not related to any single event occurring to the right leg, but was rather consistent with a systemic problem.

At the hearing, SAIF presented Dr. Bayer as a medical witness. Dr. Bayer is the associate director of emergency services at Oregon Health Sciences University and an associate professor of emergency medicine at the medical school. He did his internship in internal medicine. Dr. Bayer did not examine claimant; he reviewed the records concerning claimant's industrial injury and pertinent medical history. He indicated his disagreement with Dr. Bosker's conclusions, stating that his thinking was "more in line with" Dr. Santa's opinion. Dr. Bayer stated that congestive heart failure may or may not precede lower extremity swelling. He stated that swelling in the legs often may be an early manifestation of existing heart disease, and that swelling can exist without visible manifestations of marked congestive heart failure. He believed that claimant deserved very close follow-up for both his high blood pressure and further inspection of his cardiovascular system. His opinion was that claimant's leg swelling, which had been found to be bilateral, was due to either his high blood pressure, his underlying psoriatic condition or idiopathic factors. Dr. Bayer used idiopathic in the medical sense, that is, pertaining to conditions without clear pathogenesis, or disease without recognizable cause, as of spontaneous origin. See Taber's Cyclopedic Medical Dictionary (14th ed. 1981).

Claimant testified that his leg felt "very, very hot" when he was initially injured, that there was immediate swelling, to the extent that he had "stretch marks" from his ankle up to his calf," and that the right leg swelling never completely resolved after this incident. His left leg was not affected at all. He stated that he seldom has swelling of the left leg: "Maybe once every six months I might get a little bit of swelling . . . depending on

what I'm doing or how long I'm working." He also indicated that the left leg does not swell to the same degree as the right leg. From the time that he was hired and had his physical examination in November of 1979, until this incident in December of 1982, he had never experienced any problems related to leg pain and swelling in either leg. In his opinion, his right leg condition never improved after his injury, which apparently caused him to change attending physicians.

Claimant recalled having very slight itching or scaling on his right ankle prior to this injury. He was unable to recall whether he ever had any itching or scaling on other parts of his body prior to December of 1982.

It is claimant's burden to prove the compensability of his aggravation claim by a preponderance of the evidence. In view of the nature of the case and claimant's medical condition, we believe that claimant's burden must be satisfied by persuasive medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); William C. Myers, 36 Van Natta 851, 855 (1984). Medical certainty is not required; however, medical probability is. Claimant must prove more than the mere possibility of a causal connection between his original industrial injury and his subsequent medical condition. Gormley v. SAIF, 52 Or App 1055, 1060 (1981); Herbert E. Richards, 36 Van Natta 791, 796 (1984).

The circumstantial evidence tends to implicate claimant's injury as a cause of his continuing right leg swelling, whatever the correct diagnosis may be. However, the medical opinions are divided, not only on the question of the correct diagnosis of claimant's condition, but its cause as well. The medical opinions concerning the diagnosis and etiology of claimant's continued right leg swelling basically fall into two categories. The theory that supports the compensability of claimant's continuing problem is that claimant's right leg swelling is the result of lymphedema resulting from an infection secondary to claimant's original injury. The other theory subscribed to is that claimant's bilateral leg swelling is due to either his preexisting hypertension, his preexisting psoriasis or to a cause which is simply unknown. Drs. Bosker and Girod belong to the former school of thought. Drs. Santa, Bayer and Porter belong to the latter.

The physicians at the Kaiser Clinic appear to be ambivalent. Dr. Herring apparently believed that claimant suffered from post inflammatory lymphedema which was related to his industrial injury. He also diagnosed cellulitis. Dr. Duckler believed that claimant suffered from lymphedema, but considered the etiology obscure. He referred claimant for examination by Dr. Feldman, who indicated that the pathogenesis was conjectural; however, Dr. Feldman "supposed" that it was possible claimant suffered a severe cellulitis subsequent to his injury, which resulted in lymphedema. After claimant was examined by Dr. Porter, the vascular surgeon at the school of medicine, Dr. Duckler, who apparently was primarily responsible for claimant's treatment at Kaiser, abandoned the diagnosis of lymphedema. Instead, he adopted Dr. Porter's diagnoses of cellulitis, psoriasis and hypertension and never indicated that these conditions were related to claimant's industrial injury. Since Dr. Duckler was primarily responsible for claimant's treatment at Kaiser, and he therefore had the opportunity to observe claimant more than the

other Kaiser physicians, we accord his impressions more weight than those of the other Kaiser physicians. The fact that he adopted Dr. Porter's diagnoses and suggestions for medical management of claimant's problem indicates to us that Dr. Porter's opinion is entitled to considerable deference.

The central issue in this case is the nature and cause of claimant's continuing right leg swelling. The fact that he has bilateral leg swelling, considered to be mild in both ankles, suggests that his continuing medical problem is due to some cause other than his right leg injury. Dr. Santa is probably in the best position to judge the nature and severity of claimant's initial exposure, and to compare those findings with claimant's condition after he was discharged from treatment in February of 1983. He strongly believes that claimant's injury-related problem resolved by February 21, no matter what the correct diagnosis may have been. Although Dr. Bosker examined claimant initially, he did not have the benefit of continued observation, as did Dr. Santa. Furthermore, Dr. Bosker never examined claimant during the period in question, beginning in March of 1983. Considering the nature of claimant's medical problem, and the fact that several physicians deem the presence of bilateral leg swelling significant, we consider Dr. Santa's opportunity to examine and observe particularly significant in this case. See Givens v. SAIF, 61 Or App 490, 494 (1983); Hamlin v. Roseburg Lumber Co., 30 Or App 615, 619 (1977).

Based upon our de novo review of the record, we find and hold that claimant has failed to establish that his December 5, 1982 injury was a material contributing cause of his right leg condition on and after March 23, 1983. Therefore, we reverse the Referee's order finding to the contrary.

SAIF assigns as error the Referee's award of interim compensation from May 12, 1983 through June 17, 1983. SAIF concedes, however, that it was obligated to pay interim compensation from May 18, 1983 to June 13, 1983, the date of its denial. We find SAIF's position concerning commencement and termination of interim compensation correct and modify the Referee's order accordingly. SAIF's only contention concerning the penalty imposed by the Referee concerns the amount of interim compensation forming the basis thereof. Thus, we will modify the Referee's order in both respects.

Claimant contends that the Referee erred in failing to award an attorney's fee in association with the penalty, in addition to awarding a fee for prevailing on his denied aggravation claim. The Referee stated that he would not impose a penalty-associated attorney's fee because he was awarding a reasonable fee for prevailing on the denial. In Zelda M. Bahler, 31 Van Natta 139, 33 Van Natta 478 (1981), rev'd in part on other grounds, 60 Or App 90 (1982), we held that in cases involving an unreasonable refusal to pay compensation, as opposed to an unreasonable delay, a separate award of insurer-paid attorney fees under ORS 656.382(1) is mandatory. "In such cases the claimant has had to secure legal representation to obtain that which was his due and which was unreasonably withheld. The carrier must thus pay for claimant's legal representation." Id. at 481. This case involves an unreasonable refusal to pay interim compensation, not merely delay. The Referee erroneously applied the rule announced in Bahler applicable to situations involving delay when he decided to refrain from imposing an attorney's fee in association with the

penalty. See id. at 481. In any event, we have ruled on the compensability question adversely to claimant, and counsel's only entitlement to a fee is in connection with the penalty. Therefore, it clearly is appropriate to order the payment of a penalty-associated attorney's fee.

ORDER

The Referee's order dated April 3, 1984 is reversed in part and modified in part. That portion of the order which set aside SAIF's June 13, 1983 aggravation claim denial is reversed, and that denial is reinstated and affirmed. That portion of the order which ordered payment of "temporary total disability" from May 12, 1983 through June 17, 1983 is modified. In lieu thereof, claimant is awarded interim compensation from May 18, 1983 to June 13, 1983. In addition, the penalty imposed by the Referee is modified, and SAIF is ordered to pay claimant 25% of the interim compensation awarded herein as a penalty for unreasonable refusal to pay interim compensation. In association with the penalty, SAIF shall pay claimant's attorney $200 as a reasonable attorney's fee.

GERALD I. HALLE, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 82-02802
May 7, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of those portions of Referee Braverman's order which: (1) found that his claim was not prematurely closed; (2) found that he had not perfected a valid aggravation claim within the statutorily required 5-year period; and (3) increased his total unscheduled permanent disability award for a low back injury from 25% (80°), as awarded by a January 13, 1983 Determination Order and prior Determination Orders, to 75% (240°). On review, claimant contends: (1) his claim was prematurely closed; (2) he timely filed a valid aggravation claim to which the insurer failed to respond; (3) his aggravation claim is compensable; and (4) he is permanently totally disabled. SAIF cross-requests review contending the Referee erred in setting aside its denial of claimant's request for authorization for exploratory low back surgery and in awarding claimant 75% permanent disability.

The Board affirms that portion of the Referee's order which found that the claim was not prematurely closed. The Board also affirms that portion of the Referee's order which set aside SAIF's denial of claimant's request for authorization for exploratory surgery, but with the following comment. Following our de novo review of the record, we are persuaded that the exploratory surgery is reasonable and necessary treatment for a compensable injury, which is compensable pursuant to ORS 656.245.

We find that claimant perfected an aggravation claim in a timely manner. Therefore, we reverse that portion of the Referee's order which found that no aggravation claim had been perfected.

Claimant was 39 years of age at the time of hearing. In September 1975 he compensably injured his low back while working

as a welder for a pipe and casing company. Since his injury claimant has undergone two low back surgeries. The surgeries took place in April and November 1976. The claim was initially closed by virtue of a June 2, 1978 Determination Order which awarded claimant 25% low back permanent disability.

Since the 1978 Determination Order the claim has been reopened and closed several times, primarily for vocational rehabilitation programs. The claim was most recently closed on January 13, 1983, with time loss benefits terminated as of December 23, 1982, the effective date Field Services Division (FSD) interrupted claimant's training program due to the nondevelopment of a "Professional Crafts Program extension."

Claimant continued to receive private rehabilitation counseling. During January and February 1983, his counselor reported that claimant missed approximately 50% of his scheduled appointments. Although his counselor felt that half of claimant's excuses for his absences were legitimate, none of the excuses pertained to low back complaints. On March 24, 1983 claimant and his counselor met with the president of a local computer company. The president was looking for trainees in circuit board and minor computer maintenance who could perform "extremely light" duties in a shop setting. Claimant was receptive to the potential position, indicating that he felt the work was within his physical limitations. However, before committing to the position, claimant wanted to perform a "reference check" on his potential employer and investigate the marketability of the skills he would acquire in the new position. Claimant and his counselor scheduled a meeting concerning these matters for March 31, 1983.

The scheduled meeting never took place because on March 28, 1983 claimant sought treatment from Dr. Kaesche, orthopedist, complaining of persistent low back pain radiating primarily into the left leg. Dr. Kaesche had treated claimant beginning in late 1979. On May 12, 1980 Dr. Kaesche had reported that he was willing to periodically recheck claimant for a change in his neurological status, but that there was nothing surgically he could offer claimant. In his March 28, 1983 note Dr. Kaesche diagnosed herniated nucleus pulposus at L5, S1. Describing claimant's symptoms as a recurrence of his old back injury for which surgery had been required, Dr. Kaesche scheduled a myelogram.

The myelogram took place March 31, 1983 and its results were reviewed by Dr. Sewell. Dr. Sewell's conclusion was left lateral extradural compression defects at L4-5 and L5-S1 with involvement of the left L4, 5 and S1 nerve root sleeves, which was presumably due to scarring. It was Dr. Sewell's further conclusion that claimant was experiencing possible chronic arachnoiditis. A CT scan revealed a possible free disc at L4-5, marked narrowing of the neural foramina secondary to degenerative changes, and a bulge at L5-S1.

On April 4, 1983 claimant was examined by Dr. Hazel, Dr. Kaesche's associate. Claimant related a history of increasingly severe left leg pain for the past three months. The doctor noted that this history coincided with the termination of claimant's vocational training program. Dr. Hazel further noted that claimant's hands were greasy, black and heavily calloused. Claimant indicated that this was from automotive repairs, which

was his hobby. Dr. Hazel reported that claimant's history and physical findings "did not add up to a solid firm clinical diagnosis." The doctor was suspicious about the timing of claimant's worsened symptoms, as well as the lack of reflex changes and atrophy in a supposedly weak limb. Furthermore, it seemed "ludicrous" to Dr. Hazel that a man with gradually worsening back symptoms could have such heavily calloused hands, obviously indicative of vigorous activity. It was Dr. Hazel's opinion that claimant had genuine back disease, probably composed of some elements of arachnoiditis, epidural scarification, and degenerative intervertebral disc disease. Dr. Hazel also suspected a psychophysiological skeletal reaction. In the absence of an unequivocal diagnostic change in his neurological status, Dr. Hazel recommended non-operative treatment. Dr. Hazel did mention the possibility of an EMG to confirm claimant's left leg weakness which claimant "so graphically portrays but which appears to me to be so incongruous."

By chart note dated April 11, 1983, Dr. Kaesche reported that claimant's myelogram was "certainly indicative of some extra-dural defect, either scar or disc." However, Dr. Kaesche advised that he would "go slowly before considering re-exploring him." Dr. Kaesche recommended that claimant not work on automobiles, rest his back and be rechecked in three weeks.

Copies of these chart notes and the myelogram report were received by SAIF on April 18, 1983. A copy of the CT scan report was received on April 11, 1983.

On May 2, 1983 claimant returned to Dr. Kaesche. Dr. Kaesche advised him that there was nothing medically that could be done.

Claimant returned to Dr. Weeks. Like Dr. Kaesche, Dr. Weeks had also treated claimant in 1979. At that time Dr. Weeks had treated claimant for injuries incurred when his legs had given out, apparently related to his compensable injury.

Dr. Berkeley, neurosurgeon, examined claimant on referral from Dr. Weeks on June 16, 1983. Claimant gave a history of a 1967 low back injury, as well as 1968 and 1969 surgeries. It is not clear whether Dr. Berkeley reviewed claimant's entire medical record, but the doctor did not discuss the discrepancy regarding the dates of claimant's injury and surgeries. However, the doctor did evaluate claimant's recent myelogram and CT scan. Dr. Berkeley diagnosed several deformities and a hypertrophic facet in the low back with severe nerve root impingement on the right side at L4-5. It was Dr. Berkeley's opinion that exploratory surgery was in order, with the possibility of a discectomy among other surgical procedures. Dr. Berkeley rendered no specific opinion regarding whether claimant's condition was medically stationary.

In July 1983 Dr. Kaesche reported that having followed claimant's back problems since March 17, 1980, it was his opinion that claimant's recent complaints were expected given claimant's disability rating. Dr. Kaesche concluded that claimant's condition remained medically stationary.

In August 1983 Dr. Berkeley opined that claimant was in need of the recommended surgery on or before December 23, 1982, the date his vocational rehabilitation program was terminated. Dr. Berkeley concluded that if claimant did not have the surgery claimant's permanent impairment would be moderately severe (60% - 80%).

By letter dated August 22, 1983 claimant's attorney asked Dr. Weeks if he concurred with Dr. Berkeley's opinion that claimant needed surgery and was no longer medically stationary. Dr. Weeks checked the "yes" line and signed his name.

On September 15, 1983 SAIF's counsel directed a letter to claimant's attorney stating that it was in response to his letter of September 12. Among other issues discussed, SAIF's counsel stated that if claimant was going to proceed on an aggravation theory based on Dr. Berkeley's report, SAIF would deny the claim on the basis that claimant's condition had not worsened and that claimant's aggravation rights had expired prior to Dr. Berkeley's examination. On September 23, 1983 SAIF issued its denial of claimant's aggravation claim, listing the reasons earlier expressed by its counsel.

On October 13, 1983 claimant filed an amended request for hearing. Among the reasons listed for review, claimant mentioned SAIF's September 23, 1983 denial, claimant's need for further medical services and temporary disability, extent of permanent disability, and penalties and attorney fees. This request further amended claimant's February 14, 1983 second amended hearing request which had listed all of the same issues except the denial.

In November 1983 the Orthopaedic Consultants issued a medical opinion based upon their September 1983 examination. The Consultants opined that claimant's condition remained medically stationary and that further surgical treatment would not likely improve claimant's condition. In addition, they agreed with Dr. Kaesche that claimant was physically capable of working. However, the Consultants recommended that his activities be limited to light to sedentary work.

In December 1983 claimant was examined by Dr. Smith, orthopedist, on referral from Dr. Berkeley. Dr. Smith concurred with Dr. Berkeley's recommendation for surgery. The doctor supported the surgery "as long as [claimant] and the insurance carrier will accept [it] in the face of a meager prognosis for restoring him to full work potential." Dr. Smith stated that there were indications to proceed with the surgery "just from the standpoint of relieving his pain and reducing his dependence on medications."

The matter proceeded to hearing. At the hearing claimant's attorney contended that Dr. Kaesche's March 28, 1983 chart note qualified as a claim for aggravation within the 5 year period. Claimant further contended that SAIF failed to properly process this claim. SAIF's attorney expressed surprise at claimant's latest contentions and argued that claimant should not be permitted to raise the issues. SAIF argued that Dr. Kaesche's treatment, including the myelogram, had been processed as diagnostic procedures "apparently to the satisfaction of everybody." Furthermore, SAIF asserted that Dr. Kaesche had ultimately opined that claimant had remained medically stationary throughout this process.

The Referee sustained SAIF's objection to the raising of these issues at hearing. According to the Referee's ruling the March 28 chart note would not be considered for purposes of deciding whether SAIF failed to process an aggravation claim. The Referee reasoned that claimant could have raised the issue well in

advance of hearing, at which time the matter could have been considered and a defense prepared. However, the Referee concluded that he would consider the March 28 chart note for purposes of constituting a reopening date, should claimant establish an aggravation of his condition. In his order, the Referee found that the March 28 and April 4 chart notes did not constitute a claim for aggravation. The Referee reasoned that, at best, the chart notes represented a claim for medical services pursuant to ORS 656.245.

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. ORS 656.273(1). A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation. ORS 656.273(3).

In Hewes v. SAIF, 36 Or App 91 (1978), the court found a claim for aggravation where a physician: (1) recommended a neurological consultation and myelogram to determine the existence of a herniated disc; (2) opined that the claimant had an aggravation of her previous condition, and (3) requested that the claim be reopened for further study. We discussed Hewes and several other cases concerning this issue in Douglas Dooley, 35 Van Natta 125 (1983). In Dooley, we found an aggravation claim had been perfected where the treating physician recommended that the claim be reopened and reported that a neurological evaluation had been scheduled. We concluded that an employer/insurer is required to process a claim as one for aggravation when information received from a claimant, doctor or attorney is sufficient to give reasonable notice that claimant is requesting further medical services or additional compensation for worsened conditions related to or resulting from the worker's original injury or occupational disease. Dooley, 35 Van Natta at 127.

In the present case we conclude that the cumulative effect of the March 28, April 4 and April 11 chart notes constituted a claim for aggravation. Although Dr. Kaesche did not use the magic words of "aggravation" or "reopening", it is clear that the doctor is relating claimant's recurrence of symptoms and need for further medical treatment to the compensable injury. Furthermore, in his April 11 chart note Dr. Kaesche interprets the myelogram results as "certainly indicative" of extradural defects, discusses the possibility of exploratory surgery, and recommends that claimant refrain from automobile repair, rest his back and return in three weeks. Dr. Kaesche's ultimate conclusions that surgery is not desirable and that claimant's condition remained medically stationary are relevant to the issue of whether claimant established a compensable worsening of his condition. These subsequent conclusions are irrelevant to the issue of whether a claim for aggravation was made.

Although we find claimant perfected an aggravation claim, we are not persuaded that he established a compensable worsening. Accordingly, we uphold that portion of the employer's denial insofar as it denied the claim for aggravation.

Dr. Kaesche noted the clear indications of extradural defects and considered exploratory surgery. However, he concluded that non-operative treatment was preferable and subsequently stated that there was nothing medically that he could do for claimant. Moreover, Dr. Kaesche, as a former treating physician, opined that

claimant's condition remained medically stationary and that his complaints represented exacerbations which were to be expected given claimant's disability rating. Although Dr. Berkeley was considering further surgery, dependent on the results of his recommended exploratory surgery, he offered no opinion concerning whether claimant's condition had either worsened and/or was no longer medically stationary. Furthermore, when Dr. Berkeley's opinion is evaluated in conjunction with the opinions of the other medical experts, we are persuaded that the surgery was primarily designed to relieve claimant's pain symptoms. Finally, the opinion of Dr. Weeks, the present treating physician, is worthy of little probative weight. We find the opinion to be conclusory. The doctor merely signed his name and checked the "yes" line to the question of whether he agreed with Dr. Berkeley's opinion.

We also find that the issue of SAIF's failure to process the claim should have been addressed. It is relatively clear the parties had proceeded to the hearing construing Dr. Berkeley's report as the aggravation claim. However, the chart notes which actually compose the claim were in SAIF's possession since April 18, 1983, long before the hearing. Further, we understand SAIF to be arguing that it was surprised by claimant's interpretation of these chart notes, not the fact that the chart notes existed. In addition, claimant's contention at hearing fit within the general list of issues marked on his hearing request. Claimant's hearing contention altered SAIF's defense in that the "claim" was now within the 5 year period. However, SAIF was still required and, apparently, prepared to defend the issue of whether claimant's condition had worsened since the last award of compensation.

The record suggests that SAIF was prevented the opportunity of calling its claim representative to testify due to claimant's so-called "sneak attack." This testimony presumably would have been presented to establish the reasonableness of SAIF's conduct in processing the claim as one for medical services pursuant to ORS 656.245 rather than as an aggravation claim. Given the confusing evolution of this claim and the arguably ambiguous nature of the chart notes, we find that SAIF's conduct was not unreasonable and that penalties are not warranted. Consequently, SAIF was not prejudiced by its inability to call its claim representative. The issue turned strictly upon an objective interpretation of the chart notes. The claim representative's testimony would have had no effect on our conclusions concerning the issues of whether the chart notes constituted a claim for aggravation and a medically verified inability to work.

We conclude that claimant was entitled to interim compensation. The first installment of compensation is due within 14 days of the date of notice of a medically verified inability to work. ORS 656.273(6). In his April 11, 1983 chart note Dr. Kaesche recommended that claimant refrain from automobile repair, rest his back and return in three weeks. We find that this chart note, in conjunction with the prior chart notes, constituted notice of a medically verified inability to work resulting from claimant's worsened condition.

When the underlying aggravation claim is determined not to be compensable, interim compensation runs from the date of notice of a medically verified inability to work. Kosanke v. SAIF, 41 Or App 17 (1979). Accordingly, claimant is entitled to interim compensation commencing April 18, 1983, the date SAIF received the

April 11, 1983 and prior chart notes, and continuing until September 23, 1983, the date of SAIF's denial. As discussed above, we do not consider SAIF's conduct unreasonable, thus no penalties are warranted.

We next turn to the issue of extent of disability. We agree with the Referee that claimant has failed to prove he is permanently totally disabled. We are not persuaded that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1). Moreover, claimant has failed to establish his willingness to seek regular employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

We consider the Referee's award of 75% to be excessive. Consequently, we modify the Referee's award of unscheduled permanent disability.

Claimant was 39 years of age at the time of the hearing. He has an eighth grade education. Although he has attended several classes and programs designed to prepare him for attempting to obtain a GED, he apparently has not completed the programs nor attempted the examination. His reading skills are approximately at a fourth grade level.

Claimant has undergone two low back surgeries, both in the nature of laminectomies. He credibly testified that he experiences chronic back pain which primarily radiates down his left leg. His pain increases with activity. Due to this constant pain and his failure to return to work since his injury, claimant's mental outlook has been adversely affected.

Claimant's work experience has mostly involved physical labor activities. He has experience as a mechanic's helper and foundry worker, in addition to his approximately 12 years of experience as a welder. Claimant also has exhibited some skills which are necessary in the operation of a small auto repair and body shop.

Based on our de novo review of the record, we conclude that claimant's permanent impairment is in the moderate range and that he is physically capable of employment duties within the light to sedentary category.

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. After completing our review of the medical and lay evidence, including claimant's credible testimony, and considering the above guidelines, we conclude that an award of 55% unscheduled permanent disability would more appropriately compensate claimant.

ORDER

The Referee's order dated May 31, 1984 is affirmed in part, reversed in part and modified in part. That portion which found that claimant had not perfected a claim for aggravation within the five year period is reversed. The employer is ordered to pay claimant interim compensation benefits from April 18, 1983 to September 23, 1983. The employer's denial dated September 23, 1983 is upheld insofar as it denies the aggravation claim. The Referee's award of permanent disability is modified. In lieu of

the Referee's award, claimant is awarded an additional 30% (96°) unscheduled permanent disability, which gives him a total award to date of 55% (176°) unscheduled permanent disability for his low back injury. Claimant's attorney fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the self-insured employer.

DONALD O. OTNES, Claimant
Elliott Lynn, Claimant's Attorney
Bottini & Bottini, Defense Attorneys

WCB 83-09147
May 7, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order which, in effect, upheld the insurer's de facto denial. The Referee's order was entered pursuant to the insurer's request for reconsideration of his original order, in which he ruled in claimant's favor on the issue of authorization for a laminectomy proposed by Dr. Nash. Claimant raises various issues and assigns as error the Referee's ultimate refusal to set aside the insurer's denial of surgery; the Referee's failure to impose a penalty and associated attorney's fee for failure to accept/deny an alleged aggravation claim and/or for unreasonable denial; and the Referee's act of reopening the evidentiary record for consideration of additional evidence after issuance of his initial order and then failing to provide claimant's counsel an opportunity to respond to this additional evidence before making a decision based thereon. The relief which claimant seeks on review is an order remanding this case to the Referee for further consideration, and to "give the claimant an opportunity to present whatever evidence he has to rebut the . . . medical reports submitted by the insurer after the hearing had closed."

We have authority to remand to a Referee for further evidence taking, correction or other necessary action in the event that we determine (a) that a case has been "improperly, incompletely or otherwise insufficiently developed or heard," and (b) that, in the exercise of our discretion, remand is an appropriate disposition. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 44 (1983). Claimant contends that remand is appropriate because the effect of the Referee's ultimate order is unclear, and because he was not afforded an opportunity to respond to the additional medical reports submitted in support of the insurer's request for reconsideration.

There is no question that a Referee has the authority to reopen an evidentiary record and reconsider his or her ruling prior to the filing of a request for Board review or, if none is filed, prior to expiration of the 30-day appeal period. OAR 438-07-025(1). The insurer's motion for reconsideration was based upon "newly discovered evidence," and, as required by the rule, was accompanied by an explanation of, "why the evidence could not reasonably have been discovered and produced at the hearing." OAR 438-07-025(2). In addition, it is apparent that the insurer provided claimant's attorney with a copy of the motion and supporting medical report.

The report in question is a June 12, 1984 report from claimant's attending physician, Dr. Helle. It apparently was not received by the insurer's attorney until June 18, 1984. It

reports that claimant had been wearing a chairback brace for the preceding month, and that this apparatus had relieved claimant's pain by 40 to 50 percent. Given the fact that claimant was "significantly improved," Dr. Helle clearly stated that no surgery -- either a fusion or exploratory laminectomy -- was warranted. This statement, to a certain extent, is nothing more than a reiteration of previous statements authored by Dr. Helle. In previous reports he had indicated uncertainty concerning the advisability of further surgical intervention; however, he was reserving a final conclusion for the results of a myelogram and more conservative modes of treatment. His June 12 letter is, in essence, a statement of his ultimate conclusion concerning the inadvisability of surgery.

When the insurer requested reconsideration and submitted this medical report, claimant's attorney was out of the office on vacation. He apparently returned to the office on Friday, June 29. The Referee entered his order pursuant to the insurer's request for reconsideration on July 2, the following Monday. The order was received in counsel's office on July 3. Claimant requested Board review on July 23, 1984. There is no indication that claimant attempted to request further reconsideration or otherwise advise the Referee that he had not had an adequate opportunity to respond to the insurer's post-order submission.

Ordinarily, a party seeking remand tenders the evidence that would be introduced at a hearing on remand in order to allow the Board to evaluate its materiality, which bears on the determination of whether a case has been improperly or otherwise insufficiently developed or heard. See Martha Mount, 35 Van Natta 557 (1983). No such evidence has been proffered in support of claimant's request for remand.

We appreciate the fact that claimant's attorney was out of the office when the insurer requested reconsideration. We realize that his return to the office on July 29 provided little, if any, opportunity to respond. It is very understandable that claimant's attorney did not even become aware of the request for reconsideration until he received the Referee's reissued order on July 3. It is difficult to understand, however, if claimant felt aggrieved by these circumstances, why he failed to bring them to the Referee's attention and request a fair opportunity to further respond. Under these circumstances, and in light of the absence of any hint as to what additional evidence claimant might generate at a hearing on remand, we deny claimant's request. See also Martha Mount, supra.

Claimant suggests that it was inappropriate for the Referee to reopen the record and consider this additional evidentiary material. As indicated above, the Referee clearly had the authority to reconsider his initial decision, and the insurer's request complied with the requirements of the administrative rule. Considering the nature of the case, as well as the nature and materiality of the evidence in question, we find that it was appropriate for the Referee to reopen the evidentiary record and reconsider his original decision.

Claimant also suggests that the Referee failed to decide the question presented concerning penalties/attorney fees. We disagree. We understand the Referee's decision to be that penalties and attorney fees were not warranted because claimant was in receipt of temporary total disability benefits during all

times pertinent herein, including the period during which the Referee found that the insurer failed to accept or deny claimant's "aggravation claim." Assuming without deciding that Dr. Nash's March and April 1983 letters were sufficient to constitute a claim for aggravation, as opposed to merely a claim for medical services (a request for authorization to perform surgery), we find no legal basis for imposing penalties or associated attorney fees. Because claimant was in receipt of temporary total disability during all times in question, including the period during which the insurer delayed "acceptance" or denial of the surgery proposed by Dr. Nash, there are no "amounts then due" as to "interim compensation" or temporary total disability which could form the basis for imposition of a penalty. Whitman v. Industrial Indemnity Co., 73 Or App 73 (1985); EBI Companies v. Thomas, 66 Or App 105 (1983). Because the medical services in dispute have not been rendered and there is, therefore, no payment to be made, there are no "amounts then due" in this regard either. Gary L. Clark, 35 Van Natta 117, 119 (1983). See also Darryl W. Carr, 36 Van Natta 16 (1984), concerning entitlement to an attorney's fee pursuant to ORS 656.382(1) in the absence of a penalty pursuant to ORS 656.262(10). Cf. Purdue v. SAIF, 53 Or App 117, 122-23 (1981) (no attorney's fee imposed or awarded under the statute for failure to deny within 60 days as the delayed denial did not, in that case, amount to "unreasonable resistance in the payment of compensation").

On the merits of the claim for surgery proposed by Dr. Nash, we agree with the Referee's ultimate conclusion and find that claimant has failed to establish that this proposed surgery is reasonable and necessary for treatment of claimant's injury-related condition. We would be inclined to arrive at the identical conclusion even in the absence of Dr. Helle's most recent report.

ORDER

The Referee's order dated June 13, 1984, as modified by his order dated July 2, 1984 is affirmed.

BAVILA RIVAS, Claimant
Ann B. Witte, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-07142
May 7, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of that portion of Referee Peterson's order which awarded claimant 75% (240°) unscheduled permanent disability for a low back injury, whereas a June 14, 1984 Determination Order had awarded no permanent disability. On review, SAIF contends the award should be reduced. We agree and modify the permanent disability award.

Claimant was 20 years of age at the time of hearing. In March 1984, while working as a spinner for a bag manufacturer, claimant sustained a compensable injury. The injury occurred when claimant rose from a bent position, striking her lower back on the edge of a spool rack. Her condition was diagnosed as sacral contusion and mild strain. X-rays suggested a bilateral L5 spondylolysis.

In June 1984 Dr. Chalmers, a physician with the Occupational Medical Center, performed a closing examination. Dr. Chalmers had

initially examined claimant the day after her injury. Claimant complained of sharp pains on both sides of the lumbar area, but without radiating symptoms. Virtually any movement, as well as prolonged sitting or standing, exacerbated her pain. Dr. Chalmers diagnosed claimant's condition as "chronic low back pain syndrome, probably in part explainable by her spondylolysis." The doctor could not explain the severity of her pain symptoms, but believed they were real. Dr. Chalmers restricted claimant to a 20-30 pound lifting limitation and recommended against engaging in any repetitive bending, stooping, or crouching activities. In addition, Dr. Chalmers suggested that claimant alternate between sitting and standing in approximately one hour intervals.

Dr. Kiest, treating orthopedist, opined that claimant has a preexisting permanent impairment, spondylolysis, which is at least partially responsible for her present problem. The doctor had previously noted that claimant had exhibited mild limitation of motion in her lumbar spine. Inasmuch as repetitive bending, lifting, and twisting would aggravate the condition, Dr. Kiest concluded that a job change was "essential."

Since her injury claimant has attempted to return to work for her former employer on two occasions, subject to a light duty work restriction. However, both her April and May 1984 attempts were short lived, due to her increased pain complaints. At the time of hearing, claimant had not returned to work and doubted whether she could physically accommodate her job duties as a spinner, or any other jobs offered by her former employer.

Claimant has a sixth grade education. She received her schooling in Mexico. Claimant's work experience consists of five years with her former employer, performing the duties of a spinner. These duties included wrapping papers on spinners or spools and placing them into a cart. Her disabling pain has severely curtailed her physical activities. Claimant testified that she could sit or walk comfortably for 10 or 20 minutes. She could carry up to three or four pounds, but could not lift her arms over her head.

Although claimant testified with the aid of an interpreter, the Referee noted that she could understand "quite a bit" of English and was able to respond in English, "to some extent." Claimant testified that she was able to read "a little" English. The Referee found claimant credible, "to the extent [he] was able to do so."

We are persuaded that claimant is entitled to an award of permanent disability. However, we find the Referee's award to be excessive. In reaching our determination of the extent of claimant's permanent disability we are mindful that the "green book" rules are merely guidelines. Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

The preponderance of the evidence suggests that claimant sustained a contusion and a lumbar strain superimposed on a preexisting spondylolysis condition. Treatment has been conservative, consisting of primarily rest and pain medication. Since the injury claimant has suffered from chronic pain, which has forced her to limit her activities. The medical experts recommend that claimant be placed under limitations which we conclude would restrict claimant to light duty occupations. These

limitations have for all practical purposes foreclosed claimant from returning to her former job. Given her sixth grade Mexican education and limited work experience, claimant unquestionably lacks significant marketable skills.

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. After completing our de novo review of the medical and lay evidence, including claimant's credible testimony, and considering the above guidelines, we conclude that an award of 20% unscheduled permanent disability would more appropriately compensate claimant.

ORDER

The Referee's order dated September 11, 1984 is modified. In lieu of the Referee's unscheduled permanent disability award of 75% (240°), claimant is awarded 20% (64°) unscheduled permanent disability for her low back injury. Claimant's attorney's fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed.

EVERETT E. ROBINSON, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-08760
May 7, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests, and the SAIF Corporation cross-requests, review of that portion of Referee Quillinan's order which awarded claimant compensation for temporary total disability from November 9, 1984, until closure of the claim pursuant to ORS 656.268. Claimant contends that he is entitled to temporary total disability retroactive to September 9, 1982. SAIF contends that claimant is entitled to no temporary total disability benefits in this proceeding.

This case was previously before us on review of Referee Quillinan's June 29, 1983 order, in which she upheld SAIF's September 9, 1982 aggravation claim denial and upheld SAIF's separate denial of an ankle fusion procedure recommended by claimant's attending orthopedic physician, Dr. Martens. In our Order on Review, we affirmed and adopted that portion of Referee Quillinan's order which upheld the denial of claimant's aggravation claim. On the issue of the proposed ankle fusion, however, we remanded for further proceedings on the issue of the reasonableness and necessity of that proposed surgery. Everett R. Robinson, 36 Van Natta 1290 (1984). In discussing our decision to remand, we stated:

> "In our mind, the most appropriate disposition of this case is to remand to the Referee for reconsideration in light of the additional medical opinion submitted by claimant in support of his request for remand, as well as other evidence bearing on the issue of the reasonableness and necessity of the proposed ankle fusion.
> * * *

> "SAIF's denial is not premised on the theory that the proposed surgery will never be a reasonable and necessary form of medical treatment. The Referee's order, and our possible Order on Review affirming, would not have the effect of forever barring claimant from obtaining this form of treatment. [Citation omitted.] This record establishes that, although the proposed fusion may not now be reasonable and necessary, it is entirely possible that if claimant's pain syndrome continues unabated, and further conservative measures fail, the tide of medical opinion may turn in favor of the reasonableness and necessity of this ankle fusion. As of the date of this order, more than a year has passed since the parties were before the Referee. In the interim, claimant has been examined and evaluated by another physician, Dr. Neumann, who has considered various treatment possibilities, including pain center treatment and ankle fusion for relief of claimant's pain. Like Dr. Martens, this physician is favorably inclined toward surgical fusion." 36 Van Natta at 1294-95.

Apparently, upon receipt of our Order on Review, SAIF arranged to have claimant reexamined by the Orthopaedic Consultants. The Consultants examined claimant on November 2, 1984 and found progression of the spurring and degenerative changes in claimant's ankle joint. In addition, it was noted that claimant's symptoms seemed to be "a little more severe."

By letter dated November 9, 1984 SAIF advised claimant that based on the Orthopaedic Consultants' report, it would authorize the proposed ankle fusion procedure. Claimant was advised to contact his physician at his earliest convenience in order to arrange for the operation.

The hearing on remand convened ten days later, and the Referee was advised that, inasmuch as SAIF had authorized surgery, the only issue before her was the period of claimant's entitlement to temporary total disability. Claimant maintained, and maintains on review, that he is entitled to time loss retroactive to September 9, 1982. The parties stipulated at the hearing that claimant had not worked since that date.

Claimant's aggravation rights expired May 30, 1984. It was and is SAIF's position that claimant's only entitlement to temporary total disability is as of the date that he submits to surgery, or enters the hospital for that purpose; and, furthermore, since claimant's aggravation rights have expired, this relief would only be available pursuant to ORS 656.278, either by exercise of the Board's discretionary own motion authority or, presumably, by and through voluntary action of the SAIF Corporation. ORS 656.278(4).

As best we understand it, claimant's theory in support of his entitlement to retroactive temporary total disability is that

because he has been seeking authorization for the proposed ankle fusion since September of 1982, now that he has finally succeeded in obtaining SAIF's approval of this surgical procedure through the protracted course of this litigation, he should be entitled to temporary total disability retroactive to the time as of which he first sought this particular mode of medical treatment. As a matter of fact, we note that Dr. Martens did not request authorization for the ankle fusion procedure until December of 1982, although he had previously entertained the thought.

Thus, claimant's apparent theory is that his entitlement to retroactive time loss is derivative of his medical services claim for the proposed ankle fusion surgery, which has finally been authorized and accepted by SAIF.

" * * * [T]he right to additional medical services is independent of the right to compensation for medical services for an aggravation." Evans v. SAIF, 62 Or App 182, 186 (1983). Thus, claimant's assertion that he has finally prevailed in obtaining authorization for his long-awaited fusion has no bearing upon the period of entitlement to temporary total disability, at least not under the circumstances of this case.

Our September 1984 Order on Review, in which we affirmed the portion of the Referee's order upholding SAIF's September 1982 aggravation claim denial, served as a determination that, as of the time of the prior hearing (June 14, 1983), claimant had failed to establish a worsening of his condition since the last award or arrangement of compensation. Our records reflect that claimant petitioned for judicial review of the portion of our order concerning entitlement to temporary total disability pursuant to the aggravation statute. See Dennis Fraser, 35 Van Natta 271 (1983) (official notice of agency records). Until such time as higher authority overturns our determination that claimant was not entitled to reopening for payment of time loss, that determination remains the law of the case.

The scope of the proceeding on remand, as we contemplated it in our Order on Review, was for further evidence taking on the issue of the reasonableness and necessity of the proposed fusion procedure. Even a cursory reading of our order discloses that we did not intend to "reopen the record" on the question concerning claimant's mid 1982 aggravation claim. This does not gainsay the fact, however, that claimant could, as part of the proceeding on remand, prosecute a new aggravation claim based upon facts and circumstances which had developed subsequent to the original June 14, 1983 hearing. Claimant is not proceeding on that basis, however. Indeed, we believe that the Orthopaedic Consultants' November 2, 1984 report constitutes a valid "aggravation claim," which might justify reopening the claim for payment of temporary total disability as of that date. The problem, however, is that claimant's aggravation rights have expired, and claimant's sole remedy vis-a-vis payment of additional temporary total and/or permanent disability lies in ORS 656.278, the own motion statute. The Referee was obviously aware of the expiration of claimant's aggravation rights. Indeed, in her order she stated, "Claimant must seek relief through Own Motion procedure under ORS 656.278," in the course of addressing claimant's argument that he is entitled to retroactive temporary total disability in this proceeding. We are at a loss, therefore, to understand why the Referee then proceeded to, in effect, order claim reopening as of

November 9, 1984, with temporary total disability to continue until closure pursuant to ORS 656.268.

In conclusion, although claimant has finally obtained SAIF's approval for the proposed ankle fusion, the acceptance of this medical services claim does not, in and of itself, entitle claimant to claim reopening for payment of temporary total disability pursuant to the aggravation statute. See also Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581 (1984); Johnson v. Industrial Indem., 66 Or App 640 (1984); Mary Ann Hall, 31 Van Natta 56 (1981). The law of this case is that claimant failed to establish a worsening of his condition at any time prior to the June 14, 1983 hearing in this proceeding. There is no evidence to substantiate the conclusion that claimant's condition compensably worsened at any time prior to expiration of his aggravation rights on May 30, 1984. The Referee was without jurisdiction to order claim reopening as of November 9, 1984 under the facts and circumstances presented herein. Compare Wilma Kim Buhman, 34 Van Natta 252 (1982) (claimant had hearing rights that extended beyond the aggravation limitation where claimant perfected an aggravation claim before expiration of the aggravation period, the employer denied the claim after expiration of the aggravation period and, necessarily, claimant's request for hearing contesting the denial was also filed after expiration of aggravation rights).

ORDER

The Referee's order dated November 30, 1984 is reversed insofar as it reopened the claim as of November 9, 1984 for payment of temporary total disability until closure pursuant to ORS 656.268.

DONALD J. TATE, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-12098
May 7, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Pferdner's order that found claimant's present condition to be an aggravation of a December 29, 1978 occupational injury. SAIF contends on Board review that no claim of aggravation of the December 29, 1978 injury had been made and that the Referee's finding was error.

We note that the Referee makes several references to a "July 28, 1978" injury in his order. Our review of the record and the context of the Referee's order convinces us that this reference is an apparent clerical error, and that all references to an injury date of July 28 should be to the industrial injury of July 28, 1981. We find that the Referee's reference to the 1978 injury was the injury of December 29, 1978.

Claimant did not file a respondent's brief, and we are without the benefit of any argument urging us that the Referee's findings are correct. Based upon our thorough review of the record as a whole, we conclude that SAIF's argument that claimant's hearing request was premature is correct. The Referee found, and we agree, that the evidence does not support the finding of an aggravation of claimant's 1981 injury. This is the only injury claimant claims to have been aggravated.

In the absence of a claim for aggravation of the 1978 injury, and in the further absence of any opportunity for SAIF to either accept or deny such a claim, we find claimant's hearing request premature. Syphers v. K-M Logging, 51 Or App 769, 771 (1981).

We wish to make it clear that by reversing the Referee's order that held SAIF responsible for an aggravation of the 1978 injury we also find that SAIF is not responsible for an aggravation of the 1981 injury. We make this statement because SAIF's denial, which we reinstate, speaks only to the 1981 injury. We find that SAIF is not responsible for claimant's present condition as the worsening of any compensable condition. We specifically do not, however, address the issue of medical services under ORS 656.245.

ORDER

The Referee's order dated August 29, 1984 is reversed. The SAIF Corporation's denial dated December 9, 1983 is reinstated and affirmed.

GARY M. THOMPSON, Claimant
Galton, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-00321 & 83-04597
May 7, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee Knapp's order that ordered it to pay "interim compensation" beyond the date that claimant returned to work. Entitlement to "interim compensation" is the sole issue on review.

After the Referee's order was issued and a few days after SAIF filed its brief herein, the Supreme Court issued its opinion in Bono v. SAIF, 298 Or 205 (1984). The court in Bono held that an injured worker is entitled to temporary total disability benefits in the interim between the time a claim is made and the time it is accepted or denied if the worker has left work on account of an injury. With that standard in mind, we have reviewed this matter.

Claimant has suggested that we remand this case because the evidence is unclear upon what basis claimant returned to work prior to the issuance of the denial herein. We find that counsel stipulated on the record at the hearing that claimant left work due to an injury on March 4, 1983 and returned to work March 14, 1983. It was further stipulated that SAIF paid "interim compensation" from the date it received verification of claimant's inability to work, March 11, 1983, until claimant returned to work. Thus, claimant was paid "interim compensation" for March 11, 12 and 13, 1983. In the absence of any evidence to the contrary, we find claimant's stipulation that he returned to work March 14, 1983 to mean that he returned to full duty.

Under the rule of Bono v. SAIF, supra, we find that claimant is entitled to temporary total disability as "interim compensation" from March 4, 1983 through March 13, 1983, less

compensation already paid. On the record as a whole, we do not find SAIF's actions unreasonable, and we find a penalty unwarranted. The penalty-associated attorney fee is also, therefore, set aside. Because claimant did not prevail on any issue raised on Board review, no attorney fee will be awarded.

ORDER

The Referee's order dated July 27, 1984 is modified to award claimant temporary total disability benefits during the period March 4, 1983 through March 13, 1983, inclusive, less benefits paid. The penalty and penalty-associated attorney fee provisions of the Referee's order are reversed. The remainder of the Referee's order is affirmed as modified.

GEORGE M. TURNER, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 83-01646
May 7, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Pferdner's order which awarded claimant compensation for permanent total disability in connection with his October 17, 1980 foot injury. Previous Determination Orders awarded claimant scheduled permanent partial disability compensation totalling 54° for 40% loss of the left foot. The issue is whether claimant is permanently and totally disabled. The more narrow issue is whether claimant, who we find is not permanently and totally disabled based upon medical factors alone, is required to make reasonable efforts to obtain gainful and suitable employment; and, assuming he is, whether he has satisfied this requirement. ORS 656.206(3).

Claimant sustained a severe crushing, degloving injury to his left foot. This eventually resulted in the amputation of all five toes. In addition, in order to effectuate complete healing of the amputation site, it was necessary for Dr. Andrews, claimant's present attending physician, to perform a revision of the amputation stump with ostectomies of the first and second metatarsal heads of claimant's left foot.

As a result of his injury and the series of surgical procedures which followed, claimant is relegated to performing work of a sedentary nature. Dr. Andrews indicated that the ideal position for claimant is sitting with his leg raised. Claimant's foot does not tolerate any significant degree of weight, including the weight of his own body. The impairment of claimant's foot is severe.

Although claimant's physical impairment is severe, he is not completely incapacitated as a result of his foot injury. Claimant's ability to ambulate is substantially limited; however, he is still able to do so. Although he is unable to stand for any significant length of time, he is able to alternate sitting and standing as needed. In addition, claimant testified that he was able to sit comfortably with his left leg extended outward, thereby avoiding any pressure on his foot.

Considering claimant's severe foot impairment together with relevant social/vocational factors, we conclude that he is

permanently and totally disabled. Claimant was 52 years old at the time of hearing. He completed nine years of formal education; however, he is functionally illiterate. Dr. Rollins, who evaluated claimant's vocational capabilities and potential, determined that claimant performed at a second grade equivalent in spelling, a 2.7 grade equivalent in reading, and a kindergarten equivalent in math. Claimant's full scale IQ is 79, which is considered dull normal to borderline retarded. All of claimant's work experience has been in heavy labor. After leaving high school, he worked in the woods as a faller and choker setter. Thereafter he worked as a junk yard laborer, cutting up cars and delivering parts. He also worked as a highway worker digging ditches and flagging cars. He became employed with this employer in 1973, where he performed railroad construction work. Claimant was working as a gandy dancer when he sustained this injury.

Claimant is incapable of performing any of his pre-injury jobs as a result of the physical limitations imposed by his foot injury. He possesses neither the training nor skills to enable him to obtain and hold regular, gainful employment in an occupation suitable to his physical limitations. Although Mr. Kurtzo, an industrial therapist at the Callahan Center, indicated that claimant could functionally perform bench work at a competitive pace, Dr. Rollins' conclusions are directly to the contrary. Dr. Rollins concluded that claimant did not possess the fine motor skills required to perform any kind of bench work at a competitive pace. He did indicate, however, that claimant could probably work in a sheltered workshop or cottage industry type of setting. According to Dr. Rollins, claimant's potential for retraining is virtually nonexistent in view of his apparent inability to acquire new skills. In his opinion, attempted retraining or vocational rehabilitation would be futile.

As the Referee noted, the respective conclusions drawn by Mr. Kurtzo and Dr. Rollins are diametrically opposed. We find Dr. Rollins' conclusions, which are fully explained in his cogent testimony, more persuasive than the impressions stated in Mr. Kurtzo's vocational assessment. In addition, there is a discrepancy between claimant's medically verified ability to perform work of only a sedentary nature and Mr. Kurtzo's conclusion that claimant's sustainable weight range is in the medium category and occasionally heavy. This conclusion is inconsistent with Dr. Andrews' reports and testimony, as well as claimant's testimony. This discrepancy creates some doubt about the reliability of Mr. Kurtzo's remaining conclusions.

The insurer contends that because claimant is not totally incapacitated from performing regular, gainful employment based upon medical considerations alone, he is required by ORS 656.206(3) to make reasonable efforts to obtain employment, and that he has failed to satisfy his burden of proof in this regard. The insurer argues that a worker is only excused from the seek-work requirement of ORS 656.206(3) when total disability arises entirely from physical incapacity. The insurer relies upon Laymon v. SAIF, 65 Or App 146 (1983) and Allison v. SAIF, 65 Or App 134 (1983) in support of this contention.

There is language in these cases to support the insurer's argument, particularly in Allison, in which the court stated:

> "There are two types of permanent total disability: one arising entirely from medical or physical incapacity, and the other arising from conditions of less than total medical or physical incapacity plus additional conditions such as age, education aptitude, adaptability to nonphysical labor, and mental and emotional condition, which together result in permanent total disability. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Unless a claimant shows that he comes within the first type of total disability, making it futile to attempt to find work, he must make reasonable efforts to obtain employment before an award of permanent total disability will be granted. ORS 656.206(3); see Home Ins. Co. v. Hall, [60 Or App 750 (1982)]; Butcher v. SAIF, [45 Or App 313 (1980)]." 65 Or App at 136-37.

Similarly, in Laymon, the claimant conceded that she was not permanently and totally disabled as a result of medical factors alone. The court stated:

> "She is therefore required to show a reasonable effort to obtain employment before she is qualified for permanent total disability, ORS 656.206(3), unless she can show that she is completely incapacitated and that it would be futile for her to attempt to become employed. See Morris v. Denny's, [50 Or App 533 (1981)]; Butcher v. SAIF, [supra]." 65 Or App at 148.

In both cases the court concluded that the claimant had not made reasonable efforts to obtain suitable employment.

In Butcher v. SAIF, supra, the court held that, "[W]here a claimant is completely incapacitated a showing that he is not employable is not required." 45 Or App at 317. The court concluded:

> "Here the statements of all the doctors, taken together with the other factors of age, education, work experience and mental capacity indicate it would be futile for claimant to attempt to become employed. 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." 45 Or App at 318.

In Dock A. Perkins, 31 Van Natta 180 (1981), we articulated our understanding of the Butcher exception to the seek-work requirement of ORS 656.206(3), concluding that social/vocational factors are properly part of the Butcher calculus.

In Morris v. Denny's, 50 Or App 533 (1981), a Referee and the Board declined to award claimant permanent total disability because she had failed to look for work for two years, and she had not sought vocational rehabilitation. After reviewing the evidence concerning claimant's physical incapacity, the court discussed claimant's work history, her education and her post-injury emotional condition. The court concluded:

> "In view of claimant's guarded prognosis for return to work [which took into consideration various factors, including claimant's age, her apparent age which was much older than her chronologic age, and her "generally defeated attitude"] and the psychiatrist's conclusion that she is not a candidate for vocational rehabilitation, her failure to seek employment or vocational rehabilitation does not militate against her claim, where it would be futile for claimant to attempt to be employed. Butcher v. SAIF, [supra]." 50 Or App at 538.

In Home Ins. Co. v. Hall, 60 Or App 750 (1982), a Referee and the Board found claimant permanently and totally disabled. The court reversed. The court found that the persuasive medical evidence by itself did not establish that claimant was permanently and totally disabled. Claimant contended that she was entitled to an award for permanent disability based upon her physical condition plus non-medical factors. The court made a factual finding that claimant had failed to establish that she was willing to seek regular, gainful employment, and that she had not made reasonable efforts to do so. 60 Or App at 753. In addition, the court found that claimant was not in that "class of persons of whom it may be said that efforts to obtain employment would obviously be futile," citing Morris v. Denny's, supra, and Butcher v. SAIF, supra. 60 Or App at 754.

In cases decided since Butcher, Morris and Perkins, and before Laymon and Allison, the court has taken social/vocational factors, in addition to evidence of physical incapacity, into consideration in holding that a claimant is excused from the requirements of ORS 656.206(3). In some cases, the court has held that minimal efforts on the claimant's part were sufficient to satisfy the statutory requirement. In Looper v. SAIF, 56 Or App 437 (1982), the Board concluded the claimant was not totally incapacitated based on medical or physical considerations alone, and that claimant had failed to satisfy his burden under ORS 656.206(3). A vocational expert testified that claimant was capable of performing certain jobs, and claimant testified that he had made no attempt to obtain employment. Claimant also testified, however, that he had been in too much pain to seek work. The court concluded:

> "In our view, it would be unrealistic to say that this man (63 years old at the time of the hearing) with a 10th grade education has a reasonable expectation of being able to sell his services to an employer. . . . Under the circumstances, it would have been

> futile for claimant to have attempted to find employment. * * * * " 56 Or App at 440-42 (citations omitted).

The court awarded claimant compensation for permanent total disability.

In Petersen v. SAIF, 52 Or App 731 (1981), claimant was sixty-one years old when he sustained a low back injury while driving a truck. Surgery ensued, as a result of which claimant was limited essentially to light work. Claimant was awarded social security disability, and his file with the Field Services Division was closed. Claimant had not requested that the Field Services worker cease looking for employment prospects; nor did claimant request that the matter be pursued further. A vocational expert testified that a worker with claimant's aptitudes and restrictions was "exceedingly limited" in employment opportunities Other than a single visit to a vocational counselor for the Employment Division, claimant had made no efforts to seek employment. Field Services had evaluated claimant and concluded that he would not be able to work, and that it was not medically feasible to "place him." The Board concluded that claimant was not permanently and totally disabled based upon the medical evidence alone. The court stated and held:

> "Although that may be true . . . claimant, from a realistic standpoint, is totally foreclosed from the labor market, when one considers his age, education, work history and physical restrictions. * * * It would be 'futile for claimant to attempt to be employed.' * * *
>
> "ORS 656.206(3) requires 'reasonable efforts' to seek employment. Given the expert opinion, which is undisputed by SAIF, that someone with claimant's aptitudes, education and physical restrictions was extremely unlikely to find employment on his own, and the fact that claimant was rejected for job retraining by the Workers' Compensation Department, we find that his lack of effort to do more was not unreasonable under the circumstances." 52 Or App at 734-35 (citations omitted).

In cases decided since Laymon and Allison, the court has found workers permanently and totally disabled as a result of medical factors alone, and those workers have been excused from the requirements of ORS 656.206(3). Edge v. Jeld-Wen, Inc., 70 Or App 214, 218 (1984) ("The preponderance of the evidence establishes that claimant is completely incapacitated from employment by his physical conditions alone. Accordingly, claimant is not required to conduct a futile search for employment."); Ferguson v. Industrial Indemnity Co., 70 Or App 46 (1984) (The combination of claimant's severe psychiatric problems, combined with his physical disability, made it impossible for him to seek or obtain gainful employment.); Gulick v. Champion International, 66 Or App 186 (1983) (Claimant's physical condition alone made it futile for him to attempt to find work.). Also, see

Munger v. SAIF, 63 Or App 234, 238 (1983) (decided before Laymon and Allison,) in which the court found it would have been futile for claimant to attempt to find employment, even with the best motivation, in light of his physical and mental conditions.

Welch v. Banister Pipeline, 70 Or App 699 (1984), suggests that, in the court's opinion, even a worker who is not totally disabled based upon medical factors alone may be excused from the seek-work requirement:

> "In this case, in which the claimant does not exhibit total physical incapacity, we are involved with the so-called 'odd-lot' doctrine, under which a disabled person may remain capable of performing work of some kind but still be permanently disabled due to a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Such nonmedical considerations include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. * * * Because such an injured worker has some capacity for employment, he is statutorily required to make reasonable efforts to find work, although he need not engage in job-seeking activities that, in all practicality, would be futile." 70 Or App at 701 (emphasis supplied).

Based upon our review of the Laymon and Allison decisions, the cases cited therein, and the recent decisions of the Court of Appeals, we conclude that the insurer is mistaken in its assertion that a claimant who is not permanently and totally disabled on the basis of medical factors alone is required, as a matter of law, to satisfy the seek-work requirement of ORS 656.206(3). We believe that the scope of the futility exception to the seek-work requirement must necessarily be defined on a case-by-case basis. As we previouisly held in Dock A. Perkins, supra, a claimant may be so "incapacitated," in terms of the claimant's ability to sell his or her services in a competitive labor market, as a result of medical factors and social/vocational factors, as to be excused from the seek-work requirement.

Even if a claimant is not completely excused from the statutory requirement, it is nevertheless possible, given the evidence of the claimant's medical condition and relevant social/vocational factors, that very minimal efforts to seek and obtain employment satisfy the statutory requirement. Pournelle v. SAIF, 70 Or App 56 (1984); Petersen v. SAIF, 52 Or App 731 (1981); see also Livesay v. SAIF, 55 Or App 390 (1981). In each case, the inquiry is what constitutes "reasonable efforts" to obtain suitable employment, considering the evidence of claimant's disability.

In this case, we find that claimant is not so severely disabled, as a result of his medical condition and pertinent social/vocational factors, to justify the conclusion that he is completely excused from the statutory seek-work requirement. We

do find, however, that claimant has exhibited motivation to return to the labor force since his industrial injury, and that the efforts he has made to do so have been thwarted by his medical condition.

Before claimant's condition became stationary, he was referred for vocational assistance through the Vocational Rehabilitation Division. A rehabilitation plan was formulated with an eye toward achieving a vocational objective of maintenance worker. Claimant began an evaluation at a motel; however, after several days on the job, his foot became infected. Because additional foot surgery was considered necessary, the vocational plan was placed in interrupted status. After this fifth surgical procedure, in a series of six, was performed in October of 1982, claimant's vocational counselor remained in contact with claimant. However, little effort was made in terms of providing vocational counseling, in view of claimant's continuing medical problem.

Dr. Andrews performed the final surgical procedure in September of 1983. The following month claimant's vocational rehabilitation file with the Vocational Rehabilitation Division was closed, apparently as the result of the Field Services Division's determination that it would be appropriate to attempt direct employment placement rather than vocational retraining. The closure statement issued by the Vocational Rehabilitation Division, dated October 10, 1983, states that, "This client has not been employed, nor is it anticipated that he will be employed in the near future."

There is no documentation in the record to reflect the efforts of the Field Services Division provider in locating suitable employment for claimant. Claimant testified, however, that efforts were being made by "the State" in this regard, and that no employment had been obtained as of the time of hearing. In addition, claimant testified that he had not directly applied for work through the Employment Division, although he had delivered his resume to two or three small motor repair businesses. Of course, claimant was not able to peruse the classified section of the newspaper since he is unable to read.

Considering the severe impairment of claimant's foot, the fact that he is a fifty-two year old, functionally illiterate man who has spent his entire working life as a laborer, and Dr. Rollins' persuasive testimony concerning claimant's limited learning and functional abilities, we find and hold that claimant's failure to make greater attempts to obtain suitable employment was not unreasonable. See Petersen v. SAIF, 52 Or App 731 (1981); cf. Pournelle v. SAIF, 70 Or App 56 (1984). Claimant has satisfied the requirements of ORS 656.206(3), and he has established that he is permanently and totally disabled.

ORDER

The Referee's order dated June 27, 1984 is affirmed. Claimant's attorney is awarded $950 for services on Board review, to be paid by the insurer.

CELIA GARCIA, Claimant
Olson Law Firm, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 84-00892
May 9, 1985
Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing the employer's request for review of Referee Daron's order dated March 7, 1985 on the ground that the request was not timely filed.

As stated, the Referee's order was issued March 7, 1985. The thirty days specified by ORS 656.289(3) began to run the next day, March 8, 1985. The thirtieth day was April 7, 1985, a Sunday. The request for review was mailed to the Board and all relevant parties on April 8, 1985. The request was timely. OAR 438-05-040 (4)(c); OAR 438-11-005(2). The motion to dismiss is denied.

IT IS SO ORDERED.

JOHN A. BLAND, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 83-07275
May 15, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of that portion of Referee Baker's order which found claimant permanently and totally disabled, whereas a July 7, 1983 Determination Order had awarded him 30% (96°) unscheduled permanent disability for a low back injury. On review, SAIF contends claimant failed to prove that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment.

Following our de novo review of the record, we agree with the Referee that claimant has met his burden of proving permanent total disability as required by ORS 656.206(3).

Claimant has enclosed an affidavit from his attorney, requesting that his attorney fee for services at hearing be increased from a total of $2200 to $2604. The Referee awarded claimant's attorney $200 for prevailing on a penalty issue and 25% of the additional compensation granted by the Referee's order, not to exceed $2000. We deny claimant's request. Based on the efforts expended and the results obtained, we find that the attorney fee awards were appropriate. OAR 438-47-010(2); OAR 438-47-025.

ORDER

The Referee's order dated August 30, 1984 is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the SAIF Corporation.

JAMES A. McGOUGAN, Claimant
Noreen Saltveit, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Moscato & Byerly, Defense Attorneys
Beers, et al., Defense Attorneys

WCB 84-00639, 84-00638 & 83-07673
May 15, 1985
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated April 23, 1985.

The request is granted. Claimant's attorney requests that an attorney fee be awarded for services on Board review. The request states in part:

> "Claimant's attorney respectfully points out that this was a complicated case involving three employers/carriers. It was necessary for claimant's attorney to write a brief on this complex case because SAIF Corporation refused to deny only responsibility and, as the Board in its Order on Review correctly points out, it also denied compensability. Therefore, SAIF is responsible for an attorney's fee and in view of the complexities of the case, claimant urges a substantial attorney's fee."

Claimant's brief contains but one page and two lines of argument. Regarding responsibility, claimant does not advocate a position adverse to any one potentially responsible insurer. Claimant argues in the alternative that either EBI or SAIF is responsible. Claimant addresses the compensability issue as follows:

> "Although SAIF denied compensability at the hearing it does not seem to be arguing compensability at the present time but more that of responsibility."

We find that claimant's attorney did not contribute to the review process and, in that sense, did not perform meaningful services. We decline to award a fee for these services. See Karl J. Wild, 37 Van Natta 491 (1985); David R. Petshow, 36 Van Natta 1323 (1984).

On reconsideration, the Board adheres to its former order.

IT IS SO ORDERED.

MAYNARD G. SCHOENBECK, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-11239
May 15, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Seymour's order which set aside its denial of claimant's low back injury claim. The issue is compensability.

Claimant was involved in a motor vehicle accident on June 10,

1971 in the scope and course of his employment. He filed a report about the vehicle accident on the same day and reported that he had no injury. He reported to his supervisor that his back was a little sore and the supervisor encouraged him to make an injury report, but claimant declined. Claimant had subsequent back injury claims in 1978 and 1981 which were unrelated to this incident. Claimant filed his claim for the 1971 accident on August 8, 1983.

Claimant testified that he required chiropractic care after the accident. Claimant's wife testified that claimant had required chiropractic care after the accident, but could not remember whether claimant began chiropractic treatment before or after the accident. The medical records show that claimant had low back pain for which he obtained chiropractic treatments before November 21, 1970, and that he had complained of flank pain during the 1960's. Claimant's work record showed that he took no time off for sick leave between November 1970 and October 1971, and his vacation leave was taken in July and August 1971.

ORS 656.005(8)(a) defines a compensable injury:

> "A 'compensable injury' is an accidental injury...arising out of and in the course of employment requiring medical services or resulting in disability or death."

The evidence is clear that the injury did not result in disability causing loss of work. There is no evidence that the motor vehicle accident resulted in a need for medical services other than claimant's assertion that the accident caused his need for chiropractic care. Claimant named the chiropractor to whom he claims he went for treatment the week after the accident, but provided no statement from him. Claimant did not reveal that he had obtained chiropractic treatment for his back condition before the 1971 accident and claimant's wife could not remember when he began obtaining chiropractic treatment. On this record, we find that claimant has not sustained his burden of showing that he sustained a compensable injury as a direct result of the motor vehicle accident of June 10, 1971. Ronald A. Richard, 35 Van Natta 1635 (1983).

ORDER

The Referee's order dated July 11, 1984 is reversed. The SAIF Corporation's denial of compensability of the low back injury claim for the accident of June 10, 1971 is reinstated.

FRED H. STERNBERG, Claimant
Parks & Ratliff, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-05655
May 15, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Siefert's order which awarded claimant 37.5° for 25% scheduled disability for loss of use of the right hip in addition to the 37.5° for 25% scheduled disability awarded by Determination Order and denied an award of permanent total disability.

The Referee found that claimant was not permanently and

totally disabled due to medical factors alone and that he had failed to satisfy the requirements of ORS 656.206(3) because he only sought work with his employer at the time of injury. Since the Referee's decision, the Court of Appeals decided Pournelle v. SAIF, 70 Or App 56 (1984), which found that a claimant could prove permanent total disability even though his only work-seeking activity had been to return to the same employer.

In Pournelle, the claimant made repeated efforts to return to modified work against medical advice to retire. Each attempt to return to work made his back condition worse. In this case, claimant returned to his employer at the time of injury and attempted to perform the same kinds of heavy farm labor that he was performing before his injury. His doctor and his employer felt that claimant could no longer do the heavy work. The doctor recommended light work, but claimant declined placement assistance and made no effort to find work within his physical limitations. The employer has been cooperative, as was the employer in Pournelle, but there is no regular work available within claimant's limitations with this employer.

Claimant argues that his age, education, and preexisting disabilities preclude his reemployment. However, he has refused placement assistance and this record does not convince us that it would be futile for claimant to seek work. We find that claimant has not proven that it would be futile for him to seek suitable work and, therefore, he has not proven that he is permanently and totally disabled.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's orders dated August 10 and August 27, 1984 are affirmed.

JULIA F. AMELL, Claimant
Roll, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-00254
May 16, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Podnar's order which: (1) found claimant was not permanently totally disabled; (2) awarded 64° for 20% unscheduled disability in addition to the 96° for 30% unscheduled disability which claimant had previously been awarded by Determination Order and two stipulations; (3) found claimant had not proven an aggravation of her low back injury; and (4) found the questions surrounding the payment of interim compensation had been rendered moot by the agreement of the parties at hearing. The issues on review are extent of disability if the claim remains closed, whether claimant has proven an aggravation, and the amount of interim compensation plus penalties and attorney's fees.

The Board affirms the order of the Referee with the following comment. The Referee found that he was "unable to conclude that claimant's condition had in fact worsened to the point of meriting a claim reopening." If claimant's condition worsened, she is

entitled to have her claim reopened. There is no requirement that the worsening meet some minimum standard to merit reopening. Clark v. SAIF, 70 Or App 150 (1984); Mosqueda v. ESCO Corporation, 54 Or App 736 (1981). After de novo review of the record, we find that claimant has not carried her burden of proof that there has been a worsening of her condition since the last arrangement of compensation and, therefore, is not entitled to reopening of her claim under ORS 656.273. Maarefi v. SAIF, 69 Or App 527 (1984); Hutchinson v. Louisiana-Pacific, 67 Or App 577 (1984).

ORDER

The Referee's order dated July 31, 1984 is affirmed.

DEBORAH M. COOK, Claimant
W. Daniel Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Marcus K. Ward, Attorney

WCB 83-07636 & 83-03608
May 16, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

On behalf of Willamette Poultry, the SAIF Corporation requests review of Referee Baker's order which: (1) upheld SAIF's denial of claimant's new injury claim while employed at Edgewood Nursing Center and set aside SAIF's denial of aggravation of carpal tunnel disease attributed to employment at Willamette Poultry; (2) awarded temporary total disability compensation from October 21 through October 23, 1981; (3) awarded a 25% penalty for unreasonable delay and resistance to payment of temporary partial disability awarded by Determination Order; and (4) awarded interim compensation from May 20 through August 18, 1983, plus penalties and attorney's fees. The issues on review are responsibility, entitlement to compensation for the first three days of disability when the initial period of disability is less than fourteen days, entitlement to time loss compensation while able to work pending denial, and penalties and attorney's fees.

The Board affirms and adopts the order of the Referee except that portion granting time loss compensation plus penalties and attorney fees for the period May 20 through August 18, 1983. Claimant was taken off work by her doctor due to an aggravation of her compensable condition on May 10 and she was released to return to work on May 19, 1983. Time loss compensation was paid for that period. Claimant has failed to provide any evidence that she was not able to work full-time without restrictions after that period pending denial, therefore, she is not entitled to time loss compensation for the period from May 20 through August 18, 1983. Bono v. SAIF, 298 Or 405 (1984).

The Referee made a single lump sum fee award to claimant's attorney for prevailing on all of the issues of denial and unreasonable resistance and delay. We find that the amount of the attorney's fee that should have been apportioned to the interim compensation claim was $300 and, therefore, the attorney's fee award should be reduced accordingly.

When claimant prevails on more than one claim and claimant's attorney is entitled to an insurer or employer paid fee, the Referee should award a separate fee for each claim so that issues of reasonableness of fees can be readily identified and comparisons made and so that if there are changes in applicable

law, as for example with entitlement to compensation pending denial, the amount of the adjustment to the fee award can be readily made. Compare Jafer M. Farzana, 36 Van Natta 1630 (1984) (the Board was unable to determine from the attorney's fee award if the Referee made an award associated with a penalty for failure to pay interim compensation and declined to assume that no award had been made) and Wayne L. Vance, 36 Van Natta 1254 (1984) (the Board was unable to determine which portion of a fee award was attributable to the interim compensation issue and assigned a value of $300) with Charles M. Schwab, 36 Van Natta 333 (1984) (the Referee made separate attorney's fee awards for an interim compensation claim and an unreasonable denial claim; the Board found the denial was reasonable and reversed the attorney's fee award for that issue only).

ORDER

The Referee's order dated August 2, 1984 is reversed in part, modified in part and affirmed in part. That portion which awarded compensation and penalties for the period from May 20 through August 18, 1983, is reversed. The attorney's fee award is modified to $1700 in lieu of the $2000 awarded by the Referee. In all other respects, the Referee's order is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the SAIF Corporation.

ELSIE H. MISIAK, Claimant
Gilley & Busey, Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 83-05278 & 83-05916
May 16, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The self-insured employer requests review of those portions of Referee Shebley's order which: (1) set aside that portion of its June 7, 1983 denial denying compensability of claimant's thoracic strain and cervical problems; and (2) set aside its denial of pain center evaluation and treatment, holding such medical services compensable under ORS 656.245. Claimant cross-requests review of those portions of the Referee's order which: (1) upheld that portion of the employer's denial denying compensability of her carpal tunnel syndrome; and (2) held that the claim was not prematurely closed. Claimant contends that if the claim was properly closed, it should be reopened due to an alleged aggravation. The employer and claimant both request review of that portion of the Referee's order which awarded claimant 128° for 40% unscheduled disability in lieu of a Determination Order award of 48° for 15% unscheduled disability for her neck, mid back and low back. Claimant contends that she is permanently and totally disabled. Claimant also requests that we clarify that portion of the Referee's order setting aside the employer's denial of compensability of claimant's thoracic strain and cervical problems and order the employer to pay compensation from the date that the claim was opened or not later than June 7, 1983.

The employer's June 7, 1983 denial in part provided:

> "This will acknowledge receipt and acceptance of your July 8, 1982, injury and resultant low back strain, for which benefits have been paid.

"We have now received information that you are being treated for several unrelated condition [sic], i.e., . . . thoracic strain, and cervical problems.

"Please be advised that we must respectfully deny reopening of your claim for medical and time loss benefits as these conditions are not related to your low back injury and did not arise out of nor in the course and scope of your employment with John Deere Company."

The effect of that portion of the Referee's order setting aside the employer's June 7, 1983 denial as it related to claimant's thoracic strain and cervical problems was to hold that claimant was entitled to benefits according to law during all pertinent periods for these conditions as well as her low back condition.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated August 9, 1984 is affirmed. Claimant's attorney is awarded $700 for services on Board review, to be paid by the employer.

DONALD E. SMITH, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-10115
May 16, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee Menashe's order which: (1) upheld the SAIF Corporation's denial of compensability of claimant's neck and upper extremity conditions; and (2) declined to increase claimant's temporary total disability benefit rate. Claimant contends that for the purpose of calculating temporary total disability benefits, his "wages" include not only his salary, but also his mileage and meal allowances. See ORS 656.005(27), 656.210. SAIF contends that the Referee erred in setting aside the September 26, 1983 Determination Order as premature.

SAIF did not cross-request review, but first raised the premature closure issue in its respondent's brief. In his reply brief claimant objected to our considering that issue and requested an attorney fee. He did not address the merits of the premature closure issue. We have reviewed and affirm the Referee's finding of premature closure, but award no attorney fees. See Olin D. Monks, 37 Van Natta 481 (April 26, 1985).

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated August 10, 1984 is affirmed.

PEARLEEN K. BENNETT, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 84-04804
May 17, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests, and claimant cross-requests, review of Referee Howell's order which ordered payment of temporary total disability from May 26, 1984 through June 19, 1984 and imposed a penalty and associated attorney's fee for the employer's unreasonable refusal to pay compensation. The employer contends that it properly terminated claimant's temporary total disability benefits effective May 25, 1984, based upon claimant's attending physician's release to regular work and, therefore, that it should be required to pay neither the temporary disability benefits awarded by the Referee nor the penalties/attorney fees imposed for wrongful termination of benefits. In the alternative, the employer contends that even if it was wrong in ceasing the payment of temporary total disability benefits, its actions were not unreasonable under the facts and circumstances of this case. Claimant contends that his entire attorney's fee should be paid in addition to compensation, rather than a portion being paid as a percentage of the additional temporary disability awarded by the Referee, in view of the employer's unreasonable refusal to pay compensation. The Referee awarded claimant's attorney a $150 attorney's fee in association with the penalty. This fee was in addition to the fee he allowed claimant's attorney as a percentage of the additional temporary total disability awarded. We understand claimant to argue that, rather than requiring him to pay a portion of his attorney's fee, a larger fee should have been awarded pursuant to ORS 656.382(1) in view of the nature of the employer's conduct.

We affirm the Referee's order with the following additional comments.

The claims examiner responsible for processing this claim was understandably confused about who claimant's attending physician was. Dr. Everett, who now claims (with claimant's support) to have been claimant's attending physician since her injury, did not comply with the reporting requirements established by statute and administrative rule. ORS 656.252, 656.254; OAR 436-69-101(2) et seq. Although this physician's nonfeasance may subject him to the penalties provided by statute and the administrative rules, we do not believe his action, or more appropriately non-action, was sufficient justification for the employer's termination of claimant's temporary total disability benefits in this case.

The employer relies upon Dr. Teal's May 17, 1984 "No" response to its inquiry concerning claimant's ability to work as a result of her injury on the "one occasion" that he examined her on March 14, 1984. It should have been apparent, for several reasons, that Dr. Teal was not claimant's attending physician when the employer terminated claimant's temporary total disability on or about June 4, 1984.

As the employer was aware, Dr. Teal had examined claimant on only one occasion. Although claimant and Dr. Teal had discussed the possibility of surgery, as the claims examiner knew from his conversation with claimant in mid to late March, claimant had

"ambivalent feelings" about Dr. Teal and was uncertain whether she wanted surgery at his hands. Although there was a legitimate doubt about exactly who was claimant's attending physician during March, April and May of 1984, we do not believe that the facts and circumstances known to the employer during that period of time warrants the conclusion that Dr. Teal had become elevated to the status of an "attending physician," as that term is defined in ORS 656.005(13) and OAR 436-69-005(1). Dr. Teal never rose above the status of a "consulting physician." OAR 436-69-005(6).

Furthermore, there are factual and logical flaws in the employer's after-the-fact attempt to justify its termination of claimant's temporary total disability benefits. The employer ceased payment of claimant's time loss on June 6, 1984 upon issuance of a check for an eight day period ending May 25, 1984. At or about the same time a letter was sent to claimant informing her that "Dr. Teal and Dr. Button had released [her] for [her] regular work" and that, therefore, her temporary total disability benefits were being terminated. It is axiomatic that an independent medical examiner's statement that a claimant is capable of performing his regular work activity does not provide any basis for termination of temporary total disability, although such an examiner's opinion concerning a claimant's medically stationary status is sufficient for submitting a claim for closure. Dr. Button was an independent medical examiner, and the employer does not contend otherwise.

The employer might have had a reasonable belief that Dr. Teal was claimant's attending physician in mid to late March after conferring with claimant; however, at the time claimant's temporary disability benefits actually were terminated in early June, the employer should have known this was not the case. The employer was in possession of two medical reports, one from Dr. Gardner, an independent psychiatric examiner (whose report is dated May 11, 1984), and one from Dr. Button (whose report is dated May 5, 1984), indicating that claimant had arranged to have surgery with a physician named Sack in Seattle. In light of this information, it is difficult to understand how the employer reasonably could have believed that Dr. Teal was claimant's attending physician when temporary total disability was terminated in early June of 1984.

As stated above, there was understandable confusion on the employer's part concerning which physician, if any, was actually claimant's attending physician in the three months following her industrial injury. Although we are sympathetic with the employer's quandary, which we believe was created in large part by Dr. Everett's complete failure to comply with the statutory and regulatory reporting requirements, we do not consider the employer's termination of claimant's temporary total disability benefits justified or justifiable. Termination of claimant's time loss was unreasonable and not simply wrong.

As to the attorney's fee issue raised by claimant's cross-request for review, claimant's entitlement to an insurer-paid fee arises under the penalty provision of ORS 656.382(1). In the absence of a finding of unreasonableness, there would be no basis for any insurer-paid fee in this case. In the absence of such a finding, claimant would be required to pay his attorney entirely out of the additional temporary total disability awarded. ORS 656.386(2); OAR 438-47-030(1). Claimant appears to argue that, considering the nature of the employer's

conduct, a larger fee is appropriate as and for a penalty. We are not persuaded. Claimant's attorney clearly is entitled to an insurer-paid fee under the facts and circumstances of this case. See Zelda M. Bahler, 31 Van Natta 139, 33 Van Natta 478, 481 (1981), rev'd in part on other grounds, 60 Or App 90 (1982). However, taking into consideration the nature of the employer's conduct, as well as the efforts expended and results obtained by counsel on the penalty issue, we find the Referee's award of $150 adequate and appropriate.

ORDER

The Referee's order dated November 1, 1984 is affirmed.

GEORGE E. JOHNSON, Claimant
Phillip Schuster II, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 82-06854
May 17, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Argonaut Insurance Company requests review of Referee Quillinan's order which set aside its denial of claimant's low back aggravation claim and awarded temporary total disability commencing August 1, 1982. We reverse.

Claimant's medical history was well summarized by the Referee. To further summarize, claimant stopped working in 1971 because of back pain. In November 1978 he returned to work, but was injured during the third week on the job. Therapy and vocational rehabilitation were attempted. The claim was closed by a Determination Order of December 19, 1979, with no award for permanent disability. In August 1981 claimant's back hurt suddenly when he attempted to rise from a bed. He went to the doctor in October 1981 complaining of persistent pain. In November 1981 two doctors recommended surgery. The insurer denied compensability of the aggravation claim. There is no evidence that claimant saw a doctor between April 1982 and the hearing in February 1984.

We think the compensability of this claim depends on the credibility of claimant. In the absence of a credibility finding by the Referee based on demeanor at the hearing, we make our own determination of claimant's credibility based on the record. See Davies v. Hanel Lbr. Co., 67 Or App 35 (1984). The record in this file indicates that claimant is an inconsistent historian. Contemporaneous reports of incidents differ greatly from later reports of the same incidents. Claimant denied use of alcohol until confronted with a diagnosis of hepatitis at which time he admitted alcohol use. Claimant's explanation for termination from a rehabilitation program in 1979 at the Callahan Center was incredible when compared to the reports from the center. Although acceptance of his 1978 injury was not at issue, claimant's testimony about that accident was contradicted by his report to his physician, the work records of his employer and the insurer's corrected reports to the Workers' Compensation Department. We find claimant not credible.

The Referee relied on Dr. Misko's opinion in April 1984 that claimant's symptoms in 1981 were related to the 1978 injury and that claimant's condition had worsened due to the injury. Dr. Misko eventually reviewed all of the CT scans and myelograms and physicians' reports and concluded that the 1981 symptoms were

related to the 1978 injury and to no other cause. The Referee relied on this opinion to find that claimant had aggravated his low back condition. Because Dr. Misko's opinion relies partly on objective diagnostic tests, such as CT scans and myelograms, there is some support for his conclusion. But the conclusion is also dependent on claimant's unreliable report that there had been no activity or incident that could possibly have contributed to claimant's disability. Because the record shows that claimant's reports to doctors were not reliable, we find that Dr. Misko's opinion is not persuasive. Richard L. Schoennoehl, 31 Van Natta 25, (1981); aff'd mem., 54 Or App 998 (1981).

The other doctor who recommended reopening the claim for surgery never suggested that claimant's condition was related to his 1978 injury. His only finding was that claimant needed the surgery but gave no opinion about causation.

Claimant's burden of proof is to show by a preponderance of the evidence that his industrial injury is a material cause of his worsened back condition. Grable v. Weyerhaeuser, 291 Or 387 (1981). Claimant has failed to carry his burden of proof, therefore, we find that the insurer's denial should have been approved.

Any issue relating to the alleged overpayment of compensation may be raised and decided when and if claimant receives a further disability award against which offsets may be allowed. ORS 656.268(4); Milton O. Burson, 36 Van Natta 282, 284 (1984).

ORDER

The Referee's order dated June 11, 1984 is reversed. The insurer's denial of April 26, 1982 is reinstated.

PATRICK M. HANNUM, Claimant
Allen & Vick, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-11929
May 21, 1985
Order of Dismissal

The insurer has withdrawn its request for review of the Referee's decision in this matter and has requested an order of dismissal. Claimant objects to the request for dismissal. Claimant did not cross-request review. The insurer's withdrawal of its request for Board review has caused the Referee's order to become final. We are, therefore, without jurisdiction. The request for review is dismissed.

IT IS SO ORDERED.

EDWARD O. MILLER, Claimant
Bloom, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 79-03231 & 83-02511
May 21, 1985
Order on Reconsideration

We issued our Order on Review in these cases in tandem with our Own Motion Order in case no. 82-0210M. We received requests for reconsideration of both orders, although our review of the requests convinces us that reconsideration was only sought of our Own Motion Order. In order to avoid further complicating these already incredibly complex cases, we abated both orders. We have this date issued our Own Motion Order on Reconsideration.

The request for reconsideration is granted. On reconsideration, the Board adheres to and republishes its former order.

IT IS SO ORDERED.

EDWARD O. MILLER, Claimant
Bloom, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Own Motion 82-0210M
May 21, 1985
Own Motion Order on Reconsideration

Both claimant and the employer, Brander Meat Company, and its insurer, Glen Falls Insurance Company, have requested that the Board reconsider its Own Motion Order entered February 22, 1985. The procedural and factual history of this unique and very complex case is set forth in detail in prior orders, and will not be repeated. See Edward O. Miller, 35 Van Natta 286 (1983) (Consolidated Order Remanding), 36 Van Natta 1578 (1984) (Consolidated Order Denying Motion to Dismiss), 37 Van Natta 174 (1985) (Order on Review), 37 Van Natta 176 (1985) (Own Motion Order), 37 Van Natta 296 (1985) (Orders of Abatement). The employer requests reconsideration on three bases.

First, the employer objects to our summary rejection of its argument that claimant's request for own motion relief is barred by the res judicata or collateral estoppel effect of our previous own motion order denying relief. We summarily rejected this argument because our statutory grant of authority to exercise our continuing jurisdiction does not ordinarily contemplate the application of the common law doctrines of res judicata or collateral estoppel, except in cases involving disputed claim settlements and final orders declaring a condition to be noncompensable. See Holmes v. State Ind. Acc. Com., 227 Or 562, 575 (1961). ORS 656.278(1) provides:

> "Except as provided in subsection (5) of this section, the power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified."

The exceptions to the Board's jurisdiction to change prior orders were enacted by the legislature apparently in response to the Supreme Court's decision in Fields v. Workmen's Comp. Board, 276 Or 805 (1976), which reversed the Court of Appeals' holding that former ORS 656.278 did not permit the Board to reconsider a previous final order that held a claim to be noncompensable. See Fields v. Workmen's Comp. Board, 26 Or App 323, 329-30 (1976) (Schwab, C.J., dissenting). In its per curiam opinion, the Supreme Court noted that the Board could choose to deny relief to a claimant, "if it decides that for reasons underlying the doctrine of res judicata the claim should not be reconsidered." 276 Or at 807. As we noted in our prior order, our initial denial of own motion relief was premised upon an incomplete development of the complex interrelationship between claimant's mental conditions and the treatment thereof. We find that refusal to reconsider claimant's case for reasons underlying the doctrine of res judicata is not appropriate in this case.

The second reason for reconsideration advanced by the employer is that it should not be held responsible for claimant's arm/shoulder/hand condition. We found in our previous order that the arm/shoulder/hand condition is one component of claimant's entire symptom complex which is now present as the result of the inseparable combination of claimant's organic brain damage superimposed upon his underlying paranoid psychosis. The employer's principal argument for reconsideration, however, does not appear to object strenuously to our finding of fact, but to address the contention that no claim was ever made against this employer for the arm/shoulder/hand condition. We have reconsidered our order in view of this latter argument.

Claimant's petition for own motion reopening of the 1970 head injury claim did not in so many words request that we hold this employer responsible for the arm/shoulder/hand condition. Were this case not under our continuing jurisdiction under ORS 656.278, we might very well conclude that claimant's failure to specifically submit a formal claim for this condition precludes our affording claimant any relief. Cf. Syphers v. K-W Logging, Inc., 51 Or App 769, rev den, 291 Or 151 (1981). But see Pumpelly v. SAIF, 50 Or App 303, 308 (1981). This case is under our own motion jurisdiction, however, and we review each request for own motion relief on a case by case basis to determine what relief is justified by the particular circumstances presented.

There can be no question that this employer was on notice that claimant petitioned the Board to reopen his 1970 head injury claim. Because of the uniqueness and great complexity of this case, we conclude that the evidence justifies our having found all of claimant's symptom complex to be attributed to the sequela of the 1970 head injury, and to hold Brander Meat Company and its industrial insurer responsible therefor.

The employer's third basis for requesting reconsideration of our prior order is that claimant's complex partial seizure disorder and his underlying paranoid psychosis are separable, and that the employer is not responsible for the latter condition. We specifically found, as a matter of fact based upon expert medical opinion evidence, to the contrary in our prior order. We have reconsidered our finding and adhere to it.

Claimant's request for reconsideration addresses only one issue. Claimant claims he is entitled to temporary total disability benefits between September 19, 1977 and the date of the hearing. Claimant does not specify whether we should grant such benefits until the time of the first hearing or the second hearing. In our previous order, we found that claimant was medically stationary as of the most recent hearing. Our previous order did not address the issue of temporary total disability. The employer argues, first, that claimant is not entitled to any temporary total disability, and, alternatively, if he is, claimant was medically stationary as of a date earlier than either hearing.

We find that claimant's authorized training program was terminated December 20, 1977 due to the severity of his medical condition. Claimant has not worked since. Our policy on granting temporary total disability benefits in own motion cases is embodied in Vernon Michael, 34 Van Natta 1212, 1213 (1982):

> "When we grant own motion relief, we order compensation for temporary total disability for a claimant who was working or seeking work at the time his physical condition worsened; and we order payment for temporary total disability for a claimant who was not working or seeking work due in whole or in significant part to physical problems causally linked to the prior compensable injury; but we do not order compensation for temporary total disability for a claimant who was not working or seeking work for any other reason, such as voluntary withdrawal or retirement from the labor market."

We find that claimant has not worked or been involved in vocational rehabilitation since December 20, 1977, and that his failure to work or seek work is due in significant part to his medical condition. We further find that claimant's treating physician declared him to be medically stationary as of October 14, 1980 and that there is no medical opinion to the contrary. Accordingly, under the formula set forth in Vernon Michael, supra, claimant is entitled to temporary total disability compensation between December 21, 1977 and October 14, 1980, both dates inclusive. This finding that claimant was medically stationary on a date prior to either of the two hearings is not inconsistent with our having found that claimant was medically stationary as of the date of the most recent hearing.

Both requests for reconsideration are granted. Our previous Own Motion Order issued February 22, 1985 is modified to order that claimant be paid temporary total disability compensation between December 21, 1977 and October 14, 1980, inclusive. As modified and clarified herein, we adhere to and republish our former Own Motion Order. Claimant's attorney is granted 25% of the additional compensation awarded by this order, not to exceed $1,000. OAR 438-47-070(2). We note that, although the employer "commenced a proceeding" in also requesting reconsideration of the Own Motion Order, claimant's attorney submitted no argument addressing the employer's contentions. We conclude that claimant's attorney is not entitled to an insurer paid fee under OAR 438-47-070(1). See also Bentley v. SAIF, 38 Or App 475, 481-82 (1979).

IT IS SO ORDERED.

TODD A. AUCONE, Claimant
FRED W. & LUCILLE M. SCHOTTE dba
Fred Schotte Trucking, Employer
INTERNATIONAL PAPER COMPANY, Employer
Myrick, et al., Claimant's Attorneys
Wally P. Martin, Attorney
SAIF Corp Legal, Defense Attorney
Foss, Whitty & Roess, Defense Attorneys
Carl M. Davis, Ass't. Attorney General

WCB 84-01334, 84-02777, 84-02778 & 84-03525
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The Workers' Compensation Department requests review of those portions of Referee Brown's order which: (1) set aside the SAIF Corporation's February 3, 1984 denial of responsibility for injury to claimant's mouth issued in behalf of Fred Schotte Trucking; (2) approved International Paper Company's denial of responsibility; and (3) ordered SAIF to pay claimant's attorney $1,000 for services at hearing. The Department contends that as Schotte is a noncomplying employer, claimant should be deemed a subject worker of IP under ORS 656.029(1), and that IP should be held responsible for claimant's injury and the $1,000 attorney fee. The Department also contends that a penalty and attorney fee should be assessed against IP for alleged unreasonable resistance and denial of the claim. IP contends that the Board is without jurisdiction because the Department allegedly lacks standing to request review relative to the above listed issues.

We accept the Referee's finding that at the time of the injury claimant was a subject worker in the employ of Schotte, a noncomplying employer. If Schotte is responsible, ORS 656.054(1) provides that the claim be processed by SAIF. ORS 656.054(3) provides for the recovery of all claim processing costs from the noncomplying employer, but also states, "The director shall provide by regulation for the Administrative Fund to reimburse, on a periodic basis, the Industrial Accident Fund for any costs it incurs under this section." See Juan Anfilofieff, 37 Van Natta 257 (1985). The Department thus must pay all costs not recovered from the noncomplying employer in the event it is responsible. See also ORS 656.632; OAR 436-52-050. Such an interest is clearly sufficient to provide it standing to request review of the Referee's application of ORS 656.029. We find that we have jurisdiction to consider the Department's request, at least as it relates to the responsibility determination.

ORS 656.029(1) provides:

> "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 the 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." (Emphasis added.)

IP contends that it did not "let a contract" to Schotte, as that phrase is used in the statute. Schotte owned and operated several trucks, providing transportation services to at least several customers, including IP. Claimant was injured in the course of transporting lumber from IP's Gardiner mill to Lou Merrill Lumber Company in Grants Pass. Mr. Schotte obtained the haul by telephoning IP on a tip from Mr. Merrill. A formalized competitive bidding procedure was not followed. The agreement was apparently oral. At the approximate time of the injury Schotte's trucks were hauling 20 loads per week for IP from Gardiner to Grants Pass at approximately $150 per load. Schotte was not the exclusive hauler for IP from the Gardiner mill.

In TEC Equipment, Inc., 36 Van Natta 1171 (1984), we found the primary contracting party responsible on facts nearly identical with those before us here, but did not expressly grapple with the requirement that a contract be let. Three other recent cases, Dennis P. Cummings, 36 Van Natta 260 (1984), Richard O. Hampton, 36 Van Natta 230 (1984), and Richard F. Erzen, 36 Van Natta 218 (1984), aff'd, 73 Or App 256 (1985), are also pertinent.

In Erzen, which concerned a contract between a partnership and a construction company for the framing of a house, we noted that one of the goals of ORS 656.029 was to eliminate "phony partnerships" in the construction industry. We explained:

> "Phony partnerships" were composed of individuals who would form a partnership organization in order to avoid certain costs of doing business, including the cost of workers' compensation insurance, which would enable such partnerships to underbid other business entities that were required to pay such costs and whose bid amount reflected passing such business costs onto those with whom they did business." See also E. W. Eldridge, Inc. v. Becker, 73 Or App 631 (A32179, May 22, 1985).

We observed that the phrase "lets a contract" in a prior similar statute had been interpreted with reference to common parlance and in an effort to avoid haphazard coverage to casual beneficiaries. We noted as apparently significant that the construction company had let the contract as a part of the work it was engaged in as its principal business. We found the primary contracting party responsible, and the Court of Appeals affirmed.

In Hampton we found a theater business which contracted for the installation of heating ducts in a building that it planned to convert to a movie theater responsible for injuries sustained in installing the ducts. Noting that unlike the present statute, the prior statute had contained a provision limiting its application to situations where the contract was entered into in the course of the business in which the primary party was engaged, we stated:

> "[W]e think the more likely legislative intent was that in virtually all, if not literally all, situations in which a business entity . . . enters into a contract as a business entity, that contract is subject to ORS 656.029." (Emphasis in original.) 36 Van Natta at 232.

Board member Lewis dissented in Hampton, terming absurd the literal application of ORS 656.029 placing liability on any business person who contracts with a noncomplying employer. He stated that the legislative history shows an intent that the statute be applied to contractors who let contracts to subcontractors, not to consumers who initially contract with the contractor and who happen to be engaged in business. He stated that the legislative purpose of the statute was to prevent evasion of liability by those who subdivide their regular operations in order to escape direct employment relationships with those performing the work.

Finally, in Cummings we held that a realty firm which engaged the services of a sign company to remove a sign from a parcel of property was not responsible for injuries incurred in the course of removing the sign. We said:

> "The definition of 'letting' connotes a situation where bids normally are received and the contract is awarded to the lowest bidder. . . . [W]e are unwilling to apply ORS 656.029 to every contract for the performance of services. Just as contracting for the repair of a gas tank was not deemed letting a contract in Didier [v. SIAC, 243 Or 460 (1966)], contracting for the removal of a sign in the present case is not deemed letting a contract under ORS 656.029." 36 Van Natta at 262.

We then explained our decision in Hampton as follows:

> "Whether the movie businessperson in Hampton received bids for the sheetmetal work is not crucial. What matters is that the movie businessperson acted as a general contractor in contracting for the work required to remodel the building. In contracting for the sheetmetal work, the movie businessperson, by written contract, let a contract for the performance of labor and invoked the application of ORS 656.029." 36 Van Natta at 262.

Each of the above cases has been decided on its facts with little attempt to enunciate a precise general rule. Such a general standard may naturally evolve, but only after experience is gained from future applications of the statute in various factual contexts. A few guidelines can be gleaned from our experience thus far, however. We determine that the touchstone in applying the "lets a contract" requirement is not the nature of the primary's business, but the nature of the agreement. The contract must be of a nature that might typically be "let," as that term is used in common parlance. The actual process by which the agreement is entered into is one indication of the nature of the agreement, but is not necessarily controlling.

Although ORS 656.029(1) is not limited in its application to the construction industry, traditional construction subcontracting agreements well illustrate the sort of contracts triggering

application of the statute. They are often bid and performed pursuant to a written agreement, although neither bidding nor writing is essential. Nonetheless, typically they are circumspectly entered into. Such contracts commonly involve a subdivision of the primary contractor's regular operation, not the insignificant and incidental purchase of tangential services.

With these guidelines in mind, we consider the facts of this case. Under the agreement, Schotte was grossing approximately $13,000 per month providing substantial services directly related to IP's regular business operation. Although there was no formal bidding, commercial hauling is a very competitive field. IP can be presumed to have some familiarity with the going rates, particularly since it did not deal exclusively with a single hauler. Schotte's shoddy practices gave it the precise sort of unfair competitive advantage ORS 656.029 was enacted to eliminate. We find that IP did "let a contract" to Schotte. Claimant is to be deemed a subject worker of IP and, accordingly, IP is responsible for his injuries.

In judging the reasonableness of IP's denial, we are mindful of the uncertainty which heretofore has existed relative to the application of ORS 656.029. We find that IP did not act unreasonably, and hence an award of a penalty or attorney fees is not appropriate for its actions.

ORDER

The Referee's order dated August 31, 1984 is affirmed in part and reversed in part. The SAIF Corporation's denial of February 3, 1984 is reinstated and approved. International Paper Company's denial of February 6, 1984 is set aside and the claim is remanded to it for processing and the payment of benefits according to law. International Paper Company and not the SAIF Corporation shall be responsible for payment of the reasonable attorney fee of $1,000 awarded by the Referee to claimant's attorney. The Referee's order is affirmed in all other respects.

GREGORY A. BACON, Claimant
Terry G. Sundkvist, Claimant's Attorney
Flaherty & Hall, Defense Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Ass't. Attorney General

WCB 83-10448
May 28, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Peterson's order which upheld the denial of his injury claim by the SAIF Corporation, on behalf of the noncomplying employer. On review, claimant contends that his injury arose out of and in the scope of his employment in that he was a resident employe continuously on call. Consequently, he argues that his injury, sustained during personal comfort activities, is compensable.

We affirm the order of the Referee with the following comment. Following our de novo review of the record, we are not persuaded that an employe-employer relationship existed between claimant and Mrs. Burnam, his alleged employer. Moreover, assuming such a relationship existed, claimant has failed to prove that he was required to reside on his alleged employer's premises

and to be on-call 24 hours a day. See generally Wallace v. Green Thumb, Inc., 296 Or 79 (1983). Therefore, the injury, that occurred after regular business hours while claimant was departing from the shower of his alleged employer's mobile home which was located on his alleged employer's premises, did not arise out of and in the course and scope of his employment.

ORDER

The Referee's order dated July 16, 1984 is affirmed.

JANNA M. BRYANT, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-10360
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Foster's order which: (1) set aside the November 8, 1983 Determination Order as prematurely closing claimant's back claim; (2) awarded as a penalty 10% of all doctor bills due and owing at the time medical treatment was accepted, plus a $400 attorney fee for SAIF's unreasonable failure to formally accept or deny medical benefits in a timely manner; and (3) authorized an offset of four weeks temporary disability compensation for claimant's unreasonable failure to accept a temporary job offered her. SAIF contends that the Determination Order should be reinstated and that it should be allowed an offset for temporary disability benefits paid for periods since the medically stationary date designated in the Determination Order; that it did all that was required of it relative to the disputed medical bills, and hence that the awards of a penalty and an associated attorney fee should be reversed; and that claimant's unreasonable refusal of employment disqualified her from all future temporary disability benefits. Claimant contends that her refusal of the temporary job was not unreasonable.

The Board affirms the order of the Referee with the following comments. Dr. Damond, a chiropractor, took over claimant's care on January 30, 1984. On April 5, 1984 he wrote SAIF to discuss claimant's case with respect to SAIF's disputed payment voucher of March 14, 1984. He explained the need to treat claimant more frequently than the recommended two visits per month and offered to discuss the matter by telephone if SAIF had any further questions. SAIF took no action to formally deny the disputed treatments in advance of the July 10, 1984 hearing. On July 24, 1984 SAIF wrote Dr. Damond as follows:

> "Please consider this letter acknowledgment and authorization to treat Ms. Bryant as you think medically necessary. As I explained to you, the disputed payment voucher sent to you by SAIF requires only that you provide a reasonable basis for the frequency of treatment before SAIF will reimburse you for such treatment. Your letter to SAIF of April 5, 1984 and your conversations with me on July 16 provide a sufficient basis for authorizing your frequency of treatment.

"As I indicated to you, I will authorize the billings initially disputed by SAIF."

SAIF had 60 days to pay or deny the disputed medical charges following receipt of Dr. Damond's April 5, 1984 response to the disputed payment voucher. See Kevin Bethel, 36 Van Natta 1060 (1984), Billy J. Eubanks, 35 Van Natta 131 (1983). SAIF's failure to timely act was unreasonable. We affirm the Referee's award of a 10% penalty and $400 attorney fee.

ORDER

The Referee's order dated August 27, 1984 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

BETTY J. CAMPBELL, Claimant
Joseph McNaught, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-05230 & 84-00663
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Neal's order which set aside its denial of claimant's occupational disease claim for facet joint hypertrophy. The issue on review is compensability.

We affirm the Referee's order with the following comment. The Referee relied on Wheeler v. Boise Cascade, 66 Or App 620 (1984), and ASC Contractors v. Harr, 69 Or App 405 (1984), for the proposition that claimant need not prove a worsening of her condition. Those cases have been clarified by Supreme Court review in Wheeler v. Boise Cascade, 298 Or 452 (1985): when a worker has a preexisting underlying condition, the work exposure must worsen the medical condition in order to find the worsening of the condition compensable. The Referee went on to find that there was no indication in the record that claimant's condition preexisted her employment and that the persuasive medical evidence established that the probable cause of her condition was her work exposure. We agree with the Referee's assessment of the evidence and conclusion.

ORDER

The Referee's order dated August 15, 1984 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

RONALD D. CRUMP, Claimant
W.D. Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Roberts, et al., Defense Attorney

WCB 82-10192 & 83-10147
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

EBI Companies requests review of those portions of Referee Michael Johnson's order which: (1) set aside EBI's October 18, 1983 denial of claimant's left knee condition; (2) approved the SAIF Corporation's March 4, 1983 denial; (3) ordered EBI to pay interim compensation to claimant according to law; and (4) awarded as a penalty 10% of all interim compensation paid pursuant to the

order plus a $300 attorney fee for its allegedly unreasonable failure to pay interim compensation. The issues are compensability of and responsibility for claimant's chondromalacia of the left patella and claimant's entitlement to interim compensation, plus the associated penalty and attorney fees.

The Board affirms and adopts those portions of the Referee's order relating to compensability and responsibility.

The Referee based his award of interim compensation in part on Bono v. SAIF, 56 Or App 138 (1983), rev'd, 298 Or 405 (1984). In reversing the Court of Appeals, the Supreme Court stated:

> "The payment of temporary total disability benefits is based in part upon whether the injured worker 'leaves work.' ORS 656.210(3). Interim compensation is based on temporary total disability benefits. Thus, we hold that in order to receive interim compensation, a subject worker must have left work as the phrase is used in ORS 656.210(3)." Bono v. SAIF, 298 Or 405, 410 (1984).

The doctor who treated claimant since 1982 never authorized time loss because of claimant's knee. Claimant testified that he never missed work time due to his knee. He is thus not entitled to interim compensation. There being no amounts then due, neither a penalty based on unpaid interim compensation nor an associated attorney fee is appropriate. See, e.g., EBI v. Thomas, 66 Or App 105 (1983). We reverse those portions of the Referee's order.

ORDER

The Referee's order dated August 10, 1984 is affirmed in part and reversed in part. Those portions of the order awarding interim compensation, a penalty equal to 10% of the interim compensation awarded plus a $300 attorney fee are reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by EBI Companies.

MARK J. DELLER, Claimant
Jolles, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-05877
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of Referee Pferdner's order that set aside its partial denial of claimant's headache complaints. The issue is compensability.

On November 21, 1980 claimant, an apprentice carpenter, fell approximately 26 feet from a scaffold. Claimant testified that he landed on a concrete floor in a sitting position, then fell backward to the floor. Claimant sustained a compression fracture of the L-1 vertebra and chipped three front teeth. It was also suspected that claimant may have had a concussion. He was treated by Dr. Cordova, internal medicine specialist. Claimant returned to work December 21, 1980. Dr. Cordova's early records do not mention headaches. Claimant's claim was accepted.

On March 16, 1981 claimant was examined by Dr. Hoppert, who

noted that claimant complained of occasional headaches at night and in the morning two or three times weekly. Dr. Hoppert performed a closing examination on July 2, 1981. His report is silent about headaches. Claimant's claim was closed with no permanent disability award by a Determination Order dated July 31, 1981.

On January 13, 1982 claimant returned to Dr. Hoppert complaining of a four to six week history of chronic headaches. Dr. Hoppert referred claimant to Dr. Jennart, osteopath, for a neurological examination. In his history, Dr. Jennart related that claimant had had headaches since his fall, and more particularly during the preceding two or three months, lasting from several hours to two or three days. Dr. Jennart's conclusion was:

> "The headaches are suggestive of muscular contraction cephalgia, however common migraine cephalgia cannot be excluded. It would be somewhat unusual for headaches to begin this long following head injury as a result of a complication of closed head trauma. However, chronic subdural hematoma may occasionally present in this fashion. This would be a much less likely possibility because of the absence of signs of raised intracranial pressure and normal neurological examination otherwise."

Cranial x-rays ordered by Dr. Jennart were normal.

In September 1982 claimant began treating with Dr. Buttler, a chiropractor. Dr. Buttler opined on October 12, 1982 that claimant's back pain and suboccipital headaches resulted from spinal instability caused by claimant's fall.

Dr. Larson, neurologist, examined claimant in December 1983. His history states that claimant's headaches began about six months after the November 1980 fall. Dr. Larson's report noted that claimant's blood presssure had been elevated for at least two or three months, and concluded that claimant's headaches were vascular, "having the aspect of common migraine. . . ," possibly due to anxiety.

Dr. Conner, internist, examined claimant in March 1983. His initial impression was that claimant had migraine and muscle tension headaches. In an April 6, 1983 report to SAIF, Dr. Connor stated:

> "To respond to the questions in your letter, I am unaware of any medical evidence which would substantiate that [claimant's] headache problems were still a direct result of his industrial injury on 11/21/80, in fact if you will read my note from 3/1/83, he indicated himself that he didn't think that the injury at the present time was contributing to his headaches, at least I indicated in my note that he had stated that he was fully recovered from that injury."

On April 7, 1983 Dr. Larson wrote:

> "It is possible that he may have developed headaches after a blow to his head and some type of neck strain that would set up a problem of vascular headaches that now continue as a function of anxiousness. One can argue that a migraine pattern was set up by the blow to the head and the amount of cervical strain. However, the history I obtained was that the headaches began a number of months following his injury.
>
> "If that history is correct, then it would be difficult to relate his headache problem to the injury of November, 1980."

On May 2, 1983 SAIF issued its partial denial. Claimant returned to Dr. Buttler in July 1983. On September 20, 1983 Dr. McMahon, Dr. Buttler's associate, opined that claimant's headaches were of a recurring, post-traumatic variety, due either to tissue damage at an impact site, muscle tension or of vascular origin. The previous month Dr. Connor had again stated that he was unable to say whether the headaches were or were not related to the injury. Finally, on January 11, 1984 claimant was examined by Dr. Ash, who stated that claimant's headaches were of unknown etiology.

Claimant is required to prove the compensability of his claim by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). In cases involving complex issues of medical causation, expert medical evidence is usually required. Uris v. Compensation Department, 247 Or 420, 426 (1967). We find that this is such a case. The Referee apparently thought so, as well, as he stated in his Opinion and Order that he was reluctant to find that the medical evidence had carried the burden of persuasion. On de novo review we find that it did not. Only Dr. Buttler was willing to opine that claimant's headaches resulted from his compensable injury, and his associate was equivocal, offering three possible alternative theories. None of the other doctors would link the 1980 injury to claimant's 1983 headaches.

ORDER

The Referee's order dated April 10, 1984 is reversed. The SAIF Corporation's September 20, 1983 partial denial is reinstated and affirmed.

DELWIN A. DOUGHTY, Claimant
Bischoff & Strooband, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-09598
May 28, 1985
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Foster's order which: (1) awarded additional temporary disability from that awarded by an August 26, 1983 Determination Order; and (2) increased claimant's award of scheduled permanent disability for loss of use of his left leg from 37.5° (25%) to 75° (50%).

Our de novo review of the record has revealed that Exhibits 3A - 6F were admitted into evidence. Apparently, Exhibit 6F refers to an August 30, 1982 stipulation, which is relevant to the

temporary disability issue. Documents carrying these designations do not appear in the record.

Pursuant to ORS 656.295(5) the Board may remand a case to the Referee for further evidence taking, correction or other necessary action when it determines that a case has been improperly, incompletely, or otherwise insufficiently developed. We conclude that the omission of these exhibits constitutes an improper, incomplete, or otherwise insufficient development of this case.

Accordingly, we remand to the Referee to reconsider this matter in light of our discovery. Should the Referee conclude that a hearing is necessary to identify these documents and include them in the record, he is directed to initiate the appropriate proceedings. The Referee is further directed to issue an order on reconsideration indicating what effect, if any, the inclusion of these exhibits has upon his original order.

ORDER

This case is remanded to the Referee for further action consistent with this order.

BONNIE M. DANTON, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-10003
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee McCullough's order which set aside its denial of medical services for treatment of claimant's current left-sided cervical, shoulder and arm symptoms, recently diagnosed by claimant's attending physician(s) as thoracic outlet syndrome. The issue is the compensability of claimant's current condition. We find and hold that claimant has failed to establish by a preponderance of the persuasive evidence that there is a materially causal connection between her 1974 injury and her current medical condition. Therefore, we reverse the Referee's order and reinstate the SAIF Corporation's denial.

The Referee expressly found claimant credible based upon his observation of her demeanor. We have absolutely no reason to question claimant's veracity; however, we have some doubts about claimant's ability to accurately recall the events of her original injury and those immediately following it, which is not too surprising since at the time of hearing it had been almost ten years since claimant was originally injured. Therefore, in making our findings concerning the events surrounding claimant's injury, we place more reliance upon the contemporaneous medical reports than we do upon claimant's credible testimony.

On December 2, 1974 claimant sustained an injury while helping to lift a patient in bed during her employment as a nurse's aide. The injury involved the muscles of the left shoulder and lateral aspect of the cervical spine. A musculoligamentous strain of the cervical spine was diagnosed. Conservative treatment in the form of wet and dry heat and pain medication was administered. X-rays of the cervical spine were normal.

Claimant was apparently referred from Good Samaritan Hospital to Dr. Sanders for followup. The portion of Dr. Sanders' initial report form that was completed by claimant describes her statement of the injury: "I was helping to lift a patient from behind and my left shoulder and neck pulled, snapped back real hard." This report form also indicates that, as of the date of Dr. Sanders' examination, claimant's condition was stationary, no further treatment was required, and her injury would not cause permanent impairment. She was released for work as of December 9, 1974.

Claimant returned to work on December 12, 1974 and sustained a reinjury. Apparently she was pushing a patient in a wheelchair when the patient reached up, grabbed her around the neck and pulled. She was again seen at Good Samaritan Hospital, and the diagnosis and treatment remained the same. The hospital record of the physician's examination indicates that claimant was experiencing pain, tenderness and some muscle spasm primarily of the left cervical muscles, but without radiation to the shoulder or arm. She had slight limitation of motion of the cervical spine due to pain. There were no motor or sensory deficits in the left arm, and deep tendon reflexes were equal and active bilaterally. This reinjury was accepted and processed under the December 2, 1974 injury claim. After this reinjury, claimant did not return to work.

Claimant came under the care of Dr. Cronk, an orthopedic surgeon. His report of January 10, 1975, addressed to Dr. Sanders, describes complaints of left-sided neck pain, principally in the upper portion of the neck with some radiation into the left occiput (i.e. the back part of the skull). Claimant denied any radiation of pain into her upper extremities and also denied any numbness, tingling or paresthesias (sensation of numbness, prickling or tingling; heightened sensitivity), "except for an occasional feeling of numbness over the dorsal radial border of her left forearm." Dr. Cronk suspected the possibility of irritation of the third cervical nerve root, and he prescribed a cervical collar in addition to anti-inflammatory/analgesic medication.

Dr. Cronk followed claimant's condition during the month of January 1975 and then suggested that claimant see a neurologist. Apparently, right about that time in early February 1975, claimant moved to Idaho. However, she returned for a followup exam by Dr. Cronk in July 1975. On that examination, claimant displayed a full range of motion of her cervical spine with discomfort at the extremes of motion on the left side of her neck. Dr. Cronk found no muscle spasm of the paraspinous musculature, and a complete neurologic examination of the upper extremites disclosed no specific deficits. He stated his inability to substantiate any objective evidence of impairment, and he considered her condition stationary.

Claimant was examined by a neurosurgeon in Boise, Idaho, Dr. Keifer, apparently on referral from Dr. Cronk. Dr. Keifer's August 4, 1975 report records a complaint of pain in the neck, left posterior extending to the left occiput, and a tired feeling of the neck. Claimant apparently described the pain as not being constant, but seeming to "come and go." In addition, claimant apparently indicated that at no time had there been any radicular pain in either arm. Claimant also found that sometimes tying a

tight cloth around her head helped her headaches. Dr. Keifer diagnosed a cervical spine strain with an objectively normal neurological examination. He found no evidence of a nerve root compressing lesion. X-rays of the cervical spine disclosed no defect.

A followup neurologic examination in August of 1975, which was apparently prompted by a severe headache and left-sided neck pain the preceding evening, resulted in a normal neurologic exam. Dr. Keifer again found neck movements of completely normal range, with equal and hypotonic deep tendon reflexes. Dr. Keifer gave claimant another prescription for Tylenol #3, to be taken whenever she had severe headaches and neck pain.

On September 2, 1975 the claim was closed with an award for temporary total disability from December 2, 1974 through August 5, 1975, less time worked.

Claimant came under the care of Dr. Johnson, another orthopedic physician, in the fall of 1975. In a written report to SAIF dated September 18, 1975, he describes claimant's complaints of continuing pain in the posterior aspect of her neck. In addition, Dr. Johnson reported:

> "At times she has severe headache with numbness in the left side of her face, nausea, vomiting and occasionally has some bright lights in her vision. She denies any pain out into the shoulders, the interscapular areas or down in her arms. Headaches apparently occur one to two times a week, is [sic] somewhat related to tension, but not necessarily seeming to cause the headaches. * * * There is no relationship to pain with position or function of her upper extremities. * * * *
>
> "Physical examination demonstrates a discouraged appearing young lady, who has some tenderness in her upper posterior cervical area. Neurologically she is intact in the upper extremities. * * * * * "

Dr. Johnson prescribed medication for relief of claimant's "anxiety." He believed that an evaluation by a neurologist would be indicated if claimant's headaches became "more obvious than the cervical pain for it does indeed sound as if it is a cephalgia, rather than cervical syndrome."

Claimant was hospitalized in October of 1975 for evaluation of her apparent orthopedic and psychiatric problems. The report of history and physical on admission completed by Dr. Johnson reflects a history of headaches dating back to claimant's teenage years as well as psychiatric care for several years. Symptoms were described as "persisting in rather severe pain in the left posterior cervical spine out into her shoulder and some aching into her fingers and hand, not distinct numbness but a tingling sensation." Orthopedic examination revealed a full range of motion of the neck, deep crest absent left biceps jerk, as compared to good active biceps jerk on the right, good grip of the hands, intact pulses unchanged with elevation or external rotation

of the arm. Remaining neurologic signs seemed intact with regard to the upper extremities. While hospitalized for ten days of bed rest and conservative care, claimant was evaluated by Dr. Estess, a psychiatrist. His history reflected chronic emotional problems during the years preceding claimant's 1974 injury, and frequent psychiatric evaluations. Claimant had psychiatric evaluation as early as the eighth grade as a result of difficulties with her family. Apparently in the fall of 1974, immediately prior to claimant's injury, she was receiving outpatient psychotherapy for about six months, primarily for marital difficulties. This six month period of psychotherapy would have coincided with claimant's December 1974 injury. Dr. Estess stated his impressions of anxiety reaction, chronic; immature personality and marital difficulties. He believed that some of claimant's symptomatology certainly could be related to her symptoms of anxiety.

In November 1975, approximately one month after her discharge, Dr. Johnson reported to claimant's attorney that claimant continued to be "quite uncomfortable," but that it was difficult to determine whether "it is pain or emotional disability." In a subsequent letter to SAIF, Dr. Johnson reported his feeling that claimant's "main problem is probably more related to her anxiety than organic."

On December 30, 1975 a stipulation was approved whereby claimant's claim was reopened as of the date of her October 1975 hospitalization.

In mid February 1976 Dr. Johnson reported that the claim could be reclosed "without further disability." He again mentioned claimant's "secondary and complicated problem of her emotional stability." The claim was reclosed by Determination Order dated March 9, 1976, which awarded additional temporary total disability only.

Claimant returned to Dr. Johnson's office on March 10, 1976. Dr. Johnson noted continuing symptomatic improvement since January of 1976 when he last saw claimant. Claimant complained of numbness in the left side of her neck and head, but she had essentially normal range of neck motion. Neurologically she was intact. Dr. Johnson felt that claimant could be released to full activity, suspecting that her work would have to be modified because of continuing symptoms, but, he stated, "this is a mixed syndrome with a minimal effect from her injury." He felt claimant had no impairment as a result of her neck injury.

It appears that, in addition to treating with Dr. Johnson as of the fall of 1975, claimant was treating with Dr. Gibson, a neurosurgeon, during the same period. On January 5, 1977 Dr. Gibson reported to claimant's attorney that he had been treating claimant since September of 1975, and that her major problem had been chronic recurring daily tension headaches, the onset of which she related to her December 1974 cervical injury. He also reported that on numerous examinations, claimant had tenderness of the posterior, cervical and trapezius musculature bilaterally. He had referred her for examination by another neurosurgeon in the same office, Dr. Smith, who felt that claimant possibly could have a C-6-7 herniated disc with compression of the C-7 nerve root. This could not be definitely confirmed, however. It was definitely felt that claimant had "a large functional component" to her pain complaints. Drs. Gibson and Smith recommended that she be seen at the Portland Pain Clinic, since there was no evidence of a surgically remediable lesion.

There are two reports from Dr. Smith, the first being an October 18, 1976 report to Dr. Gibson. Dr. Smith took a history of continuous pain in the left neck, which often radiated into the left shoulder, and sometimes into the arm and forearm. Claimant apparently reported that occasionally when the pain was severe, she also experienced numbness of the entire hand, as well as numbness of the entire left side of her face. She also complained of headaches. Dr. Smith's physical examination revealed no specific muscle spasm of the neck, although there was a hint of spasm upon palpation of the anterior scalene muscles, particularly on the left side. Range of motion of the neck was within normal limits. Examination of the upper extremities revealed no trophic changes, no atrophy, and no difference in skin temperature or appearance. Motor examination of the upper extremities was normal. There was rather diffuse hypalgesia of the left upper extremity extending to the superior aspect of the shoulder. The one objective finding was a definite depression of the left triceps jerk. From claimant's description of her rather poorly localized pain and rather diffuse numbness, as well as the prolonged history of her pain, Dr. Smith concluded that there was a definite functional component to her pain problem.

In a later report to claimant's attorney, Dr. Smith stated a diagnosis of left neck pain, left shoulder and arm pain of an uncertain etiology. He was unable to state that claimant's December 1974 injury contributed to her present problem, but was only able to state that there was a temporal relationship between her present pain and her injury.

On June 3, 1977 a stipulation was approved whereby claimant was awarded "an additional" 56° (17 1/2%) unscheduled disability in connection with her industrial injury.

No further medical reports appear in the record until almost seven years later in May of 1984. In the interim, claimant treated with several physicians. No medical reports were provided to SAIF. (Nor does it appear that any billings were made for treatment at SAIF's expense.) Claimant apparently returned to Oregon in 1980. She resided in Albany, Oregon, and was treated by Dr. Reilly, an internist. He treated her for an anxiety tension state and apparently muscle contraction type of head pain. She then came under the care of Dr. Bondland, with whom she treated for approximately a year and a half. His treatment consisted primarily of analgesics and muscle relaxants.

Claimant then came under the care of Dr. Bassinger, a family practitioner. He diagnosed depression and prescribed Triavil, which claimant eventually stopped taking. In May of 1984 Dr. Bassinger referred claimant to Dr. Throop for nerve conduction velocity and EMG (electromyogram) studies. Dr. Bassinger apparently was the first to suspect thoracic outlet syndrome, and he ordered these tests with this diagnosis in mind. The nerve conduction studies were normal bilaterally concerning the median and ulnar nerves. The EMG study of the left arm also was normal.

Dr. Bassinger then referred claimant to Dr. Gerstner, a general surgeon, for evaluation of possible left thoracic outlet syndrome. On physical exam, Dr. Gerstner found pulse obliteration bilaterally with claimant's arms abducted at 85 degrees. The elevated arm stress test was positive at 20 seconds, with coldness in the left hand and aching in the upper arm with associated

fatigue. Total fatigue in the left arm was noted after one minute. He found slight decrease to pin prick sensation in the ulnar nerve distribution in the left, and stated that claimant noted decrease of strength in the left triceps and biceps muscle groups, decrease in left hand grasp and tenderness in the left supraclavicular space.

The precise history of injury recorded by Dr. Gerstner was:

> " * * * [S]he was supporting the upper protion [sic] of a patient's body when the patient fell and the weight of the patient then transferred to the left upper extremity of [claimant]. Subsequently, she noted discomfort in the neck and shoulder region on the left and an associated cold feeling in her left hand. * * * * "

Dr. Gerstner stated that the injury "described in 1975 [sic]" was compatible with a stretch injury to the brachial plexus and also a stretch injury with spasm developing in the scalene and other neck muscles. He observed that, "since her injury occurred nearly ten years ago, reliance upon her history becomes the major factor in contributing her outlet compression to her injury." He stated that if, in fact, claimant was asymptomatic prior to her injury and she continued to have problems since that time, he would contribute her outlet compression to her industrial injury. His recommended course of treatment was scalenectomy. Because claimant had undergone multiple courses of physical therapy with little or no benefit, he doubted the value of any further physical therapy.

In a June 22, 1984 letter to claimant's attorney, Dr. Bassinger stated his concurrence with the diagnosis of left thoracic outlet syndrome. He also stated his opinion that this condition was related to claimant's December 1974 injury. He reported that he had seen and treated claimant beginning in late October of 1983 through March 23, 1984 for depression and tension headaches. He stated that claimant "first discussed her symptoms arising from her thoracic outlet syndrome" on April 16, 1984. He was unable to determine the most incapacitating symptoms "in reference to the depression and headaches vs. thoracic outlet syndrome."

At about the same time, Dr. Bassinger reported to SAIF that the recommendation made by Dr. Gerstner was medically reasonable, in spite of the normal EMG and nerve conduction studies. He stated that these studies have a significant degree of validity when they are positive, "but they in no way rule out a problem such as a thoracic outlet syndrome when they are negative." He also reported:

> "Thoracic outlet syndrome frequently will have as its initiating event a stretch or injury of the scaling [sic] muscles which will gradually produce the closing of the thoracic outlet area over a period of years. The patient states that she has had symptoms in her left arm and left shoulder since the accident but they have become progressive. This history is rather typical for a thoracic outlet syndrome that

occurs as a result of trauma to the scaling [sic] muscles."

He indicated that claimant did have a significant psychosomatic overlay "to her thoracic outlet syndrome," but that this did not "remove the physical problem." Objective findings consisted of a decrease in the brachial radialis deep tendon reflex on the left as compared to the right and a decrease in the triceps deep tendon reflex as compared to the right, as well as a positive Adson's sign. He recommended surgery for correction of the thoracic outlet syndrome, the procedure of choice being removal of the first rib with its insertion of the "scaling [sic] muscles."

In July of 1984 Dr. Brown, SAIF's neurological consultant, reviewed claimant's file for an opinion regarding the diagnosis of thoracic outlet syndrome, and its possible relation to claimant's industrial injury. Dr. Brown disputed the diagnosis of thoracic outlet syndrome, as well as the surgical treatment recommended. He stated that there was "no clear cut evidence" that claimant actually has a thoracic outlet syndrome, that such a problem is rarely caused by an injury of the nature she experienced, and that the symptoms rarely required surgical treatment. He also observed that claimant had a functional overlay and psychiatric background which he felt could result in misleading physicians as to the nature of her complaints. He recommended another opinion from vascular surgeons or other neurosurgeons. Dr. Brown commented that the diagnosis was made partially on the basis of obliteration of claimant's pulse, and that most authorities agree that this finding is not sufficient to make a diagnosis of thoracic outlet syndrome. He also commented that previous examiners had not noted any obliteration of the pulse in doing this particular test (Adson's and other hyperabduction maneuvers).

Claimant was examined by a panel of the Orthopaedic Consultants in August 1984. The panel consisted of Dr. Reilly, neurologist, and Drs. Logan and Coletti, orthopedic surgeons. The Consultants ordered cervical spine and chest x-rays, which disclosed a very large right cervical rib and a relatively large left cervical rib. The Consultants took a complete and detailed history, noting that claimant's symptoms of numbness and coldness in the left arm did not occur for six to twelve months after she moved to Boise, Idaho. On physical exam they found normal range of motion of the neck, shoulders, elbows and wrists. Although initially with reinforcement, there seemed to be reflex in the left biceps and triceps, later, even with reinforcement in multiple positions, the examiner was unable to obtain any reflexes in the left arm. Significantly, claimant maintained good radial pulses with Adson's maneuver bilaterally. At the time of the exam, claimant apparently was experiencing no symptoms in her hands, particularly no numbness. Their diagnoses were shoulder strain by history, questionable bilateral cervical ribs with hypoplastic (marked by incomplete development or underdevelopment) rib on the left, and functional overlay to be documented.

The Consultants concluded that the initial history from claimant and their review of the records did not suggest any early radiculopathy or brachial plexus compression. Furthermore, they considered her present symptoms rather atypical for a thoracic outlet syndrome, "because they usually give symptoms of numbness in the ulnar distribution of the left arm or symptoms of lower cord compression which would be numbness in the ulnar aspect of

the forearm and the hand." The reflex change in C6 and C7 was not substantiated by any decreased muscle volume or weakness, or by an abnormal EMG. They believed that claimant did need further evaluation, including angiogram of the left arm, repeat EMG of the muscles of the left arm and cervical spine and, depending upon these findings, perhaps a myelogram. They did not believe, however, that this should be at SAIF's expense. Their impression was that claimant had a congenital cervical rib which was probably causing her symptoms, as opposed to her muscle strain of 1974.

Upon receipt of the Consultants' report, SAIF issued its denial.

At the hearing claimant testified that her injury occurred as follows:

> "Okay, we were lifting a patient from the wheelchair to the bed and sometimes -- I had the -- her back with my arms under her arms and she started to slip and my right arm couldn't grab her quick enough, so I grabbed with my left arm and it just -- we went clear to the floor with her."

Claimant testified that she went down on her knees to keep the patient from hitting the floor. She described immediate pain through the left side of her neck and her shoulder. Claimant also testified about immediate pain in her left arm:

> "Q. Did you notice any pain going into your -- either arm?
>
> "A. Yeah, it went down pretty hard.
>
> "Q. The pain in the arm?
>
> "A. Yeah.
>
> "Q. Which arm?
>
> "A. The left arm.
>
> "Q. What did that feel like?
>
> "A. Just like it stretched.
>
> "Q. Okay, it was a stretching pain in your arm?
>
> "A. Yeah, it was a sharp pain. It wasn't -- you know -- dull, like that."

The Referee discounted Dr. Brown's conclusions based upon his assessment that Dr. Brown believed there was little, if anything, wrong with claimant. We do not understand Dr. Brown to be stating that there is nothing wrong with claimant. We understand his opinion to be that, whatever is wrong with claimant, it is not related to her 1974 industrial injury. In addition, Dr. Brown forcefully, and we believe persuasively, takes issue with the current diagnosis of thoracic outlet syndrome. To a great extent, the question of the proper diagnosis of claimant's condition is based upon expert analysis, although the opportunity to examine claimant is also significant.

The Orthopaedic Consultants, who did examine claimant and took a complete history, essentially agree with Dr. Brown's conclusion that claimant does not present a picture representative of thoracic outlet syndrome. The history they took and based their opinion upon is supported by our review of the medical records, which indicates that claimant did not begin to experience any significant symptoms in her left arm until some time after her injury.

It appears that Dr. Gerstner was under the impression that claimant experienced arm and hand symptoms in close (almost immediate, if not immediate) temporal proximity to her injury. The first significant upper extremity symptoms apparently emerged at or about the time of claimant's October 1975 hospitalization in Boise, Idaho, more than ten months after her injury. As Dr. Gerstner stated, considering the lapse of time between claimant's original injury and her current symptomatology, reliance upon her history is the major factor in attributing the diagnosis of thoracic outlet syndrome to the injury.

Just as claimant testified that she experienced the immediate onset of left arm pain at the time of her injury, a fact not documented by contemporaneous medical reports, it appears she also related substantially similar circumstances to Dr. Gerstner and Dr. Bassinger. This creates some doubt concerning the reliability of their respective opinions on the issue of causation. Furthermore, the medical reports and accident report forms describing the December 2 and December 12, 1974 incidents are only arguably consistent with claimant's testimonial version of how her injury occurred. Claimant's attending physicians relied upon her questionable recollection of the mechanics of her injury, without benefit of the contemporaneous medical reports, which further detracts from the persuasiveness of their opinions.

In the interim between 1977 and 1984, it appears as though claimant's primary medical problems were headaches and, possibly, depression. Thus, once she returned to Oregon in 1980, she was treating with an internist for anxiety and headaches. Dr. Bassinger reported that claimant did not discuss her symptoms "arising from her thoracic outlet syndrome" until April 16, 1984, although he had been treating her since October 31, 1983 for depression and tension headaches. Similarly, when claimant was attending Linn-Benton Community College and working as a clerical assistant in the fall of 1981, it appears that she became incapacitated as a result of severe headaches, not as a result of any symptoms associated with neck/shoulder/arm pain. Claimant has experienced headaches since she was 15 or 16 years of age. They preexisted her injury for many years, and we find insufficient persuasive evidence to establish that the headaches which continued years after her industrial injury were related, in material part, to her injury.

We have serious doubts about the diagnosis of thoracic outlet syndrome. While Dr. Bassinger, a family practitioner, apparently found a positive Adson's sign, the Consultants (a neurologist and two orthopedic surgeons) found good radial pulses with Adson's maneuver bilaterally. This difference in the findings on their respective examinations tends to support Dr. Reilly's observation that there is no consistency to claimant's findings.

Viewing the evidence in the light most favorable to claimant, the most we are able to state is that she may have thoracic outlet syndrome, and that this is possibly related to her 1974 industrial injury. Claimant has failed to establish that her contentions are more likely true than not; therefore, she has failed to satisfy her burden of proving the compensability of her claim. Gormley v. SAIF, 52 Or App 1055, 1060 (1981); Herbert E. Richards, 36 Van Natta 796 (1984).

ORDER

The Referee's order dated November 26, 1984 is reversed, and the SAIF Corporation's denial dated August 27, 1984 is reinstated and affirmed.

JAMES R. DREW, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03135
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Seifert's order setting aside its partial denial of claimant's headache claim. SAIF also contends that claimant's hearing request should have been dismissed pursuant to OAR 438-06-070, as he failed to personally appear at the first scheduled hearing.

Following due notice, a hearing was convened in this matter on November 1, 1983. Claimant was not present, but was represented by counsel. An Order of Dismissal for lack of prosecution or abandonment was entered by Referee Terry Johnson on November 7, 1983. The order was subsequently abated and, on December 13, 1983, vacated. The matter was ordered remanded to the docket clerk of the Hearings Division to be rescheduled for hearing. Only the November 7, 1983 Order of Dismissal contained a notice of appeal rights. Board review was not sought within 30 days of the December 13, 1983 order directing that the case be rescheduled for hearing. That order thus became final and may not presently be reviewed. See ORS 656.289(3).

Claimant suffered persistent headaches after bumping his head on an overhead pipe on July 15, 1982. The claim was accepted as a nondisabling injury. Although claimant had a history of prior headaches, at the time of the injury he had been asymptomatic for at least four years. On February 15, 1983 SAIF notified claimant that although medical expenses related to the injury would be paid, it would no longer accept responsibility for claimant's headaches, contending that claimant's current condition was unrelated to the compensable injury.

Various treating physicians have offered opinions regarding the cause of claimant's condition. Dr. Martinez reported on November 9, 1982 that claimant's symptomatology did not follow the usual pattern of post traumatic headaches, therefore, other factors not related to the industrial injury could be involved in his complaints. He reported on January 19, 1983 that claimant had no headaches before the injury, but did have migraines, and that these were aggravated by the trauma. On May 26, 1983 he stated that as of October 1, 1982, when he last saw claimant, the etiology of the headaches was not well determined. He stated,

"[A]fter four months of a very mild head injury with a normal neurological exam and normal CT scan, I saw no reason for his headaches."

Dr. Norris-Pearce reported on December 17, 1982 that claimant was most likely suffering from post traumatic vascular headaches with some muscle contraction component. On February 17, 1983 he stated that many authorities feel that post injury headaches are more common in individuals with prior histories of headaches. He stated that the fact that the headaches began following the injury, during which claimant apparently suffered brief loss of consciousness, appeared to show a very simple cause and effect relationship. Although claimant's headaches were not typical in their location and pattern for classic post concussion headaches, Dr. Norris-Pearce noted that most authorities currently acknowledge a greater variance in the appearance of chronic headaches than previously delineated in the text books.

Finally, Dr. Patterson, claimant's most recent treating doctor, indicated on May 30, 1984 that in his opinion, more likely than not, claimant's headaches are related to his compensable injury via aggravation or precipitation of a preexisting condition.

Also in the record is a report from Dr. Brown, who reviewed the file at SAIF's request but did not examine claimant. He notes that claimant has a history of nervousness and that other people close to claimant have died suddenly after head injuries. He opined that the headaches were unrelated to the injury, and that claimant's condition may be due to nonwork related psychiatric problems giving rise to tensions.

Headaches have been claimant's chief complaint virtually from the day of the injury. While the claim was in accepted and open status, SAIF purported to disclaim future responsibility for this condition. Such a preclosure partial denial is not permitted. See Safstrom v. Riedel International, Inc., 65 Or App 728 (1983). Moreover, the medical evidence persuades us that the traumatic injuries of July 15, 1982 continue to be a material contributing cause of claimant's headaches. Accordingly, we affirm.

ORDER

The Referee's order dated August 29, 1984 is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by the SAIF Corporation.

CHARLES B. EDWARDS, Claimant
Cowling, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 82-06575
May 28, 1985
Order on Remand

This case is before the Board on remand from the Court of Appeals, Edwards v. SAIF, 72 Or App 435 (1985). We have been instructed to allow claimant's claim for his cervical spine condition.

Now, therefore, the SAIF Corporation's partial denial dated June 30, 1982 is hereby set aside and claimant's claim is remanded to the SAIF Corporation for further processing according to law.

IT IS SO ORDERED.

C.D. ENGLISH, Claimant
Kenneth Peterson, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-01867
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Leahy's order that denied his request for temporary partial disability, a penalty and an attorney fee. Claimant contends he is entitled to temporary partial disability, penalties and accompanying attorney fees because of the SAIF Corporation's failure to pay temporary partial disability as ordered by a February 9, 1984 Determination Order. In its brief, SAIF contends that the Determination Order should be modified to terminate temporary partial disability as of the date claimant was released to regular work. We have authority to consider the issue raised in SAIF's respondent brief notwithstanding its failure to cross-request review. Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983).

Claimant is a 47 year old carpenter. In December 1982 he compensably injured his right index finger. Claimant sought emergency room treatment from Dr. Gillies. Dr. Gillies diagnosed "possible ligament tear" and released claimant to light work. Claimant apparently returned to work, although it is unclear whether his duties were modified. Treatment was conservative until March 1983, when surgery was performed by Dr. Karmy, orthopedist. The surgery was designed to repair the partially ruptured flexor tendon of claimant's right index finger.

In May 1983 Dr. Karmy reported that he was still treating claimant, but anticipated releasing him for work possibly by the end of June. By chart note dated June 30, 1983, Dr. Karmy reported that claimant experienced pain in his palm and noted a poor grip while "attempting to work" and use his hammer. Dr. Karmy advised claimant to continue using his hand, try to rebuild his strength, and return as needed. Dr. Karmy opined that claimant could start engaging in a rehabilitation program, without restriction, if it was deemed necessary.

On July 18, 1983 Dr. Karmy reported that he had last treated claimant on June 30. Dr. Karmy further advised that claimant was medically stationary and was released for regular work. On August 31, 1983 Dr. Karmy repeated his "July" conclusions and suggested an independent examination.

By chart note dated September 12, 1983 Dr. Karmy reported that claimant had returned to construction work out of necessity. However, claimant was experiencing considerable pain, difficulties grasping his hammer and intermittent triggering of his ring finger. Dr. Karmy prescribed medication and recommended that claimant return for treatment on an as needed basis. Dr. Karmy further noted that "I am not sure what else to do to try to make his hand pain settle down."

In December 1983 Dr. Bills performed an independent medical examination. Dr. Bills opined that claimant was medically stationary and was capable of light work. Dr. Karmy concurred with this opinion.

A Determination Order issued on February 9, 1984. Among other awards claimant received 60% scheduled right index finger disability and temporary partial disability between May 5, 1983 and September 12, 1983, less time worked. On February 21, 1984 claimant's request for hearing was filed.

Claimant testified that he received temporary benefits until approximately July 14, 1983. Between July 14, 1983 and September 12, 1983 he received unemployment benefits totalling $198 and earned approximately $45 in income. Claimant advised SAIF of these amounts.

The Referee affirmed the Determination Order. Because claimant could work, did work, and did receive unemployment benefits, the Referee was convinced that no award was due beyond June 30 or July 18. However, reasoning that SAIF should have requested reconsideration from the Evaluation Division, the Referee declined to modify the temporary partial disability award. The Referee also declined to penalize SAIF for not complying with the Determination Order because it was justified in relying upon the attending physician's approval of claimant's return to work and because temporary partial disability could not accurately be determined.

Temporary disability benefits are due no later than the 14th day after the date of any determination or litigation order which orders temporary disability. OAR 436-54-310(3)(c).

SAIF concedes that it did not comply with the Determination Order, but contends that its conduct was justified based upon Dr. Karmy's reports that claimant had been released to regular work. SAIF's argument is convincing when offered as justification for its unilateral termination of temporary benefits or its subsequent request for modification of the temporary disability award. However, SAIF's argument does not excuse its failure to comply with the clear instructions of the Determination Order.

We find that SAIF unreasonably refused to pay temporary compensation to which claimant was legally entitled. Therefore, claimant shall receive not only that portion of the temporary partial disability awarded by the Determination Order which it refused to pay, but a penalty and accompanying attorney fees. ORS 656.262(10).

Although we consider SAIF's conduct to be unreasonable, we decline to assess the maximum penalty because of such mitigating factors as Dr. Karmy's July and August reports and claimant's prompt request for hearing, which arguably prevented SAIF from requesting reconsideration. Accordingly, SAIF is assessed a 15% penalty on "the amounts then due" and accompanying attorney fees for its unreasonable refusal to pay compensation. ORS 656.262(10). The penalty shall be based on temporary partial disability due between July 14, 1983 and September 12, 1983, less time worked and other appropriate adjustments such as unemployment benefits.

Although we conclude SAIF was required to comply with the Determination Order, we are persuaded that the temporary partial disability benefits should have terminated effective June 30, 1983. Therefore, the temporary partial disability award is modified.

We find the evidence persuasive that claimant was released for regular work and medically stationary sometime between June 30 and July 18, 1983. We consider June 30, 1983 to be the effective date for termination of temporary benefits. This date coincided with claimant's most recent examination with Dr. Karmy, claimant's

treating physician. Dr. Karmy indicated at that time that claimant was working. Moreover, this examination preceded Dr. Karmy's clear and unambiguous July and August reports which concluded that claimant was released for regular work and medically stationary. Neither Dr. Karmy's September chart note nor his subsequent agreement with Dr. Bills' "light duty" assessment convince us that temporary benefits should extend beyond June 30.

Accordingly, we modify that portion of the Determination Order which awarded temporary partial disability through September 12, 1983. Claimant's temporary partial disability benefits should have terminated effective June 30, 1983.

This finding does not excuse SAIF's failure to abide by the Determination Order, for which we have assessed SAIF a penalty. However, this subsequent modification has created an overpayment. Therefore, SAIF shall be authorized to recover this overpayment by way of offset against future awards of permanent disability.

ORDER

The Referee's order dated July 20, 1984 is reversed in part and modified in part. That portion which declined to assess the SAIF Corporation a penalty and an accompanying attorney fee is reversed. SAIF is ordered to pay temporary partial disability benefits from July 14, 1983 through September 12, 1983, less time worked and unemployment benefits, a 15% penalty based on this compensation, and a $400 attorney's fee. That portion of the Referee's order which found that temporary partial disability should terminate September 12, 1983 is modified. Temporary partial disability benefits should terminate effective June 30, 1983. SAIF is authorized to offset temporary partial disability benefits payments, made for the period beginning June 30, 1983 and running through September 12, 1983, against future permanent disability awards. The remainder of the Referee's order is affirmed.

JOHN A. GRAHAM, Claimant
Noreen Saltveit, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Lindsay, et al., Defense Attorney

WCB 84-01383 & 84-03399
May 28, 1985
Order on Review (Remanding)

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Shebley's order which: (1) upheld the SAIF Corporation's denial of his aggravation claim for a 1980 neck, right shoulder, and trapezius injury; and (2) upheld United Pacific Insurance Company's "so-called" de facto denial of his low back claim. On review, the issues are compensability and responsibility.

Our de novo review of the record has revealed that the Referee admitted into evidence Exhibit 138. The parties' briefs refer to this exhibit as a March 1984 denial letter from United Pacific/Reliance Insurance Company. Neither a March 1984 denial letter nor a document marked Exhibit 138 appears in the record.

Pursuant to ORS 656.295(5) the Board may remand a case to the Referee for further evidence taking, correction or other necessary action, when it determines that a case has been improperly, incompletely, or otherwise insufficiently developed. We conclude

that the omission of Exhibit 138 constitutes an improper, incomplete, or otherwise insufficient development of this case.

Accordingly, we remand to the Referee to reconsider this matter in light of our discovery. Should the Referee conclude that a hearing is necessary to identify the aforementioned exhibit and include it in the record, he is directed to initiate the appropriate proceedings. The Referee is further directed to issue an order on reconsideration indicating the effect, if any, the inclusion of Exhibit 138 has upon his original order.

ORDER

This case is remanded to the Referee for further action consistent with this order.

DEBORAH L. GREENE, Claimant
David Hollander, Claimant's Attorney
Tooze, et al., Defense Attorneys

WCB 83-05732
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Danner's order which upheld the insurer's denial of her low back claim. On review, claimant contends the denial was invalid since the insurer failed to close her accepted nondisabling injury claim before issuing its denial. We affirm with the following comment.

Claimant was 28 years old at the time of hearing. On February 25, 1982, while working as a clerk for the service department of an automobile agency, she caught a slipping pressure plate. She felt as though all her muscles in her back and right side had been pulled. Claimant was sore for approximately one week, but did not miss any time from work. Although she applied "Deep Heat," took hot baths and ingested "lots" of aspirin, claimant did not seek medical attention.

Claimant's injury claim was accepted as a nondisabling injury on March 10, 1982. At the time of acceptance, the insurer provided claimant with a copy of her claim and a document pertaining to nondisabling claims. "Nondisabling injury" was defined as time loss no greater than 3 days and no permanent impairment. Claimant was advised that if she objected to her injury's classification she could request a reclassification from the Workers' Compensation Department for a period of one year from the date of her injury. Should her condition worsen, claimant was advised that she had aggravation rights for a period of 5 years from the date of her injury. The document also provided claimant with the address and phone number of the Workers' Compensation Department.

Claimant continued to work for her employer until October 1982. She also continued to engage in recreational activities, including softball in the summer of 1982 and bowling from September 1982 through April 1983. Her primary physical complaints involved a sharp pain which radiated from her right hip down her leg and back pressure. As the months progressed the pain became more frequent and greater in intensity.

In mid-March 1983 claimant and her husband took a "mini-vacation" to Idaho. After the approximately nine hour one-way trip, claimant was "really sore" and her "legs gave way." Claimant's complaints continued on her return trip. Following her arrival home, claimant took a hot bath. The next morning her husband gave her a back rub. When her husband applied pressure to her low back, claimant "just about went through the ceiling."

Claimant sought emergency room treatment on March 22, 1983. Noting a history of a back problem for some time starting with a lifting incident at work, Dr. Lindquist diagnosed probable lumbar spasm. The doctor prescribed medication, bedrest, and heat. Dr. Lindquist recommended that claimant be off work from 7 to 10 days.

The following day claimant was examined by Dr. Kaesche, orthopedist, who diagnosed right leg sciatica due to a herniated nucleus pulposus, probably L5, S1. However, a subsequent myelogram and CAT scan were normal.

After learning of the massage incident, Dr. Kaesche stated that he could not make an assessment as to its effect on claimant's condition. Dr. Kaesche opined that his diagnosis remained sciatica, primarily based upon claimant's symptomatology and "some subjective type physical findings, specifically some decreased sensation."

In May 1983 the insurer denied claimant's "request for reopening" of her accepted nondisabling injury claim. The insurer stated that her husband's massage incident constituted a new injury which was unrelated to claimant's job incident.

In October 1983 claimant was examined by Dr. Miller, neurosurgeon, on consultation from Dr. Kaesche. Dr. Miller reported that he did not find any objective findings to suggest radiculopathy. It was Dr. Miller's opinion that claimant's symptoms probably related to chronic lumbosacral strain and secondary derangement. Dr. Miller did not attribute the strain to any specific incident.

In October 1983 the Orthopaedic Consultants performed an independent medical examination. The Consultants concluded that claimant's February 1982 strain of the lower back had resolved quite satisfactorily, without any permanent impairment. The Consultants further opined that claimant's continuing symptoms were "largely substantiated on a subjective basis" and did not seem to be related to the February 1982 incident.

In December 1983 Dr. Kaesche advised claimant's attorney that the "treatment" claimant received from her husband would not have significantly aggravated her back situation. Dr. Kaesche further stated that it was not uncommon for people who experienced sciatica to intermittently experience similar complaints throughout their life. Dr. Kaesche opined that "on the basis of [claimant's] history, [claimant's] back and leg pain was related to the episode at work."

The Referee found that the nondisabling injury claim had never been closed. However, he concluded the insurer's procedure was not improper because he construed Dr. Kaesche's March 24, 1983 chart notes as an aggravation claim. The Referee reasoned that

the situation came within the purview of ORS 656.262(12) which states that 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."

With respect to the merits of the claim, the Referee found that claimant had failed to establish compensability. The Referee concluded that there was: (1) no medical treatment at the time of the February 1982 incident; (2) too much time and many intervening activities between the incident and Dr. Kaesche's treatment; and (3) only claimant's allegations supported her claim, which considering the animosity between claimant and her employer was insufficient to establish compensability.

Where a claimant has a single accepted condition or an accepted condition which cannot be separated from other conditions, an employer/insurer may not issue a partial denial without first processing the claim to closure. Joji Kobayashi, 36 Van Natta 1558 (1984). Kobayashi represents our interpretation of Maddocks v. Hyster Corporation, 68 Or App 372 (1984), Roller v. Weyerhaeuser Company, 67 Or App 583 (1984), and Safstrom v. Riedel International, Inc., 65 Or App 728 (1983).

None of these cases involved a nondisabling injury and the application of ORS 656.262(12). Moreover, the present case does not involve a partial denial. We conclude that this is a significant distinction. By issuing its denial the insurer was not "short-circuiting" closure procedures as Safstrom and its progeny prohibit. Since the initial claim had been accepted as nondisabling, the insurer was not attempting to deny all future responsibility for claimant's compensable condition, but instead was denying claimant's current claim that her initially nondisabling injury had become, more than one year after the date of injury, disabling.

ORS 656.262(12) provides that if a nondisabling injury has become disabling, if made more than one year after the date of injury, a claim shall be made pursuant to ORS 656.273 as for a claim for aggravation. If the injury was nondisabling and no determination was made, the claim for aggravation must be filed within five years after the date of injury. ORS 656.273(4)(b). Consequently, Dr. Lindquist's March 22, 1983 report constituted a claim for aggravation pursuant to ORS 656.262(12) and ORS 656.273(4)(b). The insurer's denial was not directed at forsaking responsibility for the initial nondisabling injury, but was intended to deny claimant's subsequent claim for aggravation.

ORS 656.268(3) contemplates that claims for nondisabling injuries may be closed without the formal issuance of a determination order by the Evaluation Division. The statute provides as follows:

> "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."

Although not titled as a notice of claim closure, the notice provided to claimant at the time of acceptance of her initial claim complies with the requirements of ORS 656.268(3). Among other instructions, claimant was advised of the following information: that her injury had been classified as nondisabling; that her time loss did not exceed three days; that she suffered no permanent impairment; that she could request a hearing from the Workers' Compensation Department within one year regarding her classification or if she was dissatisfied with the insurer's services; that she was entitled to aggravation rights for five years from the date of injury; and the address and phone number of the Workers' Compensation Department. Furthermore, claimant was aware that she had neither missed time from work nor sought medical attention. Therefore, no compensation was due claimant.

Claimant had the information at her disposal necessary to contest any aspect of her claim. Inasmuch as claimant failed to either request a hearing or claim that her nondisabling injury had become disabling within one year from the date of her injury, her subsequent claim for time loss and medical services for a worsened condition should be treated as a claim for aggravation as provided in ORS 656.262(12) and 656.273(4)(b). Consequently, the insurer's denial was not invalid.

Finally, following our de novo review of the medical and lay evidence, including claimant's and her husband's testimony, we agree with the Referee that claimant has failed to establish the compensability of her claim. Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated August 8, 1984 is affirmed.

SAMUEL L. HOLLAND, Claimant
Emmons, et al., Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 83-11601 & 83-07490
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Quillinan's order which set aside its denial of claimant's industrial injury claim for cervical strain. The issue on review is compensability.

The Board affirms and adopts the order of the Referee with the following comment. The standard of proof of compensability of

an industrial injury claim is by a preponderance of the evidence. See Hutcheson v. Weyerhaeuser, 288 Or 51, 55-6 (1979). We find that claimant did carry his burden of proof. The Referee's statement that "it is not impossible or unreasonable that claimant did in fact sustain a cervical strain . . . given the working conditions on June 30" is not a statement modifying the burden of proof but merely a comment on credibility and the weight to be given to testimony.

ORDER

The Referee's order dated October 30, 1984, is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

DELBERT R. HUTCHINSON, Claimant
Aitchison, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Rankin, et al., Defense Attorneys

WCB 83-09115 & 84-00654
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer, Louisiana-Pacific Corporation, requests review of those portions of Referee Galton's order which: (1) set aside its denial of responsibility for a low back aggravation claim; (2) affirmed the denial of the SAIF Corporation of a new injury claim; and (3) opened the aggravation claim as of December 12, 1983. The SAIF Corporation cross-requests review of those portions of the order which: (1) awarded interim compensation benefits from September 2, 1983 through January 13, 1984; (2) awarded a 25% penalty for unreasonable delay and resistance to payment of compensation; and (3) awarded a penalty associated attorney's fee of $500. The issues on review are: (1) responsibility; (2) dates of compensable time loss; and (3) interim compensation plus penalties and attorney's fees.

We adopt the Referee's findings of fact as our own and we affirm that portion of his order which assigned responsibility for claimant's condition in September 1983 to Louisiana-Pacific Corporation because there was an exacerbation of the residual symptoms of the original industrial injury and not a new injury.

Claimant was hired as a crawler tractor operator in a logging operation. Because of circumstances unrelated to claimant's condition, the job had been modified so that claimant was not required to get up and down to and from the cab of the tractor repeatedly. Claimant suffered the increase in his symptoms at issue when he was getting down off the tractor at the end of the day on Friday, September 2, 1983. He increased his intake of pain medication over the weekend and went to an emergency room on Tuesday, September 6, 1983, because he depleted his supply of pain medication. The emergency room doctor who examined claimant on September 6, 1983, and who recommended that claimant take off work for one week found claimant had a temporary exacerbation of his chronic back problem. Claimant's employer modified the job so that claimant could return to work with only one day of lost time. On November 28, 1983, when the job was no longer modified by the unrelated circumstances, claimant felt he had to quit because he could not do the regular heavy work of a heavy equipment operator in a logging operation.

However, as the Referee noted, claimant had returned to his preemployment condition within a few days and continued to work for eleven more weeks. Claimant described the symptoms from this incident as being similar to prior exacerbations of his back pain when he had similarly exceeded his physical limitations. Claimant had been advised that he should not attempt anything but light work at his initial evaluation at a pain center in 1982, to which report Dr. Degge alluded in his independent medical examination report on January 10, 1984. Claimant was authorized four days of time loss by the emergency room doctor, but claimant returned to modified work the next day. Claimant testified that he returned to his pre-exacerbation condition within four days, and continued to work until November 28, 1983. Claimant went to see his regular attending physician, Dr. Hockey, on December 12, 1983. Dr. Hockey opined that claimant had had a temporary exacerbation of his condition and that claimant was "essentially medically stationary."

At the relevant times, claimant's "regular work" was the work which he was doing on September 2, 1983: operating a crawler tractor with a choker-setter assisting on the ground. We find that he returned to his regular work on September 12, 1983, in accordance with the emergency room doctor's recommendation and his own testimony and, therefore, find that any period of disability due to this incident ended on September 11, 1983. Jackson v. SAIF, 7 Or App 109 (1971). Claimant actually lost only one day of work, therefore, he is not entitled to time loss compensation, even if he were to prove his claim under an aggravation or new injury theory. ORS 656.210.

Time that claimant lost after November 28, 1983 was due to the chronic back problem for which claimant was compensated by Determination Order in 1980. There is no opinion that claimant's condition has at any time worsened since his last arrangement of compensation. In fact, claimant and his treating physician repeatedly report that claimant's condition had not changed, because the intermittent problems had been happening since the original injury in 1978. There is no evidence and no contention that the work claimant did for SAIF's insured was part of an authorized vocational rehabilitaton program. "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." Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581 (1984). Therefore, we reverse that portion of the Referee's order which reopened the claim.

On the issue of interim compensation, claimant missed only one day of work, then worked full-time until November 28, 1983. Time loss after that date was not due to the incident on September 2, 1983, therefore, SAIF was not responsible for interim compensation benefit payments pending acceptance or denial of the new injury claim. Bono v. SAIF, 298 Or 405 (1984). Therefore, there were no amounts then due upon which to base penalties and attorney's fees and we reverse those portions of the order which awarded interim compensation from September 2, 1983 through January 13, 1984, and penalties and penalty-associated attorney's fees. The Referee also awarded penalties and attorney's fees for unreasonable delay in denial of the claim, but there being no amounts then due, there is no amount on which to base a penalty or

attorney's fee award. ORS 656.262(10); 656.382. See also EBI Companies v. Thomas, 66 Or App 105, 111 (1983).

ORDER

The Referee's Order on Reconsideration dated June 21, 1984, is reversed in part, modified in part, and affirmed in part. Those portions of the Referee's order which awarded interim compensation, and penalties and attorney's fees based on interim compensation, are reversed. Claimant's period of disability due to the incident of September 2, 1983, is modified to end on September 11, 1983. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the self-insured employer.

NORRIS G. LANGSEV, Claimant
Arnold W. Ruonala, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 83-00552
May 28, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Gemmell's order which set aside its denial of medical treatment for claimant's right wrist condition; and awarded an additional 30° (20%) scheduled disability for loss of use or function of the right forearm on review of a Determination Order which awarded 45° (30%) scheduled disability, thereby granting claimant a total award of 75° (50%) scheduled disability. The issues are the compensability of medical services incurred in connection with claimant's right wrist condition, including a third surgical procedure performed in November of 1983 and extent of scheduled disability.

With regard to the compensability issue, we affirm the relevant portions of the Referee's order with the following additional comments. There is a potential Bauman-type of issue in this case. See Bauman v. SAIF, 295 Or 788 (1983). This potential issue was not addressed by the Referee, and we find that it need not be addressed on review based upon our conclusion that the record establishes a materially causal connection between claimant's 1981 industrial injury and the medical services in issue.

The Referee apparently relied upon the rationale expressed in Wheeler v. Boise Cascade, 66 Or App 620 (1984), which has since been rejected by the Supreme Court. 298 Or 452 (1984). Wheeler is inapposite. The criteria of Weller v. Union Carbide, 288 Or 27 (1979) have no application in this case, which involves an industrial injury as opposed to a claim for occupational disease. Jameson v. SAIF, 63 Or App 553 (1983); Boise Cascade v. Wattenbarger, 63 Or App 447 (1983); Betty L. Counts, 35 Van Natta 1356 (1983), adhered to on reconsideration, 36 Van Natta 18 (1984); Paul Scott, 35 Van Natta 1215 (1983).

Claimant's burden of proving the compensability of the medical services in issue is satisfied by evidence which establishes that claimant's injury materially contributes to his ongoing wrist symptomatology and the consequent need for further surgical revision. Patitucci v. Boise Cascade Corp., 8 Or App 503, 508 (1972); Wilma H. Ruff, 34 Van Natta 1048, 1052 (1982). The fact that claimant had preexisting degenerative joint disease of the wrist, which was relatively asymptomatic prior to this 1981

injury, does not rule out the possibility of the requisite causal connection. See also Coddington v. SAIF, 68 Or App 439 (1984).

We find and hold that a preponderance of the persuasive evidence establishes a materially causal relationship between claimant's 1981 industrial injury and the medical services in issue.

On the issue of extent of scheduled disability for loss of use or function of the right wrist/forearm, we modify the Referee's order to award a total of 60° (40%) scheduled disability.

The Determination Order in issue closed the claim with an award for 45° (30%) loss of the right forearm (wrist) in December of 1982, after claimant had submitted to two surgical procedures. The first was an arthrodesis (fusion), after which claimant continued to experience pain and instability of the wrist. The second surgery was for insertion of a silastic prosthesis at the base of the thumb (trapezium implant). Claimant returned to work as a janitor for the employer, and he worked through January and February of 1983. Because of his continuing wrist pain, he decided to retire March 1, 1983, at the age of 67.

In November of 1983 claimant submitted to surgery for a third time. This consisted of an extension of the fusion of the wrist to include the second and third carpal-metacarpal joints. This surgery did not improve the use of function of the wrist; however, it did substantially alleviate claimant's pain. Claimant testified that he now has greater stability of the wrist, and that his principal problem is lack of grip strength. Claimant testified that if he had known that the third surgery would improve his pain problem to the degree it did, he would not have retired.

After claim closure, but before the third surgery, Dr. Nathan, who had examined claimant for the insurer, reported that the award of 30% loss of the right forearm was consistent with his findings. After the third surgery was performed, Dr. Nathan reported that he would not expect it to result in improved wrist function or reduction of claimant's permanent disability.

Before the third surgery, Dr. Wright, who performed surgery number two, reported that claimant's limitation of wrist function could be described as moderate in degree, as could the amount of pain he was experiencing. After he performed the third surgery, Dr. Wright reported that he did not anticipate any improvement in claimant's prior disability rating as a result of this surgery, although he did expect it to relieve claimant's symptoms. He rated claimant's previous disability (i.e. pre-surgery number three) at 35% loss of wrist function and 15% impairment of the thumb.

Thus, although the third surgery did not serve to improve the use or function of claimant's wrist, it did serve to decrease claimant's pain. To the extent that claimant's pain was disabling before surgery number three, reduction of that pain has also, in effect, reduced claimant's disability. Dr. Wright, as the treating physician, has assessed the loss of use or function of the wrist at 35%, and of the thumb at 15%. The thumb impairment is part and parcel of the forearm/wrist disability.

As a result of his injury, claimant is not able to engage in heavy work requiring use of the right hand/forearm. Claimant's ability to lift and grip is limited. There is a conflict in the evidence concerning the degree of preexisting forearm impairment. Claimant sustained an injury to the same area of the right upper extremity approximately 40 years earlier, which necessitated surgery for removal of some bone chips. Several physicians' reports, including those of claimant's attending physicians, refer to a slight degree of stiffness and lack of grip strength prior to this 1981 injury. Claimant was able to engage in heavy labor, however, during the many years preceding this industrial injury, with little or no disability of the right arm. The independent examining physicians, including Dr. Nathan, expressed incredulity about claimant's reported lack of symptoms prior to this injury, in view of the extensive degenerative changes of the wrist. Claimant denied telling his physicians that he had experienced stiffness in the wrist prior to this injury. The Referee found claimant credible.

We reconcile these apparent conflicts in the evidence by finding that, although claimant experienced some mild symptoms of the wrist prior to this injury, such as stiffness, those symptoms did not interfere with his ability to engage in heavy work activity on a regular basis. As a result of this injury, claimant suffers loss of function of the wrist which interferes with his ability to engage in this type of work activity. He experiences a loss of motion and grip strength as a result of the combined effect of his injury, degenerative arthritis and residuals of surgery. Claimant's pain has been reduced as a result of the last surgery; however, the function of the wrist remains limited as before.

On our de novo review of the record, we find claimant entitled to an award for 60° scheduled disability for 40% loss of use or function of the right forearm, and we modify the Referee's order accordingly.

ORDER

The Referee's order dated November 1, 1984 is modified in part. In lieu of the Referee's award of an additional 30° (20%) scheduled disability, and in addition to the Determination Order award of 45° (30%) scheduled disability, claimant is awarded 15° (10%), for a total award to date of 60° scheduled disability for 40% loss of use or function of the right forearm. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $50 for services on Board review in connection with the medical services issue.

JIMMY C. LAY, Claimant
Evohl F. Malagon, Claimant's Attorney
Roberts, et al., Defense Attorneys
John Snarskis, Defense Attorney

WCB 83-07577, 83-09456 & 84-04042
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

EBI Companies requests review of those portions of Referee Michael Johnson's order which set aside its March 21, 1984 denial of further responsibility for claimant's left knee condition and which approved Industrial Indemnity Company's May 16, 1984 denial of responsibility for the condition.

Claimant compensably injured both knees on March 18, 1981 while in the employ of EBI's insured. As a result, surgery was performed on the left knee on January 24, 1983, and the previously closed claim was reopened by EBI. On April 22, 1983, the treating doctor released claimant to return to work as a faller. Claimant further injured his left knee at work on April 28, 1983. Industrial Indemnity contends that as the EBI claim was still in open status when EBI issued its denial of responsibility on March 21, 1984, the denial is invalid for the reasons stated in Safstrom v. Riedel International, Inc., 65 Or App 728 (1983) and Roller v. Weyerhaeuser Company, 67 Or App 583 (1984).

In Retchless v. Laurelhurst Thriftway, 72 Or App 728 (1985), the court held that the Bauman v. SAIF, 295 Or 788 (1983) preclusion of back up denials does not apply in responsibility cases. But see Jeld-Wen, Inc. v. McGehee, 72 Or App 12 (1985). In any event, as there has been no notice of acceptance since the April 28, 1983 incident, Bauman is inapplicable here. The mere payment of benefits does not constitute an acceptance. ORS 656.262(9).

In Joji Kobayashi, 36 Van Natta 1558 (1984) we questioned the suggestion in Safstrom that a preclosure partial denial is permissible only when an accepted condition has fully resolved. We stated:

> "We believe that it is the better policy to allow insurers to issue partial denials of conditions which are allegedly discrete from an accepted condition even when the accepted condition is not fully resolved or is not stationary. This statisfies the concern expressed in Safstrom that partial denials not be used as vehicles for circumventing a claimant's right to claim closure of an accepted claim. It is also consistent with the Supreme Court's holding in Price [v. SAIF, 296 Or 311 (1984)] which allows an appeal of a partial denial to proceed while processing of the accepted portion of the claim continues at a lower level. Finally, it satisfies our concern that insurers be encouraged to specify clearly what conditions are accepted and what conditions are denied." Id. at 1564.

We now extend the reasoning of Kobayashi to responsibility cases. We believe that it is the better policy to allow an employer/insurer to issue a preclosing denial of continued responsibility for an accepted condition where it appears that injuries or conditions attributable to a subsequent employment aggravate or exacerbate the condition such as to make a shift of employer/insurer responsibility appropriate. The practical effect of precluding responsibility denial in such a circumstance would be to make the first employer/insurer responsible for any and all effects of subsequent employments on the accepted condition between the time the claim is accepted and the time it is finally closed. We do not believe that such a result was intended. Accordingly, we reject Industrial Indemnity's contention that EBI's responsibility denial is procedurally invalid.

On the merits we affirm and adopt the order of the Referee.

ORDER

The Referee's order dated July 25, 1984 is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by EBI Companies.

HARLAN L. LONG, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-00149
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Foster's order which found that claimant was not permanently and totally disabled and awarded 30° for 20% scheduled disability of the right leg in addition to the 60° for 40% scheduled disability previously awarded by two Determination Orders. The issue on review is extent of disability.

Claimant suffered an industrial injury to his right knee on November 22, 1977. Seven operations have been performed on the knee, including two joint replacement operations. His attending physician restricted him to light work with standing and walking limited to 30 minutes at a time, a total of 60 minutes standing and 60 minutes walking per day. He is further limited to no climbing, balancing, kneeling, crouching, nor crawling, and only occasional stooping or bending at the waist. He is further required to use a cane.

Claimant was 59 years old at hearing. He had a high school education. Claimant worked his entire adult life as a heavy construction carpenter and foreman. The attending physician declared claimant permanently and totally disabled from returning to construction carpentry and outdoor work. Vocational assessment found only one area of employment to which claimant's skills might be transferable: vocational instructor in carpentry. Claimant was referred to the Vocational Rehabilitation Division (VRD) for vocational assistance in September 1981. An extensive effort by VRD and claimant proved that this possibility was not practical. On April 27, 1983 Field Services Division (FSD) ended claimant's referral for vocational assistance because: "Your physical limitations both related and unrelated to the industrial injury make vocational rehabilitation unpractical."

In March and April 1984 VRD advised claimant that it felt it would not be appropriate for him to reapply for services because it did not believe that he would benefit from any service it could offer. It did agree to arrange an appointment with a vocational counselor if claimant wanted to discuss the matter further.

On March 20, 1984 the SAIF Corporation retained a rehabilitation counselor to review claimant's history and assess claimant's employability. The counselor obtained the approval of claimant's physician of a job description on May 22, 1984, and reported on May 25, 1984 that there were jobs for vocational instructors within claimant's physical limitations.

The hearing was conducted on June 5, 1984 and the record was closed at the conclusion of the hearing. The Referee found that claimant "would return to work if he possibly could, but does not know anything he can do. . . . He has been a carpenter all his

life, and his only profession has been foreclosed to him." The Referee felt that the vocational assistance efforts had been inadequate and too narrowly restricted to occupations relating to claimant's experience and training. The Referee speculated that vocational assistance should be attempted in some untried direction.

We find that claimant is not currently employable or able to sell his services on a regular basis in a hypothetically normal labor market by reason of his age, his training and experience, and the limits placed on him as a result of his compensable injury. The evidence is persuasive that claimant is precluded from returning to his former occupations and from obtaining employment at another suitable occupation. ORS 656.206(1)(a).

Claimant cooperated with efforts to identify transferable skills and was losing weight according to his physician's recommendation. He contacted prospective employers in lumber and hardware sales in addition to identified educational employers. Only one occupation was identified as theoretically within claimant's abilities, and employment in that occupation was the object of a two year assistance program by VRD. When he was advised by the state agency that authorization for further vocational assistance was "unpractical," he sought vocational assistance from a federal agency. Claimant met his seek-work burden under ORS 656.206(3).

The job description approved by claimant's physician on May 22, 1984 appears inconsistent with some of the limitations he had set on April 21, 1984. Taking into account the efforts already made to identify a suitable occupation and obtain employment, the rehabilitation counselor's speculative opinion obtained so near the hearing date and more than one year after claimant's prior vocational assistance program had been terminated as "unpractical" does not overcome the evidence that claimant is permanently and totally disabled. Marvin v. SAIF, 67 Or App 40 (1984).

We cannot speculate on claimant's employability after some different form of vocational rehabilitation. That claimant has shown other interests and skills in his past that might be transferable to some as yet unidentified and untried occupation cannot be a basis for finding that claimant is not permanently and totally disabled. Gettman v. SAIF, 289 Or 609 (1980). We find that claimant has proven that he is permanently and totally disabled.

Having found that claimant has proven that he is permanently and totally disabled, we turn to the question of fixing the date on which he was first permanently and totally disabled. The medical evidence does not establish that claimant was ever totally disabled solely by reason of his medical condition. Other factors must be considered, including claimant's age, training, aptitudes, and motivation, in finding the date on which the evidence first established that claimant's permanent total disability was proven. Morris v. Denny's, 53 Or App 863 (1981).

Claimant was examined and physical restrictions based on medical factors were recommended on August 10, 1981 by Dr. Storino at the Callahan Center. Those limits were reapproved by

claimant's attending physician, Dr. Paluska, on April 21, 1984, therefore, there was no change in claimant's physical restrictions based on medical factors after August 1981. This only proved that claimant had some permanent disability. The other factors relevant to a determination of the extent of disability did not at that time indicate that claimant was totally disabled. Vocational aptitude assessment and placement efforts were authorized by FSD and undertaken. Claimant cooperated with vocational rehabilitation efforts to identify and locate suitable employment according to the reports of VRD and FSD. When VRD decided it had done all it could to assist claimant, FSD terminated authorization for further vocational assistance. We find that a preponderance of the evidence establishes that claimant was permanently incapacitated from regularly performing work at a gainful and suitable occupation and that he had established that he was willing to seek and had made reasonable efforts to obtain regular gainful employment when authorization for vocational rehabilitation assistance was terminated on April 27, 1983.

ORDER

The Referee's order dated June 26, 1984 is reversed. Claimant is awarded permanent total disability as of April 27, 1983. Claimant's attorney is allowed 25% of claimant's compensation as an attorney fee, not to exceed $3,000, said sum to be paid out of claimant's compensation. This fee is in lieu of and not in addition to that allowed by the Referee.

JAMES R. MANKE, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-02506
May 28, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee Gemmell's order which awarded 144° for 45% unscheduled disability for injury to claimant's neck and right shoulder in lieu of a Determination Order award of no permanent disability in addition to the 32° for 10% unscheduled disability allowed by an earlier stipulation for injury to claimant's shoulder. SAIF contends that the Referee erred in considering claimant's neck impairment and, in any event, that the award is excessive.

Claimant was compensably injured on July 22, 1982 when he fell about eight feet while working on a scaffold as a drywaller. When he fell he grabbed with his right arm, forcibly abducting it. He landed on his shoulder, back and neck. On the 801 form claimant mentioned only his right shoulder as being affected by the injury. The initial medical reports focused primarily on the shoulder, but also noted back, elbow and right leg complaints. Of these, all but the shoulder have resolved. An arthrogram of the right shoulder was performed in August 1982 with normal results, yet shoulder discomfort persisted.

Claimant had had previous neck problems. In 1977 Dr. Parsons, a neurosurgeon, diagnosed a protruding disc at C5-6, and in 1978 he performed a cervical laminectomy. The 1978 neck problem was not processed as a job injury claim. After the surgery claimant attended a community college for one and a half years taking courses in industrial drafting. Before completing the program, however, claimant left school and returned to his former occupation as a drywaller.

Although claimant's neck was not totally asymptomatic at the time of the injury, he was working full time as a drywaller without restrictions or limitations. Claimant testified that within 30 days after the accident his neck felt different. He noticed a burning sensation while packing boxes in moving. Dr. Parsons reported in August 1982 that claimant had preexisting impairment, but that the July 1982 injury would not result in greater disability than would be expected in the absence of the preexisting impairment.

Claimant came under the care of Dr. Hauschildt in August 1982. Dr. Hauschildt wrote to SAIF on September 3, 1982 that claimant had been a sheetrock worker for 17 years and that the work was having a bad and irreversible effect upon his cervical spine and shoulder. He stated that claimant was headed for permanent and total disability with respect to his current occupation and required retraining. He diagnosed chronic biceps tendinitis of the right shoulder and early cervical arthritis, both the result of claimant's occupation. In October 1982 Dr. Hauschildt reported that claimant was probably stable, but was permanently disabled from his previous occupation as a sheetrock worker. He opined that claimant would be totally disabled if he continued at that work. On December 6, 1982 he wrote SAIF as follows:

> "Mr. Manke's disability is related to his neck and arms. This comes from direct result of his occupation as a sheetrock worker wherein he uses his head to hold sheetrock in place while he fixes it from below thereby causing rather substantial strain upon the arms and shoulders. He should be able to work at any job where he will be able to work to keep his hands below his shoulders and where there is no strain on his neck and upper back."

Claimant was examined by Orthopaedic Consultants on December 7, 1982. Claimant complained of a constant dull ache in his mid lower cervical area, aggravated by overhead work or heavy lifting. He also described pain in the right shoulder, particularly after repeated lifting of approximately one hour's duration, and an occasional clicking in the shoulder. The Consultants diagnosed: (1) low back strain, resolved; (2) cervical strain, chronic, superimposed on post-operative cervical laminectomy C5-6 and diskectomy; and (3) right shoulder strain, resolved. They stated that claimant should not return to his previous occupation and rated total loss of function of the cervical spine as mildly moderate and loss of function due to the injury as mild. Dr. Hauschildt concurred.

A January 21, 1983 Determination Order awarded no permanent disability. Claimant requested a hearing. On March 14, 1983 the parties stipulated to the settlement of all issues raised or raisable. Under the stipulation claimant received 10% unscheduled disability for his right shoulder.

Claimant was referred for vocational assistance. In April 1983 he began an authorized on-the-job training program as an assistant manager in a real estate office. In conjunction with this training he attended real estate school and obtained a real

estate license. The program was completed in January 1984. Claimant's claim was again closed by a Determination Order on February 14, 1984, which granted no additional permanent disability. The present case arose when a hearing was sought on that determination.

Claimant worked for approximately one and a half months as a sales manager for a firm selling furnace flue control devices in late February and March 1984. In June 1984 he returned to doing light drywall work on a part-time basis due to financial pressures. He was unable to perform this type of work as productively as he had before the injury. His earnings when averaged on an hourly basis were less than half his prior rate.

Claimant returned to see Dr. Parsons on several occasions beginning in October 1983.

Claimant was reexamined by Orthopaedic Consultants in August 1984. The Orthopaedic Consultants stated that although claimant was only employed part-time, he could not continue with his present occupation and should be encouraged to seek other work because of his cervical problems. They stated that the shoulder problems did not restrict his work activities, the restriction being essentially the result of his cervical problem. They also stated that the 10% unscheduled disability award was proper for the impairment present in claimant's right shoulder.

Claimant testified that he constantly feels like his neck is full of sand or gravel, but does not have constant pain in the neck or shoulder. With significant lifting he experiences a bad burning sensation in the top of his right shoulder. He also experiences back problems with prolonged lifting. He is unable to do overhead work.

In evaluating claimant's loss of earning capacity the Referee considered claimant's progressive cervical impairment. SAIF contends that there is not now, nor has there ever been an occupational disease claim in regard to claimant's cervical condition. We need not determine whether, for example, Dr. Hauschildt's September 3, 1982 and December 6, 1982 letters constitute such a claim, however. The issue here before us is the extent of claimant's permanent loss of earning capacity arising out of his July 22, 1982 injuries. See 656.214(5). The clear preponderance of the evidence is that the 1982 accident is not a material cause of claimant's current cervical condition. The stipulation's recognition of only shoulder impairment is in accord. Accordingly, we decline to consider claimant's cervical impairment in determining an appropriate award.

Claimant is 40 years old, has a high school education plus one and a half years of junior college in a drafting program. On March 14, 1983 he stipulated to the adequacy of a 10% award for his loss of earning capacity as a result of the July 1982 injuries. We find little evidence of significant change in his injury related permanent physical impairment since the stipulation. Since then he has completed on-the-job training and obtained a real estate license. Weighing the pertinent social vocational factors, see OAR 436-65-600 et seq., we find that on balance any shift since the stipulation has been in the direction of enhanced earning capacity. We find that the 10% unscheduled disability previously awarded adequately compensates claimant for

his loss of earning capacity due to the July 1982 injury. Accordingly, we reverse the Referee's award.

ORDER

The Referee's order dated October 1, 1984 is reversed in part and modified in part. That portion of the Referee's order awarding an increase of 112° for 35% unscheduled permanent partial disability is reversed. The February 14, 1984 Determination Order is reinstated and affirmed. That portion of the Referee's order allowing an offset in the sum of $189.72 against the increased compensation granted by the Referee's order is modified to permit an offset of like amount against future permanent disability awards, if any.

JANET G. McCLARAN, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-05628
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee Galton's order which awarded claimant an additional 64° (20%) unscheduled disability for injury to her left shoulder on review of a Determination Order which awarded 48° (15%) unscheduled disability, thereby granting claimant a total award of 112° (35%) unscheduled disability. The employer contends that the Referee's increased award is excessive and that the Determination Order should be affirmed. We agree and, therefore, reverse the Referee's award of additional unscheduled disability.

Claimant was 47 years old at the time of hearing. She is a high school graduate who completed one year in liberal arts education in 1955. She was a homemaker and not employed outside the family home until 1964, when she began to work part time on an assembly line in a factory which manufactured cardboard boxes.

In 1976 claimant entered a training program for bus drivers. After completing the training program, she drove a school bus for the Tigard School District for one year. In 1978 claimant became employed as a bus driver for the employer herein.

Claimant sustained the injury in question on January 6, 1982, while walking across the employer's parking lot. She slipped and fell on a patch of ice, as a result of which she suffered an anterior dislocation of the left shoulder. Initially the shoulder was reduced through gentle distal traction and then placed in an immobilizer. A second immobilizer and physical therapy did not improve the range of motion of claimant's shoulder. Therefore, in April of 1982, she submitted to manipulation of the shoulder under general anesthesia.

In June of 1982 claimant changed physicians and came under the care of Dr. McNeill. Dr. McNeill diagnosed a frozen shoulder and treated claimant with cortisone injections and anti-inflammatory medication. A shoulder arthrogram disclosed no evidence of a rotator cuff tear. Because claimant's symptoms did not resolve with conservative treatment, Dr. McNeill performed surgery in November of 1982.

After surgery claimant's constant pain dissipated, and her range of shoulder motion improved markedly.

Claimant returned to part time work driving a school bus in February of 1983 and was then off work during the summer months of that year. In the fall of 1983 she returned to full time work as a bus driver.

After claimant returned to work, it became apparent that she was experiencing difficulty reaching the toggle switch which operates the flashing lights on the school bus, because it was too high on the console. Therefore, the employer installed a button which is much lower and, therefore, more accessible to claimant's now limited reach.

The hearing was held in December of 1984, and claimant testified that she had not missed any work as a result of her shoulder condition "this year," which we understand to mean the school year beginning in the fall of 1984.

Claimant testified that she was able to perform her job despite her shoulder condition. She does, however, experience pain or discomfort "quite often" while working. At the end of the work day her shoulder usually feels tired and sore. Some days it doesn't bother her much, but some days she goes home and lies on a heating pad and takes Tylenol. It sometimes affects her ability to sleep. The shoulder injury has affected her recreational activities. She no longer can hunt, and she believes that she would no longer be able to fish, although it does not sound as though claimant has tried to do so. She belongs to a 4-wheel driving club, and she is no longer able to engage in this recreational driving activity because her arm hurts and she is "scared to." Her ability to carry packages in her arm has been impaired. When asked whether she could lift ten pounds frequently and 25 pounds occasionally during the course of a work day, claimant responded, "Not if I had to do it everyday, all day long."

Before claimant's surgery, which grossly improved her shoulder condition, her former attending physician, Dr. Thompson, completed a physical assessment form used for job placement. Dr. Thompson indicated that claimant could reach above her shoulders occasionally and work at heights frequently. He further indicated that claimant was capable of carrying, on a frequent basis, weights of up to 50 pounds, although no weight in excess of that. Similarly, claimant would be able to lift from the floor weights of up to 50 pounds on a frequent basis. In addition, claimant would be able to use her arms for repetitive grasping as well as repetitive fine manipulation. However, claimant would not be able to use her arms for repetitive pushing-pulling.

Claimant testified that lifting from the ground up to a certain position does not really bother her, but trying to lift from the waist is problematic. She wakes up with a stiff shoulder, and she is unable to perform "heavy yard work." She does not paint, since this involves mostly overhead activity.

Approximately 30 years ago claimant worked for an insurance agency doing what sounds like clerical work and typing. At that time she also worked for a department store. Although claimant has no intention of applying for or performing any type of work other than her work for the employer as a bus driver, she testified that she probably would not be able to perform any job requiring typing because of the position in which she would be

required to hold her arms. In addition, claimant testified that she would not be able to perform work at the container factory because it involves too much lifting.

Claimant was examined by Dr. Pasquesi, an orthopedic surgeon, for a closing evaluation at Dr. McNeill's suggestion. Dr. Pasquesi assessed claimant's left shoulder impairment at 16% based upon the limitations of motion he found on his examination. Dr. McNeill previously had stated that, in his estimation, claimant's permanent shoulder impairment was in the mild to moderate range. After receipt of Dr. Pasquesi's report, Dr. McNeill indicated his concurrence with the doctor's findings.

The Referee correctly considered the fact that, as a result of her injury, claimant experiences shoulder pain and discomfort. We believe, however, that he overvalued the disabling effects of claimant's residual pain, particularly as it bears upon her loss of earning capacity. Claimant has been reinstated to full time employment, although it was apparently necessary for the employer to slightly modify claimant's "job site." To the extent that claimant's pain causes impairment, she is entitled to be compensated therefor. Harwell v. Argonaut Insurance Co., 296 Or 505, 511 (1984). Arguably, the question of whether pain causes physical impairment is separate and distinct from the question whether pain which admittedly causes some slight impairment of function, necessarily results in compensation for lost earning capacity. Id. at 513-14 (Carson, J., concurring).

Although claimant experiences some mild pain and discomfort during her work as a school bus driver, it obviously does not interfere with her ability to perform this job. Claimant does experience pain at other times, and obviously pays the price for having to use her left shoulder/arm in connection with her work activity. In awarding appropriate compensation for unscheduled disability, it is incumbent upon us to consider claimant's ability to obtain and hold gainful employment in the broad field of general occupations, ORS 656.214(5); however, we are also required to compare claimant's post-injury situation with her situation as it existed before her injury "and without such disability." Id.

The fact that claimant has returned to her pre-injury work on a full time basis at the same rate of pay is not dispositive and does not gainsay claimant's entitlement to an award for unscheduled disability. Howerton v. SAIF, 70 Or App 99, 102 (1984); Ford v. SAIF, 7 Or App 549 (1972). It is, nevertheless, an appropriate factor to take into consideration. Ford v. SAIF, supra; Melvin J. Wood, 36 Van Natta 1623, 1624 (1984).

Considering the record in its entirety, including claimant's credible testimony concerning her pain and residual functional abilities, we find and hold that the Determination Order which awarded 48° for 15% unscheduled disability adequately and appropriately compensates claimant for the loss of earning capacity attributable to this left shoulder injury. Therefore, we reverse the Referee's award of additional unscheduled disability.

ORDER

The Referee's order dated December 19, 1984 is reversed, and the Determination Order dated April 17, 1984 is affirmed.

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

WCB 84-02393
May 28, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Michael Johnson's order which dismissed her request for hearing because of her failure to first seek administrative review with the Director of the Workers' Compensation Department. Claimant contends that a penalty and attorney fee should have been awarded for the SAIF Corporation's alleged unreasonable failure to timely make a vocational rehabilitation referral.

In Joel I. Harris, 36 Van Natta 829, 838-840 (1984), aff'd mem, Harris v. Western Wire Works, 72 Or App 591 (1985), we determined that we lacked jurisdiction to assess a penalty for alleged unreasonable delay in referring a claimant for vocational assistance. We affirm the Referee's order dismissing the hearing request for failure to first seek administrative review with the Director of the Workers' Compensation Department.

ORDER

The Referee's order dated September 10, 1984 is affirmed.

DEAN W. NELSON, Claimant
Michael B. Dye, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 83-06793
May 28, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee Baker's order which: (1) set aside its partial denial of claimant's left knee condition; (2) awarded claimant's attorney $2,000 as a reasonable attorney's fee for prevailing on the denial; and (3) awarded claimant an additional 96° (30%) unscheduled disability for injury to the low back on review of a Determination Order which awarded 96° (30%) unscheduled disability, thereby granting claimant a total award of 192° (60%) unscheduled disability. The employer contends that claimant's left knee condition is not compensable; that the Referee's award of attorney fees is excessive; and that the increased unscheduled disability award is excessive.

On review we agree with the employer's contention that the evidence fails to preponderate in favor of finding claimant's left knee condition compensable. Therefore, we reverse that portion of the Referee's order and reinstate the employer's denial. Accordingly, it is unnecessary to consider whether the employer-paid attorney's fee awarded by the Referee is excessive, as no fee is payable in connection with this denial. As to the extent of unscheduled disability, we find the Referee's award somewhat excessive and modify the award to 160° (50%) unscheduled disability for injury to the low back.

Briefly stated, the facts pertinent to the partial denial issue are as follows. Claimant originally injured his back in April of 1980 while working for this employer, which was not then self-insured. As a result of this injury, claimant experienced

low back pain, radiating right leg pain and later left leg pain. A ruptured disc at the L5/S1 level ultimately was diagnosed. Claimant came under the care of Dr. Buza, who performed a laminectomy in December of 1980. This claim was closed by Determination Order dated July 28, 1981, which awarded 16° (5%) unscheduled disability for injury to claimant's low back.

Claimant developed coronary symptoms beginning in early 1981. Coronary artery disease was later diagnosed, and in October of 1981 claimant submitted to surgery for a double arterial bypass.

After recovering from heart surgery, claimant returned to work for the employer in early January of 1982. Claimant worked until March 11, 1982 when he began to experience increasing pain in his low back, with radiating pain into the right leg. Approximately three months later, claimant began to experience radiating left leg pain.

Claimant stopped working on March 11, 1982. By this date, the employer had become self-insured. He was seen again by Dr. Buza, who hospitalized and placed him in traction for three weeks. A repeat myelogram disclosed defects at the L3-4, L4-5 and L5-S1 levels. Dr. Buza recommended a second surgical procedure, which eventually was performed. In October of 1982 claimant submitted to a second laminectomy, at the L4-5 level.

A dispute arose concerning responsibility for claimant's worsened low back condition, as between the employer's former insurer and the employer in its capacity as self-insured. A .307 order was entered, and ultimately the self-insured employer accepted responsibility for a new injury, with an assigned date of March 11, 1982, by stipulation of the parties.

In the meantime, claimant had begun to develop left knee pain, which he believed was related to his low back condition. Dr. Buza referred claimant to Dr. Tiley, an orthopedic surgeon, for evaluation of the left knee pain. Dr. Tiley first examined claimant in October of 1982, while he was hospitalized for his second laminectomy. Dr. Tiley diagnosed a weakness of the quadriceps muscle of the left leg, resulting from claimant's back condition. The weak quadriceps muscle, in turn, had caused a recurrent dislocating patella. Dr. Tiley requested authorization to perform patella realignment and/or patella trephination (excision of a piece of bone with a cylindrical saw).

The self-insured employer refused to pay for the surgery proposed by Dr. Tiley on the grounds that the left knee condition was unrelated to claimant's back injury. The employer's former insurer likewise denied. Claimant adamantly refused to undergo surgery at the expense of his private health insurer based upon his conviction that the knee condition was caused by his back condition. In May of 1984, however, claimant finally submitted to knee surgery by Dr. Tiley. It appears as though Dr. Tiley's findings on surgery did not bear out his working diagnosis of a recurrent dislocating patella. Rather, at surgery, Dr. Tiley found degenerative joint disease of the knee, for which he performed proximal tibial osteotomy. He continued to attribute the left knee condition to claimant's back problem, although he admitted that medial arthritis can happen in anyone. In a letter to claimant's attorney, Dr. Tiley stated, "At least from a temporal point of view, the degenerative disease of the left knee

has followed a lot of weakness of the left leg and the weakness of the left leg is directly related to back problems."

Claimant has been examined and evaluated by many other reputable neurological physicians/surgeons and orthopedic surgeons, none of whom attribute the left knee complaints to claimant's back condition. In fact, several physicians ruled out the possibility of any causal connection between the back and the knee. Even Dr. Buza, who was somewhat ambivalent concerning the possibility of a causal connection, ultimately stated that the two were not related. This opinion was qualified, however, by his stating that he was a neurosurgeon, not an orthopedist. The Referee apparently accorded some weight to claimant's strong conviction of a causal relationship between his back and knee conditions, as evidenced by claimant's continuing refusal to undergo surgery.

The question of the causal relationship, if any, between claimant's back condition and his left knee condition is one of science which must necessarily be determined by testimony of skilled, professional persons. Uris v. Compensation Department, 247 Or 420, 424 (1967). Claimant's heartfelt conviction is relevant only isofar as it lends credence to the experts' opinions.

The preponderant medical opinion clearly weighs against claimant on this issue. The evidence of a temporal connection, relied upon by Dr. Tiley, is simply insufficient in this case to persuade us that we should accept his opinion over those of all other physicians who have considered the question. Even Dr. Buza is less than supportive. It is not even clear that Dr. Tiley was aware of the fact that, immediately after the March 11, 1982 injury, claimant experienced right-sided radiating leg pain, and that it was not until approximately three months later that the left leg pain became prominent. Thus, we conclude that claimant has failed to establish the compensability of his left knee condition and the associated treatment provided by Dr. Tiley.

The following facts and findings are relevant to the extent of disability issue. Viewing the evidence in the light most favorable to claimant, we conclude that he suffers mildly moderate impairment of the low back. He was 48 years of age at the time of hearing. He completed the eighth grade. He was a maintenance mechanic for the employer for five years before this 1982 injury. It is medically verified that claimant is unable to return to this type of work because it exceeds the physical limitations resulting from his back condition. Claimant also has a long history of heavy construction machinery operation. His work history essentially involves work of a heavy nature. As a result of claimant's back condition, he is relegated to performing work of a light or moderate (medium) nature.

Claimant was undergoing vocational evaluation by a rehabilitation specialist, who was working on returning him to the labor force through appropriate vocational planning. Several vocational goals had been considered taking into account claimant's past work experiences, tested interests and aptitudes, and his physical capabilities. Possible vocational goals were electric motor assembler, short haul truck driver, school bus driver, glass welder, power press tender, office machine assembly technician, electronics assembler and tester, recovery operator, dryer operator, pasting machine operator, and lead caster. The

rehabilitation specialist was developing a direct employment plan with the objective of obtaining employment as a drill press operator. A labor market survey reflected "positive bias" for employment in this line of work. A job analysis was performed providing job specifications and physical requirements, which was provided to Dr. Buza for his input concerning claimant's ability to perform that type of work. His response apparently was not forthcoming by the time of hearing, or if it was, it was not submitted as an exhibit. In any event, by the time of hearing vocational services had been terminated since claimant was in the process of recovering from knee surgery.

On the one hand, it is apparent that claimant is foreclosed from returning to types of work he has performed in the past, as a result of his back condition. On the other hand, vocational evaluations seem to indicate that, considering claimant's training, experience and work skills, there are various types of employment available without the need for retraining. Considering this evidence, we find that in attempting to obtain gainful and suitable employment in a hypothetically normal labor market, claimant will encounter moderate restriction in available occupational opportunities. OAR 436-65-608(3)(b).

An additional factor apparently not considered by the Referee in awarding claimant compensation for this 1982 injury, is the fact that claimant received an award for 16° (5%) unscheduled disability in connection with his original 1980 back injury. We are required to take this award into account in awarding claimant appropriate unscheduled disability for this injury. ORS 656.222; see Thomason v. SAIF, 73 Or App 319, 323 (1985); Cascade Steel Rolling Mills v. Madril, 62 Or App 598 (1983), 57 Or App 398 (1982); Harris v. SAIF, 55 Or App 158 (1981); Green v. SIAC, 197 Or 160 (1953).

Taking all of these factors into consideration on our de novo review, and comparing this injured worker with similarly situated workers, we find that an award for 160° (50%) unscheduled disability adequately and appropriately compensates claimant for the loss of earning capacity attributable to this industrial injury. We modify the Referee's order accordingly.

ORDER

The Referee's order dated October 8, 1984 is reversed in part and modified in part. That portion of the order which set aside the self-insured employer's denial of claimant's left knee condition is reversed, and the employer's denial dated June 24, 1983 is reinstated and affirmed. That portion of the Referee's order which awarded an additional 96° (30%) unscheduled disability is modified. In lieu of the Referee's award, and in addition to the 96° (30%) unscheduled disability awarded by Determination Order dated October 28, 1983 (as amended November 8, 1983), claimant is awarded 64° (20%) unscheduled disability, for a total award of 160° (50%) unscheduled disability for injury to the low back.

EVALD V. NIELSEN, Claimant
Garry L. Kahn, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 83-08586 & 82-05317
May 28, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Midland Insurance Company, the insurer for Coastal Trailer Repairs, Inc., requests review of Referee Menashe's order which awarded claimant compensation for permanent total disability in connection with his May 19, 1980 industrial injury. The insurer contends that claimant has failed to establish his entitlement to an award for permanent total disability.

We agree with the Referee's well-reasoned order, which we affirm and adopt with the following additional comment. As a result of his industrial injury and preexisting disability, and taking into consideration relevant social/vocational factors, claimant is in that class of injured workers whose disability is so great that any attempt to reenter the labor force would most certainly be futile. Therefore, claimant's failure to seek employment does not prevent an award for permanent total disability. ORS 656.206(3); Pournelle v. SAIF, 70 Or App 56 (1984); George M. Turner, 37 Van Natta 531 (May 7, 1985); Dock A. Perkins, 31 Van Natta 180 (1981).

ORDER

The Referee's order dated June 21, 1984 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the Midland Insurance Company.

NANCY G. PETERS, Claimant
Ernest W. Kissling, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-02626
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee Galton's order awarding a penalty and attorney fees due to the employer's alleged unreasonable resistance and delay in payment of medical expenses pursuant to a stipulation.

Claimant compensably injured her low back on October 21, 1981. Since that time she has regularly received treatment from Dr. Holman, a chiropractor. Beginning in November 1982, the employer objected to alleged excessive treatment and refused to pay for more than four chiropractic visits per month. On May 9, 1983 the employer formally denied all prior medical treatments in excess of four per month as unnecessary. The dispute was settled by a stipulation approved November 17, 1983, wherein the parties agreed that the employer would pay all Dr. Holman's bills for medical services provided to that date. The precise amount due Dr. Holman was not liquidated in the stipulation, however.

The employer wrote to Dr. Holman on December 13, 1983 requesting a complete itemization of outstanding costs of medical services not compensated to date. The chiropractor's insurance secretary wrote the employer on January 24, 1984, that $250 on the account was 90 days past due and requested prompt action. The employer responded with another request for an itemized listing of outstanding billings. On February 6, 1984 Dr. Holman's office

provided a copy of claimant's ledger back to September 8, 1982 and stated:

> "I realize that it is a very time consuming task, but perhaps someone should audit this account charge by charge and payment by payment to see exactly where the difference is. * * * If you can look at this account and give me an explanation as to what has not been paid and why, and perhaps a date that we might expect payment, I would be most appreciative."

The employer reviewed the account based on the information provided and, on February 20, 1984, sent Dr. Holman the explanation requested together with a check for the full amount it found owing. The employer asked that if there were additional billings prior to those listed on the ledger, they be indicated. After several employer requests, Dr. Holman's office provided additional ledgers on May 2, 1984. On May 17, 1984 the employer paid the remaining $206 due Dr. Holman.

OAR 436-69-701(1) requires that all billings be fully itemized and services identified. The employer's insistence upon itemized billings for use in determining the amount due Dr. Holman was not unreasonable, particularly considering Dr. Holman's office's apparent uncertainty regarding the account. Once provided with the requested itemization, the employer paid with reasonable promptness. We find no showing of unreasonable employer/insurer conduct. Accordingly, we reverse.

ORDER

The Referee's order dated September 10, 1984 is reversed.

JERRY L. SASSMEN (Deceased), Beneficiaries of
Evohl F. Malagon, Attorney
SAIF Corp Legal, Defense Attorney
Donna Parton Garaventa, Dept. of Justice

WCB 82-06927
May 28, 1985
Order on Remand

This case is before the Board on remand from the Court of Appeals, Amos v. SAIF, 72 Or App 145 (1985). We have been instructed to allow the claim of Raymond Sassmen for survivor's benefits. ORS 656.204(4).

Now, therefore, the SAIF Corporation's denial dated July 7, 1982 is hereby set aside and claimant Raymond Sassmen's claim for survivor's benefits is remanded to the SAIF Corporation for processing according to law.

IT IS SO ORDERED.

RICHARD A. SCHARBACK, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-03750
May 28, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Danner's order that upheld the SAIF Corporation's denial of his claim for aggravation of his retrocollis torticollis condition. The issue is compensability.

We adopt the following findings of fact made by the Referee:

"On November 18, 1975, claimant filed a report of injury or occupational disease (Form 801) alleging 'strain and stress causing dizziness and loss of balance,' at which time his employer was the Workmen's Compensation Board, Disability Prevention Division. This claim was accepted as a disabling injury . . . . In January 1976 Dr. Melgard first diagnosed spastic torticollis . . . . The weight of the medical evidence in the months and years following, indicated that this problem was generally psychogenic . . . .

"This claim was closed by a Determination Order dated March 9, 1979, that awarded temporary total disability and temporary partial disability only . . . .

"Claimant subsequently requested the claim to be reopened, on the basis of aggravation, and SAIF Corporation issued a formal denial on March 28, 1980 . . . .

"On December 3, 1980, a disputed claim settlement was approved by a Hearings Referee. This disputed claim settlement set forth claimant's contention that his medical condition, diagnosed as retrocollis or torticollis, worsened in or about February 1980, and that the condition was related to the accepted industrial injury of November 18, 1976 . . . .

"Another claim for aggravation was presented, and on April 6, 1982, SAIF Corporation again made a denial. The denial stated, in part:

> 'We believe that your neck condition, as related to your claim of November of 1975, has not materially worsened or aggravated, and that your present symptoms are the result of your underlying degenerative cervical disc disease.'

"This is the denial letter that is the subject of this hearing, and this Opinion and Order [and this Order on Review]."

Claimant's treating physician, Dr. Buza, has opined that although claimant's underlying condition had not materially worsened since 1980, subjectively claimant's symptomatology prevented him from working. Claimant and his wife both testified credibly that claimant suffered from increased pain which prevented him from working. The question, then, is whether claimant has perfected an aggravation claim based upon his "symptomatic worsening."

Were claimant seeking to establish in the first instance that his retrocollis or torticollis was a compensable occupational disease, the fact that working increased his subjective symptomatology would be insufficient, in itself, to prove his case. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979); cf. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). However, because claimant has already established the compensability of his retrocollis or torticollis, and because in any event his condition is not based upon an occupational disease theory, evidence of objective worsening is not required to establish his aggravation claim. See Sheidementel v. SAIF, 70 Or App 552, 555 (1984); Jameson v. SAIF, 63 Or App 553 (1983); Billy Joe Jones, 36 Van Natta 1230 (1984); James W. Foushee, 36 Van Natta 901 (1984). As we said in Foushee, supra, "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." 36 Van Natta at 904.

We find that the preponderance of lay and medical evidence, see Garbutt v. SAIF, 297 Or 148 (1984), establishes that claimant's pain due to his compensable condition is worse than it was at the time of the last award or arrangement of compensation and that claimant is unable to work because of his pain. Claimant has proven his aggravation claim. ORS 656.273(1).

We note that claimant submitted two documents directly to the Board after the case was docketed for review. We have reviewed those documents only to the extent necessary to determine whether the record was incompletely developed or heard. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 (1983); Delfina P. Lopez, 37 Van Natta 164, 170 (1985). We conclude that the record was not incompletely developed, and the documents were not considered on Board review.

ORDER

The Referee's orders dated June 25, 1984 and August 13, 1984 are reversed. The SAIF Corporation's denial dated April 6, 1982 is set aside and claimant's claim is remanded to the SAIF Corporation for processing pursuant to law. Claimant's attorney is awarded $1,250 for services at hearing and $600 for services on Board review, to be paid by the SAIF Corporation.

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

WCB 84-03135
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of Referee Galton's order which ordered it to pay dental bills in excess of $4,000 "consistent with" a prior Referee's order; imposed a penalty equal to 25% of that "compensation" for unreasonable delay, refusal and resistance to the payment of compensation due under a Referee's order; and awarded claimant's attorney an insurer-paid fee for "securing the compensation and penalties." The insurer contends that the Referee erroneously ordered payment of the aforesaid dental bills, and that, in any event, penalties/attorney fees are not warranted. Based upon our conclusion that the prior Referee's

order in this case did not order the payment of compensation within the meaning of ORS 656.313, we reverse the Referee's order in its entirety.

Late in the review process, claimant submitted a motion to remand to the Referee for further evidence taking. ORS 656.295(5). The basis for the request is a statement made in the insurer's reply brief which challenges the veracity of a statement in claimant's respondent's brief. Claimant now seeks remand in order to develop a record on ". . . whether or not the . . . statement was a lie and should be weighed against claimant."

We acknowledge claimant's desire to disprove the insurer's allegation. However, lawyers' belletristic slings and arrows have no bearing upon our review of this, or any other case. We base our decision upon the evidence of record, not upon the assertions, allegations, or accusations of counsel.

We find no basis for concluding that this case has in any way been improperly, incompletely, or otherwise insufficiently developed or heard. Therefore, we decline to remand, and claimant's motion is denied.

Claimant sustained an injury to his chin in 1978 while working as a pipe fitter. The claim was accepted and benefits were paid in accordance with law. Approximately four years later, the insurer received some dental bills from Dr. VanGordon, who had performed dental work which he claimed was related to claimant's previous industrial injury. The insurer denied the compensability of claimant's dental bills, which included treatment by Dr. Nichols, another dentist, as well as treatment by Dr. VanGordon.

Claimant requested a hearing contesting the denial, which came on for hearing before Referee Thye in September of 1983. Referee Thye concluded that claimant's dental treatment was not related to his industrial injury and, therefore, upheld the insurer's partial denial. The Referee concluded, however, that the insurer had delayed its denial of this claim for "medical services" beyond the 60 day provision of ORS 656.262(6). See Billy J. Eubanks, 35 Van Natta 131 (1983). Therefore, in reliance upon former OAR 436-69-801(4), Referee Thye ordered that the insurer pay some unspecified dental bills incurred by claimant prior to the date of its written denial. In addition, the Referee allowed claimant's attorney 25% of the dental bills as a reasonable attorney's fee.

Both parties requested review of Referee Thye's order. As appellant, claimant took issue with the Referee's determination that the medical bills were not compensable, as well as the Referee's allowance of a fee out of the bills, rather than an insurer-paid fee. As cross-appellant, the insurer contested that portion of the Referee's order which directed it to pay for some of the denied dental services under authority of the aforementioned administrative rule.

By the time the Board issued its Order on Review on April 26, 1984, the Court of Appeals had decided Kemp v. Workers' Compensation Dept., 65 Or App 659 (1983), as modified, 67 Or App 270 (1984), in which the court invalidated OAR 436-69-801(4). Therefore, the Board reversed that portion of the order which directed payment of the dental services in question. 36 Van Natta 636 (1984).

After Referee Thye had issued his order on September 29, 1983, and before either party had requested review thereof, counsel for the insurer inquired of the Referee as to whom payment for the dental services in issue should be made. The Referee, understandably, was unable to provide any meaningful direction. Apparently there was considerable confusion concerning exactly what bills remained unpaid and, more significantly, to whom payment should be made. Dr. VanGordon had initiated a civil action in the Circuit Court for Washington County against claimant and the pipe fitters union trust in an effort to collect his unpaid dental bills. Upon receipt of Referee Thye's order directing payment of the dental bills by the insurer, claimant moved to join the insurer as a necessary party in that proceeding. The motion was granted, and the insurer was joined as a party.

Negotiations ensued between the parties to the civil action in an attempt to reach a settlement. At one point, the insurer offered to tender the amounts owed Dr. VanGordon into court. This suggestion apparently was vetoed by the attorney representing Dr. VanGordon, based upon his belief that this would unduly complicate matters and possibly frustrate settlement efforts which were finally becoming productive. In any event, no funds were paid by the insurer to claimant or to Dr. VanGordon. It is apparent, however, that some payment was made to Dr. Nichols, who was not a party to the civil litigation.

Claimant filed his request for hearing in May 1984, alleging entitlement to medical services pursuant to ORS 656.245 and penalties/attorney fees for failure to obey a prior Referee's order. The matter came before Referee Galton, who heard the testimony of the attorney who represented Dr. VanGordon in the civil action. This witness verified the fact that he specifically informed counsel for the insurer to refrain from tendering the money into court.

Referee Galton ruled that the issues in this case were governed by ORS 656.313 and SAIF v. Mathews, 55 Or App 608 (1982). In Mathews the court held that the 1979 amendments to ORS 656.313, which exempted medical services from the definition of "compensation" which must be paid pending Board or judicial review, did not apply retroactively to a claimant who sustained her original injury in 1973. The court held that the law in force at the time of claimant's injury required that medical services be paid pending review of a 1980 Referee's order directing payment of compensation for a compensable aggravation. ORS 656.202(2). But see Barrett v. Union Oil Distributors, 60 Or App 483 (1982). Because this claimant was injured in 1978, the Referee concluded that, as in Mathews, the insurer was obligated to pay the dental bills ordered by Referee Thye pending a disposition on appeal.

Although the medical services in Mathews are similar to the dental bills in this case in terms of the form and nature of the "benefits," there is a significant distinction between the compensation ordered payable by the Referee in Mathews and the dental bills ordered payable by Referee Thye in this case. In Mathews claimant requested claim reopening, apparently pursuant to the aggravation statute. A Referee found the claimant entitled to claim reopening and remanded the aggravation claim to SAIF for

payment of compensation. SAIF refused to pay medical services pending disposition on review of that Referee's order. A second hearing convened by stipulation of the parties, and in that "enforcement proceeding" a Referee held that the 1979 amendments had only prospective application, i.e. applied only to injuries arising on and after the effective date of the 1979 enactment. The Board and the court affirmed.

In Mathews the court quoted from its earlier decision in Wisherd v. Paul Koch Volkswagen, 28 Or App 513 (1977), also relied upon in part by Referee Galton. Wisherd involved the employer's unsuccessful constitutional challenge of ORS 656.313. In discussing the quid pro quo format of the workers' compensation system, and how the statute requiring payment of benefits pending review fits into that format, the court stated in part:

> "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 and with the means to pay medical expenses while an employer appeals an adverse decision. The furtherance of this interest adequately supports the constitutionality of ORS 656.313.
>
> "* * * The clear intent of ORS 656.313 is to require the immediate payment of all compensation due by virtue of the order when the order is entered. Compensation, as defined by ORS 656.005(9), includes medical expenses of the type at issue here:
>
> > '"Compensation" includes all benefits, including medical services provided for a compensable injury * * *.'"
>
> 28 Or App at 517-18.

Similar to the insurer in Mathews, the employer in Wisherd was contesting its interim liability for payment of benefits found to be due and owing by virtue of a Referee's order which held that the claim was compensable. (In Wisherd the claimant's heart disease was ultimately determined not to be compensable. Wisherd v. Paul Koch Volkswagen, 27 Or App 601 (1976)).

Although the 1978 version of ORS 656.313 required payment of medical bills during the appeal process, that requirement applied only to medical bills found compensable. The dental bills that Referee Thye directed the insurer to pay in this case were not payable as "compensation" as defined by ORS 656.005(9). Indeed, Referee Thye specifically found claimant's dental treatment not compensable as a consequence of his 1978 injury. That portion of his order directing payment of the bills was in the nature of a penalty for the insurer's failure to issue a timely denial of the claim. Imposition of a penalty is not equivalent to the payment of compensation, Reed v. Del Chemical, 26 Or App 733, 741 (1976); see also Bahler v. Mail-Well Envelope Co., 60 Or App 90, 93 (1982), and there is no obligation to pay penalties pending review of an order imposing them, Reed v. Del Chemical, supra. Because Referee Thye ordered payment of the dental bills as and for a penalty, the

insurer was not obligated to pay those amounts pending review, and its failure to do so did not constitute unreasonable resistance to the payment of compensation within the meaning of the penalty provisions.

We are fortified in this conclusion by the court's discussion of OAR 436-69-801(4) in Kemp v. Workers' Comp. Dept., supra at 670:

> "OAR 436-69-801(4) does not take away from a claimant the right to recover for unreasonable delay in acceptance or denial of a claim, but rather adds an additional right to recover for medical services rendered prior to the claim if the insurer fails to deny within 60 days from the date of receipt of the first medical report, a right not granted to claimants under any statute. The legislature created a penalty for insurers for unreasonable delay in denying a claim. The Department exceeded its authority in providing an additional penalty when one had already been expressly authorized by the legislature. * * * "

ORDER

The Referee's order dated December 6, 1984 is reversed.

JANET L. STEWARD, Claimant
Greg O'Neill, Claimant's Attorney
David Horne, Defense Attorney

WCB 84-08368
May 28, 1985
Order on Reconsideration

Claimant has requested reconsideration of our order dismissing claimant's request for Board review as not timely filed. Claimant has submitted affidavits that establish that the request for Board review was mailed April 29, 1985. Requests for Board review of Referee decisions must be filed not later than the thirtieth day after the issuance of the Referee's decision. ORS 656.289(3); 656.295(2). Filing is complete upon mailing, OAR 438-11-005(2), provided acceptable proof from the Postal Service is furnished, OAR 438-05-040(4)(b). If the thirtieth day falls on a Saturday, Sunday or legal holiday, the time is extended until the end of the next business day. OAR 438-05-040(4)(c). In calculating the thirty days, the first day is the day after the Referee's order is mailed. Id.

The Referee's order was mailed March 27, 1985. Claimant contends that the thirtieth day fell on Saturday, April 27, 1985, and that her request was timely because it was mailed on the next business day therafter. Claimant is incorrect. The thirtieth day was Friday, April 26, 1985, which was not a legal holiday. The Board adheres to and republishes its former order.

IT IS SO ORDERED.

ERNEST E. THOMPSON, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys
McNutt, et al., Defense Attorneys

WCB 82-05609, 83-06222 & 84-04826
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Leahy's order which: (1) upheld Fireman's Fund's denial of the compensability of claimant's right knee condition, diagnosed as recurrent patellar tendinitis; and (2) declined to order that Weyerhaeuser Company, claimant's prior employer, repay overpaid temporary total disability. Claimant contends that the self-insured employer "unilaterally offset" this temporary total disability against permanent partial disability awarded by an April 5, 1983 Determination Order (in connection with an April 16, 1980 left knee and shoulder injury). In its respondent's brief, Weyerhaeuser, in effect, moves to dismiss claimant's Request for Hearing on the issue concerning the propriety of its recoupment of overpaid temporary disability. The basis for the motion is that claimant did not raise this issue within one year of the Determination Order in question or within one year of the employer's written notification of the offset. Thus, the issues on review are, as to Fireman's Fund, compensability of claimant's right knee condition; and as to Weyerhaeuser, jurisdiction to consider the offset issue and the propriety of the employer's action.

As to the compensability of claimant's right knee condition, we affirm the Referee's order. We do not agree with the Referee's assessment of the Orthopaedic Consultants' report, i.e. that they stated there was "clearly . . . no connection" between claimant's right knee condition and his employment for Fireman's Fund's insured. We do agree, however, that Dr. Matteri's apparent lack of knowledge concerning claimant's earlier January 1980 right knee injury seriously undermines the persuasiveness of his opinion concerning causation in 1983. We disagree with claimant's assertion that the possible connection between his work activity and his right knee condition is of such a nature that it can be determined by this forum without the benefit of persuasive medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); compare Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984); Madewell v. Salvation Army, 49 Or App 713 (1980).

As to the offset issue involving the April 1980 Weyerhaeuser injury/April 1983 Determination Order, we find the jurisdictional issue raised by the employer without any merit since claimant timely requested a hearing within one year of that Determination Order, and this is an issue properly arising under that Determination Order. Shaw v. SAIF, 63 Or App 239 (1983); Tom E. Dobbs, 35 Van Natta 1332, 1336 (1983). On the merits of this issue, we affirm the Referee's order.

Since Weyerhaeuser raised the additional, jurisdictional issue in its respondent's brief, and claimant responded thereto in his reply brief, we find it appropriate to award claimant's attorney a reasonable attorney's fee for services rendered on Board review in this regard. Judy M. Friedrich, 36 Van Natta 1210 (1984).

ORDER

The Referee's order dated November 28, 1984 is affirmed. Claimant's attorney is awarded $75 for services rendered on Board review, to be paid by Weyerhaeuser Company.

HAROLD D. WARD, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 84-04502
May 28, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of those portions of Referee Howell's order which awarded claimant interim compensation for the period March 25, 1983 through March 27, 1983 and imposed a penalty equal to 25% of that interim compensation for unreasonable refusal to pay compensation and unreasonable delay in acceptance or denial of a claim. In association with the penalty, the Referee awarded a $50 attorney's fee.

The issues on review are whether the three day waiting period, ORS 656.210(3), applies to interim compensation payments; and whether the employer's failure to include payment for the waiting period in claimant's initial installment of interim compensation was unreasonable.

Claimant was injured on February 8, 1983 while pushing a veneer cart in the employer's mill. He reported the injury to his foreman the same day. He continued working through March 24, 1983, although he sought medical attention in the interim. On or after March 24, 1983, after working his full shift for the day, he advised the employer that he could not continue working as a result of his injury. He did not return to work thereafter.

Industrial Indemnity, the employer's workers' compensation administering agent, first learned of claimant's injury on March 28, 1983, when it received a report form from claimant's attending physician. This prompted a call to the employer, whereupon it was learned that claimant had been disabled since March 25, 1983.

On April 8, 1983 claimant was paid interim compensation for the period March 28, 1983 through and including April 1, 1983. The employer deferred acceptance or denial until June 8, 1983, when it accepted the claim. In the interim, claimant received timely compensation payments.

The Referee determined that the employer had no knowledge of an injury requiring medical treatment or resulting in disability until claimant became disabled on March 25, 1983. He reasoned that the obligation to deny or pay interim compensation within 14 days arose as of that date. Thus, he concluded that the employer had until April 8, 1983 to act.

In fact, the employer did act on April 8 by issuing a check for five days of interim compensation, as mentioned above. The Referee determined that the employer was obligated to pay interim compensation from March 25, 1983, the date it had "knowledge of a claimed compensable injury." Because the employer paid interim compensation from March 28, rather than March 25, 1983, the Referee imposed a penalty for unreasonable refusal to pay compensation, reasoning:

> "The employer offered no valid reason for failing to pay interim compensation beginning on claimant's date of disability. It is noteworthy that interim compensation is distinct from temporary disability compensation. * * * ORS 656.201(3) [sic] does not apply to interim compensation."

ORS 656.210(3) provides:

> "No disability payment is recoverable for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of his compensable injury unless the total disability continues for a period of 14 days or the worker is an inpatient in a hospital. If the worker leaves work the day of the injury, that day shall be considered the first day of the three-day period."

Although the applicability of that provision to interim compensation payments may have been in doubt when the Referee decided this case, there is little remaining doubt since Bono v. SAIF, 298 Or 405 (1984), decided since the Referee's order. In Bono the court held that in order to receive interim compensation, "a subject worker must have left work as that phrase is used in ORS 656.210(3)." Id. at 410. In reaching its conclusion, the court also stated, "The amount of interim compensation payments is determined in the same manner as the amount of temporary total disability benefits," and that "[i]nterim compensation is based on temporary total disability benefits." Id. at 409, 410.

An employer/insurer is not obligated to pay interim compensation from the date of disability; liability for interim compensation runs only from the date of notice or knowledge of a claim. Stone v. SAIF, 57 Or App 808, 812 (1982); Donald C. Wischnofske, 32 Van Natta 136 (1981), 34 Van Natta 664 (1982). In this case, however, the pertinent date of notice and date of disability coincide.

When the date of disability and date of notice coincide, as they do in this case, the three day waiting period becomes relevant. Where it is relevant, Bono seems to dictate the conclusion that interim compensation, like temporary total disability in an accepted claim, is not payable for the first three calendar days after the claimant leaves work, unless the period of total disability continues for 14 days or the claimant is hospitalized.

Claimant argues that because he was continuously disabled for 14 days and thereafter, the Referee nevertheless was correct in awarding interim compensation for the three day period and imposing a penalty/attorney's fee. We agree with claimant to the extent that he was entitled to be paid, at some point, for the first three days of disability because he remained continuously

disabled for 14 days. We disagree, however, that the employer's failure to include the three-day period in the initial installment of interim compensation was unreasonable.

Claimant worked his full shift on March 24, 1983. It was either at the end of that shift or the following day, March 25, that claimant informed the employer that he was unable to continue working as a result of an industrial injury. Coincidentally, the employer's workers' comensation administering agency, Industrial Indemnity, contacted the employer on March 28, 1983 and was advised that claimant had stopped working as of the preceding Friday, March 25. Industrial Indemnity's contact with the employer was prompted by a physician's report form completed earlier that month, which indicated that claimant was released for work. Of course, this physician's report form was completed during the period that claimant actually was working. It was received by Industrial Indemnity, also coincidentally, four days after claimant's last day of work.

The Referee found, and we agree, that because the employer had the notice or knowledge contemplated by ORS 656.262 no earlier than March 25, 1983, the employer was required to act within 14 days of that date, i.e. on or before April 8, 1983. Thus, by that date, the employer was required to decide whether to issue a check for interim compensation or a denial.

Whenever the date of notice or knowledge of a claim coincides with the date of disability, the employer/insurer's obligation to issue a check for interim compensation falls on the fourteenth day thereafter. It requires no evidence to establish that the decision whether to pay interim compensation or deny often must be made before the fourteenth day, in order to promptly process the initial interim compensation payment. Thus, if such a decision is being made by a claims examiner on the twelfth or thirteenth day, for example, after the claimant "leaves work as a result of his compensable injury," the claims examiner does not then know whether the claimant will, in fact, continue to be disabled beyond the 14 day period specified in ORS 656.210(3). For this reason, it is entirely reasonable to conclude that, in most instances, the initial interim compensation payment need not include payment for the first three calendar days after the claimant "leaves work." It is generally sufficient that, in the event the claimant's disability does continue for a period of 14 days, payment for the days falling within the three day period be made as part of, or together with, the following installment of interim compensation or, if the claim has been accepted by that time, temporary total disability. We note that, under the administrative rules governing timely payment of temporary disability benefits, an employer/insurer is permitted to be no more than one week in arrears. OAR 436-54-310(4).

Of course, when a claimant is hospitalized as an inpatient, the 14 day period is irrelevant and the three-day period does not apply. Thus, under such circumstances, the initial interim compensation payment generally would include payment from the date of notice or knowledge/date of disability.

For the foregoing reasons, the employer was not required to pay interim compensation for any days falling within the three-day waiting period when the initial installment of interim

compensation was paid. The Referee found that all other payments were made in a timely fashion, and claimant does not argue to the contrary. Thus, it follows that the employer did not unreasonably refuse or delay payment of compensation. Although the employer delayed its formal acceptance of the claim beyond the 60 day period, there is no evidence of any other compensation "then due" which could provide the basis for imposition of a penalty. Therefore, the claim for penalties/attorney fees necessarily fails.

The practical effect of our holding, compared to the Referee's, is exemplified by the hypothetical of a worker who is injured, is not admitted to a hospital, and who remains off work for thirteen days. Under the Referee's decision, where the date of notice/knowledge coincides with the date of disability, such a worker would be entitled to interim compensation for the first three days of disability. Under our holding, interim compensation for the first three days is not due and owing. To extend the hypothetical, the same worker whose disability continues for fourteen days or more would be entitled to interim compensation for the first three days of disability. However, the failure to pay this three days of interim compensation in the initial installment (assuming it is timely) would not be unreasonable under most circumstances.

ORDER

The Referee's order dated November 20, 1984 is reversed in part. That portion which imposed a penalty and associated attorney's fee is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $100 for services on Board review in connection with the interim compensation issue.

VIVIAN M. WOOD, Claimant
Burt, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-11831
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee Seymour's order that granted claimant an award of 16° for 5% of the maximum allowable unscheduled permanent partial disability for injury to her low back, ordered it to pay for continuing palliative chiropractic care and awarded an employer-paid fee to claimant's attorney. The Determination Order had classified claimant's claim as nondisabling.

Claimant is a sixty year old worker who has been employed by the employer or its predecessors for over 30 years. Claimant injured her back in September 1980 when she lifted a 40 pound box of dishes while working in the merchandise receiving area. In June 1981 claimant again injured her back in an off-the-job motor vehicle accident. Both injuries were apparently quite minor and in July 1981 an independent medical examination by Dr. Anderson disclosed no impairment of claimant's back. The record does not disclose the outcome of claimant's 1980 injury claim.

On March 2, 1983 claimant was in an elevator that became stuck between floors. She was lifted out of the elevator by her arms and in the process strained her low back. She was treated by Dr. Nickila, a chiropractor. Her claim was classified by the employer as one for a nondisabling injury. Dr. Spady conducted an independent medical examination in July 1983. His examination

revealed full range of back motion with some painful symptoms on recovering from the full forward bent position. He related the symptoms to claimant's most recent injury by history. His opinion does not discuss permanency of symptoms.

Dr. Kelley conducted an independent chiropractic examination in September 1983. He opined that further chiropractic care was neither reasonable nor necessary in relation to the March 1983 industrial injury. He further opined that any symptomatology claimant was experiencing was attributable to the natural aging process rather than to any injury. Dr. Spady reexamined claimant in August of 1984. In his report he states that he agrees with Dr. Kelley's conclusions. His report also notes that his examination findings were the same as his previous examination findings, and that claimant exhibited no objective physical impairment. However, on April 16, 1984 Dr. Nickila opined that, "[Claimant] has sustained some permanent partial disability as a result of this [March 2, 1983] accident."

Although a request to do so is not a part of the record on review, we infer that claimant requested that the Evaluation Division reclassify her injury as disabling. A Determination Order issued August 29, 1984 ordered claimant's claim classified as nondisabling. Claimant has never lost any time from work on account of the March 1983 injury.

Notwithstanding Dr. Nickila's legal conclusion to the contrary, on de novo review of the record we conclude that claimant's March 2, 1983 industrial injury was correctly classified by the employer and the Evaluation Division as nondisabling. We also conclude that claimant's present chiropractic treatment is not reasonably or necessarily related to the 1983 nondisabling injury. We reverse the Referee's order.

ORDER

The Referee's order dated November 2, 1984 as corrected November 9, 1984 is reversed. The Determination Order dated August 29, 1984 is reinstated and affirmed. The self-insured employer's denials dated November 2, 1983 and May 10, 1984 are reinstated and affirmed.

DARLENE L. (STEPHENS) YOUNGBLOOD, Claimant
Allen & Vick, Claimant's Attorneys
Rankin, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 83-02302, 83-02414 & 83-05679
May 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer, James River Corporation, requests review of Referee Peterson's order which: (1) set aside its denial of responsibility for claimant's allegedly worsened thoracic outlet syndrome, effective March 11, 1983; (2) upheld Wausau Insurance Company's denial of responsibility; and (3) apportioned claim costs and attorney's fees accordingly. Insurer/employer responsibility since March 11, 1983 is presently the sole contested issue.

Claimant started working in Wausau's insured's paper mill in 1977. She continued working there after the mill was purchased by James River on July 1, 1982. Claimant experienced symptomatic periods in April 1978, November 1979, September 1982 and March

1983, for which workers' compensation benefits were sought. Each period came on without a preceding specific traumatic incident.

Claimant is particularly bothered by work requiring highly repetitive use of the arms. Claimant credibly testified that in March 1983 she was assigned to stack packages of toilet paper as they left a wrapping machine. Her shoulder and neck started hurting again within a few minutes of commencing this repetitive activity. She testified that she gradually worsened over the next five days, and was taken off work on March 11, 1983.

Based on the reports and deposition of Dr. Gerstner, claimant's treating doctor, we find that claimant has shown a pattern of recurrences of the same condition, and that the work claimant performed in the five days preceding March 11, 1983 was of a kind that could aggravate or exacerbate her condition. Dr. Gerstner noted that although his findings on examinations in February 1980 and April 1983 were pretty much the same, claimant complained of increased pain present over longer periods in 1983. He concluded that the March 1983 work conditions contributed to a progression or exacerbation of her condition. Although it is a rather close question, we find that the preponderance of the persuasive evidence is that claimant's condition worsened as a result of the conditions of the James River employment.

This case is framed as a responsibility dispute in which compensability is conceded. Responsibility tests are applied only to determine which employer will pay, not to determine what benefits a claimant is entitled to. Responsibility determinations are appropriate only upon a finding that a conflict exists as to which employer/insurer must pay particular benefits.

We agree with the Referee's characterization of claimant's condition as an occupational disease. Claimant has a previously accepted occupational disease claim against the former employer. To establish a new occupational disease claim claimant must show a new factual basis for a claim. Among other things, she must show that the underlying condition that forms the bases of the two claims are not identical. If the claims are for the same disease, claimant must show that her underlying condition has worsened. See e.g., Wheeler v. Boise Cascade Corp., 298 Or 452 (1985). Proof of a worsening is also necessary for reopening of the prior claim under ORS 656.273. As we find that claimant has shown a worsening of her underlying condition and as compensability of her condition is conceded, a determination of employer/insurer responsibility is appropriate.

Where compensability is established in the occupational disease context, responsibility is determined by application of the last injurious exposure rule, which provides that the last employment providing potentially causal conditions is deemed responsible. Meyer v. SAIF, 71 Or App 371 (1984). Here that employer is James River. Accordingly, we affirm the order of the Referee.

ORDER

The Referee's order dated June 22, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by Wausau Insurance Companies.

At this stage of the proceeding, this case presents the relatively narrow issue of whether claimant's permanent total disability status may be reevaluated, and if so, by whom. What complicates matters is that claimant's permanent total disability award arose from an injury that predates the 1965 amendments to the Workers' Compensation Act, 1965 Or Laws, Ch. 285.

Claimant was injured March 8, 1964, and on October 17, 1968 was adjudged permanently and totally disabled after a jury verdict to that effect in the Circuit Court. The Circuit Court judgment was not appealed and claimant began receiving benefits. In late 1980 the SAIF Corporation reexamined claimant's permanent total disability status pursuant to ORS 656.206(5) and thereafter petitioned the Evaluation Division of the Workers' Compensation Department to reduce claimant's permanent disability award. On July 16, 1981 the Evaluation Division issued the following statement:

> "The Department is unable to consider your request to reduce permanent total disability benefits under ORS 656.325, due to the date of the injury (March 8, 1964) preceding ORS 656.325 effective date. The Evaluation Division does not have jurisdiction to apply the provision of ORS 656.325(3) for injuries occurring prior to January 1, 1966."

SAIF requested a hearing on January 25, 1982. Claimant moved to dismiss SAIF's hearing request. After receiving argument from the parties, we dismissed SAIF's request for hearing, however, we accepted SAIF's request as a petition for Board's own motion relief under ORS 656.278. We then referred the own motion matter to the Hearings Division for an evidentiary hearing and recommendations by the Referee. 34 Van Natta 1498 (1982). The hearing was held June 21, 1984 and by agreement of the parties was confined to the jurisdiction issue. We have received Referee Neal's recommendations and a transcript of the hearing testimony and argument. We also have the benefit of extensive briefs filed by claimant and SAIF.

To distill the parties' contentions to their simplest, SAIF urges that someone, either the Evaluation Division of the Workers' Compensation Department or the Board, is authorized to reevaluate permanent total disability awards, no matter when the injury date happens to be. Claimant urges that permanent total disability awards premised upon injuries occurring prior to the effective date of the 1965 amendments cannot be reevaluated by anyone, ever. The lines are, thus, clearly drawn. As frequently occurs in complex cases such as this one, we find the answer to be somewhere between the two extremes of the parties' contentions.

ORS 656.325(3) was added to the Workers' Compensation Act as a part of the 1965 amendments. 1965 Or Laws, Ch. 285 § 41b. That subsection presently reads:

> "A worker who has received an award for unscheduled permanent total or unscheduled

> partial disability should be encouraged to make a reasonable effort to reduce the disability; and the award shall be subject to periodic examination and adjustment in conformity with ORS 656.268."

With the exception of gender amendment, the section is unchanged from 1965.

We have found no court decision that mentions ORS 656.325(3) in connection with an injury occurring earlier than January 1, 1966. See generally Pykonen v. SAIF, 3 Or App 74 (1970); Dalton v. Cape Arago Lumber, 4 Or App 249 (1970); Jenness v. SAIF, 8 Or App 95 (1972); Gutierrez v. Redman Industries, 16 Or App 421 (1974); Morton v. N.W. Foundry, 36 Or App 259 (1978); Bentley v. SAIF, 38 Or App 473 (1979).

We agree with claimant's contention that ORS 656.325(3) did not exist in any form before January 1, 1966 and that it is not retroactive. We, therefore, agree with the Evaluation Division's initial statement to the effect that it is without authority to adjust an award based upon a pre-January 1, 1966 injury. See ORS 656.202(2); Barrett v. Union Oil Distributors, 60 Or App 483, 486-87 (1982), rev den 294 Or 569 (1983); Bradley v. SAIF, 38 Or App 559, 564 (1979). See also William A. Newell, 35 Van Natta 629, 633-34 (1983) (No right to lifetime medical care prior to 1966 enactment of ORS 656.245; claimant requiring care for residuals of pre-1966 injury must petition Board for own motion relief).

Our finding that the Evaluation Division is without authority to reevaluate awards based upon pre-1966 injuries does not end the inquiry, however. SAIF has requested the Board to reevaluate claimant's disability award under our continuing authority to "modify, change or terminate former findings, orders or awards if in [our] opinion such action is justified." ORS 656.278(1). Claimant asserts that we lack the authority to do so, for reasons similar to the reason the Evaluation Division lacks the authority to reevaluate this award. We believe we do have the authority to reevaluate this pre-1966 injury based award under our own motion jurisdiction.

The authority of the Board and its predecessors to reevaluate disability awards based upon changed circumstances has long been recognized. Goss v. State Ind. Acc. Comm., 140 Or 146, 155 (1932); Chebot v. State Ind. Acc. Comm., 106 Or 660, 665-66 (1923). The common law doctrines of res judicata and collateral estoppel do not apply directly to the Board's exercise of its own motion jurisdiction. See Fields v. Workmen's Comp. Board, 276 Or 805, 807 (1976) (Per curiam); Holmes v. State Ind. Acc. Comm., 227 Or 562, 575 (1961). The Board's predecessor's authority to adjust awards has been acknowledged to extend to awards made by the courts. State ex rel. Griffin v. State Ind. Acc. Comm., 145 Or 443, 455 (1934). See also Note, 13 Or. L. Rev. 256 (1934). The Board in fact has, with the approval of the court, reduced permanent total disability awards based upon pre-1966 injuries after having reevaluated the claimants' circumstances. McDowell v. SAIF, 13 Or App 389 (1973) (1946, 1953 and 1957 injuries); Raymond Thornsberry, 35 Van Natta 1234 (1983) (1953 injury). See also Thornsberry v. SAIF, 57 Or App 413 (1982) (Reversing McDowell, supra, in part).

The relative dearth of cases such as this one is indicative of the alternative procedures available under the Workers' Compensation Law. The Court of Appeals has recognized the existence of alternative procedures in cases involving pre-1966 injuries, McDowell v. SAIF, supra; Thornsberry v. SAIF, supra, and has also recognized that an employer or insurer may seek reevaluation of a permanent total disability award either under ORS 656.325(3) or under ORS 656.278, Morton v. N.W. Foundry, supra, 36 Or App at 261 n.1. It is Board policy that own motion relief will not be afforded to any party if that party has available to it any other judicial or administrative remedy. OAR 438-12-005(1)(a). For example, before the Board will order claim reopening for medical treatment beyond the expiration of a claimant's aggravation rights, the claimant should have litigated his right to medical care under ORS 656.245. Only in cases involving pre-1966 injuries where there is no right to continuing medical treatment, William A. Newell, supra, would a direct request for own motion relief be acted upon. See also ORS 656.278(2).

We think that employer requests for reevaluation of permanent total disability awards should be treated similarly, and that before requesting own motion action by the Board an insurer or employer should first seek reevaluation by the Evaluation Division of the Workers' Compensation Department under ORS 656.325(3), as SAIF initially did in this case. Only in cases such as this one, where the injury date precludes such reevaluation, is a direct request for own motion relief appropriate.

One point strongly argued by claimant is, that by allowing employers and insurers to proceed under either ORS 656.325(3) or ORS 656.278, the Board is allowing employers and insurers an "extra" appeal. Claimant cites OAR 436-65-225(2) for the proposition that an employer or insurer has no right of appeal from an Evaluation Division decision leaving a permanent total disability award unchanged, and urges that allowing an employer/insurer to seek own motion relief after having been turned down by the Evaluation Division is an appeal contrary to the rule. We do not find it necessary to rule upon claimant's assertion that an employer/insurer may not request a hearing on an Evaluation Division order leaving a permanent total disability award unchanged. But see ORS 656.325(6). Any party may request own motion relief from the Board, without limitation in time. OAR 438-12-005(1)(a). If the effect of this right is to afford a party an "extra" appeal, that must have been the legislature's intent.

Having concluded that we have the authority to reevaluate claimant's permanent total disabiity award and adjust it if such a result is appropriate, we are now faced with the problem of whether the record contains sufficient evidence to enable us to accomplish that task. We conclude that it does not. As noted above, we previously referred this matter to the Hearings Division for the taking of evidence. In our prior order we said, "We . . . conclude that it is appropriate to refer this matter to the Hearings Division for a hearing and recommendation on the factual and legal issues raised by the parties." 34 Van Natta at 1499. A hearing was finally held June 21, 1984. Notwithstanding that we

afforded the parties a full opportunity to present evidence to a Referee and to make a complete record, the parties chose to confine their efforts solely to resolution of the legal issue, which we have now decided. Such medical and vocational evidence as there is in the record is now four or more years old, and cannot be the basis of a decision regarding claimant's current disability status.

Accordingly, we once again find it necessary to refer this matter to the Hearings Divsion. OAR 438-12-010. The purpose of the hearing shall be to take evidence relevant to determining the extent of claimant's disability as of the hearing. At the conclusion of the hearing, the Referee shall forthwith forward to the Board all documentary evidence received, a transcript of the oral proceedings had and his or her proposed findings of facts and recommended conclusions based thereon.

IT IS SO ORDERED.

RODGER K. BLANK, Claimant
Minturn, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 84-07206 & 84-06182
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Louisiana Pacific Corporation, a self-insured employer, requests review of Referee Howell's order that set aside its denial of responsibility for claimant's herniated L5-S1 disc as a new injury. The issue is responsibility between successive employers.

The Board affirms and adopts the order of the Referee. Claimant's attorney correctly acknowledged that his rights under ORS chapter 656 were not in jeopardy on Board review and did not participate further in the review process. Accordingly, no attorney fee is in order. See OAR 438-47-090; Robert Heilman, 34 Van Natta 1487, 1488 (1982).

ORDER

The Referee's order dated January 2, 1985 is affirmed.

TERESA L. BOGLE, Claimant
Francesconi & Cash, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03218
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Podnar's order which: (1) affirmed an August 13, 1984 Determination Order that did not award permanent disability for a left arm and finger injury; (2) upheld the SAIF Corporation's partial denial of responsibility for claimant's current medical treatment; and (3) declined to award penalties and accompanying attorney fees for an allegedly untimely response to submitted medical bills. On review, claimant contends: (1) her left shoulder and spine conditions, as well as her current chiropractic treatment, are compensable; (2) penalties and attorney fees are justified due to SAIF's untimely response to medical bills; and (3) she is entitled to an award of permanent disability.

We affirm the order of the Referee with the following comments. Following our de novo review of the medical and lay evidence, including claimant's testimony, we conclude that claimant has failed to prove that she has suffered permanent impairment as a result of her compensable injury. Consequently, we agree with the Referee that claimant is not entitled to a permanent disability award.

We also find that claimant has failed to establish the compensability of her left shoulder and back conditions. The preponderance of the medical and lay evidence does not persuade us that these conditions were either caused by the industrial incident or that the treatment for these conditions is so inextricably related to the compensable injury that it is impossible to treat the compensable left arm and finger condition without treating these otherwise noncompensable conditions.

Finally, we are not persuaded that the chiropractic treatment claimant received from Drs. Kennedy and Buttler was reasonable and necessary medical treatment for conditions resulting from the compensable injury. Therefore, we affirm the Referee's order which upheld SAIF's denial of responsibility for claimant's current treatment. Assuming for the sake of argument that we considered SAIF's conduct in processing Dr. Kennedy's bills unreasonable, no penalty could be assessed because there was no compensation "then due" upon which to base the penalty. ORS 656.262(10).

ORDER

The Referee's order dated November 9, 1984 is affirmed.

NEIL R. BRACHT, Claimant
Merrill Schneider, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Rankin, et al., Attorneys
Frank Vizzini, Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-04932
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Galton's order which: (1) dismissed his hearing request on the issue of a backup denial because two prior Referee's orders had also dismissed his hearing request with prejudice on the issue of a backup denial; (2) dismissed his hearing request on the issue of notice of the initial dismissal order because service of the initial dismissal order on his attorney at that time was sufficient service of the order; and (3) found the Hearings Division did not have jurisdiction to decide the closure and processing issues. In the alternative, if the Board affirms the Referee's order, claimant requests own motion relief. The issues on review are justification for issuance of a backup denial, compensability, procedural significance of prior orders, sufficiency of service of the initial order, and jurisdiction to hear a claim.

We affirm the Referee's order with the following comment. This order was issued as a result of what appears to be claimant's third request for hearing on the insurer's backup denial dated

February 23, 1983. Claimant failed to appear for the first scheduled hearing date, but his attorney was there and admitted that he was unready to proceed. The insurer moved for dismissal and the Referee dismissed the hearing request with prejudice. The record shows that claimant's attorney was served with the order. Claimant presented no evidence why he had not appeared for the first hearing. No request for review was forthcoming. The first order settled the issue of compensability by de jure affirming the denial of employment relationship to the injury. See Warren Stier, 36 Van Natta 334 (1984); Jesse Gomez, 36 Van Natta 320 (1984).

We have addressed the own motion request under a separate Own Motion Order issued this date.

ORDER

The Referee's order dated March 5, 1984, is affirmed.

ARISTEO CISNEROS, Claimant
MacAfee, et al., Claimant's Attorneys
Cliff & Snarskis, Defense Attorneys

WCB 84-08170
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Wilson's order which upheld the insurer's denial of his alleged industrial injury claim on the grounds that claimant failed to give the notice required by ORS 656.265 and failed to establish any of the circumstances excusing late notice as enumerated in subsection (4) of that statute. In addition, the Referee found that the insurer established it was prejudiced by its failure to receive timely notice. Claimant contends that his claim is not time barred, and that his condition is compensable as an occupational disease.

We affirm and adopt the Referee's order. In addition, we note that claimant was proceeding on an injury theory at the hearing, rather than on an occupational disease theory. Thus, even if we were to disagree with the Referee on the timeliness issue, we would not consider the merits of claimant's occupational disease theory as it was not advanced at the hearing. See Mavis v. SAIF, 45 Or App 1059 (1980); Richard Pick, 34 Van Natta 957 (1982). Furthermore, if we reached the merits of the compensability of claimant's alleged accidental injury, we would find and hold that claimant failed to establish the compensability of his hernia condition by a preponderance of the persuasive evidence.

ORDER

The Referee's order dated November 9, 1984 is affirmed.

ELNATHAN DAVIS, Claimant
Velure & Bruce, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-06137
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The self-insured employer requests review of that portion of Referee Stephen Brown's order which awarded 15° for 10% scheduled permanent partial disability of the left leg. The issue on review is extent of scheduled permanent partial disability.

We adopt the Referee's summary of the evidence and findings of fact as our own. We disagree with the Referee's conclusion. The Referee relied on the attending physician's failure to deny a relationship between the injury and the physical restrictions as sufficient to show that there was a relationship.

Claimant must show by a preponderance of the evidence that the loss of use or function of the affected extremity was due to his industrial injury. ORS 656.214(2). There is nothing inherent in the restrictions themselves that convinces us that they are due to claimant's industrial injury as opposed to claimant's non-compensable medical conditions. When claimant's attending physician was directly asked if the restrictions were due to the industrial injury, the physician did not reply. We find the same physician's opinion that claimant suffered no permanent impairment due to the industrial injury to be persuasive. Based on this record, we find that claimant has not carried his burden of proof that his physical restrictions are related to his compensable industrial injury nor that he has suffered any permanent disability as a result of the injury.

ORDER

The Referee's order dated October 9, 1984 is reversed in part and affirmed in part. That portion of the order which awarded 15° for 10% scheduled permanent partial disability is reversed. The remainder of the order is affirmed.

JOHN K. EDER, Claimant
Pozzi, et al., Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 83-12044
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Leahy's order which dismissed his hearing request for failure to provide any documentation to substantiate his claim of unpaid medical bills after a prior Referee's order which found his claim was compensable. The prior Referee's order was appealed to the Board, which affirmed the Referee, 36 Van Natta 274 (1984), and to the Court of Appeals, which affirmed the Board, 72 Or App 54 (1985). Claimant further requests the Board award him temporary disability compensation.

There is no evidence in the record of this case upon which to award compensation. Claimant had ample opportunity to provide evidence. The Referee's action in dismissing the hearing request was appropriate.

It is inappropriate to consider claimant's request for an award of temporary disability compensation at this time because it does not appear that claimant has presented a claim for such compensation to the insurer.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated October 3, 1984, is affirmed.

DEE A. ERICKSON, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-04406 & 84-04934
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Danner's order which upheld the SAIF Corporation's aggravation claim denial, failed to award interim compensation and declined to impose a penalty/attorney's fee. Claimant contends that SAIF's denial should be set aside, that she is entitled to interim compensation, and that a penalty and associated attorney's fee is warranted for SAIF's failure to properly process her claim(s).

We affirm the Referee's order with the following additional comments.

Claimant filed a claim with SAIF's insured in May of 1981 for bilateral carpal tunnel syndrome. The claim was accepted. Claimant submitted to surgery on the right arm; however, the left arm was treated conservatively. The claim was closed in October of 1982 with temporary total disability only.

In November of 1983 claimant returned to her attending physician with increasing complaints of left upper extremity pain. In addition to recurrent symptoms of carpal tunnel syndrome in the left arm, claimant was experiencing symptoms of the left shoulder. A left shoulder condition was diagnosed as acromioclavicular arthritis. Claimant's physician authorized time loss.

A new claim was established by SAIF, and time loss was paid commencing December 8, 1983. There was obviously confusion on SAIF's part concerning how the recurrent left carpal tunnel syndrome should be processed: whether it should be processed as part and parcel of the new 1983 claim for the left upper extremity; or whether it should be processed under the old 1981 claim, which included carpal tunnel syndrome of both upper extremities. Claimant's physician's progress note indicates that he was advised by SAIF that the recurrence of the carpal tunnel syndrome on the left should be processed under the old claim, and that the shoulder should be processed under the new, separate claim.

What actually transpired is hard to know for certain, because on April 11, 1984, the new 1983 claim was closed with an award for scheduled disability for loss of use or function of claimant's left arm. This award was obviously premised on the recurrent left-sided carpal tunnel syndrome. The Referee modified this Determination Order by awarding claimant 32° (10%) unscheduled disability for injury to her left shoulder. This award is not in issue before us.

Claimant's original hearing request in this proceeding raised several issues arising under the April 1984 Determination Order. Claimant's attorney thereafter filed another hearing request, also designated as an "aggravation application," alleging failure to process an aggravation claim, failure to pay time loss, and failure to accept or deny an aggravation claim within 60 days. This hearing request/aggravation application was assigned a new

WCB case number. Under cover of this additional hearing request/aggravation application, claimant submitted copies of her physician's progress notes, including the November 23, 1983 entry indicating that claimant was experiencing recurrent carpal tunnel symptoms on the left, as well as a new shoulder problem.

SAIF issued its denial on May 17, 1984, pointing out that the primary problem in November of 1983 appeared to be claimant's left shoulder condition, for which a new claim was established. The denial noted that as a result of "curative treatment and time off work due to [the] shoulder" claimant's carpal tunnel symptoms improved considerably. SAIF indicated that it had continued, and would continue, to pay for medical treatment for claimant's bilateral carpal tunnel syndrome pursuant to the provisions of ORS 656.245. Based on the circumstances, including the fact that time loss had been paid from December 8, 1983 until claim closure, as authorized by claimant's physician, claim reopening for claimant's bilateral carpal tunnel syndrome did not appear to be warranted at any time, either in November of 1983 or in May of 1984.

The Referee concluded that there was no showing that claimant's left wrist complaints in November of 1983 and thereafter "were of such magnitude that would have required an actual reopening, and payment of temporary total disability, as opposed to simply paying medical treatment under the provisions of ORS 656.245." He concluded that "the claim" was in fact reopened with respect to the left wrist as part and parcel of the entire treatment of the left arm, and claimant was paid temporary disability for the entire period because of her inability to work based upon the left shoulder complaints. He found the "only error" to be that the Determination Order had awarded compensation solely for the left forearm without considering entitlement to unscheduled disability for claimant's left shoulder.

Although SAIF's written denial does not admit as much, we conclude that the following has actually transpired based on the circumstantial factors presented herein. Claimant's 1981 claim was accepted and processed for a bilateral carpal tunnel syndrome resulting from work exposure at that time. Claimant changed jobs while working for the same employer. Her new position required more extensive use of her left arm. This resulted in a new exposure to the left upper extremity, which caused a recurrence of claimant's prior left-sided carpal tunnel symptoms and the emergence of an additional shoulder condition. Contrary to the entry in claimant's physician's progress notes, SAIF actually processed all of claimant's 1983 left upper extremity problems under the new claim, as evidenced by the April 1984 Determination Order which awarded compensation for scheduled permanent disability. Claimant now has two claims: a 1981 claim for bilateral carpal tunnel syndrome; and a 1983 claim involving two conditions of the left upper extremity -- carpal tunnel syndrome and acromioclavicular arthritis. She now has received an award for scheduled and unscheduled disability in connection with the 1983 left upper extremity claim. Thus, for all practical purposes, any and all future left carpal tunnel problems are to be processed under the 1983 claim, which has, in effect, superseded one-half of the earlier 1981 claim. (i.e. the left half).

With regard to claimant's May 1984 "aggravation application," the Referee held:

"There was no new evidence of an aggravation claim during this time period. There is insufficient medical evidence since May 26, 1984 which would indicate a worsening since the last award or arrangement of compensation, this being the Determination Order of April 11, 1984. Accordingly, the denial is proper."

In her appellant's brief, claimant refers to a "non-existent aggravation claim" analyzed by the Referee, specifically and emphatically referring to a May 1984 hearing request alleging "failure to process a claim which already had been made in November 1983." In her reply brief claimant further clarifies that she "only filed a Request for Hearing in May, 1984, for SAIF's failure to process the aggravation of November 23, 1983."

Thus, claimant essentially admits that, in May of 1984, she did not file a new aggravation claim, but merely requested a hearing seeking penalties/attorney fees for SAIF's alleged failure to process a November 1983 aggravation claim filed by claimant's physician in claimant's behalf. It would appear, therefore, that SAIF's denial of a May 1984 aggravation claim was superfluous.

Claimant has received all compensation to which she is presently entitled for the conditions of her left upper extremity. Those problems occurred as a result of a new industrial exposure and were properly processed under a new claim. We find no claims processing violations committed by SAIF. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated November 6, 1984 as supplemented herein, is affirmed.

EDWARD E. GALBERTH, Claimant
Vernon Cook, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06181
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Knapp's order which upheld the SAIF Corporation's denial of his occupational disease or industrial injury claim for a myocardial infarction and other vascular disease. Claimant requests reversal of the Referee's order and an award for permanent total disability, or remand to a different Referee with an order that the Referee issue a subpoena compelling attendance of claimant's consulting physician at a hearing or deposition, or striking evidence provided by SAIF's consulting physician. The issues on review are compensability and claimant's right to compel the testimony of a witness.

Claimant requests remand to a Referee with an order to the Referee to issue a subpoena under ORS 183.440 to compel attendance by claimant's consulting physician, Dr. Griswold, at a hearing or deposition. Our authority to issue subpoenas is not derived from ORS Chapter 183 (the Administrative Procedure Act), but from ORS 656.726(2)(c). We treat claimant's request for a subpoena as having been made pursuant to ORS 656.283(7), which provides:

> "Any party shall be entitled to issuance and service of subpenas [sic] under the provisions of ORS 656.276(2)(c). Any party or representative of the party may serve such subpenas [sic]."

The witness whose testimony claimant seeks to compel is a cardiologist who opined that claimant's cardiovascular condition arose out of work-related stress. Dr. Griswold suffers from a bleeding ulcer and symptomatic coronary artery disease. His treating physician, Dr. Kloster, who coincidentally is one of SAIF's experts in this case, wrote claimant's attorney to the effect that both he and Dr. Griswold's treating gastroenterologist believed that Dr. Griswold should remain under strict medical management for an indeterminate amount of time and avoid all stressful activities, most notably medicolegal consulting.

Although it may appear at first reading that the Board has no discretion and must issue a subpoena as a matter of right to any party requesting one, ORS 656.285 specifically extends the protections embodied in ORCP 36C to witnesses in workers' compensation cases. ORCP 36C provides, in relevant part:

> "Upon motion by a party or by the person from whom discovery is sought, and for good cause shown, the court in which the action is pending may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense . . . ."

After claimant moved the Referee for an order compelling Dr. Griswold's deposition, the Referee issued the following "Order on Motion to Depose":

> "Claimant seeks to depose Drs. Kloster and Griswold. SAIF objects. I find the possible benefit derived from deposing Dr. Griswold is slight compared to the danger to his health as expressed by Dr. Kloster is his letter of May 7, 1984. THEREFORE,
>
> "Claimant's motions for depositions are denied."

Although the order is not entitled "Protective Order," we believe that it is in substance and intent such an order. We do not find any abuse of the Referee's discretion in having issued his order denying claimant's motion, and, based upon the evidence and statements before the Referee, find the order reasonable. This is so particularly in view of the fact that Dr. Griswold's written report is in evidence and was considered by the Referee. We, accordingly, deny claimant's request for remand.

Claimant requests that Dr. Kloster's opinion be stricken from the record for the reason that he was a partner of Dr. Griswold. Claimant argues that Dr. Kloster was precluded from reviewing the medical reports and rendering an opinion based on the contractual relationship already formed between claimant and Dr. Griswold. Claimant analogizes the duty owed by SAIF's consulting physician to that of partners in a law firm who are not allowed to discuss

elements of a claim with or represent adverse parties in a case. There is no evidence of impropriety or breach of ethics and no reason to strike evidence originating with Dr. Kloster from the record. Both doctors were consulting physicians and did nothing more than render their opinions. Each party was free to select their consulting physicians, whether they are partners or not. All that exists are two physicians who have differing opinions. Each opinion is entitled to the weight due it. We decline to exclude Dr. Kloster's opinion.

On the issue of the compensability of claimant's condition, the Board affirms and adopts the well-reasoned order of the Referee.

ORDER

The Referee's order dated August 30, 1984 is affirmed.

DIANE L. HALSETH, Claimant
Allen & Vick, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 84-05002
May 31, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee T. Lavere Johnson's order which awarded an additional 32° (10%) unscheduled disability for injury to claimant's low back on review of a Determination Order which awarded 32° (10%) unscheduled disability, thereby granting claimant a total award of 64° (20%) unscheduled disability. The employer contends that the Determination Order award is sufficient and, therefore, seeks reversal of the Referee's additional unscheduled award. In addition, the employer requests that in the event we reduce the Referee's award, we authorize it to recover an overpayment, to be deducted in the manner provided by law.

On our de novo review, we find that the award of 32° (10%) granted by Determination Order adequately and appropriately compensates claimant for the loss of earning capacity attributable to her industrial injury. Therefore, we reverse the Referee's additional unscheduled award and affirm the Determination Order. As to the employer's request that it be authorized to recover an overpayment in the amount of the excess compensation awarded by the Referee, we have previously held that erroneously awarded compensation which has been paid pending review is not subject to recovery by the employer/insurer. ORS 656.313(2); Harry C. Jordan, 35 Van Natta 282 (1983), aff'd per curiam 68 Or App 57 (1984); Glenn O. Hall, 35 Van Natta 275 (1983); see also Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581 (1984).

The following facts are pertinent to the extent of disability issue. At the time of hearing, claimant was 25 years old. At the time of her injury, she was working as a laborer performing production work in the employer's manufacturing plant. Her previous employment included work as a cashier, waitress and laborer for mobile home manufacturers. Claimant has a high school diploma. Although she took some undergraduate classes, she never completed a term.

This injury occurred in October of 1982 when claimant sustained a strain or sprain of her mid back. This gradually

developed into a low back problem. Claimant initially received chiropractic care. After six months of chiropractic treatment, claimant was referred to Dr. Gallagher, an orthopedist, who assumed primary responsibility for her care. Dr. Gallagher treated claimant beginning in March of 1983. All care was conservative.

Claimant was released to return to light work in June of 1983. She worked for about one week and then experienced an exacerbation, apparently due to the fact that her employment required her to exceed recommended physical limitations. This exacerbation resolved.

Dr. Gallagher performed a closing examination in April of 1984. He indicated that claimant suffered no impairment of function, based upon his findings of essentially normal range of motion of the low back and the absence of neurological findings. He stated, however, that claimant would have ". . . continued disability of intermittent pain in the low back, which may well be permanent." Dr. Gallagher stated that claimant's limitations were no lifting or carrying in excess of 20 pounds on anything other than a very occasional basis, although lifting or carrying less than that was permitted on a frequent basis; no repetitive bending or twisting; and no crawling or climbing. Dr. Gallagher indicated that with these restrictions, claimant was capable of working an eight-hour day. He stated that no further treatment or impairment was anticipated.

Claimant's employment was terminated because the employer had no position for her suitable to the limitations imposed by Dr. Gallagher.

Claimant applied for work at a Radio Shack, but was unable to obtain this job because of her back condition. In order to obtain employment as a waitress, claimant failed to disclose the fact that she had sustained a back injury when she completed an employment application form with a restaurant. Claimant also testified, however, that she did not feel that her back injury would prevent her from performing the regular duties of a waitress. Claimant worked for this restaurant for only a month, when she terminated her employment. Apparently, one of her duties was to move tables, which she testified adversely affected her back condition. Approximately one week prior to the hearing, claimant had resumed treatment with her chiropractor.

It appears that claimant terminated her recent work as a waitress for a variety of reasons. One was the apparent increase in back pain. Other reasons included claimant's apparent intent to relocate her residence. Claimant indicated uncertainty when asked whether she intended to attempt to become employed again.

The Referee found that, according to Dr. Gallagher, claimant's disability is in the mild range. He reached this conclusion based upon physical capability information forms completed by Dr. Gallagher prior to his closing examination in April of 1984 (January and March of 1984 forms), on which he indicated that claimant suffered slight physical impairment. The Referee did not mention the fact that Dr. Gallagher's most recent assessment of claimant's residual impairment was that claimant suffered no "impairment of function." We agree with the Referee's finding that the rating of "slight" impairment, as it appears on

these physical capability forms, equates to the generally recognized category of "mild" impairment; however, we believe that the most recent medical assessment reflects impairment of a lesser degree than indicated by those forms.

Considering Dr. Gallagher's closing evaluation indicating no impairment of function but continuing symptoms of pain, and considering claimant's testimony describing how her pain limits her ability to perform various tasks, we find that claimant's permanent impairment is minimal, rather than mild as determined by the Referee.

Claimant's residual functional capacity is for light work, whereas prior to her injury she was physically capable of performing work requiring physical exertion of a medium level. See OAR 436-65-605(5)(a).

Considering the evidence of record and comparing claimant to similarly situated injured workers, we find the 32° (10%) unscheduled disability awarded by the Determination Order adequate and appropriate.

ORDER

The Referee's order dated September 24, 1984 is reversed. The Determination Order dated April 26, 1984, which awarded 32° (10%) unscheduled disability for injury to claimant's low back, is affirmed.

PATRICK J. HAVICE, Claimant
David C. Force, Claimant's Attorney
Coons, et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-08177 & 83-08027
May 31, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Baker's order which set aside its denial of claimant's aggravation claim and imposed penalties and associated attorney fees for SAIF's failure to pay interim compensation. The issues on review are the compensability of claimant's low back condition, which necessitated surgery in June of 1983, and the propriety of the Referee's imposition of penalties/attorney fees.

Claimant had worked in the employer's wood products manufacturing plant for approximately one year when, in August of 1978, he developed pain and swelling in the joints of his fingers, hands and wrists. Claimant also was experiencing low back pain and discomfort. He sought treatment with Dr. Jefferson, a general practitioner. The portion of the physician's initial report form completed by the claimant stated:

> "Lifting wood with hands from 15 to 20 lbs. up off a belt in approximately 8 to 10 up and down motions then thrusting them on a lower belt and pounding them tight with another stick."

Dr. Jefferson's examinations on August 18 and August 29, 1978 disclosed swelling and redness of the PIP joint (proximal

interphalangeal joint, i.e. second joint from the end of a finger), "and nothing else." Dr. Jefferson diagnosed traumatic arthritis brought on by claimant's work, which involved repetitive movements of the fingers. He also mentioned the possibility of an underlying arthritis condition which may have been "brought out" by claimant's work activity. He recommended a change in claimant's job to one requiring less digital manipulation. It was noted that claimant had a history of some type of arthritis as a child, which apparently had resolved. No mention was made of low back pain or discomfort in any written report.

An 801 form was completed by the employer on or about September 14, 1978. It designated August 31, 1978 as the date of injury or date of a diagnosed occupational disease, and identified the hands and back as the body parts affected.

In early October of 1978 SAIF accepted a nondisabling injury claim with an assigned injury date of August 18, 1978. The following month, however, on November 8, 1978, SAIF issued a formal denial of responsibility for "the condition diagnosed by Dr. Jefferson as traumatic arthritis superimposed on pre-existing arthritis." Claimant did not request a hearing contesting this denial within 60 days or 180 days.

On October 6, 1978 Dr. Jefferson noted that as of September 5, 1978, claimant's only complaint was of aching fingers, and he concluded that claimant had "reverted to his preinjury status." However, claimant continued to experience the symptomatology of rheumatoid arthritis, and he came under the care of Dr. Cassell, a rheumatologist. Dr. Cassell treated claimant's rheumatoid arthritis throughout 1979, 1980 and the first half of 1981. His reports document exacerbations and remissions of claimant's disease, which manifested itself by modest generalized swelling of the small joints of claimant's hands and feet. There is no mention of low back pain in any of Dr. Cassell's reports.

In April of 1980 claimant was examined by Dr. Carter, a neurologist, on referral by Dr. Cassell for an evaluation of claimant's headaches. Claimant presented to Dr. Carter with a history of having had headaches all of his life. Claimant was treated for migraine headaches. The neurological examination conducted by Dr. Carter, including his examination of claimant's lower extremities, was normal.

In February of 1981 Dr. Cassell reported to Disability Determination Services that when claimant was first seen in November of 1978, he had swelling of the small joints of his hands and pain localizing to joints elsewhere without objective change. He also indicated the difficulty of assessing the activity of claimant's disease, as there was a "small discrepancy between his subjective sensation and the objective findings." Later reports by Dr. Cassell indicate discussions with claimant directed toward identifying for claimant the discrepancies between his subjective complaints and the objective findings, and also to attempt to "approach the possibility of a psychophysiologic component . . . . " In fact, claimant saw a psychiatrist, Dr. Henderson, on one occasion in May of 1981, at which time he was found to be suffering from chronic anxiety.

In June of 1981, claimant again changed physicians and began

treatment at University Hospital, Oregon Health Sciences University. At that time claimant presented with complaints of severe arm stiffness, fatigue, painful joints of the hands and feet, pain in his knees and hips. For the first time since September of 1978, when Dr. Jefferson considered claimant as having "reverted to his preinjury status," the medical record reflects complaints of low back pain. X-rays of the lumbosacral spine disclosed "obvious rotatory sclerosis," well-maintained disc spaces and no evidence of spondylolisthesis. X-rays of the pelvis disclosed increased sclerosis around the hips bilaterally with some degenerative change present. Claimant was noted to have no atrophy of his lower extremities, reflexes were symmetrical, straight leg raising was negative and full range of motion was present. Localized tenderness to palpation was noted over the L2-L3 midline region. The following impression was stated:

> "We feel the major portion of this patient's LBP [low back pain] is desmogenic (mechanical). He may have an inflammatory component but since he appears not to respond to the drugs that definitely help his other joint pains, it would be no more than a minor component."

A chart note entry dated September 15, 1981, describes a patient with "recent RA [rheumatoid arthritis]" and "chronic," of approximately ten years duration, low back pain. The physicians at University Hospital prescribed a back brace, which provided some relief of claimant's low back pain.

On December 9, 1982 claimant was examined by Dr. Buck, his family physician at the time. Dr. Buck's chart note states in part:

> "Patient has had a long history of back pain off and on. States that he has been told in the past that he had some arthritis of his back. One week ago he was lifting and pushing on the wheel of a Toyota when he developed pain in his low back. The pain was much worse the next day. Has had trouble walking during the past one week."

The medical records at this time contain the first documented complaints of pain radiating from claimant's low back down the back of his left thigh. In addition to experiencing difficulty walking, claimant was noted to have trouble lying down and sitting up from the examining table. There was pain with straight leg raising on the left. Dr. Buck diagnosed a chronic low back disorder and acute strain of the lumbosacral spine. Bed rest, heat, Flexeril and Dolobid were prescribed for relief of claimant's pain. The following day claimant phoned Dr. Buck requesting a prescription for Tylenol #3.

Claimant thereafter continued to experience symptoms compatible with a disc protrusion or herniation. On April 15, 1983 Dr. Buck took a history of continuing low back pain, frequently radiating down the back of the left thigh into the leg and left foot. Claimant also described weakness of the left leg and a feeling of giving way. He was referred for examination by Dr. Golden, a neurosurgeon.

Claimant first saw Dr. Golden on April 18, 1983. Dr. Golden

tried a course of conservative treatment including bed rest and medication. Claimant returned on May 2, 1983, at which time he had a positive straight leg raising test. In view of the findings, Dr. Golden found it appropriate to conduct a myelogram. Claimant was admitted to Sacred Heart Hospital for this purpose in early May of 1983. The case history completed by Dr. Golden states that in November of 1982, while claimant was doing some lifting, he developed low back pain.

> "[Claimant] states that he has had low back pain for several years, and has had previous episodes of radiation of the left lower extremity. However, previously he has not had much distal radiation. At this time, he has pain radiating to the heel and into the calf. Coughing produces shock-like radiation and is aggravated by upright activity, bending and sitting."

On admission to the hospital, claimant was noted to have diminished range of motion in all fields and a positive straight leg raising test. A CT scan disclosed a bulging L4-5 annulus, as well as a mild amount of degenerative change in the facets at the L4-5 and L5-S1 levels. An x-ray of claimant's lumbosacral spine disclosed degenerative changes at L5-S1. A lumbar myelogram disclosed diffuse lumbar spondylosis and a "very large thecal sac" at the L5-S1 level.

On June 9, 1983 Dr. Golden performed surgery. A laminotomy was done at L5-S1; a complete hemilaminectomy was done up to the L4 level. A protruding L4-5 disc was removed, and a foraminotomy was done at the L5-S1 and L4-5 levels.

On June 24, 1983 Dr. Golden completed an 827 form which identified a date of injury of August 18, 1978. The portion of this form completed by claimant states, "On 8/18/78 while pulling table tops rapidly and hurriedly, twisted low back reaching down, causing pain in low back and right leg which has persisted [to] date." This form indicates that the condition diagnosed as "bulging of the intervertebral disc centrally, L4-5 disc herniation left" was work-related; that claimant was not released for work; that two months of further treatment was estimated; and that claimant's condition was not then medically stationary. This 827 form was received by SAIF on June 28, 1983.

On July 12, 1983 claimant completed an 801 form identifying degenerative disc disease affecting his low back and left leg as the basis for an apparent occupational disease claim. The description of work activities causing this condition was stated as, "excessive, repetitive bending/lifting/twisting/overuse of the low back caused/accelerated by employment activity over a period of time (a six month period followed by a one year period ending in August of 1978). This 801 form was submitted under cover of claimant's attorney's letter to SAIF requesting payment of "interim time loss."

On August 17, 1983 SAIF issued a formal denial stating in part:

> "We have carefully reviewed the claim filed for workers' compensation benefits while employed by Whittier Manufacturing. Based

> on the information contained, there is insufficient evidence the condition diagnosed as a herniated disc at L4-5 is the direct result of your work activities at Whittier."

On August 19, 1983 Dr. Golden reported to SAIF that the history he obtained from claimant, together with his evaluation, led him to believe that there was a definite causal relationship between claimant's work activities for the employer five years ago and the diagnosed herniated disc. He explained:

> "He has had a constant flow of symptoms from that time and it became progressively worse. There may be some aggravation from other factors and his susceptibility to inflammatory response as a result of rheumatoid arthritis, may be also a factor. Nonetheless, the significant causal factor is the injury as described."

The hearing convened in February of 1984. Claimant described the work he performed for the employer. He testified that his back would ache sometimes to the point that he could "hardly bend it." He described pain located immediately above the hips. When asked whether the pain ever went down "below your low back into your buttocks and/or your legs or leg," he responded that it always had, and he had been advised by physicians that "it was like a pulled muscle or something, it was nothing serious." He denied having any back or leg problems prior to August of 1978. With regard to the tire or wheel lifting incident decribed in Dr. Buck's December 9, 1982 chart note, claimant indicated that the incident caused a worsening of the pain that he already had been experiencing. Claimant testified that he had described the pain radiating down his leg to treating and examining physicians since his August 1978 injury, but ". . . they'd scratch my foot and they'd say, well, you don't have a disc out it's just that simple. They said if I had a disc out I couldn't walk."

SAIF produced Dr. Brown as a witness at hearing. Dr. Brown is a neurologist. He reviewed claimant's entire medical file and listened to claimant's testimony. He testified that there was no connection between claimant's August 1978 injury and the low back surgery performed by Dr. Golden. His reasoning was that at no time prior to Dr. Buck's examination on December 9, 1982, did any physician state findings consistent with a herniated or protruding disc. He stated his opinion that as a general rule, and in claimant's particular case, a disc herniation was more likely attributable to degenerative changes in the disc and joints, rather than to trauma.

After the hearing, Dr. Golden's deposition was taken. He testified that, when he first saw claimant in April of 1983, claimant related a history of low back pain with left lower extremity radiation for a period of two to three years, and that for the past five or six months, after helping someone push a car, the pain worsened with radiation down the leg as far as the heel. When questioned whether his findings on surgery were more consistent with a post-traumatic injury or the gradual onset of degenerative disc disease, Dr. Golden stated that operative findings would not make that particular diagnosis. He also stated:

> "The incident that relates to the evolution of signs and symptoms producing back pain and left leg pain was some two years previously. So there's a process of degeneration that goes on. In this case, probably after the trauma. So, it's a process of both trauma and degeneration."

When asked to clarify his reference to "some two years previously," he indicated that he actually was referring to the 1978 incident. He reiterated his opinion that claimant's August 1978 injury materially contributed to the condition requiring surgery in June of 1983.

Dr. Golden offered an explanation for the total absence of any documented low back problem in the many physicians' reports subsequent to the August 1978 incident. He stated that a physician who is looking for rheumatoid disease in the hands may not be "psychologically disposed to consider other parts of the patient's health history." The clinical findings he considered suggestive of a causal connection between claimant's 1978 injury and 1983 surgery included severely limited range of back motion, partly due to spasm, and tightness in the hamstring musculature and tendons. He regarded the Toyota wheel/tire incident as something in the nature of an aggravation of a preexisting condition.

The conclusion we draw from Dr. Golden's explanation is that his reasons for believing that there is a material causal connection between claimant's 1978 injury and 1983 surgery are largely dependent upon claimant's history, as opposed to any findings he made on his examination of claimant or during surgery. Part of the history he relied upon was claimant's description of "a gradual increase of pain with [radicular] qualities starting from the time of his injury in 1978."

When asked whether a disc herniation occurred at the time of claimant's 1978 injury, Dr. Golden replied, "Probably not right at that moment, but I really don't know for sure." He also stated that the disc herniation could have occurred at the time of the tire/wheel pushing incident. When asked how one could know what role claimant's 1978 injury played, as opposed to the mechanics of the degenerative process, he stated:

> "I think that the major proof that the 1978 incident was significant in producing the problem for which I treated him was that he had a great deal of pain at that time. That there was never a period of more than several weeks at a time that he was ever significantly free of symptoms. That prior to that time, he had not had a significant problem with his back and that particular injuries set in motion all those things that happened subsequently. And, you know, but for that particular injury at that time, the other incidents may not have been significant for him."

With regard to the question whether disc herniations are due to a degenerative process of the spine or whether trauma can cause disc

herniation, Dr. Golden stated that disc herniation can occur with either course of events, and sometimes there is a "mixture."

The Referee found claimant credible. Dr. Golden formed the impression that claimant was "an extremely honest, genuine person who, on questioning, didn't hesitate to give an accurate history without vagueness." We have no reason to doubt claimant's veracity; however, we cannot avoid taking notice that there are serious discrepancies between the evolution of back and leg pain as described by claimant at the hearing (and relied upon by Dr. Golden), and the history reflected in the medical records from the time of claimant's 1978 injury.

Claimant testified that he had continual low back and leg pain after his August 1978 injury. Although the original 827 form mentions lower back discomfort and pain in the portion completed by claimant, Dr. Jefferson never made any mention of claimant's back pain in his written reports, and his only reference to back pain is in a September 5, 1978 chart note which appears to state (although it is difficult to decipher) "chronic LS [lumbosacral] pain now." A month later on October 6, 1978, Dr. Jefferson considered claimant as having returned to his preinjury level. Dr. Cassell treated claimant for over two years and never made note of any back pain, let alone any significant back pain. In none of the reports, either injury report forms or medical reports, is there a mention of leg pain. The first indication of a significant back problem, at least as reflected by contemporaneous medical reports, is contained in the records from University Hospital, where claimant began treatment in June of 1981. These physicians carefully evaluated claimant's back problems, and none of their findings were consistent with a diagnosis of herniated or protruding disc. Their records do not reflect a radiating component. If claimant had been experiencing leg pain at that time, we certainly would expect such symptomatology to be reflected in these apparently thorough reports. X-rays taken of the lumbosacral spine were normal, except for obvious rotatory sclerosis, i.e. degenerative changes of the spine. It was not until early December of 1982, when claimant saw Dr. Buck, after the tire or wheel lifting/pushing incident, that any medical practitioner noted the complaint of pain radiating into claimant's left leg.

Dr. Golden has formed the opinion that claimant's 1978 injury materially contributed to the disc protrusion diagnosed in 1983 and the ensuing surgery. Dr. Brown is of the opposite opinion and believes that the condition of claimant's lumbosacral spine is solely attributable to the degenerative process. This is not the type of case in which Dr. Golden's opinion, as the treating physician, is entitled to greater weight. This is particularly true in light of Dr. Golden's statements that the findings on examination and surgery do not shed much light on the answer to the causation question, and that he formed his impressions primarily on the basis of claimant's history. See Hammons v. Perini Corp., 43 Or App 299, 301 (1979). It is claimant's burden to prove a causal connection between his 1978 injury and his low back condition in 1983 by a preponderance of the persuasive evidence. Considering all of the evidence in the light most favorable to claimant, we are unable to conclude that claimant has satisfied this burden of proof. Therefore, the Referee's order must be reversed.

We are uncertain whether claimant presently contends that his back condition should be found compensable as an occupational disease. Assuming he does, we find and hold that the evidence fails to establish compensability on this alternative theory.

With regard to the issue of penalties and attorney fees for SAIF's failure to pay interim compensation, we find that SAIF's obligation to pay interim compensation terminated as of August 17, 1983, the date of its denial. We reject SAIF's argument that Dr. Golden's June 24, 1983 report form was not a sufficient aggravation claim. We find that it gave SAIF adequate notice of claimant's inability to work as a result of a worsened condition allegedly related to his August 18, 1978 injury. Therefore, SAIF was obligated to initiate payment of interim compensation within 14 days. Their failure to pay interim compensation pending acceptance or denial was unreasonable under the circumstances presented herein.

The Referee determined that SAIF had an obligation to separately deny the occupational disease claim presented by the 801 form submitted under cover of claimant's attorney's July 12, 1983 letter. Claimant's request for initiation of interim compensation was superfluous in the sense that SAIF was already under an obligation to pay by virtue of the previously received aggravation claim. Assuming that the 801 form, in fact, constituted a separate claim, as opposed to notice of an additional theory in support of the compensability of claimant's back condition, we find and hold that the August 17, 1983 denial discharged SAIF's obligations in connection with this claim. Therefore, the Referee erroneously awarded interim compensation after the date of SAIF's denial, and he further erred in imposing a penalty/attorney's fee as a percentage of the interim compensation found to be "then due."

ORDER

The Referee's order dated May 30, 1984 is reversed in part and modified in part. That portion of the order which set aside SAIF's August 7, 1983 aggravation claim denial is reversed, and that denial is reinstated and affirmed. Those portions of the Referee's order awarding interim compensation and imposing penalties and attorney fees are modified as follows. Claimant is awarded interim compensation for the period June 28, 1983 to August 17, 1983. SAIF shall pay claimant a penalty equal to 25% of this interim compensation and shall pay claimant's attorney an associated fee of $200, for unreasonable failure to pay interim compensation.

TERRY L. HUNTER, Claimant
Bischoff & Strooband, Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 84-03009
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of that portion of Referee Quillinan's order which upheld the insurer's denial of his occupational disease claim for sinus condition and surgery that he relates to exposure to chemicals at work. The insurer cross-requests review of that portion of the order which awarded interim compensation pending denial plus penalties and attorney fees for unreasonable resistance to payment of compensation. The

issues on review are compensability, temporary total disability as interim compensation, and penalties and attorney fees.

On the issue of compensability, the Board affirms and adopts the order of the Referee.

On the issue of interim compensation and penalties, the Board reverses due to the fact that claimant was working full-time during the period for which the award of interim compensation was made. Bono v. SAIF, 298 Or 405 (1984).

ORDER

The Referee's order dated October 25, 1984, is reversed in part and affirmed in part. That portion of the order which awarded interim compensation from February 2 through March 7, 1984, with penalties and associated attorney's fees is reversed. The remainder of the order is affirmed.

RALPH W. ISITT, Claimant
Kilpatricks & Pope, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-04808
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Galton's order which awarded an additional 208° (65%) unscheduled disability for injury to claimant's right shoulder and side on review of a Determination Order which awarded 16° (5%) unscheduled disability for injury to the right shoulder. Claimant previously received an award for 32° (10%) unscheduled disability in connection with this shoulder injury. Thus, the Referee increased claimant's permanent disability award to 256° for 80% of the maximum allowable by law for this right shoulder injury. SAIF contends that the Referee's award is excessive. We agree and, therefore, modify the Referee's order accordingly.

Claimant was 58 years old at the time of hearing. He completed the tenth grade at Klamath Falls High School. He enlisted in the Navy after his tenth year of high school, where he received training in machinery mechanics. After discharge from the service, claimant engaged primarily in farm work, driving heavy farm equipment. In addition, and in connection with this farm work, claimant performed mechanical repairs. During his lifetime, claimant also worked in a saw mill and performed work as a logger; however, the majority of his work experience has been in farm work driving farm machinery.

Claimant sustained this injury in September of 1982 while driving a tractor. The tractor tipped over and rolled, and claimant rolled with it. Claimant sustained what appear to have been fairly serious injuries. He broke approximately nine ribs on the right side and seven ribs on the left; he fractured the left scapula and the right acromion. Claimant's injuries were treated conservatively initially. His left arm was placed in a sling.

Unfortunately the fractured acromion did not heal properly and formed a malunion. Therefore, in August of 1983, claimant's physician, Dr. Karmy, performed a right shoulder rotator cuff

repair with anterior acromioplasty. There was some question whether the rotator cuff problem was preexisting. Although claimant had a preexisting rotator cuff tendinitis of the shoulder, Dr. Karmy believed that he could not determine whether the rotator cuff tear diagnosed almost a year after the injury was or was not actually preexisting. It appears that SAIF paid for the surgery as a consequence of claimant's injury.

The claim was originally closed in March of 1983 with an award for 32° (10%) unscheduled disability. After surgery it was reclosed with an additional award for 16° (5%) unscheduled disability. Claimant requested a hearing contesting this latter, February 14, 1984, Determination Order, which gave rise to the present proceeding.

Dr. Karmy reported that claimant probably had a mild degree of shoulder impairment prior to this injury, as a result of the preexisting rotator cuff tendinitis. As a result of the injury, claimant now has moderate shoulder impairment.

Claimant is right-handed. The limitations of his right shoulder were noted in a physical limitations chart completed by Dr. Karmy in December of 1983, after Dr. Karmy had declared claimant medically stationary. The limitations on lifting, carrying, pushing and pulling weight are one to ten pounds frequently, 21 to 50 pounds occasionally, and no such activity with weights in excess of 50 pounds. Claimant is able to reach above his shoulder with the right arm on an occasional basis, he is able to repetitively use his arms and wrists on a frequent basis, and he is able to repetitively use his hands on a continuous basis. There are no limitations in claimant's ability to sit, stand or walk.

In addition to the limitations of right shoulder motion which claimant experiences, he also suffers shoulder abduction weakness (grade 4 out of 5), mild deltoid atrophy and mild crepitation.

Subsequent physical capacity evaluation worksheets completed by Dr. Karmy are essentially consistent with this earlier evaluation. Dr. Karmy has noted claimant's difficulty with use of the arm above shoulder level and reaching overhead, and this is clearly one of claimant's limitations, as established by claimant's credible testimony.

At one point Dr. Karmy indicated that he did not know whether claimant could return to his previous occupation. He later clarified that claimant could return to his previous occupation driving a "cat," but that because claimant experiences difficulty using the arm in an elevated position, the duties associated with driving farm equipment would cause problems for claimant. As an example, if claimant is driving a piece of equipment that is used to spray chemicals, he has difficulty filling the spray tank with the chemical solutions. Claimant's left arm is unimpaired.

Claimant experiences constant pain from the tip of his shoulder, down the outside of his arm and down to the area of his elbow. In addition, he experiences pain in the armpit down through his rib cage, about a third of the way down the side of his chest. He experiences limitations in his ability to pull with his right arm. Prior to this injury, he was able to perform any duty required by his work.

Prior to surgery, claimant had worked "a few days" for another employer, apparently driving a cat. Because the shoulder got worse, he submitted to surgery. Since surgery, claimant has only worked for one person and only for a few days. He ran a cat and primarily used his left hand. All he was able to do was to drive the cat. He was unable to service it in any way.

Claimant attempted to obtain additional employment of this nature; however, he was not hired. It was felt by the potential employers that he would not be physically capable of handling the work.

Claimant received vocational assistance in the form of direct employment assistance. Targeted jobs included maintenance work, tune-up mechanic work, and parts clerk. Other occupations considered by the vocational counselor, which were felt to be consistent with claimant's transferable skills, were tool crib attendant, ditch rider, combine operator and swather operator. These occupations all appear to be within Dr. Karmy's stated restrictions. Unfortunately, the direct employment program was not successful in locating gainful and suitable employment.

The Referee characterized claimant as essentially a one-armed worker who is severely limited in lifting, carrying, pushing, pulling and other movements of the right shoulder and right side. He also concluded that, as a result of his injury, claimant is now relegated to work of a light or sedentary nature.

We disagree with the Referee's assessment of the evidence. Dr. Karmy's limitations place claimant in a moderate or medium work category, not light or sedentary as the Referee concluded. Furthermore, claimant's impairment is not "severe"; it is in the moderate category according to Dr. Karmy. Claimant's testimony is not inconsistent with this medical assessment. Claimant's limitations are substantial; however, we believe that claimant retains considerable use of his right arm/shoulder, and, as indicated by the vocational counselor, there are many jobs claimant is capable of performing considering his work experience, training and skills.

To the extent that there is any question concerning preexisting shoulder impairment/disability, we agree with the Referee's finding that, prior to this industrial injury, claimant suffered no significant shoulder impairment. Therefore, for purposes of awarding unscheduled disability due to this industrial injury, we have considered claimant as having an essentially unimpaired right shoulder prior to this injury. See generally Barrett v. D & H Drywall, 73 Or App 184 (1985).

Considering the evidence in its entirety, including claimant's credible testimony concerning his pain and residual functional abilities, see Harwell v. Argonaut Insurance Co., 296 Or 505 (1984), we find and hold that an award for 128° (40%) unscheduled disability adequately and appropriately compensates claimant for the loss of earning capacity attributable to this industrial injury.

ORDER

The Referee's orders dated November 15, 1984 and November 16, 1984 are modified. In lieu of the Referee's award of 208° (65%)

unscheduled disability and in addition to the Determination Order award of 16° (5%) unscheduled disability, claimant is awarded 80° (25%) unscheduled disability, for a total award to date of 128° (40%) unscheduled disability for injury to the right shoulder.

GARY L. MANOUS, Claimant
Olson Law Firm, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 83-07482
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of that portion of Referee Seifert's order which set aside its denial of his low back injury aggravation claim. Claimant requests review of the extent of his unscheduled permanent partial disability in the event the Referee's order is reversed. The issues on review are compensability and extent of unscheduled permanent partial disability.

Claimant injured his back on December 7, 1979 while lifting a spool of wire. He obtained chiropractic care and was released for modified work in April 1980. His claim was closed by Determination Order dated September 22, 1980, which awarded him 16° for 5% unscheduled permanent partial disability.

Claimant completed a vocational rehabilitation program as a gunsmith and obtained employment at a sporting goods store. His back pain continued and he had an acute exacerbation associated with moving a heavy box of ammunition. His claim was reopened by Opinion and Order dated March 4, 1982.

Claimant was examined by Drs. Poulson and Struckman who concluded that claimant had a mild chronic cervical and lumbar sprain. Dr. Poulson concluded there was no impairment but there was disability based upon mild recurrent pain and that claimant should avoid work which required repetitive heavy bending and lifting, long periods of stooping, or repetitive climbing and crawling. The aggravation claim was closed by Determination Order dated August 5, 1982, which awarded 32° for 10% additional unscheduled permanent partial disability.

Claimant continued to have back pain associated with activity, but sought no treatment for his back from August 26, 1981 until August 14, 1983. On August 14, 1983 claimant was carrying an armload of wood up a steep, slippery embankment when he slipped and fell sideways. Claimant's pain symptomatology was much worse immediately following this incident. Dr. Urban, chiropractor, began treating claimant and related the present injury as an aggravation of claimant's previous injury relying on claimant's assertion that the workers' compensation insurer was responsible for all treatment of claimant's back since the original injury. Dr. Urban also found symptoms of foraminal encroachment which had not been reported in previous examinations.

Compensability of conditions following an off-the-job injury which follows an on-the-job injury is determined according to the rule of Grable v. Weyerhaeuser Company, 291 Or 387 (1981). The worker must establish that "the on-the-job injury is a material contributing cause of the worsened condition." Id. at 401. We find that claimant suffered a new injury which was the intervening

and superseding cause of his current condition and that his industrial injury was not a material contributing cause of the worsened condition.

Claimant had worked for two years without treatment of his back condition at the time of his fall. He fell due to the steepness and slipperiness of the embankment and suffered immediate stabbing pain in his back. He immediately sought chiropractic treatment. There was no evidence that at the time of his fall that claimant was disabled by his back condition or that his back condition contributed to his fall. There was no evidence that claimant required treatment for his back condition due to residuals from the original industrial injury or that the original injury contributed in any way to the severity of claimant's condition. The only relationship between claimant's industrial injury and nonindustrial injury is that the same part of his body was involved. We are not persuaded that claimant's industrial injury was a material contributing factor in his need for treatment or his disability after August 14, 1983, therefore, we reverse the referee's order. See Blanche M. Keeney, 36 Van Natta 1161 (1984); Robert Harral, 35 Van Natta 1734 (1983).

Claimant requested as an alternative in the event the Board found that the Referee's order should be reversed, that the Board review the extent of claimant's permanent disability based on the record as it was developed before the Referee. The parties stipulated on the record that if the August 1983 accident were found to be an intervening superseding cause of claimant's condition, that the extent of claimant's disability would be rated as of the date of the injury. The extent of claimant's disability was an issue before the Referee having been raised as an appeal from the Determination Order dated August 5, 1982. The Referee did not reach the question of the extent of claimant's disability because the claim was reopened by his order. We have reversed the Referee's order and now proceed to review the extent of claimant's permanent disability.

Claimant was 35 years old at the time of hearing. He had a high school education and was a construction lineman at the time of his injury. His impairment was rated at mild based only on pain by Dr. Poulson whose examination of May 1982 included a very thorough list of findings. Claimant was able to obtain suitable gainful employment at which he worked for more than a year before his subsequent injury. The limitations related to his compensable industrial injury did not preclude him from work rated in the medium category of physical exertion. We find that claimant's awards that total 48° for 15% unscheduled permanent partial disability of his back appropriately compensate him for the loss of earning capacity due to his industrial injury.

ORDER

The Referee's order dated November 14, 1984 is reversed. The insurer's denial dated September 6, 1983 is reinstated and affirmed. The Determination Order dated August 5, 1982 is affirmed.

CAROL McKENNA, Beneficiary
TERRY J. McKENNA (Deceased), Claimant
Pozzi, Wilson, et al., Attorneys
Keith D. Skelton, Attorney
D. Kevin Carlson, Attorney

WCB 82-05037
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of Referee Fink's order which: (1) set aside the insurer's June 4, 1982 denial of compensability of claimant's aplastic anemia and denial of survivor's benefits; (2) awarded an amount equal to 15% of unpaid hospital bills as a penalty for unreasonable delay or unreasonable refusal to pay compensation, plus a $500 attorney fee; and (3) directed the insurer to pay claimant's widow's attorney the sum of $15,000 for services at hearing in prevailing on the denials.

The Board affirms and adopts those portions of the Referee's order finding the insurer barred by its March 24, 1982 acceptance from later denying compensability of claimant's aplastic anemia. See Bauman v. SAIF, 295 Or 788 (1983). As a consequence, the Board need not and does not consider the merits on that issue. The Board affirms the balance of the Referee's order with the following comments:

The Referee awarded claimant's attorney a total of $15,500 for services at hearing; $15,000 for prevailing on the denials plus $500 for prevailing on the issue of unreasonable resistance and delay and securing penalties. In Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we held:

> "In determining the reasonableness of attorney's fees, several factors must be considered: (1) time devoted to the case; (2) complexity of the issues involved; (3) value of the interest involved; (4) skill and standing of counsel; (5) nature of the proceedings; and (6) results secured. Muncy v. SAIF, 19 Or App 783, 787-788 (1974)."

We consider those factors here. The record contains an affidavit by claimant's attorney detailing the services he and others in his office performed in connection with this matter and the times expended in providing these services. The affidavit states that 128.75 hours of attorney time and 9 hours of paralegal time were expended. This case presents issues of challenging complexity. The value of the interests involved are substantial. Claimant died at age 35 leaving a widow and a child entitled to survivor's benefits. Claimant's attorney has been a member of the Oregon State Bar since 1975. He has demonstrated a high degree of professional competence in this case and has secured a very favorable result for his clients. Finally, we consider the contingent nature of attorney fee awards to claimants' attorneys in the workers' compensation proceedings. Weighing all pertinent considerations, we affirm the Referee's attorney fee awards.

ORDER

The Referee's order dated July 12, 1984 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the insurer.

JOHN J. MEDINA, Claimant
Pozzi, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 84-02088
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Shebley's order which awarded temporary total disability compensation benefits for one week after the attending physician released claimant to return to his regular work and which found that the insurer was responsible for disability arising from a worsening of claimant's condition after closure. The issues on review are entitlement to temporary total disability compensation after release to regular work and responsibility for the worsening of claimant's condition when there are subsequent injuries that are not job-related.

Claimant was 34 years old at the time of hearing. He was working as a carpet cleaner when he sustained his low back injury on September 13, 1983. He was treated by Dr. Hinton, naturopath. On October 13, 1983 Dr. Hinton reported that claimant was released to his regular work without restrictions on October 5 and that claimant was medically stationary on October 11, 1983. Dr. Hinton supplemented that report with a letter on October 27, 1983, that confirmed the release to work without restriction on October 5, 1983, and that the back injury was "completely resolved with the exception of minimal tight muscle fibers and minimal pain discomfort." The doctor did not believe that claimant had any permanent impairment and he had discontinued therapy. The Determination Order was issued on November 9, 1983, which awarded only temporary total disability compensation from September 14 through October 4, 1983.

On December 2, 1983 Dr. Hinton wrote a letter to the insurer that was a claim for aggravation of the September 13 injury. He indicated that a narrative report would follow. Dr. Hinton began his narrative report on December 30, 1983, and finished it on January 6, 1984, according to the notation at the end of the letter.

On January 4, 1984 claimant was examined by Dr. Kelley, chiropractic orthopedist. Dr. Kelley reported that claimant related back pain incidents of November 17 and November 25, 1983. The November 17 incident involved having slept on a cot overnight while in custody of Washington County authorities. The November 25 incident involved having twisted and strained his back while attempting to inspect or remove a battery from a pickup truck. Dr. Kelley, relying on his own physical examination and claimant's history, opined that Dr. Hinton's original assessment was correct, that claimant's back had completely healed from the September 13 incident, and that the September 13 incident made no contribution to the injury of November 25 or the subsequent disability.

It is difficult to rely on dates referred to in Dr. Hinton's letters because they so often conflict, but it appears from the context that the following sequence of events happened involving him. Claimant returned to Dr. Hinton on November 17 complaining of back pain. Physical examination on that date revealed no abnormalities to account for the muscle spasms and pain and the doctor reported there was no history of intervening injury. The doctor related the worsening condition to the release for work date because therapy had stopped at that time. The doctor obtained x-ray films that showed claimant had an abnormality of his L5 vertebra

which the doctor thought was an asymptomatic condition that was rendered disabling by the September 13 injury.

Dr. Hinton felt claimant was totally disabled from October 28 through December 11, 1983, and partially disabled from December 12 through December 20, 1983, and that claimant was medically stationary and able to return to regular work on that date. However, the December 20 release was not discussed with claimant until January 12, 1984, at which time the doctor felt claimant was able to continue his rooftop solar unit repair work but unable to return to carpet cleaning; claimant disagreed and convinced the doctor that the dangerous nature of working on rooftops made the leg and back symptoms too great a hazard for claimant to be released to work at all. Dr. Hinton thereupon prohibited claimant from any type of work indefinitely after January 18, 1984, and referred claimant to an orthopedist. There is no report from this orthopedist nor any examination report from anyone after this date in the record.

On January 31, 1984 Dr. Hinton discontinued treatment of claimant because of unpaid bills. On February 17, 1984 the insurer denied responsibility for claimant's back treatments due to the intervening incidents of November 17 and November 25, 1983.

By letter of August 2, 1984, Dr. Hinton remembered that he authorized time loss to begin on November 28, 1983, even though claimant was incapacitated before that date based on telephone calls from claimant. Dr. Hinton also reported that his chartnotes indicate that claimant had sciatic left leg pain which required treatment on September 29, 1983, during the course of treatment for the September 13 injury.

Claimant testified that the November 25 incident caused back pain from the twisting around to inspect the battery in his pickup truck. He also testified that he no longer carried 150-pound solar units to rooftops after the September 13 incident, but confined himself to repair and adjustment activities.

We find that the termination of temporary total disability compensation on the date the attending physician released claimant to return to regular work was correct. The basic measure of time loss compensation for temporary total disability is that period for which the injured worker is unable to work due to his industrial injury. Other factors may be considered to shorten or extend the period of compensation. Claimant argues that ORS 656.268(1) prevents termination of temporary total disability payments until it is determined that claimant is medically stationary regardless of a release to return to regular work without restrictions. If the release to work is clear and unambiguous, the insurer is justified in terminating time loss compensation. Jackson v. SAIF, 7 Or App 109 (1971); Ramon Robledo, 36 Van Natta 632 (1984); John R. Daniel, 34 Van Natta 1020 (1982). The Determination Order should have been affirmed and time loss compensation terminated as of the date of the attending physician's release to return to regular work without restrictions.

We find the attending physician's opinion persuasive that claimant had completely recovered from his September 13, 1983 injury without any permanent impairment. After claimant returned to his rooftop solar unit repair business, the attending physician's opinions relating claimant's condition to the industrial injury are

less persuasive than the opinion of Dr. Kelley. Dr. Kelley considered the reports of the attending physician and claimant's history and concluded that claimant's back pain incident of November 25, 1983 made an independent contribution to claimant's condition. He further opined that the September 13, 1983 injury was no longer a material contributing cause of claimant's disability.

We find that the preexisting lumbar abnormality diagnosed by Dr. Hinton may have contributed to the problems that claimant had after he recovered from his September injury; however, there is no evidence in this record which persuades us that the lumbar abnormality was caused by or worsened in any way by the September injury. The evidence establishes that claimant recovered from his September 13, 1983 injury and then sustained superseding intervening noncompensable injuries to his back. The disability that claimant suffered after closure was not related to his compensable injury, and is therefore not compensable. Cf. Grable v. Weyerhaeuser Company, 291 Or 387 (1981).

ORDER

The Referee's order dated August 28, 1984 is reversed and the insurer's denial for aggravation of claimant's low back injury is reinstated. The Determination Order of November 9, 1983 is affirmed.

MICHELLE C. MENDOZA, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-05868
May 31, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee Michael V. Johnson's order that awarded claimant's attorney an insurer-paid fee. Claimant cross-requests review of that portion of the Referee's order that ordered SAIF to pay a $32 bill for medical services, contending that the medical bills that SAIF should be ordered to pay total $164.31. The issues are calculation of unpaid medical bills, if any, and attorney fees.

On November 21, 1983 Referee Foster approved a stipulated order dismissing claimant's request for hearing. The stipulated order recited that it settled all issues raised or raisable by the parties at that time. One of the issues raised by claimant's request for hearing was that of unpaid billings of claimant's treating chiropractor, Dr. Buttler. At the hearing, SAIF argued that claimant was barred by the doctrine of res judicata from relitigating her entitlement to payment of any medical bills incurred prior to the stipulation. SAIF did not and does not argue that the stipulated order operates to bar claimant from receiving medical services after the stipulation. The record shows that claimant in fact has received such services.

The Referee accepted SAIF's position with a modification. The modification was that medical bills received by SAIF during the sixty-day interval prior to the stipulation were not "ripe" for litigation at the time of the stipulation and were not precluded by res judicata. SAIF does not dispute that result. Claimant, however, argues for the first time on Board review that, to the extent that it purports to deny claimant reimbursement for medical services, the stipulation is invalid pursuant to ORS 656.263(1), the statutory prohibition against releases. Claimant relies upon EBI Companies v. Freschette, 71 Or App 526, 530 (1984).

The Board generally will not consider issues raised for the first time on Board review. ORS 656.295(3), (5). See Jeanne M. Grimes, 36 Van Natta 372 (1984). We have, however, distinguished between a "new issue" and a legal theory advanced for the first time on review, and considered the legal theory where there was no prejudice to the adverse party. Anita A. Bade, 36 Van Natta 1093 (1984), aff'd mem, 73 Or App 344 (1985). In this case, SAIF addressed claimant's argument in its cross-respondent's brief and did not object to claimant raising the argument for the first time here. As we did in Bade, we find in this case that there is no prejudice to the insurer, particularly as we decide the argument against claimant.

At the time the stipulated order was entered into, there were two requests for hearing pending and the issue of medical services was actually raised, not just raisable. We find claimant's assertion that the stipulated order was a release to be wide of the mark. By agreeing to accept a certain sum of money, claimant resolved all pending issues. One of those issues was whether SAIF or claimant would pay approximately $165 in currently due medical bills. Claimant merely liquidated a settlement; she released nothing. The Board, see, e.g., Arnold Androes, 35 Van Natta 1619 (1983), and the Court of Appeals, see, e.g., EBI Companies v. Freschette, supra, have applied ORS 656.236(1) only to releases of future rights. Such cases are not in point here. The Referee correctly applied the doctrine of res judicata. See Million v. SAIF, 45 Or App 1097 (1980).

The Referee stated: "Simple math demonstrates that on May 26, 1984 [the date of SAIF's last payment to Dr. Buttler], SAIF owed a balance of $32." On de novo review we find that during the sixty days prior to the effective date of the stipulated order, Dr. Buttler billed SAIF $504. After the stipulated order Dr. Buttler billed SAIF another $200. During the relevant interval SAIF paid Dr. Buttler $704. There is no evidence that Dr. Buttler sent any additional billings. Claimant requested a hearing on May 30, 1984. As of that date, claimant was entitled to nothing, and no contention is made that any entitlement accrued between then and the date of the hearing. Accordingly, the Referee's order must be reversed.

ORDER

The order of the Referee dated November 16, 1984 is reversed. Claimant's request for hearing is dismissed.

LUCINDA A. MOLLER, Claimant
Michael Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-04787, 84-04786 & 83-11286
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Danner's order which upheld the SAIF Corporation's denial of her occupational disease claim for conditions resulting from tobacco smoke in her workplace. The issue on review is compensability.

On May 3, 1983 claimant consulted Dr. Gambee, who specializes in urology but also practices as an allergist, with a complaint of migraine headaches and sensitivity to tobacco smoke and other

chemicals. She was working for an agency of the state government at the time and expressed a fear of not being able to continue in her job because of the smoke sensitivity.

She interviewed for a job with another state agency and advised the interviewer of her sensitivity to smoke. She was assured by the prospective, non-smoker, supervisor that such a problem could be accommodated. Claimant began working at the new agency on May 25, 1983.

In July 1983 claimant's supervisor was replaced by a smoker. Claimant's desk was between the supervisor, who was described as a chain smoker, and a moderate smoker who stopped smoking in the office when claimant requested it. Claimant asked for and received placement of her desk into a no smoking area.

In September 1983 the entire office moved and claimant was located directly between three smokers in a poorly ventilated area. The smokers were not employes of the same agency and claimant's supervisor had no authority to direct the activities or placements of those other employes. On September 15, 1983 claimant filed her first claim of occupational disease following what she alleged was a severe sinus infection. Subsequent claims were consolidated into one claim following other occasions of reactions to smoky conditions.

Claimant was treated by Dr. Bain for a sinusitis condition in August and September 1983 at which time claimant stated she had intermittent hoarseness when in a smoky atmosphere. Dr. Schultz, internist and pulmonary specialist, examined claimant and reported that cigarette smoke probably caused claimant's nasal mucosal congestion according to claimant's history and referred her to Dr. Eschelman, ear, nose and throat specialist. Dr. Eschelman diagnosed a left antral mucosal cyst and ceptal deviation and recommended that claimant avoid smoke irritation by avoiding smoke-filled rooms. Dr. Eschelman later opined that cigarette smoke was a respiratory irritant but would not state that smoke exposure was "the primary factor in the patient's development of the antral cyst and polyp."

Claimant was also examined by Dr. McDonald, allergist. He reported:

> "Her sensitivity is obviously far beyond the average or normal level zone in a healthy population. Nevertheless, I believe that her symptoms are real and are in fact triggered by an exquisiste sensitivity to levels of cigarette smoke which are not troublesome to others. I believe the solution to this problem would be to offer this patient a work environment where no one smokes. . . ."

and further:

> "It is clear that [claimant] is working in an area adjacent to many smokers and would have a moderately heavy exposure to cigarette smoke. I am suspicious that the

> heavy smoke exposure is a contributing cause of the problems which [claimant] is currently having, but I am not able to prove that this is true. Assuming that her symptomatology is being worsened by her work environment, this would be a temporary worsening of her allergy condition which would continue only as long as she continued in that environment."

An industrial hygienist tested air samples at claimant's desk area on Monday, October 17, 1983, at a time when claimant was out of the building, there was no smoke in the office, windows were open and fans were operating. The test revealed an extremely light concentration of carbon dioxide. No tests were performed for smoke particulates, phenols, formaldehyde, carbon monoxide, or other tobacco smoke products.

On April 30, 1984 Dr. Gambee opined that there was a reasonable medical probability that the work exposure was a major contributing cause of claimant's recurrent problems with smoke irritation.

Claimant had been a moderately heavy smoker prior to this employment and admitted "bronchitis" attacks had occurred prior to this employment. Claimant testified that she had become asymptomatic since termination of this employment and was not under medical care at the time of hearing. She purposefully avoids places where she could be exposed to concentrations of tobacco smoke and departs any time she is inadvertently exposed to it.

The Referee upheld the SAIF Corporation's denial of compensability of the claim for occupational disease because claimant failed to carry her burden of proof that she had a worsening of her condition which had been symptomatic and had required treatment before beginning this employment. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Weller v. Union Carbide, 288 Or 27 (1979). Whether claimant had a preexisting underlying condition is not vital to the decision in this case. Claimant's symptoms or lack of symptoms is not determinative of the standard of proof, it merely provides evidence that claimant had some indications of a preexisting underlying condition at the time she began her employment. See Wheeler v. Boise Cascade, 298 Or 452 (1985). If claimant had no preexisting underlying condition, she was still required to show that the exposure at work was the major cause of her condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). As explained in Wheeler, claimant did not have to show that her condition was permanently worsened by her exposure to tobacco smoke at the workplace. 298 Or at 457. However, this is the sort of complicated question of medical causation that requires expert medical opinion to guide us. Cf. Uris v. Compensation Department, 247 Or 420 (1967). Claimant must carry her burden of proof by a preponderance of the persuasive evidence that her work exposure was the major contributing cause of the worsening of her condition. Wheeler v. Boise Cascade, supra.

Claimant's evidence on medical causation of her condition never rises above possibilities of causation in a complex situation. No doctor opined that work exposure to tobacco smoke or other air-borne irritants was a greater cause of claimant's

symptoms than off-work exposure nor that she had become more sensitive. There is no opinion that claimant's exposure to tobacco smoke at the workplace caused or exacerbated her antral cyst and polyp. We agree with the Referee and find that claimant has not carried her burden of proof that her work exposure to tobacco smoke in the atmosphere was the major contributing cause of a condition or a worsening of a condition.

While this case is superficially similar to Mary A. Downey, 37 Van Natta 455 (WCB # 83-01911, April 23, 1985), in Downey, the claimant had never smoked tobacco and suffered from "irritative rhinosinusitis caused by exposure to tobacco smoke." Three doctors opined that claimant's exposure to cigarette smoke was the cause of her hypersensitivity to cigarette smoke and the resulting symptomatology which became worse upon repeat exposure. In this case, claimant became sensitized to tobacco smoke while a smoker herself, and the medical opinions did not support claimant's theory of causation nor was there evidence that claimant's sensitivity to smoke had worsened. See also Maxine P. Robinson, 37 Van Natta 50 (1985).

ORDER

The Referee's order dated October 17, 1984 is affirmed.

JAMES E. NELSON, Claimant
L. Thomas Clark, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Brian L. Pocock, Defense Attorney

WCB 83-03501 & 84-00627
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Podnar's order that upheld denials by both the SAIF Corporation and Aetna Casualty Company for his low back condition, diagnosed as a herniated disc on the right side at L5-S1. Aetna argues on review that interim compensation, a penalty and attorney fees should not have been assessed against it. The issues are compensability and interim compensation, penalty and attorney fees.

Claimant was age 54 at the time of the hearing and had been employed for a number of years as a ranchhand. Claimant has a fairly long history of injuries to his back and has had two laminectomies. On April 10, 1979 claimant injured his back while jumping on hay bales to press them into a loaded truck. He had an immediate onset of low back pain with radiation of pain into his left groin. SAIF accepted the claim and it was eventually closed July 11, 1980 with no disability award, apparently because claimant did not submit to a closing medical examination.

On or about May 15, 1982, while working for Aetna's insured, claimant was lifting 150 pound sacks of grain when he felt immediate low back and right leg pain. He testified he took some time off work hoping that the pain would subside, which it did somewhat. However, claimant testified that the pain generally persisted and became worse such that he sought additional medical care and was hospitalized November 1, 1982. At that time, claimant's clinical signs were indicative of a probable herniated disc on the right side at L5-S1.

Claimant's testimony was that he had worked for two other employers in the relevant interval, one between working for SAIF's insured and Aetna's insured and one after having worked for Aetna's insured. Claimant testified that he suffered no injury during either of those employments. He also testified that during his last employment he continued to feel the symptoms that arose during the grain lifting incident with Aetna's insured. The Referee did not state that claimant was not a credible witness.

On our de novo review of the record we are persuaded by a preponderance of the evidence that claimant suffered a discrete injury while employed by Aetna's insured. The evidence clearly shows that claimant's injury that was accepted by SAIF was on the left side of his body, while the evidence equally clearly shows that claimant's most recent injury was to the right side. There is no other persuasive evidence from which we could infer any logical connection between the SAIF claim and claimant's present condition.

The Referee's decision could have been based upon either an application of the last injurious exposure rule or upon claimant having submitted an untimely claim against Aetna's insured. Claimant testified that he made efforts through telephone calls and letters to his employer to inform the employer that he was injured and to obtain a claim form. Claimant's attorney wrote to Aetna's insured on April 21, 1983 regarding the claim and received no response. On June 17, 1983 claimant's attorney wrote to Aetna and enclosed a Form 801 executed by claimant. There is no evidence in the record contrary to claimant's testimony that he gave his employer notice of his injury soon after it occurred. While claimant's communication with his employer may or may not have been understood as a claim by the employer, clear notice of claim was given to the employer within one year of the injury, ORS 656.265(4)(c), and there was no showing at the hearing that the employer or Aetna were prejudiced by the manner of giving notice, ORS 656.265(4)(a).

The other avenue to the Referee's result is via the last injurious exposure rule. Apparently under that analysis the Referee declined to find Aetna responsible for claimant's condition because claimant's other employers were not before the forum. In Daniel P. Miville, 36 Van Natta 1501 (1984), we applied the last injurious exposure rule to shift responsiblity from one employer to another, an out of state, employer who was not a party to the Oregon litigation. In every responsibility case the assigning of responsibility to one employer necessarily results in a finding that one or more other employers are not responsible, and the presence, or absence, of the employers as parties to the workers' compensation litigation does not alter the fact of responsibility. As we stated above, we are persuaded by the preponderance of the evidence that claimant suffered a discrete injury while employed by Aetna's insured. The last injurious exposure rule is inapplicable in this case. See Boise Cascade Corp. v. Starbuck, 296 Or 238, 243-44 (1984); Smith v. Ed's Pancake House, 27 Or App 361, 364-65 (1976).

Finally, Aetna addresses the question of "interim compensation" and penalties. The Referee ordered Aetna to pay temporary total disability as interim compensation between the

time claimant's attorney mailed Form 801 to Aetna and the time claimant requested a hearing on Aetna's de facto denial. See Joyce A. Morgan, 36 Van Natta 114 (1984). The Referee also assessed additional compensation of 25% of the amount due and unpaid as a penalty for not processing the claim and awarded an insurer paid fee to claimant's attorney.

We have no fundamental disagreement with the Referee's approach, however, since the Referee's orders were issued, the Supreme Court issued its opinion in Bono v. SAIF, 298 Or 405 (1985). There is evidence that claimant may have worked during the period for which the Referee ordered "interim compensation," and under Bono claimant is entitled to "interim compensation" only if he left work due to his injury. However, because we order the claim accepted and processed by Aetna, the amount of temporary total disability due claimant is a claim processing matter to be resolved under the relevant law and regulations.

We agree with the Referee that, notwithstanding any other aspect of this claim, upon receipt of the signed Form 801 Aetna had a positive duty to process the claim in some manner. Its absolute failure to do so was appropriately penalized by the Referee.

ORDER

The Referee's orders dated August 17, 1984 and September 17, 1984 are modified in part, vacated in part and affirmed in part. Aetna Casualty Company's verbal denial of June 27, 1984 is set aside and claimant's claim is remanded to Aetna Casualty Company for acceptance and processing according to law. Those portions of the Referee's orders that awarded temporary total disability as interim compensation are vacated and Aetna Casualty Company is ordered to determine and pay temporary total disability compensation in accordance with this order. Claimant's attorney is awarded a fee of 25% of the compensation made payable by this order, not to exceed $2,000 and an additional fee of $1,000 for his services at the hearing in obtaining the setting aside of the denial, the additional fee to be paid by Aetna Casualty Company. Except as modified and vacated, the remainder of the Referee's orders are affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by Aetna Casualty Company.

DANIEL R. SCHIEFELBEIN, Claimant
Michael Dye, Claimant's Attorney
Lindsay, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03040 & 84-06649
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Argonaut Insurance Company and the SAIF Corporation have both requested review of Referee Foster's order that granted claimant interim compensation and a penalty and attorney fees for failure to pay interim compensation pending acceptance or denial of claimant's claims. The Referee's order was issued December 3, 1984 and Argonaut and SAIF requested review on December 12, 1984 and December 17, 1984, respectively. The Referee awarded interim compensation and an attorney fee based upon the Court of Appeals decision in Bono v. SAIF, 66 Or App 138 (1983).

On December 28, 1984 the Supreme Court reversed the Court of Appeals in Bono v. SAIF, 298 Or 405 (1984). All of the parties to this review agree that claimant did not leave work as a result of his industrial injury and that under the Supreme Court's Bono case claimant is not entitled to interim compensation or an attorney fee. Accordingly, the Referee's order shall be reversed.

We write further to address a procedural matter raised by the insurers. Immediately after the Supreme Court issued its opinion in Bono, Argonaut moved for a summary order reversing the Referee's order. SAIF concurred in Argonaut's motion. Claimant did not respond. The Board was without authority at that time to rule on the motion because the record had not been prepared by the Hearings Division pursuant to ORS 656.295(3). By the time the record was prepared, a briefing schedule had been established. Both Argonaut and SAIF then filed briefs. Claimant finally responded to the briefing schedule on March 6, 1985 by acknowledging the court's ruling in Bono v. SAIF and agreeing that Argonaut's suggested disposition of the case was appropriate.

Argonaut has requested that it be awarded its costs and attorney fees on review. Although we agree that time and effort could probably have been saved had claimant responded to Argonaut's motion in a more timely fashion, there is no statutory or other basis upon which to grant Argonaut's request.

ORDER

The order of the Referee dated December 3, 1984 is reversed.

RUSSELL D. SCHWEITZ, Claimant
Cash R. Perrine, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-11543
May 31, 1985
Order on Review (Remanding)

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of Referee Michael Johnson's order which set aside its denial of claimant's left leg injury claim. On review, SAIF contends claimant was not an Oregon subject worker.

Our de novo review of the record has revealed that the Referee admitted into evidence Exhibits 8 and 8A. The exhibits, which apparently were a copy of a letter and attachments from a bookkeeper for Cut-A-Log, Inc., do not appear in the exhibit portion of the record. Moreover, no documents marked Exhibit 8 or 8A appear in the entire record currently scheduled for review. SAIF has recently provided the Board with a copy of the aforementioned exhibits. Copies of some, but not all, of these documents already are present in the record.

Pursuant to ORS 656.295(5) the Board may remand a case to the Referee for further evidence taking, correction or other necessary action, when it determines that a case has been improperly, incompletely, or otherwise insufficiently developed. We conclude that the omission of Exhibits 8 and 8A constitutes an improper, incomplete, or otherwise insufficient development of this case.

Accordingly, we remand to the Referee to reconsider this matter in light of our discovery. Should the Referee conclude

that a hearing is necessary to identify the aforementioned exhibits and include them in the record, he is directed to initiate the appropriate proceedings. The Referee is further directed to issue an order on reconsideration indicating the effect, if any, the inclusion of Exhibits 8 and 8A into the record has upon his original order.

ORDER

This case is remanded to the Referee for further action consistent with this order.

DARYL W. SELL, Claimant
Hayner, Waring, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 84-08767
May 31, 1985
Order on Review

Reviewed by Board en banc.

The self-insured employer requests review of that portion of Referee T. Lavere Johnson's order which awarded claimant a $2,000 employer-paid attorney's fee for prevailing on a denied aggravation claim. The employer contends that the Referee's award is not a "reasonable attorney fee" and, indeed, is excessive. Considering the efforts expended and results obtained by claimant's attorney, OAR 438-47-010(2), we find the fee awarded excessive, and we modify the Referee's order accordingly.

Claimant sustained a compensable right ankle injury on September 9, 1983. This condition was diagnosed as a sprain, treated conservatively and eventually closed by the employer's Notice of Closure granting approximately five weeks of temporary disability benefits. Claimant worked regularly until June 1, 1984, on which date he reinjured his right ankle while playing softball or baseball with the company team. The employer denied this incident, which resulted in increased ankle symptoms and additional medical treatment, by a formal denial letter dated July 31, 1984. The employer stated that claimant's injury was a new, nonindustrial injury, and further that it did not constitute an aggravation of claimant's prior, industrial ankle injury.

Claimant secured the services of counsel, who requested a hearing in his behalf. In addition, counsel submitted an application and supporting affidavit for an expedited hearing. The hearing was set on an expedited basis. OAR 438-06-010.

Claimant's attorney generated one medical report from claimant's attending physician, which was submitted as an exhibit. The hearing convened on the afternoon of October 18, 1984. Twelve exhibits, including claimant's one, were offered and admitted. Claimant testified in his own behalf. Claimant also presented testimony of a friend and coworker. The employer presented one witness. The record of the hearing was closed that same date.

Claimant attempted to establish that his June 1, 1984 injury arose out of and in the course of his employment. The Referee was not persuaded. The Referee concluded, however, that the evidence preponderated in favor of concluding that claimant's reinjured ankle was a compensable consequence of his original industrial injury under the standard enunciated in Grable v. Weyerhaeuser Co., 291 Or 387, 401 (1981).

The transcript of the oral proceeding before the Referee is 81 pages. No written closing argument was requested or received by the Referee. Claimant's attorney has submitted an affidavit detailing a total of 9.5 hours expended in representing claimant in connection with the employer's denial.

None of the issues in this case are particularly complex. Claimant proceeded on two theories at hearing: one theory was that he sustained a new injury arising out of and in the course of his employment; the other theory being a compensable aggravation. The former theory failed, and the latter prevailed. Counsel generated a single report from claimant's attending physician. No depositions were involved. Counsel's affidavit reflects that at the time of the hearing, his law firm's hourly rate was $80 per hour.

The employer relies upon our decision in Clara M. Peoples, 31 Van Natta 134 (1981), in which we reduced the insurer-paid attorney's fee awarded by the Referee from $1,436.17 to $1,000. (The Referee in Peoples had erroneously included a doctor's fee for writing a report as part of the fee awarded counsel.) We noted in Peoples that the average denied claim warranted a fee in the range of $800 to $1,200 which was subject to variation depending upon efforts expended and results obtained. See also John C. Roop, 35 Van Natta 1652 (1983).

On the efforts expended/results obtained continuum for denied aggravation claims in general, on a scale of 1 (minimum) to 10 (maximum), this case rates about a 4. The time consumed is fairly modest and the factual/legal issues are very straight forward. The immediate benefits that accrued to claimant as a result of overturning the denial were temporary disability benefits from the date of claimant's injury in June of 1984 through the date he returned to work in mid September of that year. In addition, claimant received payment for the additional medical services incurred as a result of the aggravation. All treatment rendered was conservative. Perhaps more significant is the fact that, considering the nature of the original injury and the "reinjury," if claimant had failed to prevail it would have been difficult to "jump over" this denial in the future, in the event he continued to suffer ankle problems.

Considering the efforts expended and results obtained in claimant's behalf, as partially established by counsel's affidavit, we find that $950 is a reasonable attorney's fee.

ORDER

The Referee's order dated October 31, 1984 is modified insofar as it awarded claimant's attorney $2,000 for prevailing on this denied aggravation claim. In lieu of the fee awarded by the Referee, claimant's attorney is awarded $950 for services at hearing.

RINALDO F. SINCLAIR, Claimant
Emmons, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney
WCB 82-11050
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review and the self-insured employer cross-requests review of Referee Seymour's order which awarded claimant an additional 160° for 50% unscheduled disability for injury to his low back and functional disturbance in addition to prior Determination Order awards totalling 64° for 20% unscheduled disability for low back injury and 15° for 10% loss of use of claimant's left leg. Claimant contends that he is permanently and totally disabled. The employer contends that the Referee's award was excessive.

We affirm the order of the Referee with the following comment. The Referee stated:

> "First, I am not considering the August 1, 1983 report of Mark Ackerman, psychologist. I do not consider the conclusions of a psychologist as probative. A psychiatrist yes, a psychologist no."

We take exception. See Barrett v. Coast Range Plywood, 294 Or 641 (1983). On our de novo review we have considered Dr. Ackerman's report.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated September 14, 1984 is affirmed.

JOSEPH R. SMITH, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys
WCB 83-11027
May 31, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Baker's order which awarded claimant compensation for permanent total disability effective October 10, 1984, the date of hearing. The only issue on review is whether claimant is entitled to an award for permanent total disability. This, in turn, depends upon our findings and conclusions concerning whether claimant is so severely disabled as to be entirely excused from the seek-work requirement of ORS 656.206(3). See generally George M. Turner, 37 Van Natta 531 (May 7, 1985).

The medical and vocational evidence persuades us that this 61 year old former dock foreman is permanently incapacitated from regularly performing work at a gainful and suitable occupation, and that it would be futile for him to attempt to be employed. Therefore, we affirm the Referee's order awarding permanent total disability.

ORDER

The Referee's order dated October 30, 1984 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the SAIF Corporation.

DONALD M. VAN DINTER, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwenn, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys

WCB 81-05303, 82-06302, 82-07084, 82-09038, 83-02631, 83-06962, 83-06963 & 83-06964
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation, as insurer for Trailer Equipment (TE), requests review of Referee Galton's order which: (1) set aside its de facto denial of claimant's April 1981 claim for a new injury; (2) increased claimant's unscheduled permanent disability award for a low back injury to 5% (16°), whereas a November 25, 1980 Determination Order had awarded no permanent disability; (3) assessed it penalties and accompanying attorney fees for an unreasonable delay and refusal to timely furnish medical reports; (4) ordered it to pay temporary disability compensation from the date of the April 1981 injury through the date of a prior Referee's order at an April 1981 wage rate, less time worked and time loss benefits paid at a lower wage rate; and (5) assessed penalties and attorney fees for failing to comply with the prior Referee's order.

SAIF (TE) contends: (1) The Board had no authority to remand its prior request for review and, in effect, delegate its reviewing function to the Hearings Division; (2) the Referee misconstrued the Board's Order on Remand by enforcing prior orders but not allowing the insurers to assert possible defenses; (3) the Referee erroneously awarded time loss, penalties and accompanying attorney fees for overlapping and concurrent time periods; (4) claimant is not entitled to an award of permanent disability; and (5) claimant's award of attorney fees was excessive.

SAIF, as insurer for Columbia Battery (CB), cross-requests review of those portions of Referee Galton's order which: (1) set aside its September 1982 denial of claimant's December 1981 new injury claim; (2) awarded claimant's attorney an insurer-paid fee for prevailing on the denied claim of $2,000; (3) ordered it to pay temporary disability from the December 1981 injury date until claim closure; and (4) awarded interim compensation, penalties and accompanying attorney fees.

On review, SAIF (CB) contends: (1) A previous Referee's order, since vacated by Board order, should be binding on claimant and SAIF (TE), thereby dismissing SAIF (CB) and Fireman's Fund Insurance Company as parties; (2) the Board erred in remanding to the Referee for a hearing on responsibility; (3) the Referee exceeded the scope of his instructions on remand; (4) the Referee improperly assessed duplicative, overlapping and excessive awards of temporary disability benefits, interim compensation, penalties and accompanying attorney fees; and (5) claimant sustained an aggravation rather than a new injury as a result of the December 1981 incident.

Fireman's Fund Insurance Company cross-requests review of those portions of Referee Galton's order which: (1) set aside its denial of claimant's April 1981 new injury claim; (2) awarded temporary disability benefits from the April 13, 1981 injury through September 21, 1981, the date of claim closure relative to the April 1981 incident; (3) awarded claimant an insurer-paid

attorney's fee of $3,000; (4) assessed a penalty, less penalties paid pursuant to a previous Referee's order, based on temporary disability benefits accrued between July 7, 1982, the date Fireman's received notice of the claim, and September 8, 1982, the date Fireman's issued its denial, and accompanying attorney's fees; (5) ordered Fireman's to pay temporary disability benefits, plus penalties and accompanying attorney fees, as directed by a prior Referee's order, as well as through the date of its September 1982 denial, less amounts previously paid; and (6) partially set aside Fireman's denial which attempted to deny future responsibility for claimant's medical treatment.

On review, Fireman's contends: (1) The Referee erred in awarding temporary disability benefits which were duplicative, covered overlapping periods and were excessive; (2) the Referee erroneously failed to allow the insurers' offsets, which resulted in a windfall to claimant; (3) claimant's attorney fee awards were excessive; and (4) Fireman's was not responsible for claimant's April 1981 incident nor his subsequent condition.

This matter is once again before the Board for review. The facts of this case were set forth in our previous Order on Review (Remanding), Donald M. Van Dinter, 35 Van Natta 1574 (1983), and shall not be repeated herein. Suffice it to say that we described this case as a "procedural morass," vacated all previous orders and remanded with the goal to "make a 'fresh start' to determine the real question in this case, i.e., employer/insurer responsibility."

The Referee has made those responsibility determinations in a logical, cogent manner, well supported by the facts and prevailing law. Therefore, we affirm those portions of the Referee's order which pertain to insurer responsibility for three separate and distinct new injuries suffered by claimant.

We disagree with the insurers' contentions that the Board, in effect, delegated its appellate responsibility by remanding to the Referee. Further, we disagree that the Referee exceeded the scope of his authority in hearing the case on remand. The Board may remand the case to the Referee for further evidence taking, correction or other necessary action if it determines that a case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). In view of the complex procedural entanglements present in this case, as well as claimant's failure to receive compensation due to the insurers' failure to procure a .307 order, we conclude that our decision to remand was necessary and fully supportable. Furthermore, given our intention to allow the Referee an opportunity to make a "fresh start," we find that he did not exceed his authority in issuing his order. Finally, in conducting our de novo review of the record, we have considered all of the arguments raised by the insurers, including collateral estoppel, res judicata, waiver and the like, and have found them unpersuasive.

We reverse and modify certain portions of the Referee's order which awarded claimant temporary disability and assessed Fireman's penalties and attorney fees.

Specifically, we conclude that claimant is not entitled to temporary disability concerning his April 1981 injury for the period from December 9, 1981 through July 6, 1982. Although

Referee Pferdner's February 1983 order directed Fireman's to process the claim, we are persuaded that had the claim been appropriately processed claimant would not have been entitled to compensation during this period. SAIF (TE) had paid compensation for this period relative to claimant's December 1981 incident, which at that time SAIF (TE) was treating as an aggravation. Since there would be no compensation "then due" for this period, it follows that no penalty and attorney fee can be awarded. Whitman v. Industrial Indemnity, 73 Or App 73 (1985); Darrell W. Carr, 36 Van Natta 16, 17 (1984).

Furthermore, we conclude that Fireman's should only be obligated to pay time loss between April 13, 1981 and September 21, 1981 once. The time loss award granted by the Referee's order in WCB Case No. 82-07084 will suffice. Therefore, that portion of the Referee's order in WCB Case No. 83-02631 which directed an additional temporary disability award for the same period is reversed.

The above reasoning results in the following modifications to the Referee's order concerning penalties and accompanying attorney fees regarding this particular matter. The 25% penalty should only be applied to temporary disability benefits payable between April 13, 1981 and September 21, 1981 as ordered in WCB Case No. 82-07084. Claimant's reasonable attorney's fee should be reduced to $500.

In addition, the evidence suggests that Fireman's did attempt to comply with that portion of Referee Pferdner's order which found that claimant was entitled to interim compensation between July 7, 1982, the date of notice of the claim, and September 8, 1982, the date of Fireman's denial, as well as penalties and attorney fees. Therefore, Fireman's should pay interim compensation between the aforementioned dates, less compensation previously paid. Fireman's shall also be assessed a penalty of 25% of any amount left unpaid, less penalties previously paid, if any. Claimant is entitled to a reasonable attorney's fee of $400 concerning this issue. Those portions of the Referee's order pertaining to WCB Case Nos. 82-07084 and 83-02631 which are inconsistent with the conclusions expressed in this paragraph are hereby modified.

Our decision should not be interpreted as rewarding Fireman's recalcitrance in complying with a prior Referee's order. Given the extent of the remaining temporary disability awards which we are affirming, as well as the significant penalties assessed on these awards, we are reasonably certain that Fireman's would be the first to argue against any conclusion that today's order was lenient and encourages employers/insurers to disobey Referee orders.

The so-called "double payments" issue, or compensation for overlapping periods, stems primarily from the insurers' failure to process outstanding claims or to abide by prior Referees' orders. ORS 656.313(1) provides that the filing of a request for review shall not stay the payment of compensation. Consequently, in some instances Referee Galton not only echoed the prior Referees' conclusions in his own order, but enforced their orders, thereby penalizing the insurers for their deliberate refusals to comply with the prior orders.

We support the Referee's analysis because to fail to enforce the previous orders would serve as an impetus to employers/insurers to refuse to comply with the Referee's order with the hope that the order will ultimately be overturned. If such an attitude is countenanced, even implicitly, a principle critical to not only the efficiency, but the integrity of the workers' compensation system could be irreparably damaged.

As we noted in Darrell Messinger, 35 Van Natta 161, 166 (1983), "Assessment of penalties and attorney fees, while punishing the recalcitrant insurer after the fact, does nothing for the claimant when he is most in need of compensation benefits." This situation presents similar circumstances. On first blush it appears claimant is receiving a windfall of benefits from a multitude of sources, a result which we generally refrain from supporting. See Charles E. Fischer, 36 Van Natta 1500, 1553 (1984). However, one must consider that for a significant period claimant received no compensation from any insurer, not only due to his lack of success in obtaining the benefits of a ".307" order, but even in the face of outstanding claims and Referee orders. Considering the intent and purpose behind the workers' compensation system, awards of temporary disability benefits covering overlapping periods from several insurers is fully supportable, particularly where the insurers' inactions or omissions represent separate, distinct and deliberate decisions to refrain from following established procedures as they pertain to individual claims.

Finally, following our de novo review of the record, and considering (1) the unique circumstances presented in this case, which includes numerous legal and factual issues of varying degrees of complexity; (2) the protracted litigation necessary to reach the ultimate resolution of these issues; and (3) the "efforts expended and the results obtained," we conclude that the Referee's awards of attorney fees, not otherwise reversed by this order, were appropriate. See OAR 438-47-010(2).

However, we reverse that portion of the Referee's order which awarded claimant a $400 attorney's fee to be paid by SAIF (TE) in WCB 83-06962. Due to the lack of medical verification of an inability to work and other reasons, SAIF (TE) was under no obligation to pay interim compensation concerning claimant's aggravation claim. Since there was no compensation upon which to base a penalty, no penalty or attorney fee can be awarded. Darrell W. Carr, 36 Van Natta 16, 164 (1984).

The remaining portions of the Referee's order are affirmed.

ORDER

The Referee's orders dated October 31, 1983 and November 22, 1983 are affirmed, modified and reversed in part. The following portions of WCB Case Nos. 82-07084 and 83-02631 are modified. Claimant shall receive from Fireman's Fund Insurance Company temporary disability compensation due between July 7, 1982 and September 8, 1982, less amounts previously paid. Fireman's shall be assessed a 25% penalty on this amount, less penalties previously paid, if any. Claimant is awarded a reasonable attorney's fee of $400 concerning this issue. Claimant's award of temporary disability compensation, and accompanying 25% penalty, between December 9, 1981 and July 6, 1982 in WCB Case No. 83-02631 is

reversed. Claimant's award of temporary disability compensation between April 13, 1981 and September 21, 1981 in WCB Case No. 83-02631 is reversed. Fireman's shall be assessed a 25% penalty on the temporary disability compensation due between April 13, 1981 and September 21, 1981 as ordered by WCB Case No. 82-07084. Claimant's attorney fee award is reduced to $500. Claimant's award of a $400 attorney fee in WCB Case No. 83-06962 is reversed. The remainder of the Referee's orders are affirmed. Claimant's attorney is awarded $900 for services on board review, to be paid in equal proportions by the three insurers herein.

SYLVIA A. WEAVER, Claimant
Bottini & Bottini, Claimant's Attorneys
Beers, et al., Defense Attorneys
David Horne, Defense Attorney
John Snarskis, Defense Attorney

WCB 84-01115, 84-04251 & 84-04252
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

EBI Companies requests review of that portion of Referee Fink's order that declared it responsible for claimant's left foot condition, diagnosed as Morton's neuroma. Industrial Indemnity Company cross-requests review of that portion of the Referee's order that assessed a penalty and insurer-paid attorney fee against it. The issues are responsibility between sucessive insurers of the same employer and penalties and attorney fees. Wausau Insurance Company is also a party to Board review. The compensability of claimant's condition is conceded by all three insurers.

EBI insured the employer prior to and through February 1982. Wausau insured the employer from March 1, 1982 through February 1983. Industrial Indemnity was on the risk from March 1, 1983 to the present. Each of the insurers advance arguments directed at placing responsibility on one of the other insurers.

EBI argues that Industrial Indemnity, as the last insurer, is responsible for claimant's condition under the last injurious exposure rule. Industrial Indemnity argues that the last injurious exposure rule does not apply in this case and that EBI is responsible as the aggravation insurer, or, in the alternative, that if the last injurious exposure rule does apply, Wausau is responsible because claimant became disabled while the employer was insured by Wausau. Wausau argues that the Referee's order should be affirmed, or, in the alternative, that the last injurious exposure rule requires that Industrial Indemnity be held responsible. Claimant urges that Industrial Indemnity is responsible, again under the last injurious exposure rule, as amplified by the Court of Appeals since the Referee's order was issued.

Claimant has worked as a waitress for over 30 years. In 1976, while working for this employer, claimant's condition of Morton's neuroma was accepted by EBI, processed as a disabling occupational disease claim and ultimately closed by a 1979 Determination Order that granted claimant a scheduled award of 13.5° for 10% loss of use of the left foot. In 1980 claimant was again treated for pain, which was relieved by local injections. Claimant again came under her doctor's care on February 22, 1983. Dr. Fraser, claimant's treating podiatrist throughout, opined in 1983 that claimant's clinical situation remained a neuroma, and

that the same or similar symptoms had persisted throughout claimant's claim history. He noted that after repeated visits, he found a palpable mass between the metatarsal heads that had become larger over time. Finally, Dr. Fraser opined that (1) claimant's condition was a progression of her initial condition and (2) "[claimant's] work has been a substantial factor in the worsening of this condition." There is no medical evidence persuasively contrary to Dr. Fraser's opinion.

Reduced to fundamentals, the question we must resolve is whether claimant's present condition is an aggravation of her 1976 occupational disease accepted by EBI, or a new condition for which one of the subsequent insurers is responsible. Industrial Indemnity argues that claimant's condition is an aggravation, pointing to authority that aggravations of occupational disease cases are treated the same as aggravations of industrial injuries. Professor Larson states:

> "Recurrences of disability in occupational disease cases are treated the same as recurrences of disability in accidental injury cases. Thus, when disability has once resulted from occupational disease, a second disability occurring under a different carrier will be chargeable to the first carrier if it is a recurrence of the first disability."

4 Larson, Workmen's Compensation Law, § 95.27 (1984) (Emphasis added).

Professor Larson's statement, while persuasive in the abstract, does not answer the question, however, because of the italicized "if" in the quoted passage. Whether a present condition is a "mere recurrence" as opposed to a new condition will always be a question of fact to be decided on a case by case basis. To this extent, analysis of this case is not unlike that in an "aggravation versus new injury analysis" in a successive injury case.

EBI argues that the last injurious exposure rule applies to this case, and under that rule either Wausau or Industrial Indemnity are responsible. EBI relies upon Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984) and FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified, 73 Or App 223 (April 17, 1985). Industrial Indemnity argues that these cases are to be distinguished from the present case because each of them dealt with determining compensability of an occupational disease in the first instance. In this case, the compensability of claimant's occupational disease was established when EBI accepted the claim in 1977, thus, Industrial Indemnity argues, the present condition can be nothing more than an aggravation of that accepted condition.

There are persuasive aspects to both arguments, and we find very little in the way of specific guidance in the appellate decisions. As noted above, however, whether claimant's present condition is an aggravation or a new condition is first a question of fact. We believe that our determination of the factual question must be guided by the Supreme Court's opinions in the

line of cases beginning with Weller v. Union Carbide, 288 Or 27 (1979), and most recently supplemented by Wheeler v. Boise Cascade, 298 Or 425 (1985). The so-called "Weller test" for establishing the compensability of an occupational disease claim was stated by the court as:

> "[I]n order to prevail claimant would have to prove by a preponderance of the evidence that (1) his work activity and conditions (2) caused a worsening of his underlying disease (3) resulting in an increase in his pain (4) to the extent that it produces disability or requires medical services."

Weller v. Union Carbide, supra, 288 Or at 35.

The "Weller test" has been applied by the courts so far only in deciding compensability of occupational disease claims in the first instance. However, the Supreme Court has recently decided that the analysis of Weller applies whether or not a claimant's condition is symptomatic at the time of employment. Wheeler v. Boise Cascade, supra, 298 Or at 457-58. That being the case, the significance in this case of EBI's acceptance of claimant's condition in 1977 and the closure of her claim in 1979 is to establish the baseline from which to measure whether a "Weller worsening" has occurred, as opposed to a "mere recurrence of disability." That claimant continued to be symptomatic after the 1979 Determination Order is a fact rendered less significant by Wheeler. Further, we find no meaningful distinction between a compensable underlying condition and one that is noncompensable. The only question is whether the condition worsened due to employment. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

We are persuaded by a preponderance of the evidence that claimant's underlying disease worsened because of her employment after EBI no longer insured the employer. The Referee's assignment of responsibility to EBI was, therefore, erroneous. This finding does not, however, end the inquiry.

We must now apply the last injurious exposure rule to determine responsibility between Wausau and Industrial Indemnity. Claimant sought medical attention for her worsened condition six days prior to the termination of Wausau's coverage. The evidence persuades us that claimant's condition continued to worsen between February 1983 and the hearing. We determine responsibility as of the hearing.

The evidence establishes that claimant's worsened condition was caused by continued weight-bearing due to the nature of her employment. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified, 73 Or App 223 (April 17, 1985), also involved a single employer and exposure to occupational disease over time while different insurers provided workers' compensation coverage to the employer, including a period when the employer was self-insured. The Court of Appeals applied the last injurious exposure rule to hold the self-insured employer liable as the last "insurer" where the conditions during its "coverage" could have caused the condition and where it could not prove that an earlier exposure was the sole cause or that its employment could not possibly have caused the disease. 70 Or App at 374. As the court

made clear in its opinion on reconsideration, that the employer was responsible for the claimant's condition was never in question. FMC Corp. v. Liberty Mutual Ins. Co., 73 Or App 223 (On Reconsideration, April 17, 1985), Slip Op. at 1. We find this case to be virtually indistinguishable from FMC Corp. v. Liberty Mutual Ins. Co. We also find that claimant's employment activities during Industrial Indemnity's coverage could have caused claimant's worsened condition at the time of the hearing, and that Industrial Indemnity did not prove that claimant's activities during Wausau's or EBI's coverage were the sole cause of claimant's worsened condition. Accordingly, Industrial Indemnity is responsible for claimant's condition. See also Industrial Indemnity Co. v. Kearns, 70 Or App 583, 588 (1984).

The Referee also assessed penalties against all three insurers. EBI was ordered to pay additional compensation of 15% of any unpaid temporary disability benefits during a seven month delay in acceptance or denial of claimant's aggravation claim. EBI does not contest this penalty on Board review, and it will be affirmed. Industrial Indemnity and Wausau were ordered to pay as a penalty 25% of any compensation due to claimant as of May 25, 1984, the date an order was entered designating Industrial Indemnity as paying agent pursuant to ORS 656.307. Each insurer was also ordered to pay a $500 penalty-associated attorney fee.

On Board review, Industrial Indemnity objects to the penalty and attorney fee, while Wausau's brief is silent on the issue. Notwithstanding Wausau's apparent acquiescence, we conclude that the Referee's rationale for imposing a penalty and associated attorney fee is without statutory basis, and we reverse that portion of the Referee's order.

The Referee imposed the penalties because both Wausau and Industrial Indemnity initially contested the compensability of claimant's condition, thereby delaying the issuance of an order under ORS 656.307. On February 10, 1984 the Worker's Compensation Department communicated with all three insurers regarding the issuance of a .307 order. On February 16, 1984 EBI denied responsibility only. On February 27, 1984 Industrial Indemnity denied responsibility and compensability. On March 8, 1984 Wausau denied compensability and, by implication, responsibility. Industrial Indemnity withdrew its denial as to compensability on April 19, 1984 and Wausau did likewise on May 18, 1984. The .307 order issued May 25, 1984.

A similar issue arose in EBI Companies v. Thomas, 66 Or App 105 (1983), where we awarded an insurer-paid attorney fee for the insurer's delay in seeking a .307 order. In reversing our award, the court stated:

> "ORS 656.307 and OAR [436]-54-332 do not provide for attorney fees (or penalties) if an insurer unreasonably delays a request to designate a paying agent. Neither does 656.262(9) [sic - now ORS 656.262(10)] so provide. EBI's request for a .307 order might have been more prompt if its denial of the claim had not been delayed, but in the absence of specific statutory authority for imposition of attorney fees (or

penalties) the Board may not impose them, even if the delay in requesting the .307 order results from unreasonable delay in denial of a claim."

66 Or App at 111-12.

In this case, Wausau's and Industrial Indemnity's denials were timely. Additionally, we have neither found nor been referred to any authority that requires an insurer to concede the compensability of a claim for the purpose of obtaining a .307 order. In the absence of such a requirement and in the further absence of statutory authority to penalize delay in requesting or acquiescing to a .307 order, the Referee's imposition of penalties and attorney fees as to Wausau and Industrial Indemnity was erroneous.

We finally note that claimant's attorney took the position on Board review that Industrial Indemnity should be held responsible for claimant's condition, the result that we now reach. We conclude that claimant's attorney's participation was active and meaningful, and that claimant's attorney is entitled to a fee, to be paid by Industrial Indemnity. See OAR 438-47-090.

ORDER

The Referee's order dated August 1, 1984 as amended August 15, 1984 is affirmed in part, reversed in part and modified. That portion of the Referee's order that held EBI Companies responsible for claimant's condition is modified to order that Industrial Indemnity Company accept claimant's claim as a disabling ocupational disease and process the claim pursuant to law. That portion of the Referee's order that imposed a penalty of 15% of compensation due and unpaid between June 22, 1983 and January 20, 1984 together with an attorney fee of $200 to be paid by EBI Companies is affirmed. That portion of the Referee's order that imposed penalties and insurer-paid attorney fees against Industrial Indemnity Company and Wausau Insurance Company is reversed. Claimant's attorney is awarded $550 for services on Board review, to be paid by Industrial Indemnity Company.

MARION R. WEBB, Claimant
Welch, et al., Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 83-07371
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review and the SAIF Corporation cross-requests review of Referee Daron's order which awarded 320° for 100% unscheduled disability in lieu of Determination Order awards totaling 96° for 30% unscheduled disability for injury to his low back. Claimant contends that he is permanently and totally disabled. SAIF contends that the Referee's award was excessive.

Claimant, a faller, quit school after the 8th grade and went to work in the woods. He had worked in the woods for 53 years when he compensably injured his low back on July 31, 1981, when a sliver from a falling tree hooked his saw, giving him a sudden jerk. Claimant received medical treatment and improved. He attempted to return to work as a faller in November 1981, but left

work after a fall in which he injured his left knee and worsened his back. A June 1982 attempt to return to falling was also unsuccessful. Since that time job search efforts have been limited to scanning the want ads. At the time of the hearing claimant was 69 years old and receiving social security.

Claimant was examined by Orthopaedic Consultants in March 1983. He complained of pain in his left knee, low back and right leg. The panel diagnosed lumbar spondylosis L4, L5 and L5-S1, not injury related, and lumbar sprain, injury related but resolved. They opined that claimant was capable of gainful employment on a reasonably continuous basis with a 30 pound lifting restriction and no repetitive bending or lifting.

Dr. Altrocchi, a neurologist, reported on May 3, 1983 that he did not agree with the Orthopaedic Consultants' diagnosis of claimant's problem as but a lumbar sprain, nor with their belief that claimant's problem had resolved. He diagnosed a herniation of the L3-4 disc on the right with compression on the right L4 nerve root based on EMG testing, decreased right ankle jerk and numbness. He rated claimant's physical capabilities as limiting him to two hours of sitting at a time for a total of four hours per day, restricting lifting and carrying to five pounds on an occasional basis and barring all bending, squatting and climbing. He termed claimant's overall impairment due to his compensable injury as moderate.

Dr. Smith, claimant's treating chiropractor throughout the early part of the claim, reported on May 6, 1983 that claimant could do light work requiring no more than one to two hours at a time on his feet, no lifting over 25 pounds and no repetitive stooping, bending or twisting.

Of the various medical reports we find most helpful those of Dr. McCleery, claimant's treating chiropractor since July 1983. Dr. McCleery's chart notes through the fall and early winter of 1983 indicate that claimant performed such activities as stacking a cord of wood, working on a ladder and roof on rain gutters and shoveling snow. At one point he reported that claimant was walking two to five miles per day. On January 18, 1984 he reported that claimant stated that he felt 70% improved concerning his low back and right leg pain under Dr. McCleery's care. At that time claimant was complaining of tingling numbness throughout the right leg, dull low back pain, and transient sharp mid-thoracic pain and associated heart chest pains. Dr. McCleery reported essentially normal cervical and lumbar ranges of motion. He reported a diagnosis of (1) chronic lumbosacral sprain/strain with concomitant lumbosacral subluxation and resultant chronic right vertebrogenic sciatic neuralgia, moderate lumbalgia, transient thoracic radiculitis and cervicalgia; and (2) chronic cervical spondylosis at levels C4 and C5 with concomitant cervical subluxation and resultant cervicalgia. He opined that these conditions were caused by the occupational incident. He termed claimant medically stationary, but did not release claimant for regular or modified work due to the probability of more severe injury.

On January 18, 1984 Dr. McCleery stated that claimant could sit two hours at a time for a total of eight hours per day, stand two hours at a time for four hours per day and walk three hours at

a time for six hours per day. He said that claimant could frequently lift up to 10 pounds and occasionally lift and carry up to 25 pounds. He restricted claimant from repetitive right leg movements and from bending and twisting, but authorized occasional squatting, stooping and climbing and frequent crawling, kneeling and reaching. He rated claimant's overall impairment at moderate or mildly moderate.

Dr. McCleery's January 19, 1984 chart notes report that claimant's chief complaint then concerned neck and upper thoracic stiffness and aching plus some sharp left knee pain and weakness. His May and June 1984 chart notes indicate that claimant's chief complaint was then thoracic neuralgia.

Field Services Division notified claimant of eligibility for vocational rehabilitation on December 30, 1981. After minimal activity claimant declined further return to work assistance on July 8, 1983 because, at age 67, claimant felt he could no longer be considered for returning to work in any capacity.

Steven R. Van Houten, a certified rehabilitation counselor, reported on February 7, 1984 that claimant had scored in the bottom third on eight of nine aptitude tests. Considering claimant's age, impairments and abilities and the labor market in the area where claimant lives, he stated that he believed that he would not be successful were he asked to help claimant find reemployment.

Claimant testified that he had not cut any wood since his injury, could not split wood and could not step up on a ladder. He testified that he could walk up to a mile, but that that brings on burning and aching. SAIF's investigator testified that in February 1984 he observed claimant climbing a ladder without apparent impairment.

The insurer offered for impeachment what appear to be July 26, 1983 notes by claimant's Field Services Division counselor regarding a visit to claimant's neighbor wherein she reports observing claimant doing strenuous wood chopping. She also records the neighbor's reports that he had observed claimant working on his house, including his roof, and chopping wood on a daily basis. The Referee held the exhibit inadmissible, sustaining claimant's hearsay objection and finding that the document was not adequately identified.

In workers' compensation hearings neither common law or statutory rules of evidence nor technical or formal rules of procedure are to be permitted to interfere with the primary objective of achieving substantial justice. See ORS 656.283(6). Our comparison of the impeachment document with other notes apparently by the same counselor admitted as substantive evidence satisfies us that the impeachment document is what it appears to be. Claimant's hearsay objection is answered by Armstrong v. SAIF, 67 Or App 498, 501 n. 2 (1984), wherein the court quoted ORS 656.283(6) and stated:

> "Technical hearsay objections have no place in a workers' compensation hearing. C.f. Higley v. Edwards, 67 Or App 488, ___ P2d ___ (1984) (discussing hearsay objections under the Administrative Procedures Act, ORS 183.450(1)). OEC 606-1 does not apply to a workers' compensation hearing. . . ."

As claimant points out, in most cases the admissibility of vocational reports is governed by ORS 656.287 and OAR 438-07-010. Here, however, a vocational counselor's notes are offered solely for impeachment. When an exhibit is offered for the limited purpose of discrediting other evidence and not as substantive proof of the matters contained within it, prehearing disclosure is not required. OAR 438-07-015(2). We have considered the exhibit for impeachment purposes in our de novo review. See Edward Morgan, 34 Van Natta 1590 (1982).

Finally, claimant has attached to his brief various Employment Division statistical reports and asked that we take official notice of a high unemployment rate in his home county and consider this in determining whether claimant's work search efforts were reasonable. See ORS 656.206(3). We decline to do so for the reasons set forth in Thomas C. Whittle, 36 Van Natta 343 (1984), and treat claimant's request as a motion for remand for the taking of additional evidence, see ORS 656.295(5). There being no reasonable explanation offered as to why such evidence could not have been introduced into the record at the time of hearing, we determine that remand is not appropriate. See Casimer Witkowski, 35 Van Natta 1661 (1983).

Claimant is 69 years old. He completed the 8th grade and has somewhat limited academic skills. All of his work experience has been in the woods. He cannot return to his former job as a faller. We are convinced, however, that his physical impairment as a result of the compensable injury would not prevent him from regularly performing light work and, considering these impairments together with those preexisting the injury, that claimant is not so incapacitated as to render work search efforts futile. Although we find that a capacity to work remains, claimant has not established that he is willing to seek regular gainful employment or that he has made reasonable efforts to obtain such employment. Considering claimant's physical impairment as a result of his compensable injury together with the social/vocational considerations relating to loss of earning capacity, see OAR 436-65-600 et seq., we find that claimant would be most appropriately compensated by a total award of 176° for 55% unscheduled permanent partial disability.

ORDER

The Referee's order dated September 21, 1984 is modified. Claimant is awarded 176° for 55% unscheduled permanent partial disability in lieu of all prior permanent disability awards in this claim. Claimant's attorney's fees are adjusted accordingly.

DAWN C. WHITE, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-09151
May 31, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of that portion of Referee Shebley's order which set aside its partial denial insofar as it attempted to deny responsibility for claimant's bilateral hip girdle pain. On review, the insurer contends claimant is precluded by the doctrine of res judicata from litigating the compensability of her bilateral hip condition, or, alternatively,

that her compensable injury did not materially contribute to her present condition. Claimant cross-requests review of those portions of the Referee's order which upheld: (1) the insurer's denial of her aggravation claim; and (2) that portion of the insurer's partial denial that denied responsibility for claimant's sacroiliitis, fibrositis and chronic back pain.

Claimant has forwarded to the Board copies of additional medical reports and a denial letter which have been issued post-hearing. We treat this submission as a motion to remand for the taking of further evidence. We deny the motion. Following our de novo review of the record, we are not persuaded that this case has been "improperly, incompletely, or otherwise insufficiently developed." ORS 656.295(5). Moreover, we note that the aforementioned denial letter is currently the subject of a pending request for hearing which is the appropriate forum for the matter.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated October 5, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review pertaining to the "bilateral hip girdle pain" issue, to be paid by the insurer.

DAVID A. YODER, Claimant
Schwabe, et al., Attorneys

WCB 83-07861
May 31, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Mongrain's orders which reversed the decision of the Director of the Workers' Compensation Department that claimant was not eligible for further vocational assistance and further ordered that: "The claimant be provided with reasonable additional training and writing skills and basic typing skills that will allow him to obtain an 'AA' degree in insurance adjusting," and "[t]he claimant be entitled to temporary total disability benefits during the time he is receiving reasonable additional training, if that additional training satisfies the criteria of OAR 436-61 pertaining to receipt of temporary disability benefits."

As to the issues actually decided by the Referee, claimant is not aggrieved. The Director found claimant was not entitled to further vocational assistance. On review of the Director's decision, the Referee concluded to the contrary. See former ORS 656.728(6). Although we are not entirely certain, it appears as though the issue claimant is raising concerns his entitlement to temporary total disability during his enrollment in the classes he is taking or will be taking in order to obtain his associate degree. This was not an issue before the Referee at the hearing, and it was only after the hearing that it became a potential issue. Thus, claimant is presenting an issue which was neither before the Referee nor decided by him.

What appears to have transpired is that the Field Services Division has determined that in order for claimant to obtain his

associate degree he must complete a writing skills class and a basic typing class, each of which consists of three credit hours. Claimant is entitled to temporary total disability during an authorized program of vocational rehabilitation, ORS 656.268(5), which, for purposes of the present controversy, would consist of a formal training plan as defined by OAR 436-61-060(3)(e) and 436-61-154(3)(b). OAR 436-61-410(1). OAR 436-61-154(3)(b) requires that in formal training, a claimant is required to take a maximum caseload consistent with the claimant's capabilities, which is normally considered not less than 15 credit hours per term, nine hours per summer term, or the equivalent courseload at a particular educational facility. The rule also provides that in some instances, 12 credit hours is an acceptable courseload. Because claimant is only entitled to those classes necessary to complete his associate degree, and those classes only amount to six credit hours, claimant is not entitled to temporary total disability during his enrollment in these classes, under the applicable administrative rules.

Ordinarily, we decline to decide issues that are not raised before a Referee. The issue of claimant's entitlement to temporary total disability was in its embryonic stages of development when the Referee issued his supplemental order on March 20, 1984. Claimant appeared pro se at the hearing and likewise appears on review. He has presented this issue for our resolution. The self-insured employer, while noting that the issue, arguably, was not before the Referee and was not decided by him, joins claimant in his request that we rule on the temporary total disability issue. Under the peculiar facts and circumstances of this case, we deem it appropriate to decide the question. ORS 656.295(6).

Therefore, we find and hold that claimant is not entitled to temporary total disability pursuant to ORS 656.268(5) and applicable administrative rules during his participation in the "additional training" ordered by the Referee.

ORDER

The Referee's orders dated February 24, 1984 and March 20, 1984, as supplemented herein, are affirmed.

DONALD J. TATE, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-12098
June 4, 1985
Order on Reconsideration

Claimant has requested reconsideration of our Order on Review dated May 7, 1985. In our order, we reversed the Referee's order that found that claimant's condition was an aggravation of his 1978 industrial injury. As we noted in our previous order, because of some apparent confusion regarding injury and aggravation dates, it was unusually difficult for us to determine exactly what the Referee intended in his order. In the face of this confusing situation, claimant apparently chose to not file a respondent's brief. After our order was issued, claimant filed what amounts to a brief in his request for reconsideration. Although claimant submitted no argument before our decision, and his present submission is well beyond the time established by rule for briefs on Board review, OAR 438-11-010(3), we have considered claimant's request and found it, with one exception, to be without merit.

The one exception is claimant's request, joined in by SAIF, for a clarification of our statement: "We find that SAIF is not responsible for claimant's present condition as the worsening of any compensable condition." By that statement we meant that we found by a preponderance of the evidence that claimant's present condition is not related to his 1981 industrial injury and that there was no evidence presented at the hearing that claimant's condition has worsened since the 1978 industrial injury. We reiterate that the basis of our reversal of the Referee's order is that no claim was made for aggravation of the 1978 injury.

As clarified herein, we reaffirm and republish our previous order.

IT IS SO ORDERED.

A. G. McCULLOUGH, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 83-04115
June 5, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee Baker's order which set aside its denial of claimant's myocardial infarction. The issue is the compensability of claimant's November 21, 1982 myocardial infarction.

Although the question is a close one, we find that the record establishes it is more likely than not that claimant's work activity in the early morning hours of November 21, 1982 materially contributed to his myocardial infarction. We find that claimant engaged in work activity requiring significant physical exertion, greater than that generally required by claimant's job duties as a millwright. Immediately after performing this work activity, claimant began to experience symptoms. Within an hour he was hospitalized and a myocardial infarction was diagnosed.

There is persuasive medical evidence in support of the compensability of claimant's myocardial infarction. There is equally persuasive medical evidence in opposition thereto. The evidentiary scales tip ever so slightly in claimant's favor when we consider the circumstances surrounding the onset of symptoms and the diagnosis of myocardial infarction very shortly thereafter.

For the foregoing reasons, we affirm the Referee's order finding this claim compensable.

ORDER

The Referee's order dated December 7, 1984 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the self-insured employer.

PATRICK MURPHY, Claimant
David Force, Claimant's Attorney
Coons, et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-03984 & 84-0184M
June 5, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Nichols' order which awarded claimant an insurer-paid attorney fee for services rendered in prompting SAIF to reopen his claim pursuant to ORS 656.278, pay temporary disability benefits, and pay medical bills pursuant to ORS 656.245. On review, SAIF contends: (1) there is no precedent for an insurer-paid attorney fee award when no hearing has occurred; or, alternatively, (2) the $800 award is excessive.

Claimant has moved for remand, requesting that a hearing be set concerning this issue. We deny claimant's motion. Following our de novo review of the record, we are not persuaded that this case has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

We affirm that portion of the Referee's order which awarded an insurer-paid attorney fee with the following comment. Claimant sustained a compensable neck injury in December 1977. His claim was closed by a July 26, 1978 Determination Order. In January 1984 claimant underwent several diagnostic procedures and various modes of medical treatment for his neck, arm and hand complaints. In March 1984 an anterior cervical diskectomy and interbody fusion was performed. In July 1984 the Board postponed action on SAIF's own motion request, noting that a request for hearing was currently pending. Claimant's initial request for hearing had been filed in April 1983, listing "aggravation" as one of the contested issues.

At the time of hearing, the parties advised the Referee that they had reached a settlement and would shortly provide her with a proposed stipulation and order. As a result of the stipulation the claim was reopened pursuant to ORS 656.278, claimant received approximately 5 months of time loss (less time worked), and SAIF agreed to pay all medical bills pursuant to ORS 656.245. The parties agreed that the Referee would "separately set and assess the attorney fee in this matter."

The Referee subsequently issued her order which stated as follows:

> "The claimant's attorney appears to have been instrumental in obtaining specific benefits for the claimant in this matter and is entitled to an attorney fee that reflects those results. It should be noted that the settlement was not arrived at until the time of hearing. A fee of $800 paid by SAIF would be appropriate...."

If a proceeding is commenced on the Board's own motion because of a request from an employer/insurer and compensation previously awarded is not reduced or is increased, the Board, in accordance with ORS 656.382(2), shall allow a reasonable attorney's fee in addition to compensation. OAR 438-47-070(1).

If the own motion proceeding is prompted by a request from claimant and an increase in compensation is awarded, claimant's attorney is entitled to a reasonable fee payable out of the increased compensation. OAR 438-47-070(2). This latter rule has been followed in own motion matters concerning denied medical treatment claims in which a hearing was held, Joseph F. Weckerle, 35 Van Natta 1693 (1983), as well as where the claimant was awarded time loss apparently without a hearing, Bernie Hinzman, 35 Van Natta 1374 (1983).

The statutes and administrative rules discussed above involve either strictly own motion proceedings or hearings before a Referee. This matter is distinguishable in that it pertains to a stipulation reached at the time of hearing. As such we agree with the Referee's apparent reliance upon OAR 438-47-015. This rule provides that if an attorney is instrumental in obtaining compensation for a claimant without a hearing before a Referee, a reasonable attorney fee may be allowed or approved. The rule further provides that the amount of the fee shall be determined in a summary proceeding by a Referee.

We find that pursuant to OAR 438-47-015 claimant was entitled to a reasonable attorney fee for services rendered in prompting the stipulation without the need for a hearing. Inasmuch as one of the resolved issues concerned a denial of medical treatment pursuant to ORS 656.245, we conclude that the attorney's fee should be paid in addition to the increased compensation. Moreover, we find that the parties' agreement to have the Referee "set and assess" claimant's attorney fee constituted a summary proceeding.

Finally, we conclude that the award of attorney's fees should be modified. Following our de novo review of the record and considering the efforts expended and the results obtained, we find that an attorney's fee of $600 is appropriate. See OAR 438-47-010(2).

ORDER

The Referee's order dated October 26, 1984 is affirmed in part and modified in part. Claimant's attorney fee is modified to $600. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services on Board Review, to be paid by the SAIF Corporation.

GEORGE W. PROFFITT, Claimant
James D. Church, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-03141
June 5, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Peterson's order which set aside its denial of claimant's respiratory conditions diagnosed as chronic obstructive pulmonary disease/emphysema and asthma. The issue is compensability of this firefighter's respiratory disease pursuant to ORS 656.802(1)(b). We affirm the Referee's order with the following additional comments.

The evidence establishes the facts necessary to give rise to the presumption contained in ORS 656.802(2). The Referee held

that the 1983 amendment requiring "clear and convincing medical evidence" would not be given retroactive effect to this 1982 claim, and claimant has not taken issue with this conclusion. See Richard S. Ingram, 36 Van Natta 776 (1984), affirmed Ingram v. SAIF, 72 Or App 215 (1985). The Referee also concluded:

> "That is was more probable than not -- giving weight to the presumption and the medical opinions -- that claimant's work exposure as a firefighter was the major contributing cause of a worsening of his asthma and the development of emphysema."

On review SAIF contends that considering the evidence as a whole, including the presumption, it fails to establish that claimant's employment was the major contributing cause of his respiratory condition.

The Referee correctly concluded that the symptoms/underlying condition dichotomy of Weller v. Union Carbide, 288 Or 27 (1979), has no application in this case. Wright v. SAIF, 289 Or 323, 334-35 (1980). The reason that Weller is inapplicable to claims involving specified diseases contracted by a firefighter, as stated by the court, is that the statutes considered in Weller were ORS 656.005(8), 656.802(1)(a) and 656.804, which make an "injury," "disease or infection" compensable if it either requires medical services or results in disability. ORS 656.802(1)(b) and (2), the provisions concerning firefighters, were not involved in Weller.

The major contributing cause standard of compensability for occupational disease claims is the common law formulation of the second part of the two-part statutory definition of occupational disease stated in ORS 656.802(1)(a): "Any disease or infection which arises out of and in the scope of the employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein." Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570 (1982); see James v. SAIF, 290 Or 343 (1981). For the same reasons that the Wright court held Weller inapplicable in claims involving firefighters, we conclude that the major contributing cause standard/quantum of proof has no application.

The presumption is that claimant's respiratory conditions result from his employment as a firefighter. In order to overcome this presumption, it is incumbent upon the employer/insurer to produce opposing evidence that the cause of the claimant's "condition or impairment" is unrelated to employment. There is evidence in this case that the symptomatology associated with claimant's respiratory conditions is caused, in part, by factors other than his employment, such as his history of smoking cigarettes; however, this same evidence establishes that claimant's employment is nevertheless a cause of his conditions or "impairment of health." Unlike Ingram v. SAIF, supra.; Lines v. SAIF, 54 Or App 81 (1981), and William E. Urton, 34 Van Natta 1263 (1982), aff'd mem 63 Or App 383 (1983), SAIF has failed to overcome the statutory presumption of compensability in this case.

ORDER

The Referee's order dated July 26, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

FAYE CHILDERS, Claimant
Samuel Hall, Jr., Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 78-01507
June 6, 1985
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Childers v. SAIF, 72 Or App 765 (1985). The court has ordered that claimant's aggravation claim be accepted by the SAIF Corporation.

Now, therefore, the SAIF Corporation's denial dated April 3, 1978 is set aside and SAIF is ordered to accept claimant's aggravation claim denied therein and to process the claim and pay benefits according to law.

IT IS SO ORDERED.

RUTH B. HAYES-GODT, Claimant
Cromwell & Hess, Claimant's Attorneys
Frohnmayer, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-08445 & 82-11751
June 6, 1985
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Hayes-Godt v. Scott Wetzel Services, 71 Or App 175 (1984), rev den, 299 Or 118 (1985). The court has ordered that the SAIF Corporation accept claimant's occupational disease claim for carpal tunnel syndrome.

Now, therefore, SAIF's denial dated August 10, 1982 is set aside and the SAIF Corporation is ordered to accept claimant's occupational disease claim and to process the claim and pay benefits according to law.

IT IS SO ORDERED.

VIRGIE KILLMER, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 83-00075
June 6, 1985
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985). We have been instructed to reinstate the employer's denial of the compensability of claimant's groin cyst.

Now, therefore, the employer's denial dated December 21, 1982 is reinstated and affirmed.

IT IS SO ORDERED.

JOSE G. PEREZ, Claimant
Michael B. Dye, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 81-08151
June 6, 1985
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Perez v. EBI Companies, 72 Or App 663 (1985). We have been instructed to determine temporary total disability payments for the period July 14 to August 27, 1981 and to determine the amount of a penalty and attorney fee for unreasonable delay in the payment of compensation.

The court found as fact that claimant was entitled to temporary total disability between July 14, 1981, the date of the first Referee's order, and August 27, 1981, the date a Determination Order issued closing claimant's claim. This entitlement was based upon the language in the Referee's order that ordered the claim to be processed to closure. The court also found that the insurer's failure to pay temporary total disability pursuant to the Referee's order was unreasonable and should be penalized by an award of additional compensation and an attorney fee.

Now, therefore, the insurer shall pay temporary total disability compensation to claimant for the period July 14, 1981 through August 27, 1981, inclusive. In addition to the temporary total disability compensation ordered herein, the insurer shall pay to claimant as a penalty additional compensation in an amount equal to 25% of the temporary total disability compensation ordered herein. Claimant's attorney is awarded $400 for services on the issue of the penalty, to be paid by the insurer in addition to compensation.

IT IS SO ORDERED.

HARLAN L. LONG, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-00149
June 7, 1985
Order on Reconsideration

The SAIF Corporation requests reconsideration of the Board's Order on Review dated May 28, 1985, which awarded permanent total disability effective April 27, 1983. SAIF requests authorization for an offset of temporary total and permanent partial disability payments made since the effective date of the disability against the permanent total disability award. Reconsideration is granted. The issues on reconsideration are offsets for temporary total disability and permanent partial disability against an award for permanent total disability.

The Referee's order, dated June 26, 1984, awarded claimant 30° for 20% scheduled permanent partial disability of the right leg in addition to previous awards of 60° for 40% scheduled disability. The Board found that claimant was permanently and totally disabled under the odd-lot rationale. We found that he had fulfilled the statutory requirements for an award for permanent total disability when the Vocational Rehabilitation Division and Field Services Division of the Workers' Compensation Department terminated further vocational assistance as "unpractical," and awarded permanent total disability as of that date: April 27, 1983.

Claimant was awarded temporary total disability compensation

through November 11, 1983 and 45° for 30% scheduled disability by Determination Order dated December 7, 1983. The Referee's order modified the Determination Order by awarding additional scheduled disability. The Board's order further modified the award by reversing the Referee's order and increasing the disability award. By finding that claimant was permanently and totally disabled on April 27, 1983, the Board's order created an overpayment of compensation, because claimant should not have temporary total disability compensation, permanent partial disability compensation, and permanent total disability compensation for the same condition at the same time. We find that the compensation paid for temporary total disability after April 27, 1983, and permanent partial disability paid pursuant to the Determination Order dated December 7, 1983, and the Referee's Order dated June 26, 1984, should be recouped by SAIF as an offset against the permanent total disability award. Cf. Albert Nacoste, 37 Van Natta 76 (1985) (permanent total disability award made effective date of Board's Order on Review to avoid overpayment/offset situation where full payment not complete on permanent partial disability award).

ORDER

The Board's Order on Review dated May 28, 1985 is modified to allow the SAIF Corporation an offset for compensation paid for temporary total disability after April 27, 1983 and permanent partial disability paid pursuant to the Determination Order dated December 7, 1983, and the Referee's Order dated June 26, 1984. In all other respects, the Board adheres to and republishes its Order on Review dated May 28, 1985.

PEARLEEN K. BENNETT, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 84-04804
June 10, 1985
Order on Reconsideration

Claimant requests reconsideration of our Order on Review dated May 17, 1985 insofar as that order fails to award a reasonable attorney's fee for services on Board review. The self-insured employer requested review of the Referee's award of temporary total disability and imposition of a penalty/attorney's fee for the employer's unreasonble refusal to pay said compensation. We affirmed. Our failure to award a fee for services on review was an oversight. See ORS 656.382(2). Therefore, we modify our prior order accordingly.

ORDER

On reconsideration of the Order on Review entered herein on May 17, 1985, that order is modified to award claimant's attorney $350 for services on Board review, to be paid by the self-insured employer. Except as modified, we adhere to our prior order, which hereby is republished effective this date.

NEIL R. BRACHT, Claimant
Merrill Schneider, Claimant's Attorney
Schwabe, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Rankin, et al., Attorneys

WCB 84-04932
June 10, 1985
Corrected Order on Review

In the order portion of our Order on Review issued May 31, 1985 the date of the Referee's order is incorrectly stated as March 5, 1984. The date of the Referee's order is in fact September 27, 1984.

Now, therefore, our previous order is modified to state:

"ORDER

"The Referee's order dated September 27, 1984 is affirmed."

As modified we republish our former order.

IT IS SO ORDERED.

GEORGE E. JOHNSON, Claimant
Phillip Schuster II, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 82-06854
June 10, 1985
Order on Reconsideration

Claimant requests reconsideration of the Board's Order on Review dated May 17, 1985, and requests abatement of the order pending reconsideration. In the alternative, if the Board does not change its credibility finding on the record, claimant requests remand to the Referee for a credibility finding based on demeanor at hearing. Claimant's request for abatement of the order is denied. Claimant's request for reconsideration is granted.

Claimant seeks reconsideration of our finding of claimant's lack of credibility based on the record. He argues that the Referee's findings of facts imply a finding that claimant was credible. On de novo review of the entire record, we took notice of facts not discussed in the Referee's Opinion and Order which persuaded us that claimant was not credible based on the record. We found that the record established that claimant was not credible based on prior inconsistent statements about the events directly relating to his injury and about collateral matters, including his exposed attempt to conceal a chronic alcoholic condition from his doctors. See Randal R. Senner, 36 Van Natta 1126 (1984).

Claimant's treating physician's opinion that claimant needs surgery for a diagnosed medical condition is very persuasive on the need for surgery, but his opinion is not entitled to extra weight in determining causation of that condition. We found that claimant was not a reliable historian when discussing his medical conditions with his doctors and further found that claimant's treating surgeon's opinion based on claimant's history was not persuasive on the issue of causation. Cf. Miller v. Granite Construction Co., 28 Or App 473 (1977).

Claimant's summary dismissal of any other possible cause for his back condition other than a minor back strain six years previously is not credible on its face. In spite of an

intervening incident of sudden pain, he insists that the only cause of his condition was his industrial injury. Claimant only needed to show that his industrial injury was a material cause of his worsened back condition such that it required surgery. Grable v. Weyerhaeuser, 291 Or 387 (1981). Claimant's testimony about his symptomatology was not persuasive that the industrial injury in 1978 contributed to his condition in 1984, nor were his conclusions. His treating doctor's opinion of causation was not persuasive, largely because it depended so heavily on claimant's unreliable history. Claimant failed to carry his burden of proof and, therefore, the insurer's denial should have been approved.

There is no requirement that a Referee make a finding relating to credibility of any witness based on demeanor at hearing. We find that the record before us on review has not been incompletely, inadequately or improperly developed by the Referee at hearing, therefore, we will not remand to the Referee for a credibility finding based on demeanor of the witness at hearing.

ORDER

The Board's Order on Review dated May 17, 1985 is adhered to and republished.

ROBERT K. McDONALD, Claimant
Robert L. Burns, Claimant's Attorney
Bottini & Bottini, Defense Attorneys

WCB 83-11884
June 10, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Braverman's order which affirmed an August 25, 1983 Determination Order in all respects and authorized the offset of an overpayment of temporary total disability in the sum of $5,927.40 against future permanent partial disability awards. The August 25, 1983 Determination Order declared claimant medically stationary on July 19, 1983 and awarded temporary total disability through that date. It awarded no permanent disability. This Determination Order was affirmed by a subsequent Determination Order dated September 2, 1983. Claimant contends that he is permanently disabled due to his compensable injuries and contests the offset.

The employer has provided us with a copy of a June 30, 1983 stipulation that is not part of the record below. ORS 656.295(5) requires that we base our review upon the record. In limited circumstances, however, certain materials outside of the record can be officially noticed by the Board. Compare Thomas C. Whittle, 36 Van Natta 343 (1984) with Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). In Dennis Fraser, 35 Van Natta 271, 274 (1983), we held that the Board can properly take notice of prior agency orders. We explained:

> "ORS 40.065, (Rule 201(b), now provides that notice may be taken of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." . . . It has long been generally accepted that where the results of one case are determinative of the current case, notice may be taken of the judgment of the other proceeding. . . .

> "Going one step further, we believe that the better rule allows Referees and this Board to take notice of prior orders of this agency whether requested or not. McCormick on Evidence, §330 (2nd ed.). To require formal "proof" of prior orders seems to be a needless elevation of form over substance and serves little purpose other than to clutter evidentiary records that are already sufficiently long and complex. We do believe, however, that if notice is taken without request that the parties should be given an appropriate opportunity to comment."

After providing opposing counsel an appropriate opportunity to comment, we have considered the stipulation in our de novo review.

The Board affirms and adopts those portions of the Referee's order denying an award of permanent disability.

Claimant correctly points out that the Referee's order is inconsistent as it relates to the offset. Although the order affirms the Evaluation Division's finding that claimant was not medically stationary until July 19, 1983, it allows an offset for temporary disability paid for the period after April 5, 1983.

Dr. Urban, the treating chiropractor, declared claimant medically stationary as of April 5, 1983 and authorized time loss only through that date. Notwithstanding the May 31, 1983 opinion of Orthopaedic Consultants that claimant was then still improving, the treating doctor's opinion persuades us that claimant was medically stationary as of April 5, 1983.

ORS 656.268(4) provides that closing determinations may include necessary adjustments in compensation paid prior to the determination, including the crediting of temporary disability payments against permanent disability awards. We find that the offset for temporary disability compensation paid for the period after April 5, 1983 was legally and factually correct.

ORDER

The Referee's order dated July 24, 1984 is affirmed in part and modified in part. The August 25, 1983 and September 2, 1983 Determination Orders are modified to declare claimant medically stationary on April 5, 1983. The Referee's order is affirmed in all other respects.

RONALD A. PICKETT, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03535 & 84-05660
June 10, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Michael Johnson's order which set aside its denial of claimant's industrial injury claim. The primary issue is whether claimant sustained a compensable injury at work on February 27, 1984. In

his respondent's brief, claimant contends that the Referee's award of attorney fees for prevailing on this denied claim is inadequate. In view of our disposition of the compensability issue, it is unnecessary to address the issue raised by claimant.

We are in complete agreement with the following portion of the Referee's order, which we set forth verbatim:

> "In this case, there was no traumatic incident which was observed by neutral witnesses, so it is vital to determine whether [claimant] has told the truth in regards to the onset and extent of his disability. Also, this case involves the type of a disability which does not produce obviously discernable physical manifestations which would clearly establish the causal connection between an initial incident and subsequent disability. In establishing medical causation, a doctor is forced to rely almost entirely upon claimant's rendition of the history of the problem and, therefore, a medical statement regarding causation is only as accurate as was the history the claimant provided to the doctor. If claimant is an untrue witness, then neither his testimony regarding the accident nor the doctors' opinions based thereon are trustworthy and must be disregarded. Miller v. Granite Construction Co., 28 Or App 473 (1977). If claimant's testimony is found to be untrue in any part, then his entire testimony may be presumed to be untrue (uniform jury instruction 2.04), and, therefore, claimant will be deemed to have failed to have met his burden of proof regarding compensability."

The Referee made the following credibility finding:

> "Claimant has an interesting personality. He is extremely precise in his choice of words, and expects others to be the same. If he does not know the precise answer to a specific question, he will generally refuse to answer, rather than hazard a guess or give an estimate. He frequently cogitates at length before responding to a question. His behavior could appear to some as being evasive or even misleading, but I do not find it to be so. I find that claimant seeks accuracy to an uncommon extent, and that he only gives an answer after reflection and when he is satisfied that the answer is accurate. Precision and truthfulness may well be two different things, but I find that claimant's insistence upon precision is strong evidence that his statements are also true."

Claimant's testimony, as well as the testimony of his wife, was impeached in two significant respects, which we will discuss more fully below. The impeaching evidence consists of the testimony of two other witnesses, Mr. Hinkley and Mr. Wilson. Mr. Hinkley is a neighbor and fellow worker. Mr. Wilson is a foreman of the work shift following claimant's. The Referee discounted Mr. Wilson's testimony, and found claimant's credibility "eroded" by Mr. Hinkley's, "but not destroyed."

On the basis of our de novo review of this record, taking into account the Referee's credibility findings and giving due deference thereto, we find that claimant has failed to establish the compensability of his alleged injury by a preponderance of the persuasive evidence. In reaching this conclusion, we have noted and considered the cases cited by claimant in support of the proposition that the Board is required to "give due deference" to the Referee's credibility finding. One of these cases is Fredrickson v. Grandma Cookie Co., 13 Or App 334, 338 (1973), wherein the court also noted that, although we generally defer to the Referee in this regard because he or she had the advantage of seeing and hearing the witnesses, we are not bound by the Referee's findings on our de novo review. In Fredrickson the Referee's credibility findings were considered "persuasive."

In discussing the weight generally accorded a Referee's credibility finding, we recently stated:

> "We normally defer to a Referee's findings concerning witness credibility, unless there is a strong basis to do otherwise. Donald W. Hardiman, 35 Van Natta 664 (1983). The ultimate issue in every case, however, is, giving due deference to the Referee's advantage in seeing the witnesses, can we honestly say we are persuaded by the evidence produced by the party with the burden of proof. Dale Donaldson, 34 Van Natta 1154 (1982), aff'd mem 63 Or App 529 (1983). Although a Referee's credibility finding, particularly one based upon witness demeanor, generally is given considerable weight, it is not binding. Hannan v. Good Samaritan Hosp., 4 Or App 178, 192 (1970). We review the record de novo, and we must resolve the case as our independent judgment dictates. Bicknell v. SAIF, 8 Or App 567, 569 (1972). Although resolution of the issues in this case, to a certain extent, turns on witness credibility, we cannot ignore the other evidence in the record. Swanson v. Westport Lumber Co., 4 Or App 417, 421 (1971). * * * * * " John R. Dayton, 37 Van Natta 210 (1985).

Claimant's testimony identifies the following series of events. He was injured during the morning hours of his work day on February 27, 1984. He informed his foreman, Mr. Lunsford, at or about 10 o'clock a.m. He continued working, in pain, until lunch time, which was 11:30 a.m. He went home, at which time he

decided he would be unable to complete the remainder of the day's work. He returned to work and informed his foreman that he was taking the remainder of the day off. He then scheduled an appointment with his brother's chiropractor, Dr. Boyer, from a phone booth. He made an appointment to see Dr. Boyer at 5 o'clock p.m. that day, possibly 5:30 p.m.

Claimant then traveled a short distance to a friend's house, Mr. Sivalong, in order to obtain a one or two ton flatbed truck for the purpose of picking up a load of peeler cores from a nearby mill, Champion. The peeler cores were to be used by claimant as firewood, which is his only source of heat at home. Claimant had previously arranged to pick up the peeler cores that day with the assistance of Mr. Sivalong and his truck. Claimant's work shift would have ended at 3 o'clock p.m.

Claimant and Mr. Sivalong drove to the Champion mill, where the peeler cores were loaded into Mr. Sivalong's truck by a hyster driven by a Champion employe. The truck was then driven to claimant's home. Claimant's wife, who was home, drove Mr. Sivalong home. The truck with the peeler cores remained at claimant's residence. After taking Mr. Sivalong home, claimant's wife picked up her brother, David, and returned home.

With his brother-in-law's assistance, claimant cut enough firewood to supply his family with a day's heat. David positioned himself at the front end of the flatbed (towards the cab of the truck). Claimant was situated at the back end of the flatbed, at the top of the pile of peeler cores. The logs were loaded in such a way as to form a stairway-like ascent to the top. From his end, David pushed individual peeler cores toward the back end of the flatbed. From his position atop the logs, claimant was operating a 360 Homelite chain saw cutting the lengths of peeler core. The only exertion required on claimant's part was to start the saw, stand there, "and just [drop] the saw up and down, up and down" until two or three logs had been cut. Claimant began to split some "rounds," however, his wife chastised him for attempting this activity and took over.

After enough firewood had been cut and split for that day and night, claimant drove his brother-in-law home and began his journey to Dr. Boyer's office. After traveling a portion of the distance to the doctor's office, claimant recalled that he had placed his chain saw on top of the truck and had neglected to place it safely away. Thereupon, he called Dr. Boyer's office, cancelled his appointment for that day, made an appointment for the following day, February 28, 1984, and returned home. Claimant saw Dr. Boyer the following day, most likely in the morning. Thereafter, he engaged in no further wood cutting or wood splitting activities. He made an arrangement with another brother-in-law, Ron Steward, whereby Mr. Steward agreed to cut and split the remainder of the peeler cores on the Sivalong truck. According to claimant, Mr. Steward cut all of the peeler cores remaining on the truck in one or two days, with claimant's wife's assistance in splitting and possibly with some assistance from his other brother-in-law, David.

Claimant remained off work for approximately three weeks. About one week before he returned to work on March 19, 1984, he partially resumed some of his wood cutting activities. This consisted essentially of splitting into kindling the pieces of peeler core that had been cut and split by Mr. Steward.

Claimant returned to work on March 19, 1984. He worked three hours and then went home. He was experiencing pulsating pain in his low back on the right side, as well as pain radiating down the right leg. As of the time of the hearing on June 21, 1984, claimant had not returned to work.

Claimant's testimony, as well as his wife's testimony, is to the effect that for at least two weeks after the March 19, 1984 episode, which is being regarded as an exacerbation of claimant's original back problem, claimant engaged in no firewood cutting or splitting activities. Claimant's brother-in-law, David, might have come over periodically to help claimant's wife carry in some wood. For the most part, however, claimant's wife took care of the firewood chores until claimant was able to resume this activity. As of the time of hearing, claimant had been performing the firewood chores alone, although he did not know how long this had been so. Claimant testified that aside from the single load of peeler cores, which were brought to his home in the Sivalong truck, he believed he had no other peeler core deliveries in the four months preceding the hearing.

Mr. Hinkley, who has been claimant's neighbor for four or five years, testified that in the mid-afternoon of a late February day he observed claimant and another man in claimant's yard cutting and splitting wood, which was loaded on a flatbed truck. Mr. Hinkley observed that claimant was on the truck cutting the wood with a chain saw. The other person was on the ground behind the truck. After claimant cut a piece of wood with the chain saw, he would toss it from the back of the truck to the other man standing on the ground. When several pieces had been cut, claimant would climb down from the truck and assist the other man in splitting. Mr. Hinkley observed this activity for approximately 15 minutes, and he saw claimant get down from the truck and climb back up one time. There was no other person on the truck positioning the wood to be cut. Mr. Hinkley did not observe anything unusual about claimant's physical activities. Although Mr. Hinkley did not recall the exact day in February on which he made these observations, the evidence is convincing that the date was February 28, 1984, the day after claimant's alleged injury. On the following day, Mr. Hinkley learned that claimant was off work because of a back injury. Mr. Hinkley's residence, his viewpoint, was located across the road from claimant's residence, a distance of approximately 200 or 300 yards.

Mr. Wilson testified that on the afternoon of March 29, 1984 (ten days after claimant's brief return to work) he was driving on the road in front of claimant's residence on his way to work, when he observed claimant in his front yard cutting large peeler cores off the tailgate of a pickup truck. As did Mr. Hinkley, Mr. Wilson testified to his certainty that the individual observed was claimant.

On rebuttal claimant denied that he was cutting firewood with a chain saw on February 28, as Mr. Hinkley testified. Claimant testified that the individual observed by Mr. Hinkley was his brother-in-law, Ron Steward, who is of the same height, build and hair color as claimant.

The Referee found no reason to question Mr. Hinkley's veracity. He considered the "look-alike" theory posed by claimant but did not adopt it. He went on to conclude that claimant was

"honestly mistaken" concerning his activities on the afternoon of February 28, 1984. He "assumed" that claimant was wearing the back brace provided by Dr. Boyer earlier that day, which would account for the lack of any obvious manifestation of disability. He also reasoned that if there were no objective findings by Dr. Boyer upon which to establish the actual occurrence of the alleged industrial injury, he would "probably find the evidence to be in equipose and would therefore rule against claimant." The "objective findings" noted by Dr. Boyer on February 28, 1984 and considered by the Referee were "myalgia and muscle spasm."

The Referee reconciled the testimony of claimant and his wife with the contrary testimony of Mr. Wilson by determining that there was merely a four-day difference between claimant's and claimant's wife's report of no firewood activities for two weeks subsequent to March 19, 1984, and Mr. Wilson's observations on March 29, 1984. What the Referee failed to note, however, was the fact that Mr. Wilson's testimony contradicted claimant's in another regard. Claimant testified that he received no other deliveries of peeler cores after the delivery in the Sivalong truck on the date of claimant's alleged injury. Mr. Wilson testified that claimant was cutting peeler cores off the tailgate of a pickup truck, not a flatbed. Thus, claimant was either mistaken or prevaricating in this regard as well.

There are very many minor inconsistencies in the record, not simply between the testimony given by claimant's witnesses and others, but inconsistencies in claimant's own version of his alleged injury and the events which followed. These minor inconsistencies, when they are considered as a whole, give us some pause concerning claimant's veracity. Standing alone, these rather minor discrepancies would not provide a sufficient basis for disagreeing with the Referee's conclusions concerning claimant's credibility. However, when we consider the testimony of Messrs. Hinkley and Wilson, together with these other, various discrepancies, we are constrained to conclude that claimant has failed to persuade us that his testimony is worthy of belief.

The Referee's analysis concerning Dr. Boyer's "objective findings," and why they lend credence to claimant's testimony, is analytically unsound. To begin with, "myalgia" is simply muscular pain, Dorland's Illustrated Medical Dictionary (26th ed. 1981); Taber's Cyclopedic Medical Dictionary (14th ed. 1981), which may be exhibited on examination by, for example, tenderness on palpation. Pain is a subjective complaint, as opposed to an objective finding. Muscle spasm, on the other hand, is an objective finding, assuming it is present. No other physician found objective findings on their examination of claimant, including Dr. Altrocchi, a neurologist who examined claimant on referral by Dr. Boyer. Indeed, in his May 23, 1984 report he stated that claimant had "no objective reflex motor or sensory changes [and] no visible muscle spasm" when examined earlier that month. Although Dr. Altrocchi believed claimant's back pain was related to his employment activity, he was relying upon claimant's history, and, as discussed above, we find reason to doubt claimant's credibility. To the extent that Dr. Boyer's statement of causation depends upon claimant's recitation of the facts supporting his claim of injury, his opinion is also persuasive only to the extent that claimant's testimony is worthy of belief.

For the foregoing reasons, we find and hold that claimant has failed to establish, by a preponderance of the persuasive evidence, that he sustained a compensable injury as alleged. Therefore, we must reverse the Referee's order finding to the contrary.

ORDER

The Referee's order dated July 3, 1984 is reversed and the SAIF Corporation's denial dated March 27, 1984 is reinstated and affirmed.

JOSEPH M. ALLEN, Claimant
Lindsay, et al., Claimant's Attorneys
Callahan, et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-11335
June 11, 1985
Order Denying Motion to Dismissal

The SAIF Corporation and the putative employers have moved the Board for an order dismissing claimant's request for review of Referee Tenenbaum's order that upheld the denial of claimant's claim on the ground that claimant was not a subject worker. SAIF and the employers contend that claimant's request for Board review was not served upon them within the statutory time period.

The Referee's order was issued April 19, 1985. The thirtieth day after the issuance of the order was May 19, 1985, which was a Sunday. Claimant, therefore, had until the end of the next business day, May 20, 1985, to serve his request for Board review on all parties. ORS 656.295(2); OAR 438-05-040(4). The Board received the request for review on May 14, 1985. On May 16, 1985 the Board sent a computer generated letter acknowledging claimant's request for Board review. Copies of the letter were sent to the attorney for the putative employer and to SAIF. It is presumed that a letter duly mailed is received in the normal course of the mail. OEC Rule 311 (1)(q). Claimant did not mail a copy of his request to SAIF and the employers until May 21, 1985, after the expiration of the statutory period. However, we conclude that the putative employer and SAIF had actual notice, in the form of Board acknowledgement of claimant's request for review, prior to May 20, 1985. See Argonaut Insurance v. King, 63 Or App 847, 852 (1983). The motion to dismiss claimant's request for review is denied.

IT IS SO ORDERED.

MINNIE A. DANIEL, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03123
June 11, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee McCullough's order which held that SAIF was not required to pay permanent partial disability awarded by a prior Referee's order during claimant's enrollment in an authorized training program, during which she was in receipt of temporary total disability benefits. Based upon his conclusion that SAIF's conduct was not improper, the Referee declined to impose a penalty/attorney's fee.

On review claimant contends that SAIF's suspension of Referee-ordered permanent partial disability is not authorized by statute; and that the administrative rule which purports to allow this, OAR

436-54-232(3), is invalid as it attempts to "expand the precise language" of ORS 656.268(5). Claimant contends, therefore, that SAIF should be penalized for unreasonable resistance to the payment of compensation.

The facts are not in dispute. Claimant sustained an injury to her back in October of 1982. The claim was accepted and closed by Determination Order in September of 1983, which awarded 80° (25%) unscheduled disability. In December of 1983 claimant entered an authorized training program with a planned completion date of December 11, 1984. Claimant requested a hearing contesting the adequacy of the permanent disability awarded by the Determination Order. The matter came on for hearing during claimant's enrollment and active participation in the authorized training program. In February 1984 a Referee awarded claimant an additional 32° (10%) unscheduled disability. Within 30 days of the date of the Referee's order, SAIF notified claimant that it was suspending payment of the additional permanent disability award pending completion of claimant's vocational rehabilitation program. Claimant requested a hearing challenging SAIF's failure/refusal to pay the permanent disability and the matter came before Referee McCullough.

We need not decide this case on the basis of claimant's challenge of the administrative rule in question, OAR 436-54-232(3). This rule was first adopted by the Workers' Compensation Department by WCD Admin. Order 6-1981 with an effective date of January 1, 1982. The rule states:

> "When a training program is authorized in accordance with OAR 436-61 after the issuance of a determination order, Opinion and Order of a Referee, Order on Review or Mandate of the Court of Appeals, the insurer or self-insured employer shall suspend any award payments due under the order or mandate and pay time loss."

Subsection (4) of the rule provides that upon completion or termination of the training program, any award payments shall be resumed pending issuance of a subsequent Determination Order by Evaluation Division, unless the worker's condition is not medically stationary.

This rule was promulgated after our decision in Charles C. Tackett, 31 Van Natta 61 (1981). In Tackett we held that, although ORS 656.268(5) appears to refer only to suspension of permanent disability payments due under a Determination Order entered by the Evaluation Division, there is no logical reason to conclude that a different rule should apply where the permanent disability award is granted by a Referee's order, rather than a Determination Order. In view of the apparent policy considerations underlying ORS 656.268(5), we found every reason to conclude that a Referee's order and a Determination Order should be accorded equal treatment vis-a-vis suspension of permanent disability payments while a claimant is enrolled and actively participating in an authorized training program and receiving temporary total disability benefits.

Our reasoning is stated in Tackett. We reaffirmed our decision in Tackett in Thomas Musgrove, 33 Van Natta 616 (1981). Claimant has failed to persuade us that our rationale in Tackett

was wrong, or that it should be reconsidered in light of more recent developments in the law. Accordingly, we adhere to our reasoning in Tackett, which is dispositive of the question presented in this case.

We direct claimant's attention to a recent administrative rule, OAR 438-06-105, and our decision in Thomas D. Craft, 36 Van Natta 1649 (1984). The rule provides:

> "When an injured worker is participating in an authorized vocational training program, a hearing will not be held on an issue of unscheduled disability except where there is an interruption of compensation or upon a showing of good cause."

The rule was adopted with an effective date of May 1, 1984, and obviously was not in effect when the Referee in the proceeding involved herein awarded claimant an additional 10% unscheduled disability. In Craft we explained that the rule, "represents the Board's policy judgment that hearings involving the extent of unscheduled disability should not be held until reasonable efforts to minimize an injured worker's disability have been completed." 36 Van Natta at 1652. The issues raised in this case are tangential to the considerations which led to the adoption of OAR 438-06-105.

Claimant asserts that OAR 436-54-232(3) and by implication our Tackett decision, authorizes the Workers' Compensation Department "to modify or completely overturn extent of disability decisions by a Referee, the Board or the Court of Appeals," upon completion or termination of an authorized training program. Neither the rule nor our Tackett decision require this. The statute itself requires that the Department make such a reevaluation following completion/termination of a training program. ORS 656.268(5); see Hanna v. SAIF, 65 Or App 649, 652 (1983).

Perhaps claimant can convince another forum that the legislature's failure to specifically provide for suspension of permanent disability payments due under a Referee's order in ORS 656.268(5) requires the result she seeks. As far as we are concerned, however, we are unable to discern if the legislature ever considered the subject. Furthermore, we believe that if it did, for the reasons stated in our Tackett decision, it would arrive at a conclusion very similar to, if not exactly the same as, the conclusion we have reached.

As far as claimant's request for penalties/attorney fees is concerned, the very case that claimant relies upon in support of her argument that SAIF's suspension of permanent disability payments was wrong refutes her contention that SAIF's action also was unreasonable. Forney v. Western States Plywood, 297 Or 628, 633 (1984); also see Zwahlen v. Crown Zellerbach Co., 67 Or App 3 (1984).

For the foregoing reasons, we affirm and adopt the Referee's well-reasoned order.

ORDER

The Referee's order dated January 15, 1985 is affirmed.

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

WCB 83-02503
June 11, 1985
Order on Review on Remand

Reviewed by Board Members Ferris and Lewis.

This matter is before the Board on remand from the Court of Appeals. In our previous order, 36 Van Natta 602 (1984), we dismissed as moot claimant's request for a hearing challenging the Workers' Compensation Department Compliance Division's order of consent to suspension of compensation for claimant's alleged failure to submit to reasonably essential medical treatment. Our rationale was that the Board majority's ruling on another hearing request involving this claimant, 36 Van Natta 213 (1984), upheld a Determination Order insofar as it terminated claimant's temporary disability compensation as of a date prior to the suspension of such compensation by the Compliance Division, and, therefore, there was no compensation due to be suspended. Claimant petitioned for judicial review. The SAIF Corporation conceded that our prior order in this claim was erroneous and moved the court to remand this matter for a decision on the merits. That motion was allowed by the court.

The SAIF Corporation requested review of Referee Seymour's order that set aside the Compliance Division's order consenting to suspension of compensation and penalized SAIF by awarding additional compensation equal to 15% of the compensation withheld during the period of suspension. The detailed facts of claimant's injury and subsequent medical treatment are set forth in our Order on Review (Remanding) in WCB Case No. 82-05128, 36 Van Natta 213 (1984), and will not be repeated in detail here. In summary, claimant was compensably injured in a fall from a roof in 1979. The injury consisted of traumatic disc herniation and radiculopathy of the cervical spine from C4 to C7. Claimant has continued to experience severe pain ever since, and the medical opinions substantiate that claimant's pain complaints are objectively related to his compensable injury. However, no physician has been able to diagnose the precise etiology of claimant's pain.

The preponderance of the evidence persuades us that claimant has refused to cooperate in three vocational assessment efforts, has twice refused to be examined by psychiatrists and has refused to participate in a multidisciplinary pain center approach to the control of his neck and shoulder pain. We are further persuaded that claimant is dependent upon prescription pain medication, and that claimant's treating and consulting physicians unanimously agree that this dependence is harmful to claimant.

Dr. Jefferson, claimant's treating physician, recommended as early as April 1980 that claimant participate in a multidisciplinary pain center program, and in fact referred claimant to the Northwest Pain Center in Portland in August 1980. Claimant went to the pain center, but refused to participate in the program. SAIF has requested several times since that claimant participate in a pain center program, most recently in June 1983, however, claimant has consistently refused to participate. It is the most recent refusal that led to the suspension of compensation. Dr. Jefferson has recently retreated from insisting that claimant participate in a pain center program, however, we are persuaded that the reason for this retreat is that Dr. Jefferson has become convinced that further insistence would be

futile. Claimant has indicated a willingness to submit to exploratory surgery to attempt to reach a firm diagnosis of the etiology of his pain, and Dr. Jefferson has recommended that such surgery be performed, whether or not claimant participates in a pain center approach. However, Dr. Jefferson is not a surgeon, and there is no evidence of record that any surgeon has stated that he or she would perform such surgery before conservative treatment modes had been exhausted. Dr. Butters, a consulting surgeon who addressed this question, has indicated that he would not perform surgery while the pain center approach remained untried.

Claimant's objections to the pain center approach are as follows:

1. The approach involves physical therapy, which exacerbated claimant's pain when he submitted to it early in his treatment for this injury;

2. Claimant suffers from a physical problem, and the psychological therapy that is a part of the pain center approach does not relate to the resolution of his physical problem;

3. Claimant knows at least three other people who have tried the pain center approach without success;

4. Dr. Jefferson does not believe that the pain center treatment is essential to the treatment of claimant's condition;

5. Pain center treatment is unlikely to affect rating of the extent of claimant's disability.

The statutory authority to suspend compensation for failure of a claimant to submit to reasonably essential medical treatment is contained in ORS 656.325(2):

> "For any period of time during which any worker . . . refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery, . . . the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. . . ."

At the time this claimant's compensation was suspended, OAR 436-54-281 and 436-54-286 as adopted by WCD Admin. Order 6-1981 set forth the procedure to be followed by insurers/employers and the Compliance Division in seeking and granting consent to suspend compensation for failure to submit to reasonably essential medical treatment. That procedure did not provide a mechanism whereby a claimant whose compensation an employer/insurer sought to have suspended was granted a right to communicate formally or informally with the Compliance Division to voice objection to suspension of compensation or give reasons to justify his or her refusal to submit to treatment. OAR 436-54-286 was amended by WCD Admin. Order 8-1983 to, among other things, add subsection 5(g), as follows:

> "NOTICE TO WORKER: IF YOU THINK THIS APPLICATION FOR SUSPENSION OF COMPENSATION IS NOT RIGHT YOU MAY RESPOND IN WRITING TO

> THE COMPLIANCE DIVISION, WORKERS' COMPENSATION DEPARTMENT, LABOR AND INDUSTRIES BUILDING, SALEM, OREGON 97310. YOUR RESPONSE MUST BE RECEIVED BY THE DEPARTMENT WITHIN 10 WORKING DAYS OF THE DATE OF THIS NOTICE."

We believe that the amendements to OAR 436-54-281 through 436-54-286, all of which relate to suspension of compensation, were promulgated in direct response to the Court of Appeals' opinion in Carr v. SAIF, 65 Or App 110 (1983), pet for rev dismissed, 297 Or 83 (1984). The petitioner in Carr objected to the Department's procedures in suspending compensation under ORS 656.325 on due process grounds. The court ultimately held:

> "[W]e conclude that, in addition to the right to a post-suspension evidentiary hearing, claimant was entitled to the following presuspension procedural safeguards: (1) notice that SAIF had petitioned for and the Division was considering suspension of his benefits; (2) notice of the basis on which SAIF contended that benefits should be suspended and of the evidence SAIF relied on; and (3) an opportunity informally to respond to SAIF's contentions either orally or in writing. . . .
>
> "Because none of these procedural safeguards were provided, we hold that the procedures employed under ORS 656.325 and OAR 436-54-281 and 436-54-283 to suspend clamaint's benefits did not comply with the procedural due process guarantees of the Fourteenth Amendment and Article I, section 10, of the Oregon Constitution. Because his suspension was invalid, claimant was entitled to receive temporary total disability benefits until he was suspended pursuant to procedures that complied with due process or he was no longer medically eligible, whichever came first. . . ." 65 Or App at 124.

The first two of the three criteria set forth by the court as required to meet the requirements of due process of law were substantially met in this case. Claimant was sent a notice that if he did not submit to the pain center treatment by a date certain SAIF would seek to have his compensation suspended. When claimant did not submit or consent to pain center treatment by the specified date, SAIF submitted its request for suspension to the Compliance Division and mailed a copy of the request to claimant. Claimant, we therefore find, had adequate notice that SAIF intended to have his compensation suspended. The third requirement, an opportunity to be heard, was not met, however. Under Carr v. SAIF, we believe that the two requirements, that of notice and an opportunity to be heard, are of equal importance.

The opportunity to be heard, without notice of the necessity to speak, is meaningless. Likewise, notice of an impending event is of little use to a person who does not know that he has the right to attempt to affect the outcome of the event. With the exception that in this case claimant received part, but not all, of the procedural process due him, we are unable to distinguish this case from Carr v. SAIF, supra, and we believe that that case requires us to affirm that portion of the Referee's order that vacated the suspension order, although for the reasons set forth in this order and not those given by the Referee.

We reverse that portion of the Referee's order that imposed additional compensation as a penalty, for two reasons. First, the reasons advanced by claimant for not participating in the pain center treatment are not, in our eyes, acceptable. Claimant has placed himself in the position of attempting to be his own diagnostician. Were we not bound by Carr v. SAIF, supra, to rule as we have, we would rule in SAIF's and the Compliance Division's favor on the facts. The second reason for reversing the penalty is that it was the Compliance Division that authorized suspension of claimant's compensation, and not SAIF. There is no evidence that SAIF misbehaved in any way by being less than candid in furnishing evidence to the Compliance Division or in attempting to mislead. The combination of the facts of this case and SAIF's reasonable reliance on the Compliance Division's authorization convince us that no penalty is warranted.

Claimant is entitled to an insurer paid attorney fee under ORS 656.382(2) for defending SAIF's appeal to the Board. We conclude that a reasonable fee for the services rendered, in view of the difficulty of the issues and result obtained is $1,750. In arriving at this fee we have considered that claimant filed a brief in the Court of Appeals before SAIF conceded that the case should be remanded and decided by us.

ORDER

That portion of the Referee's order dated September 9, 1983 that assessed a penalty against the SAIF Corporation is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,750 for services on Board review, to be paid by the SAIF Corporation in addition to compensation.

MILLIE LOWERY, Claimant
Doblie & McSwain, Claimant's Attorneys
Nelson & Denorch, Defense Attorneys

WCB 84-01055
June 11, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Knapp's order upholding the insurer's denial of her claim for neck and back injuries. In the alternative, claimant requests remand for the taking of additional evidence.

Claimant requests remand for the admission of two medical reports, both dated before the hearing date. She contends that she was ineffectively represented by counsel at hearing, and as a result, that the record was incompletely or otherwise insufficiently developed. See ORS 656.295(5). The Board has established a restrictive policy regarding remands because of the

numerous mechanisms available for keeping the record open at the hearing level. Once the record is closed, it is in the interests of administrative economy that the record remain as final as possible. There being no adequate explanation as to why the evidence which claimant now seeks to have included in the record could not reasonably have been included when the case was previously before the Referee, we hold that remand is not appropriate. Casimer Witkowski, 35 Van Natta 1661, 1663 (1983).

On de novo review of the record the Board affirms the order of the Referee. In doing so we note that even were we to consider the evidence claimant now seeks to have included in the record, we would reach the same result.

ORDER

The Referee's order dated August 31, 1984 is affirmed.

MICHAEL L. McKINNEY, Claimant
Cash Perrine, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 84-08202
June 11, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee McCullough's order which declined to impose a penalty and attorney's fee for the self-insured employer's failure (1) to pay temporary total disability at the correct rate; (2) to correct its admitted error within 14 days of claimant's demand; and (3) to provide claims documents -- specifically two 1502 forms -- within fifteen days of demand as required by OAR 438-07-015(2).

Although we find the employer's violation of the disclosure rule technically wrong, we agree with the Referee's reasoning and conclusion that this technical violation was not sufficiently unreasonable to warrant imposition of a penalty and attorney's fee. Accordingly, we affirm and adopt the relevant portions of the Referee's order.

With regard to the other penalty/attorney fee issue, relative to the employer's failure to pay the correct temporary disability rate, we reverse. The facts pertinent to this issue are as follows.

This claim arose out of a right shoulder injury in February of 1983. The claim was originally accepted as nondisabling. On December 8, 1983, the employer denied continuing compensability on the basis of intervening causes. Claimant filed a request for hearing challenging the employer's denial. A hearing was held in March of 1984. On August 15, 1984, a Referee's order was entered setting aside the employer's denial and remanding the claim for acceptance and payment of compensation.

Claimant's attorney advised the employer's claims adjuster, by letter dated October 18, 1984, that claimant had worked mandatory overtime at the rate of one day per month. Counsel requested that claimant's temporary disability rate be adjusted accordingly. Claimant filed a supplemental hearing request in this proceeding designating as issues, among other things, failure to pay time loss at the correct rate and failure to pay within 14

days. The hearing convened on November 29, 1984. At the hearing, the parties agreed that claimant was entitled to have his temporary disability adjusted to reflect his overtime earnings. The parties further agreed that the employer made this rate adjustment as of the date preceding the hearing, but that a check for the adjusted temporary disability had not yet been forwarded to claimant. The employer argued at hearing that a request for an adjustment in the rate of temporary disability constitutes a "claim," similar to a claim for medical services of the nature discussed in Billy J. Eubanks, 35 Van Natta 131 (1983). Thus, the employer contended, it should have 60 days within which to investigate and make the adjustment or deny, depending on which course of action is appropriate. Since, as of the time of hearing, 60 days had not yet elapsed from the date of the "claim," the employer had not unreasonably delayed making the appropriate adjustment. The Referee found this argument persuasive and adopted it as his rationale for refusing to impose a penalty/attorney's fee. We disagree.

A request that an employer/insurer adjust a claimant's temporary disability rate is fundamentally different from a request that the employer/insurer pay medical services alleged to be reasonable and necessary as a result of an industrial injury/occupational disease. The medical service claim can involve myriad issues, including questions of causation and reasonableness of treatment. In a sense, medical service claims are frequently like a claim in the first instance. Independent medical examinations are often necessary in order to make the payment/denial decision. Although there are a variety of potential issues that might arise where there is a question concerning the proper rate of temporary disability, many of these potential problems can be resolved by a simple verification of the claimant's work schedule. This information is already within the employer's possession and should be very accessible to the employer's insurer or adjuster.

The statutes and rules governing payment of temporary disability benefits require payment within 14 days after notice or knowledge of "the claim," or the date of a determination or litigation order requiring payment of temporary disability. ORS 656.262(4); OAR 436-54-310(3). We believe that these provisions contemplate payment of the correct rate of temporary total disability as calculated under ORS 656.210 and applicable administrative rules. The policy of prompt payment of the correct rate of compensation, ORS 656.262(2), 656.012(2)(a), (c), would not be furthered by allowing an employer/insurer 60 days from the date of demand to cure an alleged error in computation of temporary disability. Although this 14/60 day issue has not previously been before us, at least not recently, we have in the recent past stated that upon being advised of an error in a claimant's temporary disability rate, the employer/insurer is obligated to immediately correct the problem once it has been notified. Richard N. Couturier, 36 Van Natta 59 (1984).

We believe that 14 days is an adequate period to allow an employer/insurer to either (1) correct its error and pay the correct rate of temporary disability, or (2) ascertain that no error has been made and notify the claimant of the fact. In some cases, a failure to pay or "deny" within fourteen days might be found unreasonable, in others it might not. Each case will have to be judged on the basis of its peculiar facts and circumstances.

In this case, more than five weeks elapsed between the date of claimant's demand that his temporary disability rate be adjusted and the date of hearing. At the hearing, the employer admitted that claimant was entitled to the adjusted rate. The failure to pay the correct rate in the first place is not, in and of itself, necessarily unreasonable; however, we fail to understand why the employer was not able to ascertain the correct rate and make the appropriate adjustment any time prior to the date of hearing. The employer has offered no explanation in defense of its failure to act more promptly. Under the circumstances, we find a penalty and attorney's fee appropriate.

This case is factually similar to Richard N. Courtier, supra, in which SAIF was informed by claimant's attorney's letter of an error in the calculation of claimant's time loss, a hearing convened less than one month afterward, at which time SAIF acknowledged its error and agreed to pay the correct rate of time loss. We affirmed that portion of the Referee's order which imposed a penalty equal to 25% of the differential in claimant's adjusted temporary disability and an associated attorney's fee of $150. Although the Referee apparently imposed the penalty for "failure to pay the correct amount of time loss," we affirmed the imposition of a penalty/attorney's fee on the basis of SAIF's failure to correct the error in a more immediate fashion.

Attached to his appellant's brief, claimant has submitted a motion to accept additional evidence, together with proffered evidentiary material. We have no authority to consider evidence not made a matter of record before the Referee; therefore, we regard claimant's motion as a request for remand to the Referee for further evidence taking. ORS 656.295(5). We have authority to remand in the event we determine that a case has been improperly, incompletely or otherwise insufficiently developed or heard, and that remand is otherwise appropriate. There has been no incomplete or improper development of the record as to the penalty/attorney fee issues presently before us; therefore, remand is not an appropriate disposition, and claimant's request is denied.

ORDER

The Referee's order dated December 6, 1984 is reversed in part. That portion of the order which declined to impose a penalty/attorney's fee for the employer's failure to promptly adjust claimant's temporary disability rate is reversed. The self-insured employer shall pay claimant, as a penalty for unreasonable delay in the payment of compensation, an amount equal to 25% of the additional compensation payable to claimant as a result of the correction of claimant's temporary disability rate. In association with the penalty, the employer shall pay claimant's attorney a reasonable fee of $250 for services at hearing and on Board review in connection with this penalty issue. The remainder of the Referee's order is affirmed.

MARTIN J. RIDGE, Claimant
David Force, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-04476
June 11, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee Michael Johnson's order which awarded claimant interim compensation from April 27, 1983 through June 16, 1983. The issue is whether claimant has established his entitlement to the interim compensation in issue.

After the Referee's order in this case, the Supreme Court decided Bono v. SAIF, 298 Or 405 (1984). The Court held that in order to receive interim compensation, a subject worker must have left work as that phrase is used in ORS 656.210(3). Id. at 410. The Court also stated:

> "It is not necessary for a worker to be totally disabled in order to receive interim compensation. Any claim for a disabling compensable injury will trigger the ORS 656.262(4) payments. However, to the extent that the amount of such payments cannot be calculated, the worker should receive as interim compensation the temporary total disability benefits specified in ORS 656.210." Id.

In this case, claimant contended that he sustained a finger injury during his enrollment and participation in an authorized training program. The Referee upheld SAIF's denial of the finger injury claim, which was partly based on the allegation that claimant did not sustain his finger injury during the course of his authorized training program. Based primarily on credibility grounds, the Referee concluded that claimant failed to establish that he injured his finger while participating in the training program. He nevertheless awarded interim compensation, which was arguably justified under the Court of Appeals Bono decision, 66 Or App 138 (1983).

Since the evidence fails to establish that claimant sustained his finger injury during his authorized training program, it follows that the record fails to establish claimant "left work," or in this particular instance, left his authorized training program, as that phrase is used in ORS 656.210(3). Therefore, claimant has failed to establish his entitlement to interim compensation.

It is on this basis that we reverse the Referee's order of interim compensation, and we make no comment concerning his "aggravation vs. new injury" analysis.

ORDER

That portion of the Referee's order dated August 27, 1984 which awarded interim compensation from April 27, 1983 through June 16, 1983 is reversed.

LAURENCE E. SAXTON, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-10671
June 11, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Foster's order which: (1) set aside as prematurely issued an August 29, 1983 Determination Order; (2) awarded claimant an additional 48° (15%) unscheduled disability, thereby increasing claimant's total award to 128° (40%) unscheduled disability for injury to the low back; (3) imposed a 10% penalty and associated attorney's fee for SAIF's failure to timely pay temporary partial disability in accordance with the aforementioned Determination Order; and (4) imposed an additional 10% penalty and associated attorney's fee for SAIF's failure to pay interim compensation in connection with an aggravation claim. On review the issues are premature claim closure, extent of unscheduled disability and the propriety of the Referee's imposition of penalties/attorney fees on the above-stated grounds.

As to the premature closure issue, we find that claimant has failed to establish that his condition was anything other than medically stationary when his claim was closed on August 29, 1983. There is no medical evidence to support claimant's contention that he was not medically stationary. Indeed, the medical evidence bearing on the question seems to indicate that claimant was stationary when his claim was closed, and that his condition worsened to some extent thereafter. We reject claimant's argument that this case represents the type of situation contemplated by our decision in William Bunce, 33 Van Natta 546 (1981), wherein we discussed the "objective reality" unknown prior to claim closure but discovered post-closure, which warrants setting aside a Determination Order as prematurely issued. See also Florine G. Johnson, 35 Van Natta 572 (1983). Based upon the medical opinion and information available at the time the Determination Order issued, the only reasonable conclusion is that claimant's condition was medically stationary at that time. See Sullivan v. Argonaut Insurance Co., 73 Or App 694 (May 22, 1985); Alvarez v. GAB Business Services, Inc., 72 Or App 524 (1985); Roy McFerran, Jr., 34 Van Natta 621, aff'd mem 60 Or App 786 (1982). Accordingly, we reverse that portion of the Referee's order which set aside the August 29, 1983 Determination Order, and reinstate that Determination Order, as amended September 6, 1983, as the proper initial claim closure. Claimant's aggravation rights run from the date of that claim closure. ORS 656.273(4)(a).

As to the unscheduled disability issue, we find the Referee's additional award for 48° (15%) unwarranted and conclude that the 48° (15%) awarded on the initial claim closure, together with the additional 32° (10%) awarded by the more recent July 3, 1984 Determination Order, adequately and appropriately compensate claimant for the loss of earning capacity attributable to his low back injury. ORS 656.214(5).

Dr. Woolpert, claimant's attending orthopedic physician, initially indicated that claimant suffered mild to moderate back impairment. In his deposition, he clarified that roughly one-half of claimant's overall back impairment was attributable to

pre-existing degenerative disease and obesity, and that only one-half of claimant's overall back impairment was due to his injury. The Referee noted Dr. Woolpert's impairment rating of mildly moderate; however, he failed to mention Dr. Woolpert's more recent statement that one-half of this impairment is attributable to causes other than claimant's injury. We proceed to evaluate claimant's unscheduled disability using his injury-related permanent impairment as the foundation. Barrett v. D & H Drywall, 73 Or App 184 (1985).

Claimant was 32 years of age at the time of hearing. He has an 11th grade formal education and no GED. At the time of his injury, he was working as a yarder operator for the employer's logging operation. Most of claimant's work experience has been in logging. He is no longer physically capable of performing heavy work, which is due in material part to his industrial injury. He is able, however, to run machinery such as a yarder, as evidenced by his return to modified work after his injury. Claimant ran the yarder and restricted his work activities by, for example, not engaging in heavy lifting. In fact, claimant is relegated to performing work of a light nature. Considering claimant's residual functional capacity, his education, work experience and consequent training and skills, we find that the occupational opportunities available to him are moderately restricted. OAR 436-65-608(2)(b).

In consideration of the above, we find that the Determination Order awards which total 80° for 25% unscheduled disability adequately and appropriately compensate claimant. Therefore, we reverse the Referee's additional unscheduled award.

On the remaining issues of penalties and attorney fees, we affirm and adopt the relevant portions of the Referee's order. We note that although in some cases fourteen days might not be a sufficient period of time in which to calculate and pay a Determination Order award for temporary partial disability, the eight weeks that passed between the date of the Determination Order and SAIF's payment in this case appears neither justified nor justifiable.

SAIF challenges the Referee's award of a penalty-associated attorney's fee on the basis of our decision in Zelda M. Bahler, 33 Van Natta 478 (1981), rev'd in part on other grounds 60 Or App 90 (1982). In Bahler we held that where there is an unreasonable refusal to pay compensation, a separate award of attorney fees under ORS 656.382(1) is mandatory, but that where there is an unreasonable delay in payment of compensation, a separate award of fees is discretionary. We held that where the award of fees is discretionary, no fee generally should be awarded if delayed payment of compensation is a secondary or minor issue and claimant's attorney is otherwise reasonably compensated by fees awarded in connection with principal issue(s). 33 Van Natta at 481. SAIF's failure to pay interim compensation in this instance represents a case of refusal and not merely delay; therefore, an additional fee is warranted. By virtue of our order reinstating the Determination Order and reversing the Referee's additional unscheduled award, the only fee payable to claimant's attorney in this proceeding is in connection with the penalties imposed by the Referee. Therefore, payment of an insurer-paid fee in association with the penalty for untimely payment pursuant to the Determination Order was appropriate.

ORDER

The Referee's order dated October 30, 1984 is reversed in part. That portion of the order which set aside as premature the Determination Order dated August 29, 1983, is reversed. That Determination Order is reinstated and affirmed as a proper initial claim closure, and claimant's aggravation rights run five years from the date of that order. That portion of the Referee's order which awarded an additional 48° (15%) unscheduled disability is reversed. The Determination Orders dated August 29, 1983 (as amended September 6, 1983) and July 3, 1984, which awarded claimant a total of 80° (25%) unscheduled disability for injury to the low back, are affirmed. The remainder of the Referee's order is affirmed.

GAVIN L. SMITH, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04541
June 11, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The SAIF Corporation requests review of Referee Foster's order which found that claimant had perfected an aggravation claim under ORS 656.273 and set aside its denial of claimant's low back injury aggravation claim. SAIF argues that the evidence as a whole does not show that claimant's condition worsened and that the Referee did not have subject matter jurisdiction because claimant's aggravation rights expired under ORS 656.273(4) before he made his aggravation claim. The initial question on review is whether claimant made a claim for aggravation of his condition under ORS 656.273 before his aggravation rights expired.

Claimant was compensably injured on March 10, 1977. His claim was closed by Determination Order pursuant to ORS 656.268(4) on September 27, 1977, with an award for 15% unscheduled disability. Claimant requested a hearing, which was held on April 1, 1980, and was awarded 224° for 70% disability. The Board reduced the award to 160° for 50% disability; Gavin L. Smith, 30 Van Natta 109 (1980); the Court of Appeals reinstated the Referee's award for 70% disability. Smith v. SAIF, 51 Or App 833 (1981). The last date on which compensation was arranged was the date of the hearing: April 1, 1980. Claimant's aggravation rights expired by statute on September 27, 1982.

The date of the hearing on the issue of the extent of claimant's permanent disability was April 1, 1980. Dr. Clibborn first examined claimant on April 16, 1980 and reported the following complaints and findings:

> "Describe complaints:
> neck pain, sleeping problem, back pain, dizziness, pins and needles in legs, numbness in toes, ears ring. . .
>
> "Findings of examination:
> Sitting: cervical flexion -- impaired; extension -- impaired; left lateral flexion -- partially impaired; right lateral flexion -- partially impaired; left rotation -- impaired; right rotation --

impaired; foramina compression test -- positive; Reflexes: biceps -- normal; triceps -- normal; patellar -- impaired; Standing: dorso-lumbar flexion -- impaired; extension -- impaired; left lateral flexion -- impaired; right lateral flexion -- impaired; rotation --impaired."

Dr. Clibborn diagnosed cervical and lumbosacral sprains and recommended chiropractic adjustments.

On August 13, 1980 Dr. Clibborn wrote a letter to SAIF:

"This patient is not the usual case. As you know he has been disabled since March 10, 1977.

"He first came in to our office on April 16, 1980. He complained of severe pain in his low back with burning pain into both of his legs.

"The patient's improvement has been slow but steady. We will get him down to two (2) visits a month as soon as we can. He should be at that level within two (2) months."

On April 13, 1981 Dr. Clibborn wrote a note on a Physician's Supplemental Report:

"This patient has required regular care during the past year due to a deterioration in his low [back] condition, which produced severe pain in his low back. He is much better off at this point. Our treatment from this point on should be considered palliative only. He should be able to get by now with 2-3 visits per month. . . ."

We find that the deterioration referred to by Dr. Clibborn happened before the last arrangement of compensation, and before Dr. Clibborn's initial examination of claimant. In addition, there is nothing to support a finding of any worsening of claimant's condition at the time referred to by Dr. Clibborn.

On May 14, 1981 Dr. Clibborn wrote a letter to SAIF:

"As you know, this man has been on disability for quite some time.

"We have been rendering treatment to this patient because his low back pain had become very severe. We are now treating this man two to four times per month, which is keeping his pain under control.

"We will only give this patient treatments as it is necessary to prevent a worsening of his condition. . . ."

Dr. Stanley first examined claimant on July 17, 1981. He reviewed the myelogram of 1977. The physical examination found no new complaints or limitations. He concluded, "I can see no treatment that I can offer him today."

Dr. Stanley next examined claimant on January 16, 1982. Claimant's chief complaint was about an unrelated condition in his knees. Claimant was "still having his back trouble." He further stated: "I think he is basically unchanged. Perhaps his back is getting a little worse but he has had no dramatic difference over the last several years. He definitely has a permanent disability and cannot function much at all because of his back. . . ."

On February 14, 1982 Dr. Stanley examined claimant for unrelated pain in the left hip. Claimant had no pain on full flexion of the leg with the knee either straight or flexed.

Claimant saw Dr. Stanley on March 5, 1982, complaining of right elbow and shoulder pain which was unrelated to his back injury. The doctor recorded his recommendation of medication for the arm conditions, but there was no mention of back problems.

On April 22, 1982 Dr. Stanley reported:

> "[Patient] returns. He has had increased back pain. This is essentially similar to what he had previously. This is another bad episode.
>
> "EXAMINATION is the same as it was previously. I think it is just recurrence of his back pain. . . . If he does not improve might consider bringing him in for some P[hysical] T[herapy] and some pelvic traction."

On April 26, 1982 Dr. Clibborn wrote to SAIF:

> "As you probably realize, this patient had a worsening of his back pain in September of 1981. Since that time, he has had pain in his low back with tension in his upper back and neck.
>
> "These problems began after his March [10], 1977 injury. Although this man is permanently disabled, we feel his present treatments are necessary to minimize his present pain.
>
> "Our treatments are not corrective relating to his low back, but they are corrective relating to his upper back and neck pain.
>
> "He has improved a great deal over the last several months, and we hope he will soon be medically stationary."

The next entry in claimant's chartnotes from Dr. Stanley's office was on May 19, 1982. Someone with the initials "BP" entered the following note:

"PHYSICAL THERAPY: [Claimant] has been present for moist heat, U[ltra] S[ound] and massage on 4 occasions since 3/5/82. His last P[hysical] T[herapy] session was on 5/3/82 and at that time he was recovering steadily from his most recent exacerbation of L[ow] B[ack] P[ain]."

Claimant's next chartnote in Dr. Stanley's records indicates no more visits until after September 27, 1982.

On June 10, 1982 claimant signed a notification of change of attending physician which designated Dr. Stanley as the new attending physician. Dr. Stanley indicated that his services included physical therapy as needed since July 17, 1981, when he first examined claimant. His diagnosis in July 1982 continued to be "chronic back pain, probably degenerative disc disease [with] chronic nerve-root compression at L5 on the right."

The evidence shows that claimant continued to receive treatment for his compensable condition from time to time as the symptoms of his back condition waxed and waned. The frequency and types of treatment seem entirely consistent with the award for 70% disability. No physician reported that claimant's condition had worsened nor that claimant was unable to work due to a worsening of his condition during the aggravation period.

Claimant argues that three reports of Dr. Stanley and one report of Dr. Clibborn are sufficient to establish that a claim for aggravation was made before September 27, 1982. We have reviewed those reports and find that they presented claims for medical services, as provided for under ORS 656.245, but when read for their entire meaning did not suggest that claimant's condition had worsened since his last arrangement of compensation, April 1, 1980.

Claimant argues that ORS 656.273(3) requires only a "physician's report indicating a need for further medical services or additional compensation" to be statutorily sufficient to make a claim for aggravation. This argument overlooks the inter-relationship of ORS 656.273(3) and ORS 656.245. This inter-relationship has been explained in Evans v. SAIF, 62 Or App 182 (1983); Dwayne G. Cary, 36 Van Natta 265 (1984); and William A. Newell, 35 Van Natta 629 (1983) and we find nothing in this case to cause us to depart from the reasoning in those cases. Cf. Haret v. SAIF, 72 Or App 668 (1985) (not every medical report is an aggravation claim, but almost anything that indicates a worsening of the condition would be enough); Gerald I. Halle, 37 Van Natta 515 (May 7, 1985) (aggravation claim is made when there is a request for further medical services due to a worsened condition). A claim for medical services within the aggravation period does not present an aggravation claim requiring reopening unless there is something about the claim that makes it clear that the medical services are needed to treat a worsened condition that is related to a compensable injury.

Another point that has been overlooked is the time of comparison. Claimant's condition improved and worsened regularly, and from day to day it could be better or worse, but in relation

to the time of the last arrangement of compensation, no physical examination report or treatment report suggested that claimant's condition worsened.

The right to a reopening of a claim under ORS 656.273 expires five years after the first closure of the claim under ORS 656.268(4). After the aggravation period runs under ORS 656.273, claimant can still have his claim reopened, but his method of obtaining reopening is to petition the Workers' Compensation Board under its own motion authority pursuant to ORS 656.278.

In contrast, claims for reasonable and necessary medical services for a compensable condition have no limitation period. A claimant's condition need not worsen to obtain medical services and any request for medical services is sufficient to present a claim under ORS 656.245. Evans v. SAIF, supra. The claim need not be reopened to process medical service claims in the absence of a worsening of claimant's condition. Hutchinson v. Louisiana-Pacific, 67 Or App 577 (1984).

Therefore, we find that claimant did not present a claim for worsened condition within the aggravation period provided by ORS 656.273, and that the claim of worsened condition was not properly before the Referee. The lack of subject matter jurisdiction, conferred only by statute, prevents us from reviewing the Referee's order further. See Hazel M. Willis, 35 Van Natta 1750 (1983).

ORDER

The Referee's order dated June 22, abated July 20, and reinstated August 2, 1984 is reversed and the request for hearing is dismissed.

FRANK SPANGLER, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 81-02380
June 11, 1985
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Gemmell's order which awarded claimant an additional 64° (20%) unscheduled disability, thereby granting claimant a total award to date of 128° (40%) unscheduled disability for injury to his low back. Determination Orders dated November 17, 1982 and January 25, 1984 awarded 48° (15%) and 16° (5%) unscheduled disability respectively. SAIF contends that the Referee's additional unscheduled award is excessive, and that the Determination Order awards of 64° for 20% unscheduled disability adequately compensated claimant for the loss of earning capacity attributable to his industrial injury. We agree and, therefore, reverse the Referee's order.

Claimant was 30 years of age at the time of hearing. In January of 1981, while working as a yard salesman for Hatch Lumber, he fell off of a ladder from the third or fourth rung and struck his back. As a result, he sustained injury to his back which required surgical treatment. Claimant had two low back operations in fairly rapid succession. In February 1981 he had a bilateral discectomy and foraminotomy at the L4-5 level and negative exploration at L5-S1. Claimant's back pain continued and, therefore, he submitted to surgery approximately four months

later in June of 1981 for bilateral discectomy and foraminotomy at L4-5 and negative exploration at L3-4 and L5-S1.

Claimant testified that neither surgery seemed to improve his back pain. Post-surgical treatment has consisted of conservative measures such as Pain Center treatment and a TNS unit. Neither the Pain Center modality nor the TNS unit seem to have alleviated claimant's back pain to any considerable extent. As of the time of hearing, claimant's only form of treatment was oral medication in the form of muscle relaxers. He was not undergoing active treatment with a physician.

Considering claimant's testimony concerning his pain and physical limitations, as well as the medical evidence assessing the extent of permanent back impairment, we find that, as a result of his back injury, claimant suffers permanent impairment of a mild degree. Claimant's impairment is in the upper limits of mild according to the Orthopaedic Consultants, and this comports with our own assessment, which is based upon the record in its entirety.

Claimant has been retrained as a computer repair technician. As of the hearing in late August of 1984, claimant had been gainfully employed in that capacity for approximately seven months. He works as a "senior bench technician" in a computer shop, where he performs computer repair work, and assists customers and salespeople. This is light work, which is compatible with claimant's restricted residual functional capacity.

Claimant formerly was capable of performing, and did perform, work of a heavy nature. His employment experience included work as a short order cook, washing dishes, washing cars, setting chokers in the woods, building fiberglass boats, and working in a pizza parlor as a manager, which included the responsibility of supervising about 12 employes. Claimant is precluded from performing many of these jobs as a result of his injury; however, as a result of successful vocational rehabilitation efforts, claimant has learned new skills which have resulted in new employment opportunities and, in fact, apparently very successful reemployment.

At the time of his injury claimant was earning between $1,400 to $1,800 a month gross, which varied with the amount of overtime he worked. Presently he earns $1,300 a month. It appears that claimant is paid a monthly salary which is not affected by the number of hours he works each month. Claimant testified that he works approximately 176 hours per month.

Claimant has a formal tenth grade education. As a result of his involvement with vocational rehabilitation, claimant has obtained his GED. It appears that claimant has above average aptitude in math skills, as well as above average general learning ability.

Claimant sustained a significant injury to his back, which required two surgeries. As a result, he suffers pain and limitations of the back. Many of the jobs he performed in the past are no longer available to him as a result of his back condition. Claimant is young, however, and, as a result of successful vocational rehabilitation efforts, he now has the ability to obtain and hold gainful employment in a segment of the

labor market not previously available to him. Claimant enjoys his present employment, and there is every indication that he will continue to work in this field.

Considering all of the above, we find the Referee's award excessive. Our de novo review satisfies us that the Determination Order awards totaling 64° (20%) unscheduled disability are adequate and appropriate.

ORDER

The Referee's order dated September 12, 1984 is reversed, and the Determination Orders dated November 17, 1982 and January 25, 1984, which granted claimant a total award of 64° (20%) unscheduled disability for injury to the low back, are affirmed.

WINNIE M. THOMAS, Claimant
SAIF Corp Legal, Defense Attorney

WCB 83-10920
June 11, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Presiding Referee Daughtry's order dated December 11, 1984 which dismissed her hearing request because of failure to respond to an order to show cause why her hearing request should not be dismissed for failure to prosecute her claim. The issue on review is adequacy of the procedures followed to protect claimant's procedural due process rights.

Claimant requested a hearing on the denial of her aggravation claim. She was advised of her right to obtain the services of an attorney. She obtained the services of an attorney and requested that her hearing request be placed in inactive status. The request was granted, and she was advised that she must reactivate her hearing request by October 1, 1984, if she wished to pursue her right to a hearing. The Hearings Division received no request to reactivate the hearing request by October 24, 1984, so the Presiding Referee issued an order to show cause within 30 days why the hearing request should not be dismissed. The Hearings Division received no communication from claimant by December 11, 1984, so the Presiding Referee issued his order dismissing the hearing request.

On December 24, 1984 the Board received claimant's request for Board review of the Presiding Referee's order and which advised of a change of attorney. On February 13, 1985 the Board received claimant's request for an extension of time in which to file her brief. Claimant was granted an extension of 20 days. The Board received claimant's pro se brief on review on February 28, 1985. No response brief was submitted by the SAIF Corporation. The case was docketed for Board review in the usual course.

After reviewing the record submitted to us, we find that claimant's due process rights have been adequately protected by the procedures followed and that the Presiding Referee's Order of Dismissal of claimant's hearing request was correct.

Claimant's pro se brief does not address the issue of her failure to request reactivation of her hearing request. It provides a narrative account of her injury and course of treatment

and she attached copies of letters and claims processing reports. The evidence that claimant submitted with her brief was not considered on review. ORS 656.295(3) and .295(5).

ORDER

The Board affirms the Presiding Referee's order dated December 11, 1984 dismissing claimant's hearing request.

KIMBERLY A. BURTON, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-07083
June 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Danner's order which set aside its denial of claimant's bilateral bunions, awarded interim compensation from April 25, 1984 through June 22, 1984 and imposed a 10% penalty for failure to pay interim compensation. The issues are compensability of claimant's bunions, interim compensation and penalties.

Claimant was employed as a trim saw operator in the employer's manufacturing plant. Her duties required that she stand all day and operate a machine, which required that she push a pedal with her right foot. On being employed, claimant was told that she had to purchase and wear a pair of steel toed boots for safety purposes. She was free to select her own footwear. The employer paid one-half the cost of the boots.

It appears that claimant purchased a pair of ill-fitting boots. Approximately six months after she began to work, her feet began to hurt, primarily the left foot. She continued working a year and a half, however, before seeking attention for her increasingly painful feet. Claimant never missed any time from work as a result of her foot problems.

On or about April 25, 1984, claimant came under the care of Dr. Schink, a doctor of podiatric medicine. He diagnosed bunions, hallux valgus, of both feet. Claimant filed her claim with the employer by 801 form dated April 26, 1984. Claimant continued to work. SAIF denied the claim June 22, 1984.

Claimant submitted to surgery on June 25, 1984 for an operation on the left foot. After surgery she returned to modified work for the employer performing a desk job. She then had surgery on the right foot in September of 1984, after which she did not return to work for this employer. She presently works at a desk job in the State of Washington.

Claimant testified that she never had any problems with her feet prior to her employment. The Referee reasoned that the law controlling this case was stated in Wheeler v. Boise Cascade, 66 Or App 620, 624 (1984), in which the court found the claimant's skin condition compensable because, " * * * [T]he claimant had been asymptomatic and was not receiving medical care for his disease until the conditions at the mill caused his symptoms to appear and to require medical treatment that would not otherwise have been necessary." The Supreme Court has since reversed the Court of Appeals' decision and held that the analysis of Weller v. Union Carbide, 288 Or 27 (1979), applies whether conditions are symptomatic or asymptomatic at the time of employment. 298 Or 452 (1984).

Thus, in order for claimant to prevail, she must have established, by a preponderance of the evidence, that (1) her work activity and conditions (2) caused a worsening of her underlying disease (3) resulting in an increase in her pain (4) to the extent that it produced disability or required medical services. Wheeler v. Boise Cascade, supra, 298 Or at 457; Weller v. Union Carbide, supra, 288 Or at 35. In addition, if claimant satisfies her burden of proving a worsening of her underlying condition, as opposed to merely the worsening of symptoms, she also must establish that her work conditions were the major contributing cause of the worsening of her underlying condition. SAIF v. Gygi, 55 Or App 570 (1982).

The medical evidence concerning the cause of claimant's bunions is divided. Claimant's treating podiatrist, Dr. Schink, is of the opinion that, although claimant's bunions are inherited and result from a medial "drifting" of the first metatarsal with a resultant deformity about the first metatarsalphalangeal joint (i.e. hallux valgus), the boots she was required to wear at work "seriously aggravated" her bunions, making them painful and difficult to stand throughout an entire work shift.

Claimant was examined by Dr. Rockey, orthopedic surgeon, at SAIF's request. He concluded that claimant's bunions are a developmental problem which cause progressive symptoms by their nature and become an increasing problem for shoe fitting. He did not believe they were work related.

Dr. Norton, an orthopedic surgeon and SAIF's medical administrator, reviewed claimant's medical records for an opinion concerning the relationship between claimant's work and her bunions. He explained that hallux valgus is the medical term describing an angular deviation of the great toe toward the second toe, and that there are contributory factors of foot structure and alignment which biomechanically increase the tendency toward development of this angulation of the first metatarsal bone away from the second metatarsal bone. He stated that it is not unusual for adolescent girls and young women to present for treatment with advanced hallux valgus because of their propensity to wear "style shoes" rather than the more sensible shoes ordinarily worn by males. Dr. Norton explained that a bunion is the term given to "a disease or condition" that develops in association with hallux valgus, and that it is basically a response to excessive focal pressure between the first metatarsal head and the shoe. He stated that claimant undoubtedly had well-developed hallux valgus and bunion prone feet prior to her employment if she had progressed sufficiently to warrant surgical correction at her young age of 25. He saw nothing "occupationally specific" about the development of claimant's symptomatic bunions.

SAIF also had claimant's medical records reviewed by Dr. Baker, another orthopedic surgeon. He also opined that claimant's bunions were congenital in origin and that her symptoms were primarily due to the congenital foot deformity, as opposed to industrial conditions. Dr. Baker was aware of claimant's ill-fitting shoes and noted that these shoes would tend to accentuate the symptoms.

On August 8, 1984 Dr. Schink reported to claimant's attorney as follows:

> "I firmly believe the work boots she has to wear at work in conjunction with her stepping on a pedal all day severely aggravated her 'bunions' causing great discomfort. When I first saw her the area of involvement was very inflammed [sic] and tender to the touch as a direct result of boot irritation. It is safe to say the condition would only get worse as it is a progressive problem. Had she not been wearing such boot on a regular basis her need for surgery would most likely have been delayed for a number of years as most people have such surgery in the later years, usually after age 50."

We question Dr. Schink's statement that claimant's work boots in conjunction with her stepping on a pedal all day were responsible for the "severe aggravation" of her bunions for two reasons. First, she used her right foot to operate the pedal of the trim saw, but it was the left foot that was operated on first, apparently because it was more symptomatic. Second, claimant testified that six months before she had surgery, she stopped wearing the boots. The fact that claimant had surgery six months after she stopped wearing the boots suggests to us that the medical opinions stating that claimant's bunions are developmental, progressively symptomatic and unrelated to her work activities are closer to the truth than Dr. Schink's contrary opinion.

We find that the evidence fails to establish that claimant's work activities, including her ill-fitting work boots, did anything more than worsen the symptoms of a preexisting, underlying condition. Thus, we find claimant has failed to satisfy the requirements of Weller v. Union Carbide, supra. Were we to conclude, however, that claimant actually has established a worsening of her underlying condition, as opposed to the mere worsening of symptoms, we would nevertheless have to conclude that she failed to satisfy her burden of proving that her work activity was the major contributing cause of this worsening, as opposed to hereditary and developmental factors.

SAIF poses an additional argument in support of its denial. SAIF argues that because claimant was required to purchase and wear the boots as a condition to or qualification for employment, she assumed any risk attendant upon meeting that job qualification. Because claimant negligently chose a pair of boots that did not fit well, the resultant condition does not arise out of or in the scope of her employment. In support of this theory, SAIF relies upon our decision in Sharon M. Gow, 36 Van Natta 1156 (1984), and Haugen v. SAIF, 37 Or App 601 (1978).

These cases are clearly distinguishable from the case before us and are not controlling. In determining whether claimant's condition arises out and in the scope of her employment, the work-connection approach of Rogers v. SAIF, 289 Or 633 (1980), is the standard to be applied. See also Jordan v. Western Electric, 1 Or App 441 (1970). This claim does not fail for reasons of work relatedness under the Rogers analysis. It fails because the record does not establish the necessary elements of medical

causation. Weller v. Union Carbide, supra; SAIF v. Gygi, supra. See also Cochell v. SAIF, 59 Or App 391 (1982).

The remaining issue concerns the Referee's award of interim compensation and the related penalty issue. This portion of the Referee's order was premised upon the Court of Appeals decision in Bono v.SAIF, 66 Or App 138 (1983), which has since been reversed by the Supreme Court. 298 Or 405 (1984). It is now clear that interim compensation is intended to compensate an injured worker for leaving work, like temporary disability. In order to receive interim compensation, a claimant must have "left work," as that phrase is used in ORS 656.210(3). Id. at 410. It is undisputed in this case that claimant never missed work as a result of her bunions. We assume that claimant was off work for a period of time after the surgery performed by Dr. Schink on June 25, 1984; however, this occurred after SAIF had denied the compensability of the claim. Thus, in the interim between the filing of the claim and SAIF's June 22 denial, there was no obligation to pay interim compensation because claimant was working. It necessarily follows that the Referee's award of interim compensation and the related penalties for failure to pay the same must be reversed.

ORDER

The Referee's order dated December 17, 1984 is reversed.

JERRY L. JENNINGS, Claimant
Quintin Estell, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-01244
June 12, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Seifert's order which: (1) affirmed the Determination Order which awarded 22.5° for 15% scheduled permanent partial disability of his right leg; (2) found that the temporary total disability compensation was paid at the correct rate; and (3) upheld the SAIF Corporation's denial of his aggravation claim. The issues on review are extent of scheduled permanent partial disability, rate of temporary total disability compensation and aggravation.

Claimant was orally offered a job on July 28, 1982, to work as a choker setter. No daily or weekly hours were discussed nor was the rate of pay. Claimant learned from a fellow worker that they worked a maximum of 49 hours per week, but there was no discussion with the employer about hours of work. The logging company hired its workers on a daily on-call basis, notifying them at the end of each day if there would be work the next day.

The first week, claimant worked 26 hours on three days. The second week, claimant worked 49 hours on five days. The third week, claimant worked 29 hours on three days. The fourth week, claimant worked 42 hours on five days. Eleven days later, claimant worked one day for 4.5 hours. One day during the third week, claimant suffered two blows to his left knee. He continued working through the next week because he thought the injury would resolve, but he finally left work on August 20, 1983, at the end of the fourth week.

On the injury report, the employer reported claimant's hours

of work at a 40 hour per week rate. Claimant was paid temporary total disability at the 40 hour per week rate. Claimant contends that the agreement he made as an on-call worker was to work and be paid for 49 hours per week. The employer contends that no worker was hired with such an expectation and that no hours of work were ever discussed because everyone in the company was on an on-call basis due to the uncertainties of weather and the log market in 1982. SAIF introduced evidence that the employe with the most overtime during the four month period following claimant's injury averaged 2.375 hours per week of overtime and conceded that it would pay claimant compensation for overtime at that rate.

OAR 436-54-212 is applied to determine the correct rate of temporary total disability compensation due claimant. Claimant met neither the 26-week nor the 4-week test of on-call employment, therefore, the rate of compensation should be governed by the intent at the time of hiring. We find that claimant should have been paid at the rate of compensation for hours that would have most nearly approximated the hours of the other workers in similar circumstances as his, and no more than the employe in similar circumstances who was paid for the most hours of work. We find that claimant should have been compensated at the rate of 42.375 hours per week as SAIF conceded.

Claimant contends that the employer concealed the true hours of employment from SAIF and that a penalty and attorney's fee for unreasonable resistance should be awarded. Claimant also contends that SAIF's failure to pay claimant compensation conceded for overtime in spite of the Referee's order was unreasonable resistance for which a penalty and attorney's fee should be awarded. We find that the employer did not act unreasonably in reporting claimant's hours and that the SAIF Corporation did not act unreasonably in relying on the Referee's order, therefore, no penalties or attorney fees will be awarded.

Claimant contends that he has not been properly compensated for the partial loss of use of his left leg. The Determination Order incorrectly awarded disability for injury to the right leg, and the order will be corrected to show that the award was for the injury to the left leg. On the issue of the extent of the scheduled permanent partial disability of claimant's left leg, we affirm the order of the Referee.

Claimant also raised the issue of premature closure and contests the denial of aggravation. On those issues, we affirm and adopt the order of the Referee. See Roy McFerran, Jr., 34 Van Natta 621, aff'd mem. 60 Or App 786 (1982).

ORDER

The Referee's order dated September 12, 1984 is modified. The Determination Order award for disability of the right leg is modified to show that the award was for disability due to injury of the left leg. The rate of temporary total disability compensation will be paid at the rate of 42.375 hours per week. In all other respects, the Referee's order is affirmed. For prevailing on the issue of rate of compensation for temporary total disability compensation, claimant's attorney is allowed 25% of the increased compensation awarded by this order up to a maximum of $3,000.

DONALD A. HACKER, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 84-12383, 84-02755 & 82-05864
June 13, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of that portion of Referee Leahy's order awarding 64° for 20% unscheduled disability for claimant's right hip in lieu of a Determination Order award of 7.5° for 5% scheduled disability for loss of use of the right leg. The employer objects to the award on procedural grounds alone, contending that claimant did not raise the question of whether the award should be unscheduled and that the Referee's subsequent award of unscheduled disability constituted an improper gratuitous finding. It contends that a 20% scheduled award for the right leg would be appropriate.

Claimant's initial hearing request is dated June 30, 1982. A box checked on that request form indicated that among the reasons for the request was extent of scheduled permanent partial disability. The unscheduled permanent partial disability box was not checked. However, the unscheduled permanent partial disability box was the only box checked on claimant's subsequent Supplemental Request for Hearing and Application for Hearing Date forms, both dated October 5, 1983. A hearing was held on October 30, 1984 regarding issues arising out of this claim and subsequent injury claims. Claimant began his opening statement as follows:

> "Very briefly. The evidence we'll present today will bear on two issues. One, is the extent of unscheduled disability."

Claimant appended an affidavit to his brief regarding the issues discussed in the unreported closing arguments. The Board may not consider evidence not a part of the hearing record. ORS 656.295(5). We treat the submission as a request for remand. This is one of the very rare cases where, due to the customary practice of not recording closing arguments, the record might arguably be incompletely developed. In such cases, remand is discretionary with the Board. Bailey v. SAIF, 296 Or 41 (1983). Because we find the record amply developed on the procedural question, we decline the request. See ORS 656.295(5), (6).

The Board has authority to reach issues not raised by the parties. Larsen v. Taylor & Co., 56 Or 404, 406 n. 1 (1982); Russell v. A & D Terminals, 50 Or App 27, 31 (1981); Neely v. SAIF, 43 Or App 319, 323 (1979), rev den, 288 Or 493 (1982). In Neeley the court explained:

> "The Board may reverse or modify the order of the referee or make such disposition of the case as it determines to be appropriate. ORS 656.295(6).
>
> "Fundamental fairness may dictate that the Board should not decide a claim on the basis of evidence not in the record. McManus v. State Acc. Ins. Fund, 3 Or App 373, 375 . . . (1970), or on issues to which no evidence was presented. . . . If claimant had been given no opportunity to

present evidence on that issue in the hearing below, the proper procedure would be for the Board to remand the case to the referee, ORS 656.295(5), for the taking of evidence on that issue."

Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue before it is decided. A reasonable opportunity to present evidence on an issue cannot exist where there is no prior notice that the particular issue is in controversy. Consistent with our restrictive policy regarding remands, see generally Casimer Witkowski, 35 Van Natta 1661 (1983), the Board has elected to concentrate its attention on making the best possible decisions on the issues raised by the parties without the distraction of volunteering decisions on issues not raised, and we have admonished the referees to do the same. Michael R. Petkovich, 34 Van Natta 98 (1982).

The precise procedural question before us is whether the Referee should have refrained from making an unscheduled award because allegedly insufficient notice to the employer may have deprived it of a reasonable opportunity to present pertinent evidence. The record clearly establishes that the employer had notice both before the hearing and at the hearing before evidence was taken that extent of unscheduled permanent partial disability was in issue. It had a reasonable opportunity to develop the evidentiary record on that point. We conclude that the Referee's award of unscheduled disability was procedurally proper.

The issue before us is extent of permanent disability. The procedural question raised by the parties and the appropriateness of the award on the merits are merely different aspects of the same basic inquiry. We, hence, review the merits also. See Larson v. Taylor & Co., supra. Claimant's compensable condition arose early in 1981, apparently as a result of his work setting chokers and riding in a crummy. On March 3, 1981 Dr. White noted tenderness over claimant's right greater trochanter and diagnosed right trochanteric bursitis. Although Dr. Adams, an orthopedist, noted very little if any back pain, his impression on March 5, 1981, was that claimant's hip and leg pain was due primarily to a herniated disk. Dr. Adams' chart notes in May and June 1981 report continuing tenderness behind the greater trochanter. Claimant was treated with injections.

On May 18, 1981 Dr. Bernstein performed a neurological examination at Dr. Adams' request. He reported that there was no tenderness about the posterior iliac crests, lumbar spine, sciatic notches, sacroiliac joints or hamstrings, however, the posterior aspect of the right greater trochanter was quite tender. Claimant's EMG was essentially normal. Dr. Bernstein recommended against performing a myelogram.

Dr. Adams reported on July 22, 1981 that he had not found much wrong with claimant other than persistent tenderness behind the greater trochanter. He stated that he had little to offer claimant other than anti-inflammatories.

Orthopaedic Consultants diagnosed chronic sub-trochanteric bursitis on August 27, 1981. They noted tenderness quite well localized to the posterior superior aspect of the greater trochanter in what the examiner believed to be the insertion of

the gluteus medius muscle on the trochanter. They recommended that claimant receive more injections.

On September 21, 1981 Dr. James, an orthopedist, noted some low back and sciatic notch tenderness, but marked tenderness over the gluteus medius minimus insertion on the greater trochanter and over the superior portion of the trochanteric bursa. Back x-rays indicated mild degenerative changes but no other significant problems. His impression was: (1) spondylolysis of L5, bilateral, with mild lumbar scoliosis; (2) trochanteric bursitis; and (3) gluteus medius tendinitis. He recommended further conservative care.

Dr. Adams performed further injections. He released claimant to try to return to work in a plywood mill on December 7, 1981. Claimant returned to Dr. Adams with pain complaints on December 30, 1981 and was released from work until January 4, 1982. On December 30, 1981 Dr. Adams stated that claimant had too well localized exquisite tenderness for a sciatic nerve problem. He recommended that another opinion be obtained.

Dr. White, an internist, examined claimant on January 19, 1982. He found no tenderness other than over the posterior aspect of the right greater trochanter. On January 28, 1982 he stated that he did not feel claimant was malingering and should be referred to an orthopedic surgeon.

Claimant was again examined by Orthopaedic Consultants on April 9, 1982. They reported that claimant had performed a variety of mill jobs recently. One job involving using a foot pedal while standing had aggravated claimant's symptoms. They reported that claimant complained of pain aggravated by being on his feet continually or lying directly on the right hip and that he stated that he could continue working if his condition did not worsen. Chronic subtrochanteric bursitis was diagnosed. The doctors opined that claimant's condition was stationary and that further specific treatment was not indicated. They noted that although claimant had returned to his mill job without limitations, were he working in the woods, he might have trouble with slopes. They rated claimant's permanent impairment as minimal. Dr. Adams subsequently indicated his agreement with the Orthopaedic Consultants' report.

Dr. White reported on May 14, 1982 that claimant had plateaued with almost continuous pain while on his feet at work, and he recommended further treatment. Claimant returned to see Dr. James on June 30, 1982. Dr. James reported complaints of persistent and increasing problems with the right trochanteric area and posterior gluteus medius minimus insertion region. His examination detected no trochanteric tenderness or significant low back pain, but slight gluteal fascia origin tenderness and severe tenderness of the gluteus medius and minimus insertion which was well localized to the posterior right greater trochanter. On September 13, 1982 Dr. James reported that claimant also complained of increased low back discomfort, aggravated by his work. Dr. James recommended that claimant be considered medically stationary, with permanent partial disability due to unilateral spondylolysis and gluteus medius and trochanteric bursitis. He recommended retraining.

Claimant subsequently injured his neck at work and his back in a confrontation with police. He was referred to the Callahan Center in mid 1983. In July 1983 Dr. Bert reported that claimant stated that he had been hit in the face and kicked in the ribs in a bar brawl. Claimant strained his back at work in April 1984.

The overwhelming weight of the medical evidence is that the condition arising in early 1981 involved the greater trochanter and adjacent soft tissues. The greater trochanter is part of the femur, the bone of the upper leg. It is not part of the pelvic girdle. We, therefore, conclude that the Referee erred in making an unscheduled award. Compare ORS 656.214(2)(c); OAR 436-65-550 and OAR 436-65-555(2) with Robert L. Akins, 35 Van Natta 231 (1983) and ORS 656.214(5). The employer proposes that claimant's award be modified to 20% scheduled disability for loss of use of the right leg and that it be granted the right to offset any amounts paid in excess of the value of that award against future awards, if any. We agree that a 20% scheduled award will appropriately compensate claimant. The requested offset is not permitted by statute. ORS 656.313(2); Glen O. Hall, 35 Van Natta 275 (1983).

ORDER

The Referee's order dated November 28, 1984 is affirmed in part and modified in part. Claimant is awarded 30° for 20% scheduled permanent partial disability for loss of use of the right leg in lieu of all prior awards on claimant's upper right leg claim, WCB No. 82-05864. Claimant's attorney's fee is modified accordingly.

HAROLD D. WARD, Claimant
Evohl F. Malagon, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 84-04502
June 17, 1985
Order on Reconsideration

Claimant and the self-insured employer both request reconsideration of our Order on Review entered herein on May 28, 1985. 37 Van Natta 606 (1985). Both parties request reconsideration of that portion of our order which awarded claimant's attorney $100 for services on Board review. The employer contends that there is no statutory authority for such an award in this case. Claimant requests that we increase the award. The employer, in addition, requests that we expressly state a factual finding that interim compensation for the three day waiting period, ORS 656.210(3), ultimately was paid in a timely fashion.

As to the employer's contention that there is no statutory authority for an award of attorney fees on Board review, we disagree. The Referee awarded interim compensation for the period March 25, 1983 through March 27, 1983. In addition, he imposed a penalty equal to 25% of that interim compensation and an associated $50 attorney's fee. The employer requested review seeking reversal of the Referee's award of interim compensation and the imposition of penalties/attorney fees. Claimant submitted his respondent's brief arguing that the Referee's order should be affirmed in all respects. We reversed that portion of the order which imposed a penalty/attorney's fee, and we affirmed the award of interim compensation. Since claimant prevailed on the issue of entitlement to interim compensation, he is entitled to a reasonable fee for services rendered in that regard, despite the

fact that we eliminated the imposition of penalties/attorney fees. ORS 656.382(2); Bahler v. Mail-Well Envelop Co., 60 Or App 90 (1982); see also Mobley v. SAIF, 58 Or App 394 (1982).

The legal issues framed by the parties were whether the three day waiting period applies to interim compensation payments, and whether the employer's failure to include payment for the waiting period in claimant's initial installment of interim compensation was unreasonable. The employer took issue with the Referee's statement that the three day waiting period does not apply to interim compensation payments. Having the benefit of the Supreme Court's decision in Bono v. SAIF, 298 Or 405 (1984), we agreed with the insurer's contention on review that the provisions of ORS 656.210(3) do apply to interim compensation payments. We disagreed with the employer's argument that application of this statute required reversal of the Referee's award of interim compensation, because the evidence established that claimant was continuously disabled for 14 days. Thus, although we agreed with the employer that the three day waiting period applies, claimant nevertheless was entitled to interim compensation because of the 14 day provision also contained in ORS 656.210(3).

Concerning the employer's request that we expressly state a factual finding that interim compensation for the three day waiting period ultimately was paid in a timely fashion, we do not believe that the evidentiary record developed before the Referee, including the documentary exhibits submitted and admitted prior to closure of the record, and the transcript of the oral proceedings, establishes the facts necessary to make such a finding. In any event, it was not necessary to our disposition of the issues before us.

In support of his request that he be awarded an additional employer-paid attorney's fee on Board review, claimant has submitted an affidavit of counsel detailing 7.5 hours expended in representing claimant before the Board. Claimant requests a fee of $750. The criteria for awarding a reasonable attorney's fee are efforts expended and results obtained. OAR 438-47-010(2).

Claimant's respondent's brief is just that -- brief, as would be expected considering the nature of the issues on review. At least half of the effort was made in support of claimant's argument that the penalty/attorney's fee imposed should be affirmed. Counsel's affidavit satisfies us that the $100 awarded is inadequate; however, we decline to increase the award to the extent requested.

ORDER

On reconsideration of the Order on Review entered herein on May 28, 1985, we modify that order to award claimant's attorney an additional fee of $150, for a total fee of $250 for services on Board review, to be paid by the self-insured employer. Except as modified, we adhere to our prior order, which hereby is republished effective this date.

ROBERT B. WILLIAMS, Claimant
Yturri, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB TP-85007
June 17, 1985
Interim Order of Partial Distribution of Third-Party Settlement

The insurer requests that the Board exercise its authority pursuant to ORS 656.593(1)(d) and resolve a conflict between the insurer and claimant as to what is a just and proper distribution of the proceeds of a third-party settlement entered into between claimant and the party ultimately responsible for claimant's injuries. Pending full resolution of the conflict, which centers around a determination of the present value of reasonably to be expected future expenditures for compensation and medical services, the insurer asks that we suspend distribution of the proceeds.

Claimant was injured in the course and scope of his employment in a motorcycle accident on April 16, 1983. He initiated his workers' compensation claim on May 9, 1983. The insurer asserts that as of March 29, 1985 it had expended $19,467.55 on claimant's workers' compensation claim, and that that amount has in fact been tendered to the insurer. A Determination Order was issued on July 31, 1984 awarding claimant 20% scheduled disability for loss of use of the right leg. A second Determination Order issued August 14, 1984 increased claimant's temporary disability award, but granted no further permanent disability. On April 15, 1985 claimant requested a hearing on the extent of his scheduled and unscheduled disability. The hearing request is still pending.

The insurer urges that if full distribution of the third-party proceeds, which we have been told is $80,000, is permitted now, claimant may be awarded additional compensation in the future, the amount of which is presently unknown and incapable of determination. Under ORS 656.593(1)(c), the insurer is entitled to be compensated out of the third-party proceeds for such future compensation. If the distribution is made now, the insurer argues, the proceeds will be beyond the reach of the insurer when the true amount of the insurer's lien becomes known.

In George Bedsaul, 35 Van Natta 695 (1983), we were faced with an identical issue, which we resolved by ordering a statutory distribution of all sums then liquidated, and ordering that the remaining balance of the third-party proceeds be retained in trust pending resolution of the question of the insurer's reasonably to be expected future expenditures for compensation and other claim costs. We will take the same approach here. See also John J. O'Halloran, 34 Van Natta 1101, 1103 (1982), in which we stated a policy in favor of partial distributions pending Board action to resolve issues remaining in conflict.

We wish to make it clear that the distribution ordered today is that mandated by statute and that no conflict exists as to this statutorily mandated distribution. The only conflict existing relates to the insurer's entitlement to additional sums for reasonably to be expected future claim costs and the amount of the present value of those costs. It is resolution of this conflict that we defer, pending final determination of the extent of claimant's scheduled and unscheduled disability.

ORDER

Upon receipt of the settlement proceeds, claimant's attorney shall make the following distribution:

1. The costs of litigation shall be paid;

2. Claimant's attorney shall receive a reasonable attorney fee in accordance with his agreement with claimant, but not in excess of that permitted by OAR 438-47-095;

3. Claimant shall be paid 33 1/3% of the balance remaining after payment of items 1 and 2; and

4. The insurer, United States Fidelity & Guaranty Company, shall be paid and retain a sum equal to its expenditures to date paid to or on behalf of claimant, including temporary and permanent disability compensation and medical expenses.

The remaining balance of the third-party recovery proceeds shall be retained by claimant's attorney in trust for claimant until such time as a final determination has been made concerning the extent of claimant's permanent disability, at which time, upon being advised by the parties and having received all relevant evidence, the Board will order distribution of the remaining balance.

ALICIA W. CARDELL, Claimant
Peter O. Hansen, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 84-05498
June 18, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Thye's order which: (1) found that claimant did not participate as a trainee in a work experience program and, thus, was not entitled to compensation pursuant to ORS 656.033; and (2) found that she was not entitled to interim compensation, penalties and accompanying attorney fees. On review, claimant contends that: (1) she was enrolled in a "work experience program" pursuant to ORS 656.033; (2) the self-insured employer was not prejudiced by the filing of her claim one year post-injury; and (3) she is entitled to interim compensation, penalties and accompanying attorney fees.

The Board affirms the order of the Referee with the following comment. Assuming for the sake of argument that claimant was entitled to compensation pursuant to ORS 656.033, we would find that the claim is barred as untimely according to ORS 656.265(4). We are persuaded that the employer has been prejudiced by the filing of the claim approximately one year post-injury. Not only was the employer denied an opportunity to promptly conduct an independent investigation and medical examination, but claimant sustained a compensable injury to the same part of her body during this one year interim while working for a subsequent employer.

ORDER

The Referee's order dated November 20, 1984 is affirmed.

BLAINE E. CROXFORD, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-00513
June 18, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Galton's order which awarded 128° for 40% unscheduled permanent partial disability in addition to prior awards totalling 160° for 50% permanent disabilty for a total of 288° for 90% unscheduled permanent partial disability for low back injury. The issue on review is extent of unscheduled permanent partial disability.

Claimant strained his low back at work on March 3, 1978. His claim was first closed by Determination Order dated August 28, 1978 which awarded 32° for 10% unscheduled disability. After an aggravation of his injury, claimant was awarded 16° for 5% additional disability resulting from injury to his low back by Determination Order dated March 5, 1980. A program of vocational rehabilitation as a hydraulic jack repairman was attempted but not completed, after which the Determination Order dated June 12, 1981 awarded no additional permanent disability. On December 15, 1981 a hearing was held at which one issue was the extent of claimant's permanent disability. The Referee's order dated March 22, 1982 awarded claimant 112° for 35% unscheduled permanent partial disability in addition to the previous awards. The Referee's order was affirmed without opinion by the Board's Order on Review dated October 8, 1982. Claimant subsequently completed a vocational rehabilitation program in woodworking, after which the Determination Order dated November 7, 1983 made no award for additional unscheduled permanent disability.

At the time of the hearing claimant was 56 years old. He had completed the eleventh grade. At the time of his injury he was a truck driver. His injury was a strain injury to his low back. He has undergone two myelograms and a discogram. He has continuing pain in his back. Corrective surgery has been recommended by his treating physician, but claimant has not undergone surgery. Claimant has documented functional overlay and psychological sequelae from his injury. Claimant completed a vocational rehabilitation program in woodworking and has set up a small shop where he and his family make furniture on contract. He has not sought employment outside of his self-employment venture. He works full-time at the shop and at the related tasks necessary to operation of a small business.

Claimant has a preexisting severe asthmatic condition unrelated to his industrial injury. The asthma severely impairs claimant's ability to work in the woodshop with the saws and to do shop housekeeping. It also contributes to blackout spells. His industrial injury does not contribute to the blackout spells.

The Referee relied on Barrett v. D & H Drywall, 70 Or App 123 (1984), and considered the effect of the preexisting unrelated conditions on the extent of claimant's loss of earning capacity. Since the Referee's order that opinion has been withdrawn. 73 Or App 184 (1985). Claimant's award for permanent disability must be based on the loss of earning capacity due to the industrial injury. 73 Or App at 186. Considering claimant's loss of earning capacity due to his industrial injury and the relevant social and

vocational factors, we find that claimant has been adequately compensated by his award of 160° for 50% unscheduled disability and reverse the Referee's award for additional disability.

ORDER

The Referee's order dated November 30, 1984 is reversed. The Determination Order dated November 7, 1983 is affirmed.

MARK A. DOWNEY, Claimant
Thomas O. Carter, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 83-11880
June 18, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of Referee Galton's order which awarded 32° for 10% unscheduled permanent partial disability. The Determination Order ordered no award for permanent disability. The issue on review is extent of unscheduled permanent partial disability.

Claimant suffered a compensable hernia on October 19, 1982. Compensability of his condition was the subject of a prior hearing and Board Order on Review. 35 Van Natta 1590 (1983).

Claimant's doctor reported claimant suffered no impairment as a result of his injury and surgery and released claimant to return to work without restrictions. Claimant returned to work at his former employment for more than one year. Claimant sought no further medical attention nor did he lose time from work due to this injury. Claimant testified that he felt tension, tightening and pulling sensations in the area of his surgical scar when lifting objects weighing greater than 50 pounds, when straining at a bowel movement and when engaging in sex. Claimant was terminated from his job for unrelated reasons and had not been reemployed by the time of hearing.

Claimant is entitled to compensation for permanent partial disability only if there is permanent loss of earning capacity as a result of the hernia injury. ORS 656.214(5). The discomfort of which claimant complained did not interfere with his ability to keep and hold his former job for more than a year without modification of the work and without medical attention. We find that claimant suffered no loss of his earning capacity as a result of this industrial injury, therefore, we reverse the Referee's order.

ORDER

The Referee's order dated November 28, 1984 is reversed and the Determination Order dated May 5, 1983 is reinstated and affirmed.

DARLENE L. (YOUNGBLOOD) STEPHENS, Claimant
Allen & Vick, Claimant's Attorneys
Rankin, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 83-02302, 83-02414 & 83-05679
June 18, 1985
Corrected Order on Review

The Wausau Insurance Companies have requested correction of the Board's Order on Review dated May 28, 1985.

The request is granted. Our order is corrected to read as follows:

ORDER

The Referee's order dated June 22, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the self-insured employer, James River Corporation.

IT IS SO ORDERED.

BRADLEY D. SAIVILLE, Claimant
Mark R. Malco, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 83-11737
June 18, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee McCullough's order which increased the rate of his temporary total disability and assessed the insurer penalties and accompanying attorney fees for unreasonable claim processing. On review, claimant contends that: (1) his temporary disability rate should be increased; (2) further penalties should be assessed; and (3) his attorney fee award should be greatly increased. The insurer contends: (1) claimant was not regularly employed and should be treated as an "on call" employee; and (2) claimant's temporary disability was not untimely paid and that its claims processing was not unreasonable. We have authority to consider the insurer's contentions notwithstanding its failure to cross-request review. Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983).

The Board affirms the order of the Referee with the following comment. Although we are persuaded that the insurer unreasonably failed to timely comply with the full disclosure requirements of OAR 438-07-015, there are no further amounts "then due" upon which to base a penalty. The insurer has already been assessed the maximum penalty of 25% of the compensation "then due" for its other acts of unreasonable conduct. Consequently, we are unable to assess an additional penalty. See Gary L. Clark, 35 Van Natta 117 (1983).

ORDER

The Referee's order dated November 9, 1984 is affirmed. Claimant's attorney is awarded $600 for services pertaining to the insurer's contentions on Board review, to be paid by the insurer.

MARK T. STURGIS, Claimant
Roll, et al., Claimant's Attorneys
Stoel, et al., Defense Attorneys

WCB 84-02489
June 18, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of that portion of Referee Quillinan's order which set aside its denial of claimant's aggravation claim for a low back condition. On review, the employer contends claimant failed to prove that his present condition is compensable. We agree and reverse.

Claimant was 35 years of age at the time of hearing. In February 1981, while working as a stockroom employe for an electronics company, claimant suffered his compensable injury.

According to the employer's accident report, claimant tripped on a bolt, slipped on the ice and fell. The part of the body affected was noted to be the right shoulder and neck. Claimant sought no medical treatment until April 1981, approximately two months after the injury. At that time Dr. Weingarten diagnosed a cervical and right shoulder strain, prompted by a fall upon claimant's back and neck. Claimant's August 1981 claim for a "dislocated back" involving the "right cervical" area was accepted.

The first reference to low back complaints appears in August 1981 when Dr. Grossenbacher noted that claimant experienced some dull and aching "bandlike" pain across the lumbosacral area, along with his cervical and thoracic discomfort. Recording a history of a direct injury to the base of the cervical spine, shoulder area and thoracic region, Dr. Grossenbacher diagnosed cervical, thoracic and lumbar strain. In November 1981 Dr. Langston, orthopedist, performed an independent medical examination. The doctor reported that claimant landed on his neck and shoulders during the February 1981 fall. In addition to neck and shoulder discomfort, Dr. Langston reported that claimant was experiencing low back pain. Dr. Langston diagnosed musculoligamentous strain of the cervical and dorsal area and opined that claimant suffered no permanent impairment to those areas. Noting that claimant was then working as a butcher, Dr. Langston did not recommend vocational assistance.

A November 1981 Determination Order awarded claimant 5% unscheduled permanent disability for a "right shoulder and upper or mid back" injury. A November 1982 Referee's order increased this award, granting claimant an additional 20% permanent disability for "his right shoulder and upper and mid-back conditions."

In March and April 1983 claimant sought treatment on approximately ten occasions from Dr. Hurd, chiropractor. Dr. Hurd opined that the angle of claimant's low back was greatly increased which made him susceptible to low back problems. Dr. Hurd evaluated claimant's current x-rays and noted wedge shaped vertebra which apparently were "old healed compression fractures" in the mid back, as well as "significant rotational displacement" areas primarily in the neck, shoulder and mid back areas. Dr. Hurd concluded that claimant's x-rays also demonstrated the existence of one "displacement" area in the low back area. These interpretations appear to differ with the results of an April 1982 bone scan which indicated there were no abnormal findings in the cervical, thoracic or lumbar spine.

Claimant sought no further medical treatment until January 1984, at which time Dr. Utter became his treating chiropractor. Claimant's complaints included neck, back, and low back pain with radicular symptoms. In Dr. Utter's opinion claimant suffered from a degenerative condition in his low back due to the February 1981 injury. This degenerative process has slowly progressed to the point where claimant has experienced increasing low back and leg pain, thereby resulting in a worsening of his condition.

Dr. Utter testified at hearing that it was his impression that claimant had landed on his shoulder and low back in February 1981 and had experienced constant lower back pain since. This trauma was of sufficient intensity to initiate the degenerative

process in claimant's low back. The doctor answered affirmatively when asked if the history of claimant's injury was "somewhat critical" to his conclusions. Without an actual physical blow and trauma to the specific area, Dr. Utter felt that it was "not likely" that claimant's problems could occur as he had diagnosed. Dr. Utter admitted he had not seen any prior x-rays, nor had he reviewed claimant's prior medical records other than "reports" shown him by claimant's attorney apparently minutes prior to the hearing.

Dr. Utter concluded that an August 1984 thermography directly correlated his conclusions that claimant suffered from a L5-S1 nerve root impingement. Dr. Wilson, chiropractor, performed the thermographic examination. Noting abnormal nerve physiology, Dr. Wilson opined that barring a significant or symptomatic intervening injury to the lumbar spine, claimant was suffering permanent residuals attributable to the February 1981 injury.

The Orthopaedic Consultants performed an independent medical examination in July 1984. The Consultants diagnosed cervical, dorsal and lumbar strain by history, with functional overlay. Their examination revealed no objective findings to substantiate claimant's complaints. In the Consultants' opinion claim reopening was unnecessary.

Dr. Tilden, chiropractor, reviewed claimant's medical record, performed an independent medical examination and testified at the hearing. Dr. Tilden concluded that claimant's current condition was not related to his compensable injury. In Dr. Tilden's opinion claimant had probably sustained a cervical, thoracic and lumbar strain in February 1981. Had claimant suffered a direct trauma to the low back in February 1981, Dr. Tilden would have expected claimant to experience profound local symptoms such as muscle spasms and pain. Moreover, the doctor would have anticipated some findings of abnormalities from the April 1982 bone scan. Claimant's recent examination had revealed completely normal findings with the exception of lower thoracic and diffuse lumbar tenderness. Dr. Tilden opined that these symptoms were consistent with mild scoliosis and postural strain inasmuch as he had found no objective evidence to support a diagnosis of a degenerative condition of any kind or a nerve loss problem.

Claimant testified that he experienced immediate "midback" pain following the February 1981 injury. The low back pain has also been present since shortly after the injury, but has increased in intensity and lowered in location since the last award of compensation. There have been no intervening injuries or incidents and, until just prior to the hearing, he had not worked significantly since February 1982. His low back did not suffer a direct impact in the February 1981 fall. Claimant stated that he landed on "[B]asically the upper part of my body."

To establish an aggravation claim, claimant must prove that his original compensable condition has worsened since the last award or arrangement of compensation. ORS 656.273(1). He is not required to show a substantial worsening. Mosqueda v. ESCO Corporation, 54 Or App 736 (1981). However, the evidence must preponderate that the worsened condition is causally related to claimant's compensable injury. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984).

We are not persuaded that claimant's current low back complaints are causally related to his February 1981 compensable injury. In reaching our conclusion, we find the opinion of Dr. Utter unpersuasive. Dr. Utter admitted that he had not reviewed claimant's prior medical records, other than some unidentified "reports" apparently immediately prior to the hearing. Such an admission diminishes the degree of probative weight to be given to the treating physician's opinion, particularly where that physician began treating claimant approximately three years post-injury for a condition which presents a complex medical issue. Moreover, Dr. Utter based his opinion on the erroneous assumption that claimant had incurred a direct trauma to the low back. A physician's conclusions regarding causation are only valid to the extent that a patient's history is complete and accurate. Stephen F. Taafe, 36 Van Natta 1634, 1636 (1984); Charlene V. Devereaux, 36 Van Natta 911 (1984).

Finally, we find the opinion of Dr. Tilden more persuasive inasmuch as it is based on a review of claimant's prior medical record, as well as a recent physical examination, and correlates with past and current objective findings. Furthermore, the opinion provides a cogent, reasonable analysis concerning the mechanics of claimant's original injury and the cause of his current condition.

Although lay testimony may be sufficient to establish a compensable aggravation claim, Garbutt v. SAIF, 297 Or 148, 151 (1984), we find claimant's testimony concerning the worsening of his compensable condition insufficient in this case, especially when one considers the extensive history and variety of his back complaints, the complexities of his condition, and the persuasiveness of Dr. Tilden's opinion.

ORDER

The Referee's order dated November 27, 1984 is reversed. The employer's denials dated January 31, 1984 and August 1, 1984 are reinstated and affirmed insofar as they deny claimant's aggravation claim.

STEPHEN P. GESE, Claimant
Steven Yates, Claimant's Attorney
J.W. McCracken, Defense Attorney

WCB 84-02846
June 19, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Brown's order that awarded claimant 32° for 10% unscheduled permanent partial disability for the neck and left shoulder. Claimant asserts entitlement to a greater unscheduled award.

The Board affirms and adopts the order of the Referee with the following comment. In determining the extent of claimant's disability, the Referee, inter alia, took official notice of information contained within the Dictionary of Occupational Titles. Subsequent to the Referee's order, the Court of Appeals issued its decision in Groshong v. Montgomery Ward Co., 73 Or App 403 (1985), in which it held that review is limited to evidence found in the record developed below. Because information from the Dictionary of Occupational Titles was not actually entered into evidence at hearing, we have disregarded it on review.

ORDER

The Referee's order dated September 14, 1985 is affirmed.

DENNIS P. HAUGHTON, Claimant
Allen & Vick, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-10291 & 84-00494
June 19, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Podnar's order which: (1) upheld the SAIF Corporation's partial denial of medical/chiropractic treatment for claimant's cervical and thoracic spine in connection with a November 15, 1982 injury; and (2) modified a Determination Order dated March 1, 1984, which closed claimant's November 1, 1983 injury claim with an award for temporary disability only, by awarding claimant 16° for 5% unscheduled disability. The Referee expressly found the evidence insufficient to support a finding of a causal connection between claimant's November 1982 injury and his cervical problem. Although SAIF denied cervical and thoracic problems, the Referee made no express finding concerning a possible relationship between claimant's thoracic problems and the November 1982 injury. Claimant does not contend on review that his cervical condition is related to the November 1982 injury. His only contention is that his thoracic problems are a compensable consequence of the November 1982 injury. In addition, claimant contends that the Referee's unscheduled award is inadequate. In its respondent's brief, SAIF contends that there is no persuasive evidence to support the Referee's conclusion that claimant suffers permanent impairment. Therefore, SAIF contends that the Referee's award of permanent disability should be reversed. In the alternative, SAIF requests that we affirm.

We affirm the Referee's order with the following additional comments. The only diagnosis of a thoracic sprain or strain was made at the time claimant sustained a September 22, 1982 lifting injury. This was accepted as a nondisabling injury. Almost two months later, in November of 1982, claimant sustained an injury lifting a steel I beam. Although he experienced "mid to low back pain," every medical examiner diagnosed lumbar or low back strain. Claimant eventually came under the care of Dr. Close, a chiropractic physician, in February of 1983, by which time he was experiencing neck pain and stiffness, upper back pain and stiffness, mid back pain and stiffness, as well as low back pain and stiffness and headaches. Thus, by this time, claimant's complaints had become rather generalized. The history taken by Dr. Duff, an independent orthopedic examiner, in May of 1983, led him to a diagnosis of "lumbar sprain times two," with reference to claimant's September and November 1982 back injuries.

In this type of situation, we tend to rely on contemporaneous medical reports and diagnoses, rather than a claimant's assertion at hearing that he experienced pain in a particular area of the body at a particular point in time. This record establishes it is more likely than not that claimant sustained a thoracic strain in September of 1982 and a lumbar strain in November of 1982, with no further injury to the thoracic spine resulting from the November 1982 injury. In any event, claimant has failed to sustain his burden of proving any injurious consequences to his thoracic spine as a result of his November 1982 low back injury.

With regard to the Referee's award of unscheduled disability, we find that this award adequately and appropriately compensates claimant for the loss of earning capacity attributable to his November 1, 1983 industrial injury. We note that this injury involved complaints of neck pain, headaches, mid back pain and low back pain, although the mid back and low back were the primary areas of concern. We also note that the Referee was rather unspecific in identifying that portion of claimant's body which he considered to be permanently impaired as a result of this November 1983 injury. Therefore, we expressly state our finding that the only permanent residuals reflected by this record involve claimant's low back, i.e. the lumbosacral area of the spine. Furthermore, we find this impairment to be of a very minimal degree. We disagree with claimant's contention that Dr. White's statement, which was understood by the Referee to be a statement of permanent disability, actually was a statement of permanent impairment. In fact, Dr. White's statement was: "I would estimate his permanent partial physical impairment as a Category I of the Washington State Industrial Code or this would be approximately equal to 5% PPD compared to a maximum unspecified amount."

Regardless of what Dr. White estimated claimant's permanent disability to be under Washington law, we consider his findings on examination, as well as the remaining evidence of record, reflective of very minimal low back impairment. Considering this impairment together with the relevant social/vocational factors, we find the Referee's award appropriate.

ORDER

The Referee's order dated November 7, 1984 is affirmed.

ROBERT D. KLUM, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 82-08975
June 19, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Mongrain's order which awarded 320° (100%) unscheduled disability in lieu of all prior awards. Prior to the hearing, claimant had received awards totalling 208° (65%) unscheduled disability for injury to his low back and 7.5° (5%) scheduled disability for partial loss of use or function of the left leg. Claimant contends that he is entitled to an award for permanent total disability. The SAIF Corporation contends that the Referee's order should be affirmed.

In stating the facts, we borrow liberally from the Referee's order. Claimant was 47 years of age at the time of hearing. This injury arose on August 2, 1976 while claimant was working as a choker setter. A log rolled and struck claimant, flipping him into the air, as a result of which he injured his low back. The claim was accepted as one for a disabling injury.

In February of 1977 claimant submitted to a lumbar laminectomy. This procedure failed to diminish claimant's pain or otherwise improve his condition. Therefore, in February of 1978,

he submitted to a second lumbar laminectomy and, in addition, spinal fusion. A second spinal fusion at L4-5 was performed in January of 1980. Upon discharge claimant's condition was diagnosed as pseudoarthrosis, spinal fusion, double level L5-S1 and L4-5.

The medical evidence establishes that, as a result of his injury and consequent surgeries, claimant experiences low back pain, bilateral leg pain and numbness, and pain throughout most of his spine, all of which severely restricts his ability to sit, stand, bend, lift, walk and, in general, perform repetitive activity. In addition, the medical evidence establishes that, as a material result of his injury and surgeries, claimant experiences a significant emotional reaction, most likely depression or "conversion reaction."

Claimant did not finish high school, but he has obtained his GED. His work history is almost exclusively involved with the logging and sawmill industries. He has not worked since the date of his injury. The hearing was held February 9, 1983.

We find and hold that, as a result of his industrial injury, claimant is permanently and totally disabled on the basis of medical factors alone. The reason that the Referee declined to award claimant compensation for permanent total disability and, instead, awarded the maximum allowable for unscheduled permanent partial disability, is that he concluded claimant had not demonstrated sufficient motivation or made all reasonable efforts to "mitigate" his disability. The facts relevant to this determination are stated in the Referee's order as follows:

> "The claimant was enrolled at the Western Pain Center in Roseburg from February 27, 1983 through March 18, 1983 with the approval of Drs. Emori and Roux [his present, primary attending physicians], put forth good effort and made some significant improvements in control of his pain. Thereafter, the claimant returned to the pain center for a few days in May for a follow-up evaluation, at which time it was noted the claimant had maintained his gain but adamantly refused to attend a work tolerance evaluation program in Roseburg, that would have required him to temporarily reside in Roseburg. Because of this a rehabilitation counselor was unable to commence any kind of rehabilitation program for the claimant. The Director of the Western Pain Center, a family practice specialist, testified by deposition that the claimant had actually demonstrated good motivation; that depression and associated emotional difficulties stemming from his industrial injury had made it difficult for him to comply with recommendations; that he demonstrated a lot of fear, depression and discouragement."

In reliance upon ORS 656.206(3), 656.325(3) and Nelson v. EBI Companies, 296 Or 246 (1984), the Referee held that claimant was not entitled to an award for permanent total disability. He reasoned in part:

> "There is no medical evidence reflecting the fact that the claimant would be emotionally unable to deal with a work evaluation program such as proposed by the Western Pain Center. There is no medical evidence indicating that the claimant is emotionally unable to voluntarily decide to participate. There is no expert evidence indicating that such a program would be psychologically contraindicated. Considering the clear and significant gains the claimant realized at the pain center, I am not willing to consign him, at only 47 years old, to the employment scrap heap because it would be difficult for him to participate in a program one hour's drive from his home that would provide some kind of expert assessment of his probable ability to regularly engage in employment activities."

In view of our conclusion that claimant is permanently and totally disabled based upon medical factors alone, it follows that he is not required to satisfy the seek-work requirement of ORS 656.206(3). Ferguson v. Industrial Indemnity Co., 70 Or App 46 (1984); Gulick v. Champion International, 66 Or App 186 (1983); Munger v. SAIF, 63 Or App 234 (1983); see also George M. Turner, 37 Van Natta 531 (May 7, 1985). Therefore, claimant's failure to make reasonable efforts to obtain "gainful and suitable employment" does not prevent an award for permanent total disability under this statutory provision. Realistically, the reason that the Referee declined to award permanent total disability was not claimant's failure to seek work. It was because of a related concern: claimant's apparent lack of any motivation to attempt to improve his life situation, as evidenced by his refusal to participate in the work evaluation program recommended by the Western Pain Center. Indeed, the Referee concluded his order by stating that, "Absent the claimant's refusal to accept the pain center recommendations I would probably conclude he is permanently and totally disabled."

The issue, therefore, boils down to the question whether claimant's refusal to participate in the work evaluation program precludes an award for permanent total disability because he has unreasonably refused to participate in vocational assistance efforts. Phrased differently, the issue is whether claimant has failed to make reasonable efforts to minimize his disability.

A case in point is Seaberry v. SAIF, 19 Or App 676 (1974), decided during a time when shifting burdens of proof were characteristic of "odd-lot" permanent total disability litigation. In that case, SAIF questioned claimant's "motivation to improve his situation," referring to claimant's uncooperative attitude with regard to counselling and physical and occupational therapy. The court stated:

> "Motivation becomes a factor only if claimant's physical condition and his inability to adapt to alternative employment do not place him prima facie in the 'odd-lot' category. [Citation

> omitted.] * * * Claimant's recent uncooperative attitude appears to be a manifestation of his psychopathology which, as Dr. Hickman indicated, was directly attributable to his physical problems. A broken body can cause a broken spirit. This should not prevent a finding of permanent and total disability where claimant is otherwise unable to re-enter the work force." 19 Or App at 682-83.

Of course, "odd-lot" status is not here relevant, since we conclude that claimant is permanently and totally disabled on the basis of medical factors alone.

Nelson v. EBI Companies, supra, involved the claimant's failure to make a reasonable effort to lose weight, which, in turn, was found to justify a downward adjustment of claimant's permanent partial disability award. The rationale was that the insurer should not be found responsible for the full extent of the claimant's permanent disability since there was a significant likelihood that her disability was partly attributable to her unreasonable rejection of appropriate treatment. Patricia R. Nelson, 34 Van Natta 1078 (1982), affirmed Nelson v. EBI Companies, 64 Or App 16 (1983). The Supreme Court allowed claimant's petition for review to consider the issue of "which party bears the burden of proving whether claimant unreasonably failed to follow needed medical advice or otherwise to mitigate damages." 296 Or at 248. Based upon common law principles which assign to the defendant the burden of proving that the plaintiff unreasonably failed to mitigate damages, the court held that it is the employer's burden of proof "to persuade the trier of fact that the worker unreasonably failed to follow needed medical advice or otherwise to mitigate damages." 296 Or at 252.

In every case the test for determining whether a permanent disability award should be adjusted because of the claimant's refusal to submit to "recommended treatment" is reasonableness. Nelson v. EBI Companies, supra, 296 Or at 251; Clemons v. Roseburg Lumber Company, 34 Or App 135, 139 (1978):

> " * * * The relevant inquiry is whether, if compensation were not an issue, an ordinarily prudent and reasonable person would submit to the recommended treatment. Such a determination must be based upon all relevant factors, including the worker's present physical and psychological condition, the degree of pain accompanying and following his treatment, the risks posed by the treatment and the likelihood that it would significantly reduce the worker's disability."

Also see Sarantis v. Sheraton Corp., 69 Or App 575 (1984); Grant v. SIAC, 102 Or 26 (1921); 1 Larson, Workmen's Compensation Law §13.22 (1985).

The authorities discussed above all address a claimant's refusal to submit to recommended medical treatment; however, in Nelson the Supreme Court apparently contemplated the issue as being not only the question of an alleged unreasonable failure to

follow medical advice, but also an alleged failure to "otherwise mitigate [one's] damages." ORS 656.325 recognizes not only that a claimant's disability may be reduced by following medical advice, but also by participating in physical restoration or vocational rehabilitation programs. ORS 656.325(4). Thus, we believe that the Nelson analysis applies; however, the Referee's order suggests that he imposed upon claimant the burden of proving that he did not unreasonably fail to participate in the proposed work evaluation program.

The Referee's apparent conclusion that claimant presently possesses some "probable ability to regularly engage in employment activities," is purely speculation on his part. The most optimistic characterization of claimant's present ability to function vocationally is that it is "a very borderline situation." The work evaluation program proposed by the Western Pain Center was described by Dr. Holmes, director of the pain center, as a "last ditch effort" to increase claimant's functional abilities and, hopefully, lead to "respectful employment." Although we do not believe that claimant's refusal to make this "last ditch effort" was reasonable when viewed in isolation, when we consider the totality of the circumstances, we are unable to conclude that this failure on claimant's part should preclude an award for permanent total disability. Claimant's physical impairment is severe. He also suffers significant emotional difficulties in the form of depression as a direct result of his injury. His trips to Roseburg for treatment and evaluation at the pain center were physically demanding and ultimately became a source of frustration for him when the expenses of these trips were not reimbursed by SAIF. It is unknown whether the work evaluation program would, in any way, favorably influence claimant's disability. The program, by its very nature, is an evaluation, one of the purposes of which is to determine whether vocational assistance is even feasible. This is not a situation in which an admittedly disabled worker has refused an authorized training program, or refused to participate in direct employment assistance. This is a situation of a severely disabled worker who, for some very legitimate reasons, is unwilling -- and perhaps even unable -- to exert that last ounce of effort the system is demanding of him.

To the extent that the Nelson analysis is helpful, it serves us to consider the policy underlying the refusal of treatment cases in the context of this case:

> "The rationale for the reduction of benefits when treatment is unreasonably refused is that an employer should not be responsible for the full extent of a claimant's permanent disability if there is a significant likelihood that such disability is partly attributable to the claimant's unreasonable rejection of appropriate treatment. The cases reflect the corollary objectives of the Workers' Compensation Act to favor restoration of the worker over compensation for permanent loss and to relieve the employer of financial liability for the voluntary tolerance by the worker of avoidable

incapacity. Under such circumstances, a claimant may not be compelled to undergo treatment, but neither should he be compensated for the consequences of his refusal." Clemons v. Roseburg Lumber Co., supra, 34 Or App at 138.

There is no question that claimant is presently permanently and totally disabled. Gettman v. SAIF, 289 Or 609 (1980). There is no doubt in our mind that this is due to claimant's industrial injury and the residual effects thereof. To the extent that claimant's refusal to participate in the work evaluation program in question is an indication of a lack of motivation, this is clearly caused in significant part by his injury-related depression. Furthermore, it is likely that even with the best motivation, claimant would not be capable of obtaining and engaging in gainful and suitable employment. Finally, considering all of the relevant factors, we are unable to conclude that claimant's failure to participate in this work evaluation program was sufficiently unreasonable to preclude an award for permanent total disability.

The most recent Determination Order entered in this claim, dated September 2, 1982, terminated temporary total disability as of May 3, 1982. We find that claimant is entitled to compensation for permanent total disability as of May 4, 1982. See Morris v. Denny's, 53 Or App 863 (1981).

ORDER

The Referee's order dated August 6, 1984, which awarded claimant compensation for 320° (100%) unscheduled disability in lieu of all prior awards, is reversed, and claimant is awarded compensation for permanent total disability effective May 4, 1982. In lieu of the attorney's fee allowed by the Referee's order, claimant's attorney is allowed 25% of the additional compensation made payable herein, not to exceed $3,000, for services at hearing and on Board review. The SAIF Corporation is authorized to offset permanent partial disability benefits paid after May 4, 1982 against benefits made payable by this order.

JANINE VANHERWAARDEN, Claimant
Marilyn K. Odell, Claimant's Attorney
Coons, et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-03747
June 19, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Seymour's order that upheld the SAIF Corporation's denial of her occupational disease claim for mental stress. The issue is compensability.

The Board affirms the order of the Referee. Proof of causation of a condition allegedly arising out of mental stress is a complex matter usually requiring expert analysis and opinion, see Uris v. Compensation Department, 247 Or 420, 424 (1967), especially where, as here, it is acknowledged that claimant was subjected to stress both on and off the job. The only medical opinion in evidence concludes that the majority of the stress claimant was subjected to was from off the job sources. Claimant failed to carry her burden of proof that her emotional condition arose out of and in the scope of her employment. ORS 656.802(1)(a).

ORDER

The Referee's order dated November 26, 1984 is affirmed.

LIDDIE B. HIGHT, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

Own Motion 84-0265M
June 21, 1985
Second Own Motion Order on Reconsideration

The Board has issued two previous Own Motion Orders declining to grant claimant the relief she seeks based on Vernon Michael, 34 Van Natta 1212 (1982). Claimant again asks the Board to reconsider its most recent order based on the premise that the Supreme Court decision in Cutright v. Weyerhaeuser Co., 70 Or App 357 (1984), review allowed 298 Or 470 (1985), will affect the outcome of the instant case.

We decline to abate our Own Motion Order while awaiting a Supreme Court decision in Cutright. This does not preclude claimant from petitioning the Board for relief at a later date should the case law affecting own motion matters change. Claimant's request for abatement of the Board's June 5, 1985 order is denied.

IT IS SO ORDERED.

CHARLES D. DeVOE, Claimant
Allen & Vick, Claimant's Attorneys
Beers & Zimmerman, Defense Attorneys

WCB 84-06905
June 24, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Podnar's order that approved the insurer's denial of claimant's claim for aggravation of his low back condition and affirmed Determination Orders granting a total of 64° (20%) unscheduled permanent partial disability for injury to the low back.

We affirm the Referee's order, with one supplementation. The Referee stated:

> "Claimant's most recent exacerbation has not been shown to be a worsening of his condition. Further, the reality is that the treatment is not persuasively related to the compensable injury."

To the extent to which the above-quoted statement may be interpreted as holding that claimant's continuing medical treatment is not compensable, it is erroneous. The issue of claimant's right to treatment pursuant to ORS 656.245 was not before the Referee, nor is it properly before us. Therefore, the issue was neither raised nor decided. See Michael Petkovich, 34 Van Natta 98 (1982).

ORDER

The Referee's order dated November 6, 1984 is affirmed as supplemented.

CHARLES W. GRABENHORST, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 85-0175M
June 24, 1985
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for additional benefits pursuant to the provisions of ORS 656.278. Claimant's aggravation rights have expired. Claimant is in need of periodic treatment with sodium chloride ointment. The ointment is not expected to improve claimant's right eye condition, but it does relieve his symptoms.

The right to lifetime medical benefits was not granted to claimants who sustained an injury prior to 1966, except where the claimant was determined to be permanently and totally disabled. The Board has made it a practice to allow medical services for pre-'66 claimants only for a period of time during which a claimant undergoes curative medical treatment. The request for medical services is granted.

IT IS SO ORDERED.

MICHAEL R. HARMAN, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-02979 & 82-03232
June 24, 1985
Order on Reconsideration

The SAIF Corporation has requested reconsideration or clarification of our Order on Remand issued April 3, 1985 to the extent to which our previous order did not allow SAIF to offset scheduled permanent partial disability benefits paid after the effective date of claimant's award of permanent total disability. We abated our order so that both parties could present their positions. After having received written argument from both parties, we allow SAIF's motion for reconsideration and grant the requested offset.

Although claimant's argument that a scheduled, as opposed to an unscheduled, award of permanent partial disability should be allowed notwithstanding a permanent total disability award covering the same time period has surface appeal, we believe the Court of Appeals has already resolved the issue against claimant's position. In Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 32 (1983), the court said, "We . . . hold that an injured worker who is receiving payments for permanent total disability is not entitled to separate, additional payments for permanent partial disability." The court did not distinguish between scheduled and unscheduled permanent partial disability awards and the claimant in Yeager, in fact, had a scheduled permanent partial disability award in addition to his permanent total disability award.

The SAIF Corporation is authorized to offset against claimant's permanent total disability award all permanent partial disability compensation paid to claimant after December 14, 1981. As modified, we republish our former order.

IT IS SO ORDERED.

JIMMIE B. HILL, Claimant
SAIF Corp Legal, Defense Attorney

WCB 83-11137
June 24, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant has requested review of Referee Mongrain's order that granted him an award of 144° (45%) unscheduled permanent partial disability in lieu of the 112° (35%) awarded by Determination Order. Claimant also claimed at hearing that his claim was prematurely closed or, in the alternative, that he has suffered an aggravation of his industrial injury. The issues are premature closure/aggravation and, if neither premature closure nor aggravation are found, extent of permanent partial disability. Claimant specifically agreed that he is not permanently and totally disabled.

Claimant has filed no brief on Board review. In the absence of an indication of what error the party requesting review believes the Referee may have made, our review of the record will result in a modification of the Referee's order only if we find clear error on the record. This is a case in which we have found such error, although it results solely from the Referee having followed the law in existence at the time of the hearing, and not from any mistake on the part of the Referee.

We adopt the Referee's findings of fact, which we summarize. Claimant sustained a low back injury on March 2, 1981. One year later he underwent a lumbosacral foraminotomy and fusion. He has complained of chronic mechanical low back pain since. In September and October 1983, after pain center evaluation, claimant reported to his treating neurosurgeon, Dr. Saez, that he was continuing to have difficulty coping with his pain. Dr. Saez nevertheless reported claimant to be medically stationary.

Claimant's claim was closed November 18, 1983 with an award of 112° (35%) unscheduled permanent partial disability. In December 1983 Dr. Saez reported that claimant was suffering increasingly frequent attacks of low back pain and that he had experienced a "worsening of mechanical back syndrome." SAIF Corporation denied claimant's aggravation claim on February 6, 1984. Claimant testified that he has been improving since about January of 1984.

After having made his findings of fact, the Referee stated that any entitlement to additional temporary disability would "require a conclusion that [claimant] experienced an aggravation of his compensable condition." He went on to state that under the then recent Court of Appeals decision in Scheidemantel v. SAIF, 68 Or App 822, 826 (1984) (Scheidemantel I), a worsening of symptoms only was insufficient to establish an aggravation claim.

On the same date the Referee issued his order, the Court of Appeals issued its opinion on reconsideration in Scheidemantel v. SAIF, 70 Or App 552 (1984) (Scheidemantel II), in which it withdrew its former opinion, upon which the Referee's conclusion regarding claimant's aggravation claim was based. This Board had held, both before and after Scheidemantel I, that a worsening of symptoms only may be sufficient to establish an aggravation claim, depending upon the facts of the case. Billy Joe Jones, 36 Van

Natta 1230 (1984); James W. Foushee, 36 Van Natta 901 (1984). One of the factors to be considered, indeed a major one, would be whether a claimant had received a permanent disability award that took into account expected future symptomatic flareups.

Considering all of the medical and lay evidence, see Garbutt v. SAIF, 297 Or 148 (1984), we conclude that claimant has shown by a preponderance of the evidence that he experienced in December 1983 a worsening of his symptoms beyond that which would be expected as a part of the disability for which he had been awarded compensation. We believe the Referee would have so found had he not been compelled to make his decision under Scheidemantel I. Claimant has proven an aggravation, ORS 656.273(1), and we, therefore, reverse the Referee's order, set aside SAIF's denial and remand this claim to SAIF for processing and closure.

Because of our order setting aside SAIF's denial, claimant is entitled to an award for attorney fees. ORS 656.386(1); OAR 438-47-040(2). We conclude that a reasonable attorney fee for services at hearing is $1,000. On Board review, however, no attorney fee will be awarded as no brief was filed. (We note that correspondence in our file suggests that claimant may no longer be represented by an attorney.)

ORDER

The Referee's order dated October 31, 1984 is reversed. The SAIF corporation's denial dated February 6, 1984 is set aside and claimant's aggravation claim is ordered accepted for further processing and closure as provided by law. Claimant's attorney is awarded $1,000 for services at hearing, to be paid by the SAIF Corporation.

LORI A. PODRABSKY, Claimant
Allen & Vick, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 84-08155
June 24, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests, and the insurer cross-requests, review of Referee Howell's order which awarded 32° for 10% unscheduled disability on review of a Determination Order dated July 30, 1984, which awarded no compensation for permanent partial disability in connection with claimant's September 21, 1983 low back injury. Claimant contends that she is entitled to an increased award of unscheduled disability. The insurer contends that claimant is entitled to no award because whatever impairment she may have is attributable to her obesity, and she has unreasonably failed to follow appropriate medical treatment directed toward reducing her weight. See Nelson v. EBI Companies, 296 Or 246 (1984).

The Board affirms and adopts the order of the Referee.

Claimant contends that she is entitled to an insurer-paid fee as a result of the insurer's cross-request for Board review. Claimant would be entitled to an insurer-paid fee in the event the insurer had raised an additional issue by its cross-request. Teel v. Weyerhaeuser Co., 294 Or 588 (1983); see also Judy M. Friedrich, 36 Van Natta 1210 (1984). We have previously stated that an insurer's request that a disability award be reduced does not raise an issue in addition to or different from the issue

raised by a claimant's request that a disability award be increased. Gleason W. Rippey, 36 Van Natta 778 (1984). Thus, we have declined to award an insurer-paid fee for services on Board review where the proceeding is initiated by the claimant seeking an increased award, and the employer/insurer has responded (with or without filing a cross-request for review) by arguing that the award should be decreased. See, e.g. Donald K. Chambers, 37 Van Natta 148 (1985). In this case, there is but one issue: the extent of permanent disability resulting from this industrial injury. The issue raised by the insurer's cross-request raises no issue "that would otherwise not be dealt with" by the Board. Teel v. Weyerhaeuser Co., supra, 294 Or at 590. Therefore, claimant is not entitled to an insurer-paid fee on Board review. Cf. Thomas H. Bowen, 37 Van Natta 434 (1985).

ORDER

The Referee's order dated October 15, 1984 is affirmed.

FRANK R. ROBERTS, Claimant
Francesconi & Cash, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-04813
June 24, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Baker's order which declined to grant his request to set aside a disputed claim settlement. The insurer cross-requests review to preserve its rights to contest several procedural and evidentiary rulings should the Referee's finding on the merits be reversed.

Claimant has requested permission to present oral argument should we deem it appropriate. We normally will not entertain oral arguments. OAR 438-11-010(1). We find that this matter has been fully developed and briefed. Consequently, oral argument will not be necessary and claimant's request is denied.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated August 15, 1984 is affirmed.

DANIEL SCOTT, Claimant
Evohl Malagon, Claimant's Attorney
Beers, et al., Defense Attorneys

WCB 84-08741
June 24, 1985
Order of Dismissal

The employer has requested review of Referee's order dated April 18, 1985. The request for review was filed with the Board on May 2, 1985, more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

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

EVA L. (DONER) STALEY, Claimant
Pozzi, et al., Claimant's Attorneys
Keith Skelton, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 83-07726 & 83-09071
June 24, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Crawford & Company requests review of Referee Leahy's order which set aside its denial of claimant's "new injury" claim and upheld Liberty Mutual Northwest Insurance Company's denial of claimant's "aggravation" claim for her current back condition. On review, the issue is responsibility.

The Board affirms the order of the Referee with the following modification.

In successive injury cases "where a compensable injury at one employment contributes to a disability occurring during a later employment involving work conditions capable of causing disability, but which did not contribute to the disability, the first employer is liable." Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984).

Following our de novo review of the medical and lay evidence, we are persuaded that: (1) claimant's condition had worsened; (2) the 1983 injury while Crawford was on the risk not only contributed to her disability, but was the more likely cause of that disability; and (3) her 1978 injury while Liberty was on the risk was not the sole cause of her disability. Had we been unconvinced as to which injury was the more likely cause of claimant's disability, application of the "last injurious exposure" rule would also place liability on Crawford, as the insurer on the risk at the time of the last employment exposure which was capable of causing claimant's disability. See Boise Cascade v. Starbuck, supra. at page 245; CECO v. Bailey, 71 Or App 784, 786 (1984).

ORDER

The Referee's order dated December 17, 1984, as modified herein, is affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by Crawford & Company.

ERNESTINE W. WARD, Claimant
David J. Hollander, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 82-01538
June 24, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of those portions of Referee Fink's order that awarded claimant compensation for permanent total disability, ordered the employer to pay claimant benefits for temporary total disability from June 20 through September 27, 1981, and from December 15, 1981 through July 16, 1982, and prohibited the employer from offsetting any of those temporary total disability awards against claimant's award of permanent total disability. Claimant has cross-requested review of those portions of the Referee's order that affirmed the employer's January 10, 1983 denial of claimant's cervical condition and failed to award a separate employer-paid attorney fee.

Claimant, who was 51 years of age at the time of the hearing, had been employed by Georgia Pacific for approximately 14 years. On December 18, 1977 she sustained a compensable low back strain. Claimant had experienced previous difficulties with her back due to a non-work related injury sustained in approximately 1970 and for which she underwent a myelogram. Claimant had also treated with Dr. Bert in 1977 for neck pain which was diagnosed as mild cervical arthritis.

Although claimant continued working following the 1977 injury, she did so in a rather sporadic manner due to flare-ups in her condition. In June 1978 claimant visited the Callahan Center. The diagnosis was resolving lumbar strain. On September 8, 1978 Dr. Bert reported that claimant had returned to work at a light duty job plugging plywood and was getting along quite well. Dr. Bert stated that claimant should permanently refrain from activities involving heavy lifting, squatting or stooping. A September 21, 1978 Determination Order awarded claimant 10% unscheduled low back disability. Claimant requested a hearing.

A hearing was held before Referee T. Johnson in March 1979. Referee Johnson described claimant's condition at that time as follows:

> "Claimant's complaints at hearing were of chronic back pain, intermittent and periodic. Her back pain is aggravated by activities such as bending, stooping, heavy lifting, prolonged standing, prolonged driving and prolonged walking. Claimant is now limited in her ability to perform such activities. Her ability to perform heavy household work has been adversely affected. Additionally, she has quit bowling because of her back condition. Claimant now uses a lumbosacral corset."

It was noted that claimant was permanently restricted from activities requiring heavy lifting, squatting or stooping. Referee Johnson found claimant entitled to a total of 20% unscheduled permanent partial disability.

Despite some periodic back difficulties, claimant continued to work at Georgia Pacific throughout the first half of 1979. On July 13, 1979 Dr. Bert reported that claimant was experiencing a flare-up of back pain and that he was taking her off work for a short period of time. Dr. Bert also noted that the mill at which claimant was working was scheduled to be permanently closed in a few days. When Dr. Bert released claimant to return to work on July 25, 1979, he noted that she had no work to return to as the mill had shut down.

A second Determination Order issued on October 4, 1979 awarding claimant benefits for temporary total disability only.

Since claimant's formal education ended at either the third or seventh grade, claimant began a program of remedial education in January 1980 in preparation for entry into an authorized program of vocational rehabilitation.

Claimant continued to treat with Dr. Bert throughout 1980 and 1981 on an "as needed" basis. On May 8, 1980 Dr. Bert reported that he estimated claimant's permanent impairment as a result of her 1977 injury to be in the range of ten to twenty percent.

On November 19, 1980 claimant was notified that her approved program of vocational rehabilitation at Southwestern Oregon Community College would begin on November 17, 1980 and continue to December 14, 1981. Claimant was to be trained for a job as a medical receptionist.

Claimant's initial progress in her vocational program was satisfactory. By spring of 1981, however, claimant began experiencing difficulty in the program. At that point, claimant also began to register complaints with Dr. Bert of increased back pain. Dr. Bert, however, continued to treat claimant conservatively and his chart notes indicate he was of the opinion that claimant should continue with her classes.

In June 1981 claimant informed her vocational counselor that, based on Dr. Bert's recommendation, she was temporarily withdrawing from the program and applying for social security benefits. Dr. Bert's chart notes indicate that he was not initially aware that claimant had withdrawn from the program.

In a letter to claimant's attorney dated September 15, 1981, Dr. Bert indicated that:

> "I did indeed advise [claimant] not to attend classes this summer because she was having enough discomfort that I did not feel she could sit in a classroom but I did suggest to her that she try classes again this fall."

In another letter to claimant's attorney dated May 20, 1982, Dr. Bert stated:

> "In regards to your question concerning [claimant's] status, she is now medically stationary. I would state that she has moderate permanent partial impairment based upon pain with minimal objective findings. She was indeed stationary from 9-19-79 through 11-17-80 and 7-27-81 through 9-29-81."

On July 27, 1981 the employer terminated time loss payments to claimant.

In September 1981 claimant re-entered her vocational program and the employer reinstated time loss benefits. Claimant completed the fall term at SWOCC with poor grades. On December 24, 1981 claimant informed her vocational counselor that she did not intend to return to SWOCC and did not want an extension of the program. Claimant had some discussions with her counselor concerning on-the-job training, but apparently little came of this. At that point the employer again terminated claimant's time loss benefits.

On February 15, 1982 claimant was examined by Dr. Rankin, an orthopedic surgeon. Claimant informed Dr. Rankin that she could

not stand for more than fifteen minutes, could not sit for more than forty minutes, that any bending or lifting aggravated her back pain. Although she was able to do most of her own housework, she frequently had flare-ups of pain when doing so. Dr. Rankin stated that he did not have a diagnosis to explain claimant's low back complaints. Although some slight narrowing of the disc space at L5-S1 was noted, he did not feel that this was explanatory of claimant's pain complaints. He suggested that a bone scan, a laminagram and possibly a CT scan could be performed and felt that a psychiatric evaluation was not contraindicated.

On March 11, 1982 Dr. Bert issued another report. He was apparently under the impression that claimant was still continuing with her vocational program, as he stated he did not wish to proceed with the tests suggested by Dr. Rankin unless claimant was unable to continue with her schooling.

Claimant was examined by the Orthopaedic Consultants on June 16, 1982. The Consultants diagnosed chronic low back strain, chronic cervical strain unrelated to the industrial injury, unrelated possibly lower extremity vascular disease and possible functional overlay. Although the Consultants were of the opinion that claimant could not return to the same occupation, they believed that she would be able to return to work in a different capacity. Claimant was found to be medically stationary with permanent disability as a result of the industrial injury in the range of mildly moderate.

A Determination Order issued July 16, 1982 awarding claimant benefits for temporary total disability from November 17, 1980 through June 19, 1981 and from September 28, 1981 through December 14, 1981. Claimant was awarded an additional 15% unscheduled disability for a total of 35% permanent partial disability.

On September 9, 1982 Dr. Bert reported that claimant was able to engage in light duty work on a permanent basis. He indicated that her permanent impairment would be based on pain and limitations in motion. He also stated that he did not believe claimant's cervical condition was historically related to her industrial injury.

Claimant was examined by Dr. Rosenbaum on December 7, 1982. Dr. Rosenbaum concluded that claimant's symptoms were not consistent with his objective physical findings which basically involved pain on palpation. Dr. Rosenbaum did not believe claimant's cervical pain was related to her industrial injury and he concluded that her low back condition precluded her only from occupations involving heavy lifting or bending.

On December 8, 1982 claimant was examined by Dr. Raaf who also performed a very thorough analysis of claimant's medical history. Dr. Raaf diagnosed a chronic low back strain, osteoarthritis and degenerative disc disease in the cervical and lumbar areas, arthritis in both thumbs and the right knee, ankle pain, pain in the right groin of undetermined origin and mild functional overlay. Dr. Raaf stated that claimant suffered a ligament and muscle strain in 1977 and that this was superimposed on chronic arthritic changes in the lumbar area. He estimated

claimant's total loss of function to the low back to be in the range of 20-40% and the loss as a result of the injury to be 10-20%. Dr. Raaf concluded, "From the objective point of view I find nothing in her examination that would prevent her from doing light work."

On January 10, 1983 the employer denied the compensability of claimant's cervical condition.

At the request of claimant's attorney, a vocational assessment of claimant was performed and a report issued on October 17, 1982. The vocational consultant stated that although he could not rule out the possibility of claimant securing employment with job placement assistance, he did not feel that claimant was currently employable.

The first issue for review is the extent of claimant's disability. The Referee found that the medical evidence, when combined with the relevant social/vocational considerations, led to the conclusion that claimant was permanently and totally disabled. We disagree.

From a medical standpoint, there is not a single physician who has opined that claimant is permanently and totally disabled from gainful employment. All of claimant's treatment has been of a conservative nature and at no time has surgery been indicated. The Orthopaedic Consultants found claimant's impairment to be in the mildly moderate range. Dr. Rosenbaum was of the opinion that claimant was only precluded from occupations involving heavy lifting or bending. Dr. Raaf similarly concluded that claimant's impairment was in the mild to mildly-moderate category and was of the opinion that claimant was fully capable of performing light duty work. Dr. Bert's opinion does not appear to be contrary as he has consistently indicated that claimant would be capable of light duty work.

With regard to claimant's physical complaints, we do not understand them to be substantially different than those which were noted by Referee Johnson in his April 27, 1979 order by which claimant was awarded a total of 20% unscheduled permanent partial disability. Claimant does, however, appear to have more restrictions than she did in 1979 as she currently would not be able to return to her former job.

Although a claimant may not be permanently and totally disabled from a medical standpoint, permanent total disability may be established by a combination of medical and social/vocational factors. Unlike the Referee, however, we cannot conclude that claimant is permanently and totally disabled, even when all such factors are combined.

One of the main obstacles claimant faces from a social/vocational standpoint is her limited education. Claimant's limited education, however, is somewhat balanced by the fact that claimant appears to be of at least average intelligence and has an established record of stable employment. The fact that claimant is 51 years of age, and the fact that the majority of her work experience has been in the plywood industry, while somewhat negative factors, are not insurmountable obstacles to re-employment. This is especially true in view of the fact that claimant's impairment has generally been rated in the range of mild, and claimant is still capable of light and sedentary employment.

An additional consideration in cases involving permanent total disability is the seek-work requirement of ORS 656.206(3), which was not mentioned by the Referee. Claimant has not worked since 1979 when her job terminated after closure of the Coos Bay mill. Although claimant was engaged in a vocational rehabilitation program, the only attempt she made to obtain employment occurred in early 1983 when claimant requested Georgia Pacific to put her back to work at her old job.

Clearly claimant has not complied with the requirements of ORS 656.206(3), nor can we conclude from the evidence that claimant should be excused from the requirements of that statute. We find nothing in the record which would indicate that it would be "futile" for claimant to attempt to seek work. Cf. Butcher v. SAIF, 45 Or App 313 (1980).

Based on the above we conclude that claimant is not permanently and totally disabled.

The question of the appropriate extent of claimant's disability remains. Considering the social/vocational factors in conjunction with claimant's medical condition, we conclude that an award of 65% unscheduled permanent partial disability appropriately compensates the claimant for the loss of earning capacity as a result of her industrial injury.

The next issue for our consideration concerns the question of the compensability of claimant's cervical condition. The Referee concluded that claimant had not established the compensability of her cervical condition. We agree, and we affirm and adopt that portion of the Referee's order relevant to this issue.

We next address the issue of claimant's entitlement to temporary total disability benefits from December 15, 1981, when claimant terminated her participation in her vocational rehabilitation program, to July 16, 1982 when a Determination Order issued redetermining claimant's status.

As the Referee correctly noted, this was the exact issue presented in Billy Joe Jones, 34 Van Natta 655 (1982), aff'd Boise Cascade v. Jones, 63 Or App 192 (1983), where we concluded that temporary total disability benefits must continue to be provided to a medically stationary claimant following completion of a vocational rehabilitation program and prior to issuance of a Determination Order. The employer attempts to distinguish Jones on the basis that it only applies to claimants who successfully complete a vocational rehabilitation program, and not to claimants who voluntarily cease to be involved in a rehabilitation program.

Neither the employer's attempt to distinguish Jones nor its other arguments in relation to this issue are convincing. There is nothing in either the Board or Court opinions that distinguish between claimants who successfully complete a vocational program and claimants who, for various reasons, are unsuccessful. Whether the vocational program is completed or finally terminated, temporary total disability benefits must continue to be provided pending issuance of a Determination Order. See OAR 436-61-420(1).

The employer also argues that the Referee should not have imposed a penalty for its unilateral termination of time loss benefits following termination of claimant's program of vocational

rehabilitation. We disagree. The employer had no authority to unilaterally terminate benefits and a penalty is warranted for its action. We fail to understand the significance of the employer's arguments concerning the difficulty it was encountering obtaining a medical report stating claimant was medically stationary. As noted by the Referee, the medical evidence conclusively establishes that claimant was medically stationary at the time she entered her vocational rehabilitation program, and at the time she ceased active participation in that program.

With regard to claimant's contention that the Referee should have awarded a separate attorney fee for prevailing on this issue, we disagree and affirm and adopt those portions of the Referee's order relevant to this issue.

The last issue we address in this case is also the most difficult. As explained above, Jones requires that temporary total disability benefits continue to be provided to a medically stationary claimant in the period between completion or termination of a program of vocational rehabilitation and the issuance of a Determination Order authorizing termination of such benefits. However, does Jones require that such benefits continue to be provided during periods of interruption in a vocational program? The Referee concluded that Jones was dispositive of the issue and found claimant entitled to such benefits from June 20 through September 27, 1981.

Former OAR 436-61-420(1) (WCD Administrative Order 6-1980) provided:

> "The insurer shall pay temporary disability compensation to a worker who is enrolled and actively engaged in an authorized training program and payments will continue until termination of compensation is authorized by the department as provided in ORS 656.268."

The operative language of that rule has remained basically identical despite numerous other changes in the rules relating to vocational rehabilitation over the years.

Former OAR 436-61-410 provided:

> "(2) Workers injured after December 31, 1973 are entitled to temporary disability compensation while enrolled and actively engaged in an authorized training program.
>
> * * *
>
> "(4) During periods of interruption in the program, when temporary disability compensation is not due, the insurer shall resume any suspended award payments." (Emphasis added.)

Although it is far from clear, we interpret the "when temporary disability compensation is not due" language to be referring to situations involving an interruption in a vocational program during a period in which a claimant is medically

stationary. In other words, the rule seems to state that temporary disability is payable during interruptions in a vocational program if the claimant's condition aggravated, or if the claimant was not medically stationary when he or she entered the program. If the vocational program was interrupted during a period when claimant was medically stationary, the employer or insurer would be required to reinstitute payment of any previously awarded permanent disability benefits, which were suspended pursuant to ORS 656.268.

The current version of OAR 436-61-410(1) is similar to that version in effect in 1980. The current rule provides:

> "Workers injured after December 31, 1973, are entitled to temporary disability compensation while enrolled and actively engaged in an authorized training program under these rules. <u>During periods of interruption in the program, temporary disability compensation will not be due unless the worker is not medically stationary.</u>
>
> "(2) * * * During periods of interruption in the program when temporary disability is not due, the insurer shall resume any suspended award payments." (Emphasis added.)

We believe that the current version of OAR 436-61-410 simply makes explicit what was implicit in the prior version of that rule. That is, that temporary disability is not paid during periods of interruption in a vocational program unless the claimant is not medically stationary.

At first blush, this may seem inconsistent with the rule announced in Jones. However, there are valid bases for distinguishing situations involving interruptions in vocational programs from those involving termination of a vocational program. Unlike the situation in Jones, where the rules stated that the employer or insurer was required to continue paying temporary disability in the interim from completion of a vocational program to issuance of a Determination Order, the rules pertinent to the current situation specifically state that the employer or insurer is <u>not</u> required to pay temporary disability during periods of interruption of a vocational rehabilitation program unless the claimant is not medically stationary.

We conclude that claimant is not entitled to temporary disability benefits from June 20, 1981 through September 27, 1981. It follows that the employer should not be penalized for failure to pay such benefits during this period of time.

ORDER

The Referee's order dated April 19, 1983 is affirmed in part and reversed in part. Those portions of the Referee's order awarding claimant benefits for permanent total disability are reversed. Claimant is awarded 208° for 65% unscheduled permanent partial disability, that being an increase of 30% (96°) over and above all prior awards and/or arrangements of compensation.

Claimant's attorney fee shall be adjusted accordingly. Those portions of the Referee's order that found claimant entitled to benefits for temporary total disability from June 20, 1981 through September 27, 1981 and penalizing the employer on such amounts are reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a reasonable attorney fee in the amount of $400 for prevailing before the Board on the issue of claimant's entitlement to temporary total disability benefits from December 15, 1981 through July 16, 1982, to be paid by the self-insured employer.

ANTHONY P. BRECH, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04044
June 25, 1985
Order on Remand

This case is before the Board on remand from the Court of Appeals. Brech v. SAIF, 72 Or App 388 (1985). The Board has been instructed to award claimant permanent total disability and to determine an allowance of attorney fees to claimant's attorney. The mandate does not specify the effective date of claimant's permanent total disability award, and the court's written opinion provides no assistance in that regard. We, therefore, look to the record.

The standard for determining the effective date of a retroactive permanent total disability award is "the earliest date that claimant's permanent total disability is proved to have existed." Morris v. Denny's, 53 Or App 863, 867 (1981). See also Wilke v. SAIF, 49 Or App 427, 431 (1980). Although that date is frequently found to be the date on which a claimant was declared to be medically stationary, see, e.g., William B. Johnson, 36 Van Natta 98, 104 (1984), there is no rule of law that requires such a finding, see Michael R. Harman, 37 Van Natta 418 (1985); Albert D. Richey, 36 Van Natta 1580, 1583 (1984). A finding of the appropriate effective date is based upon all of the relevant medical, social and vocational factors. Morris v. Denny's, supra.

In this case, the court found that claimant was permanently and totally disabled from a physical standpoint alone. Claimant's disablity is based upon the combination of his knee injury and his tinnitus. The medical evidence persuades us that there has been no change in claimant's physical condition since his treating physician last declared him to be medically stationary on May 17, 1982. Claimant is, therefore, awarded permanent total disability as of May 17, 1982.

On the issue of attorney fees, claimant's attorney is allowed 25% of the increased compensation awarded by this order, not to exceed $3,000, payable out of and not in addition to claimant's compensation. See ORS 656.386(2); OAR 438-47-040(1), 438-47-045(1); Morris v. Denny's, 53 Or App 863, 866 (1981).

The SAIF Corporation is authorized to offset against the benefits awarded by this order all permanent partial disability benefits paid after May 17, 1982. See Pacific Motor Trucking v. Yeager, 64 Or App 28 91983).

IT IS SO ORDERED.

DEE A. ERICKSON, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-04406 & 84-04934
June 25, 1985
Order of Abatement

The Board has received claimant's request to reconsider our Order on Review dated May 31, 1985

In order to allow sufficient time to consider the request, the above noted Board order is abated.

IT IS SO ORDERED.

LEWIS M. YOCK, Claimant
Galton, et al., Claimant's Attorneys
Mitchell, et al., Defense Attorneys

WCB 84-00449
June 25, 1985
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Podnar's order that upheld the employer's denial of claimant's occupational disease claim for his mental condition allegedly caused by employment stress. The issue is compensability. The employer has not objected on Board review to that portion of the Referee's order that awarded interim compensation, additional compensation as a penalty and an employer paid attorney fee.

Claimant was 53 years old at the time of the hearing. He had worked for about 20 years as a mechanical engineer in the wood products machinery industry. In 1978 he attempted to go into business on his own, but that business failed due to economic conditions and was liquidated in bankruptcy in September 1979. In early 1980 claimant began working for this employer. He asssumed steadily increasing responsibilities. In July 1981 the employer acquired control of another corporation and claimant became president and chief operating officer of the subsidiary company. It was soon discovered that the subsidiary was in poor financial condition. Beginning in September 1981 an attempt was made to reorganize the subsidiary under the bankruptcy law, but that effort ultimately failed and the subsidiary was liquidated. During the period of time claimant was president of the subsidiary company, his mental and physical health declined to such an extent that claimant stopped working on August 3, 1983 and has not worked since.

The medical reports in the record show that, beginning in 1972, claimant has had numerous hospitalizations for conditions thought by his treating physicians to be caused by or related to alcohol abuse. The various diagnoses include severe epigastric pain of uncertain etiology, recurrent pancreatitis, acute alcoholic hepatitis, essential hypertension, alcoholism, and adult onset diabetes mellitus. At one point in 1974 it was thought that claimant exhibited signs of early cirrhosis, and claimant was treated with librium for early delerium tremens.

Claimant admitted that he had engaged in binge drinking prior to 1979, but testified that he had not used alcohol between early 1979, when his diabetes was diagnosed, and July 4, 1982, when he began drinking again in response to employment-caused stress. Claimant's family and co-workers, however, testified that claimant resumed his drinking in late 1981 or very early 1982. We find that the preponderance of the persuasive evidence is that claimant

resumed his heavy alcohol intake in late 1981 or very early 1982, although we do not believe that this inconsistency in claimant's testimony on this point renders his other testimony regarding relevant matters less credible.

The president of employer and its in-house counsel both testified by deposition that at the time claimant began working for employer he was apparently healthy. The attorney met claimant in July 1981 and described claimant's initial appearance as "robust," "eager," "upbeat -- very upbeat," and as having a "can do attitude." He confirmed that a proceeding for reorganization under Chapter II of the Bankruptcy Code was begun in September 1981, but that by January 1982 the proceeding had been converted to one for liquidation under Chapter 7 of the Code. During the interval, the attorney testified, claimant had been trying to keep the subsidiary afloat. He had had to terminate some employes and reduce the incomes of others, some of whom were personal friends.

Claimant routinely was required to decide which creditors would be paid with very limited funds. Several lawsuits were filed against the subsidiary and claimant was called upon to represent the company at depositions and court proceedings. Claimant testified, and the president and attorney of employer confirmed, that he worked seven days per week, often 14 or more hours per day. Also, during this period of time claimant was held personally liable under the 100% penalty provisions of the Internal Revenue Code for unpaid federal income tax withholdings of about $50,000 because of his position as president of the subsidiary. Claimant's wife testified that she left him when she found out about the tax liability. (Claimant was indemnified by employer for the tax liability and penalty.)

According to the employer's attorney, by the end of 1981 claimant was observably physically "worn down." His personal appearance had declined as had his concentration ability. The attorney stated that it had become impossible to deal with claimant clearly. He had heard from others that claimant was drinking heavily in late 1981. By early 1982 it was apparent to employer's president and attorney that claimant was impaired by alcohol abuse.

After the subsidiary company was liquidated, claimant returned to work for employer as a sales engineer. He was, however, not able to function at his previous level. In July 1982 he was hospitalized for unexplained hypotension. An alcohol rehabilitation program was suggested and refused. However, in November 1983 claimant admitted himself to the hospital for alcohol withdrawal and treatment. He apparently continued as an outpatient, although he was hospitalized several more times for diabetic ketoacidosis and alcohol abuse was noted in the treatment records. As stated above, claimant left work August 3, 1983 and has not worked since.

The legal standard for establishing an occupational disease claim based upon employment related stress has been clarified by the Supreme Court in McGarrah v. SAIF, 296 Or 145, 165 (1983). In Elwood v. SAIF, 67 Or App 134, 137 (1984), rev'd on other grounds, 298 Or 429 (1985), the court stated that McGarrah posed four questions:

> "1. What were the 'real' events and conditions of [claimant's] employement?

"2. Were those real events and conditions capable of producing stress when viewed 'objectively,' even though an average worker might not have respond[ed] adversely to them?

"3. Did [claimant] suffer a mental disorder?

"4. Were the real stressful events and conditions the 'major contributing cause' of [claimant's] mental disorder?"

See also Wesley G. Marquis, 36 Van Natta 742, 745-46 (1984).

We find that a clear preponderance of the evidence supports affirmative answers to questions one, two and three posed by McGarrah and Elwood. All of the testimonial evidence is that claimant was operating under severe stressors and that the stressors were real and not imagined. The events surrounding claimant's employment and the conditions under which he functioned were, we find, capable of producing and did produce significant stress when viewed objectively. That claimant has a mental disorder (depressive neurosis and, arguably, alcoholism) is agreed to by both psychiatrists, as is claimant's need for psychiatric care and the disabling nature of his mental condition.

We are left with the issue of causation. The Referee based his decision upon the following reasoning:

"For claimant to prevail, he must prove by a preponderance of the evidence that his on-the-job stressors were a major contributing factor to his disability. In this case, the medical evidence is divided. Claimant's past history of recurrent, unexplained bouts with alcoholism and their effects upon him tend to overshadow those alleged job stressors to the point where Dr. Parvaresh's testimony, concerning alcoholism as a disease and the effects it has had on claimant, are more persuasive than claimant's contention that the stressors drove him to drink."

Unlike the Referee, we find Dr. Pidgeon to be more persuasive than Dr. Parvaresh. Dr. Pidgeon prioritized claimant's diagnoses as depressive neurosis, anxiety neurosis and alcohol abuse. The latter he found to be a symptom of the former. It was also significant that, although claimant did have a history of alcohol abuse, he had functioned successfully for years prior to encountering the stresses of this employment. Dr. Pidgeon also related that the clinical symptoms of the neuroses were the same as those independently described by the president of employer and its attorney as having begun in late 1981 and early 1982, at the peak of the most difficult time of claimant's employment. Even Dr. Parvaresh acknowledged that employment related stress was a cause of claimant's difficulties. There is no evidence of any significant non-employment stressors; indeed, almost all of

claimant's waking hours were spent working. We find that a preponderance of the evidence establishes that the employment stress was the major contributing cause of claimant's mental condition. See Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); SAIF v. Gygi, 55 Or App 570 (1982). All of the criteria of McGarrah having been met in the affirmative, claimant is entitled to compensation for his condition.

ORDER

The Referee's order dated November 5, 1984 is reversed in part and affirmed in part. That portion of the order that approved the employer's denial of claimant's claim for his mental condition is reversed. The employer's denial dated December 8, 1983 is set aside and the employer is ordered to accept claimant's claim for processing and the payment of benefits according to law. Those portions of the Referee's order that awarded interim compensation, additional compensation as a penalty for untimely denial and an attorney fee for services in connection with the interim compensation and penalty are affirmed. Claimant's attorney is awarded an additional $1,250 for services at hearing and $850 for services on Board review for overcoming the denial, both sums to be paid by the employer in addition to and not out of compensation.

PAMELA J. HAZELETT, Claimant
Huffman, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-01990
June 27, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Galton's order that upheld the insurer's partial denial of claimant's neck and right shoulder condition and upheld the Determination Order insofar as the date upon which claimant's claim was closed. The insurer cross-requests review of that portion of the Referee's order that increased claimant's scheduled permanent partial disability award for loss of use of the right forearm (wrist) from the 15° (10%) awarded by the Determination Order to 45° (30%). The issues are compensability of the neck and shoulder condition, premature closure and extent of disability.

The parties do not take issue with the Referee's findings of fact, and the parties agree that if the neck and shoulder condition is not compensable the claim was not prematurely closed. We adopt the Referee's findings of fact, which we summarize.

Claimant was injured April 8, 1980 when she slipped on wet concrete and fell. She broke her fall by using her right arm. She went to the emergency room where she was diagnosed as having sustained a Colle's fracture of her right wrist. The fracture was treated by closed reduction and a long arm plaster cast applied. Claimant testified that she began experiencing shoulder and neck symptomatology from and after the time the cast was applied, however, she did not mention this to any physician until two years later, April 7, 1982.

In October 1980 Dr. Fry performed an osteotomy and removal of a portion of the ulna. Claimant testified that this procedure improved her right wrist, but that she continued to experience neck and shoulder pain. As noted above, she did not at the time complain of neck and shoulder pain to her physicians. When

claimant told Dr. Fry about her neck and shoulder pain, he merely made a chart note, and did not treat claimant for this condition. In July 1982 Dr. Fry performed another surgical procedure to claimant's wrist, in which he removed a plate from the dorsum of the wrist.

In November 1982 claimant was living in California when she experienced a significant increase of neck and shoulder pain. She was treated by a chiropractor, who was paid by the insurer. Claimant was found to be medically stationary as to her wrist on December 13, 1983 by Dr. Friedman, however, on January 11, 1984 Dr. Jesperson opined that claimant's acute neck and shoulder symptomatology was related to the original 1980 injury and was symptomatic. Dr. Gripekoven, an orthopedist, subsequently reviewed claimant's medical file and opined that the neck and shoulder condition was not related to the original injury. Dr. Rosenbaum, a neurologist, also opined that the neck and shoulder condition was not related to the 1980 injury.

The disputed Determination Order was issued January 27, 1984 and the insurer partially denied responsibility for claimant's neck and shoulder condition on April 20, 1984.

The Referee found that none of the medical evidence was persuasive that claimant's neck and shoulder condition resulted from the 1980 injury. He further found that, even considering claimant's credible testimony, the long delay in reporting symptoms rendered the case sufficiently complex that persuasive medical evidence of a causal connection between the injury and the neck and shoulder condition would be required, relying upon Westmoreland v. Iowa Beef Processors, 70 Or App 642, 645 (1984).

We agree with the Referee's conclusion on the issue of compensability of the neck and shoulder condition, however, we do not agree with his statement that claimant did carry her burden of proof under Chatfield v. SAIF, 70 Or App 62 (1984). Unlike the Referee, we do not read Chatfield as having possibly liberalized the standard of proof required by Aquillon v. CNA Insurance, 60 Or app 231, 236 (1982), rev den, 294 Or 460 (1983) and Patitucci v. Boise Cascade, 8 Or App 503 (1972). That standard is that claimant must prove that her injury materially contributed to her neck and shoulder condition. We do not believe that Chatfield and Aquillon and Patitucci are inconsistent insofar as they apply the burden of proof. We further note that Chatfield was decided in reliance upon the symptomatic/asymptomatic distinction set forth in the Court of Appeals' case of Wheeler v. Boise Cascade, 66 Or App 620 (1984), since reversed by the Supreme Court, 298 Or 425 (1985).

Claimant also argues that the denial of her neck and shoulder condition is prohibited by Bauman v. SAIF, 295 Or 78 (1983). We disagree. At the time claimant's claim was accepted, claimant had not told her doctors or the insurer that she had a neck and shoulder condition or symptoms in those areas of her body. Thus, the insurer neither knew, should have known, nor could have known that the claim included such discrete symptomatology. See Joji Kobayashi, 36 Van Natta 1067 (1984). Cf. Gracia A. Carter, 36 Van Natta 1604 (1984) (Psychological component of claim reported by three physicians before acceptance). The mere fact that claimant's medical expenses were paid does not, as a matter of law, constitute claim acceptance. ORS 656.262(9).

Because we affirm that portion of the Referee's order that held claimant's neck and shoulder condition not compensable, the issue of premature claim closure is resolved against claimant, and that portion of the Referee's order is also affirmed.

The remaining issue is extent of scheduled disability of the right forearm (wrist) raised by the insurer's cross-appeal. Claimant testified that, except for occasional radiating pain from her neck and shoulder, her forearm is pain free. Dr. Friedman documented impairment as loss of 5° extension of the wrist, loss of 10° each of pronation and supination of the forearm, loss of 20° ulnar deviation of the wrist, loss of 15% right hand grip strength and loss of 5° flexion of the interphalangeal joint of the right thumb. The Referee awarded claimant a total of 45° (30%) loss of the right forearm. Considering that claimant does not have disabling pain and considering the minimal losses of range of motion and minimal weakness occasioned by the injury, we believe this award is excessive. Having considered all relevant factors, we believe claimant would be appropriately compensated by an award of 22.5° (15%) loss of use of the right forearm (wrist), in lieu of all previous awards.

ORDER

The Referee's order dated October 26, 1984 is modified in part. Claimant is granted an award of 22.5° (15%) scheduled permanent partial disability for loss of use of the right forearm (wrist), in lieu of all other scheduled awards. Claimant's attorney's fee is adjusted accordingly. The remainder of the Referee's order is affirmed.

HAROLD A. LESTER, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-08239
April 3, 1985
Order of Abatement

The self-insured employer has requested that the Board reconsider its previous two orders relating to the award of a penalty and employer-paid attorney fee on remand of this claim from the Court of Appeals. In order that claimant may have sufficient time to respond to the employer's request, our previous order dated March 15, 1985 is hereby abated. Claimant should respond to the employer's arguments within ten days from the date of this order.

IT IS SO ORDERED.

HAROLD A. LESTER, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-08239
June 27, 1985
Order on Reconsideration

The self-insured employer has requested that the Board reconsider its Order on Reconsideration issued March 15, 1985. As a threshhold matter, we wish to make it clear that repetitive requests for reconsideration will ordinarily be summarily denied, for obvious reasons. See John B. Bruce, 37 Van Natta 135 (1985). In this case, however, we grant the second request for reconsideration in order that we may address what we are now persuaded is an important question of first impression.

This case was remanded to the Board by the Court of Appeals

"for determination of penalty and attorney fees." Lester v. Weyerhaeuser Co., 70 Or App 307, rev den, 298 Or 427 (1984). The court found that a seven month delay in requesting medical claim closure data required by the Evaluation Division constituted unreasonable delay in the payment of compensation, which it concluded should be penalized. ORS 656.262(10). In arriving at its finding, the court stated that it found no meaningful distinction between the facts of this case and the facts of Georgia Pacific v. Awmiller, 64 Or App 56 (1983). We are bound by the court's finding of fact that the employer's conduct was unreasonable, and we agree that on the question of the reasonableness of the employer's conduct there is no meaningful distinction between this case and Awmiller. In Awmiller, the court affirmed the Board's penalty and attorney fee award for the employer's one year delay in requesting a Determination Order.

On its second request for reconsideration, the employer argues that the language of the court's mandate must be interpreted in the light of existing law regarding penalties. (The employer does not, however, contest our statement in our most recent order in this case, that we are required to obey the mandate. Rexnord, Inc. v. Ferris, 69 Or App 146, 148 (1984).) In sum, the employer's argument is that, no matter how unreasonable its conduct, a penalty may only be awarded if there are "amounts then due" upon which the penalty may be quantified. The employer relies upon EBI Companies v. Thomas, 66 Or App 105, 111 (1983). As we stated in our most recent order in this case, the employer made this same argument to the court. However, the court did not address that argument and we are left to decide the issues raised, if the scope of the mandate permits. We are persuaded that the mandate does allow us to decide whether there were any "amounts then due" upon which to quantify a penalty in this case. We do so, however, mindful of the context in which the mandate was issued and the general goal of the Worker's Compensation Law.

Although there is no meaningful distinction between this case and Awmiller regarding the unreasonableness of the employers' conduct, there is a meaningful distinction between the cases on the question whether there was compensation due and unpaid. In Awmiller, the employer unilaterally terminated temporary disability benefits during the delay interval, leaving the claimant without compensation. It was on that basis that we awarded a penalty. Our reading of Georgia Pacific v. Awmiller convinces us that it was also upon that basis that the court affirmed our order. The court noted: "Claimant does not appeal the referee's failure to award a penalty for the delay in closure prior to the termination of [temporary total disability benefits.] We make no finding as to whether such a penalty would have been appropriate." 64 Or App at 60 n. 2.

The court in Awmiller thus did not decide whether payment of temporary disability during a delay in closure would insulate an employer/insurer from a penalty for the delay. In our Order on Review in this case, we implicitly adopted the Referee's reliance upon Newman v. Murphy Pacific Corp., 20 Or App 17 (1975), to the effect that some prejudice to the claimant and/or intentional delay by the employer/insurer was a prerequisite to the imposition of a penalty. To the extent that Newman supported that proposition, it was overruled by the Court of Appeals in this case. Lester v. Weyerhaeuser Co., supra, 70 Or App at 311.

In this case, claimant was paid temporary disability benefits during the entire period of the delay in claim closure. The employer argues that because of this, no compensation was due and no penalty can, therefore, be quantified. With one exception not relevant here, the awarding of a penalty is a discretionary act. Unreasonableness is determined on a case by case basis. See, e.g., Barrett v. Coast Range Plywood, 56 Or App 371 (1982). Under EBI Companies v. Thomas, supra, however, the ability to penalize unreasonable conduct will be limited to a tonguelashing unless there is compensation that was in fact not paid. See Ray A. Whitman, 36 Van Natta 160 (1984), modified, Whitman v. Industrial Indemnity, 73 Or App 73 (1985).

We conclude that the reasoning behind the "amounts then due" language of ORS 656.262(10) is to provide a means by which to make the punishment fit the crime. By quantifying the penalty based upon the amount actually withheld, the penalty usually will bear a reasonable relationship to the wrong done. Where no amounts are actually withheld, it could be reasonably argued that there was no wrong done. We believe that this is the rationale behind EBI Companies v. Thomas, supra. It is, therefore, important to pay close attention to what conduct is being penalized in deciding whether amounts were "then due."

The employer appears to argue that in order to be penalized an employer/insurer must be in default at the time of the hearing. We find no authority or persuasive reasoning to bolster this argument. Considering especially that the conduct being penalized in this case is delay in performance rather than total nonperformance, such a proposition would almost totally defeat the penalty provision of ORS 656.262(10). We do not believe such a result was intended either by the legislature or the court. During the time that claim closure was delayed in this case, claimant was due permanent partial disability compensation that was not timely paid. We conclude that the delay period is the "then" referred to in the phrase "amounts then due." To arrive at any other result would render the penalty provision utterly toothless.

Having found that there were "amounts then due," we assess a 25% penalty upon that amount, viz, the permanent partial disability award granted by the Determination Order issued August 31, 1982.

Now, therefore, having granted the self-insured employer's request for reconsideration, we adhere to and republish our Order on Remand dated February 28, 1985.

IT IS SO ORDERED.

RONALD D. McCARTY, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-01350
June 27, 1985
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order Denying Dismissal dated April 18, 1985.

The request is granted. On reconsideration, the Board adheres to and republishes its former order, with the following correction. Our prior order refers to the pending request for review as being filed by claimant. The request was filed by the insurer.

IT IS SO ORDERED.

EDWARD C. PERRY, SR., Claimant
David Force, Claimant's Attorney
Moscato & Byerly, Defense Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-10426 & 82-11849
June 27, 1985
Order on Review (Remanding)

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee T. Lavere Johnson's order which upheld the denials of his hearing loss claims issued by Home Indemnity Insurance and the SAIF Corporation, on behalf of Smith & West Construction Inc. On review, claimant seeks remand for the taking of further evidence on the issue of whether SAIF, as the insurer for a subsequent employer, was or should have been joined as a party to this proceeding, and was responsible for claimant's occupational disease claim.

Claimant was 58 years of age at the time of hearing. He has spent most of his years of employment as a manual laborer, performing a variety of duties in a noisy environment. Claimant worked for Smith & West Construction, Inc. from 1973 until November 1980. Smith & West was insured by Home Indemnity between 1973 and July 1, 1975 and by SAIF from July 1, 1975 through November 1980. Claimant also worked for God's Country Logging for approximately six weeks in 1981, ending his employment in August 1981 after suffering a left knee injury. God's Country was insured by SAIF.

The record establishes that claimant's attorney sent a hearing loss claim to SAIF, as insurer for God's Country Logging, on December 2, 1981. There is no indication that SAIF responded. On February 24, 1982 claimant's attorney forwarded a request for hearing to the Board, identifying God's Country Logging as the employer and SAIF as the insurer. The request indicated that one of the issues for hearing would be a challenge of a de facto denial. The claim number was listed as "Unknown." On March 2, 1982 the Hearings Division issued an ackowledgment of claimant's hearing request, listing a WCB case number of 82-01781. This number coincided with the claim number attributed to claimant's earlier appeal from a March 1982 Determination Order which pertained to claimant's 1981 left knee injury claim with God's Country/SAIF.

At the hearing, the parties agreed that WCB case number 82-01781, generally described as an appeal from the March 1982 Determination Order, would be postponed. The attorney for God's Country/SAIF concerning the "Determination Order" issue also represented Smith & West/SAIF concerning the denial of claimant's hearing loss claim. We take administrative notice that WCB case number 82-01781 was subsequently settled without reference to claimant's hearing loss claim. See Dennis Fraser, 35 Van Natta 271, 274 (1983).

The Referee identified the issues before him as compensability and/or responsibility of the hearing loss claims. He listed two WCB case numbers: (1) WCB case number 82-10426, which was the appeal from the denial by Home Indemnity Insurance, on behalf of Smith & West; and (2) WCB case number 82-11849, which was the appeal from the denial by SAIF, on behalf of Smith & West. The Referee did not identify as an issue a de facto denial from God's Country/SAIF of claimant's hearing loss claim. Moreover, other than to refer to the postponement of WCB case number 82-01781, which involved God's Country/SAIF, he did not refer to God's Country/SAIF as a party to the proceeding.

The Referee found that claimant had proven a compensable hearing loss claim against his last employer, God's Country Logging. However, the Referee concluded that his decision was not binding on God's Country because it was not a party to the proceeding. The Referee reasoned that if a request for hearing challenging a de facto denial from God's Country/SAIF was filed, it had been docketed under WCB case number 82-01781, which the parties had agreed to postpone.

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Following our de novo review of the record, we find that remand is appropriate.

The record establishes that this matter has been beset by a number of misunderstandings, clerical and otherwise. Unfortunately, it appears that this agency has contributed to, if not precipitated, the series of misunderstandings and mistaken assumptions which have culminated in denying claimant and God's Country/SAIF the opportunity to litigate the compensability of, and responsibility for, claimant's hearing loss claim. Admittedly, claimant voiced no objection to the Referee's identification of the issues, parties and claims at the hearing. However, considering the amount of confusion created by the processing of these claims, claimant's mistaken assumption that God's Country/SAIF was a party to the proceeding and that its de facto denial was an issue was entirely understandable, particularly where the attorney who had stipulated at the hearing to a postponement of the left knee claim on behalf of God's Country/SAIF was also representing Smith & West/SAIF regarding its denial of claimant's hearing loss claim.

Accordingly, this matter is remanded to the Referee for hearing at which time SAIF, on behalf of God's Country Logging, shall have the opportunity to appear. At the hearing all parties shall be allowed to present further evidence concerning the compensability and/or responsibility for claimant's hearing loss claims. Following the hearing the Referee shall issue his order regarding these matters as though no prior orders had issued.

ORDER

The Referee's prior orders are vacated and this case is remanded to the Referee for further proceedings consistent with this order. The Hearings Division is directed to establish a claim file and case number for claimant's request for hearing, dated February 24, 1982, in which he challenged the de facto denial of his hearing loss claim by the SAIF Corporation, on behalf of God's Country Logging.

WILLIAM H. ROMEIKE, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 83-05132 & 83-03806
June 27, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee Leahy's order which set aside its denial of medical services for claimant's exposure to asbestos. The issue on review is compensability.

Claimant was 75 years old at the time of hearing. He worked in the shipyards during World War II and then worked as a steamfitter for about 30 years. Claimant began using a protective mask when working around asbestos in 1967. He retired around 1975 due to his heart and coronary artery condition.

Claimant had infrequent chest x-rays until 1977 when his primary physician suggested annual examinations. X-rays began showing signs of thickening and calcifications in claimant's pleura and diaphragm, but no disease was diagnosed. Claimant took a treadmill pulmonary function test in April 1983 which showed that claimant's physical limitations were related to his heart condition and not to the condition of his lungs.

Claimant has no need for medical treatment related to the conditions noted in his pulmonary structures. The doctors agree that claimant does not have pulmonary disease. The doctors recommend that claimant continue to have regular physical examinations, including chest x-rays and spirometry, so that if he does begin to show signs of developing lung cancer that it may be detected early. The doctors agree that claimant has an increased risk of developing lung cancer as a result of his exposure to asbestos. As his attending physician, Dr. Lawyer, stated:

> "However, aside from the need for yearly chest x-rays, and immediate checkup on the development of any exacerbation of respiratory symptoms or the development of any symptoms of cancer, his need for medical services at present would be that required by his coronary artery disease and age."

We find that claimant has not proven by a preponderance of the evidence that he has an occupational disease related to his exposure to asbestos and, therefore, we reverse the Referee's order. See Robert W. Brown, 36 Van Natta 1627 (1984).

ORDER

The Referee's order dated December 13, 1984 is reversed and the SAIF Corporation's denial dated May 26, 1983 is reinstated.

MARION R. WEBB, Claimant
Welch, et al., Claimant's Attorneys
Minturn, et al., Defense Attorneys

WCB 83-07371
June 27, 1985
Order on Reconsideration

Claimant requests reconsideration of our Order on Review issued May 31, 1985. Claimant's request is limited to that portion of our order that set aside that portion of the Referee's order that sustained claimant's objection to the admission of a supplemental vocational report and excluded the evidence. We concluded that the objection should have been overruled and the evidence admitted for the purpose of impeachment. We considered the report in that light in our review.

We discussed this issue at some length in our Order on Review, and we believe that our discussion fully and adequately explains what we believe to be the legal standard for the admission of evidence in workers' compensation hearings in view of

Armstrong v. SAIF, 67 Or App 498 (1984). We grant claimant's request for reconsideration only to expand somewhat on our previous discussion.

Claimant does not appear to argue that the vocational report was not relevant. His argument turns, rather, on the premise that admission of the report without claimant having been afforded the opportunity to cross-examine its author violates one of claimant's basic rights. We point out that the courts have consistently held that under ORS 656.283(6) and analagous statutes dealing with administrative hearings, the fact that evidence may be hearsay is not a reason to exclude it if it is relevant and of a type of evidence commonly relied upon by prudent persons, whether or not the author of the hearsay is available for cross-examination. See Armstrong v. SAIF, supra; Higley v. Edwards, 67 Or App 488 (1984). The mere fact that a piece of evidence is admitted into the record, however, says nothing of the weight it will be given by the factfinder. We admitted the vocational report only as impeachment evidence, i.e. evidence attacking the weight to be given other evidence, in this case claimant's testimony.

On reconsideration we adhere to and republish our previous order.

IT IS SO ORDERED.

DARRYL W. BODLE, Claimant
Galton, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-04181
June 28, 1985
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of that portion of Referee Fink's order which granted claimant an award of permanent total disability, whereas an April 10, 1984 Determination Order and previous Determination Orders had awarded 25% (80°) unscheduled permanent disability for a low back injury. On review, SAIF contends claimant is not entitled to an award of permanent total disability. We agree and reverse.

Claimant was 42 years of age at the time of hearing. In March 1978 he sustained a compensable "lifting" injury while performing his duties as a garbage collector. Dr. Cherry, claimant's treating orthopedist, has diagnosed severe and chronic low back strain, with a probable "mild" herniated disc. Treatment has been conservative.

Claimant credibly testified that he experiences constant low back pain, which intermittently radiates into his right hip and leg. These symptoms increase when claimant engages in physical activity. Consequently, claimant avoids bending and lifting, limiting himself to light housework and carrying no more than 10 to 15 pounds in groceries. He walks with a limp and uses a cane to guard against a "buckling" right leg. In addition to medication and heat, claimant resorts to traction on a daily basis to relieve his pain.

In November 1983 the Orthopaedic Consultants performed their most recent of four examinations. The Consultants diagnosed chronic low back pain with a history, but no neurological findings, suggestive of radiculopathy. In the Consultants'

opinion claimant's residual impairment had not changed since their March 1983 examination. At that time, the Consultants opined that claimant's permanent loss of function was mildly moderate. The Consultants further concluded that claimant was physically incapable of returning to his former occupation, but was capable of performing light to sedentary work on a reasonably continuous basis.

In February 1984 Dr. Beals, orthopedist, performed an independent medical examination. Dr. Beals concluded that claimant was able to return to work, subject to considerable limitations. These limitations included no prolonged periods on his feet and no significant climbing, bending, lifting, twisting or carrying. Dr. Beals recommended a 20 pound lifting restriction.

Dr. Cherry concurred with Dr. Beals' report. In August 1984 Dr. Cherry reported that claimant had back and leg pain, could not walk without a limp and used a cane. Dr. Cherry concluded that claimant was "an intelligent man and he did outstanding work at Portland Community College, but has just not been able to find any type of job because of his impairment."

Claimant's vocational rehabilitation reports have been exemplary. Numerous reports take particular note of claimant's positive and cooperative attitude. The reports also foresee claimant's prospects for a return to work as favorable. The Callahan Center reported that claimant demonstrated a "high average level of intelligence" and "above average" work skills, excluding physical limitations. Claimant's best aptitude was exhibited in administrative and clerical areas. In view of this aptitude and his past work experience in the manual labor and construction field, a career as an insurance adjustor or building inspector was explored. To reach this objective claimant entered an authorized training program in building construction technology. Claimant successfully completed this two-year program in one year with a 4.0 GPA and received an Associate of Applied Science Degree. This degree complemented a GED and his other associate degrees in business management and merchandising which he earned in 1974 and 1975, attaining a 3.6 GPA.

Claimant has contacted literally hundreds of potential employers in the insurance and construction trade. Claimant's means of contact has primarily been through applications, resumes and telephone conversations. Out of these hundreds of contacts claimant has received less than a dozen interviews. Unfortunately, apparently due in part to his lack of supervisory experience and his physical limitations, no job offer has been forthcoming.

The Referee found that claimant was entitled to an award of permanent total disability under the so-called "odd lot" doctrine. Noting that he did not recall any other case where the claimant was so vigorous and diligent in seeking employment, the Referee concluded that claimant had established that there was no employment that he could obtain within his physical and vocational limitations.

In order to establish permanent total disability, a claimant must prove that he is unable to perform any work at a gainful and suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403

(1977); ORS 656.206(1a). The standard has been expressed as "whether the claimant is currently employable or able to sell his services on a regular basis in a hypothetically normal labor market." Harris v. SAIF, 292 Or 683 (1982). Permanent total disability may be established through medical evidence of physical incapacity or through the so-called "odd lot" doctrine, under which a disabled person may remain capable of performing work of some kind but still be permanently disabled due to a combination of medical and non-medical disabilities which effectively foreclose him from gainful employment. Welch v. Banister Pipeline, 70 Or App 699 (1984). Whether a claimant is permanently and totally disabled must be decided on the basis of conditions existing at the time of the decision, not on the basis of a speculative future change in employment status. Gettman v. SAIF, 289 Or 609 (1980).

We find that claimant has failed to establish that he is unable to perform any work at a gainful and suitable occupation. Therefore, he is not entitled to an award of permanent total disability.

Although claimant has demonstrated an extremely high degree of motivation in seeking work, his failure to obtain employment does not necessarily result in a conclusion that he is incapable of performing gainful activity. The evidence does not preponderate that he is so physically, vocationally, or intellectually handicapped that he is currently unable to obtain and perform regular gainful employment. The medical opinions suggest that claimant could engage in work activities, subject to light or sedentary duty restrictions. Claimant's scholastic achievements and vocational assessments further indicate that there are numerous potential employment opportunities available to an injured worker with his experience, aptitudes and physical limitations. His current failure to obtain employment appears to be more a function of a depressed labor market than a commentary on his inability to perform gainful work activities. Accordingly, we cannot conclude from this record that claimant's current opportunities for gainful employment have been effectively foreclosed as a result of his medical and non-medical disabilities.

Turning to a determination of the extent of claimant's permanent disability, we find that the Determination Order's award of 25% should be increased. 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. After completing our de novo review and considering the above guidelines, we conclude that an award of 60% unscheduled permanent disability would more appropriately compensate claimant.

ORDER

The Referee's order dated October 23, 1984 is reversed in part. That portion awarding permanent total disability is reversed and claimant is awarded 60% (192°) unscheduled permanent low back disability, that being an increase of 35% (112°) from his prior award of 25% (80°). The remainder of the Referee's order is affirmed. Claimant's attorney's fee shall be adjusted accordingly and shall not exceed $2,000.

BOARD MEMBER LEWIS DISSENTING:

Claimant is permanently and totally disabled if he establishes that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation which he has the ability and the training or experience to perform, or an occupation which he is able to perform after rehabilitation. ORS 656.206(1). Claimant must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

I agree with the Referee that claimant has met the above-mentioned criteria under the "odd lot" doctrine. See Clark v. Boise Cascade Corp., 72 Or App 397 (1985). Thus, he is entitled to an award of permanent and total disability.

A permanent total disability award cannot be reduced on the basis of a speculative future change in employment status but only on the actual conditions existing at the time of the hearing. Gettman v. SAIF, 289 Or 609 (1980); Clark, supra. If through training claimant becomes employable in the future, his status can be reassessed pursuant to ORS 656.206(5) or, should he participate in an authorized training program, at its completion pursuant to ORS 656.268. Given claimant's predisposition to expand his intellectual and vocational horizons, I am confident that a reassessment will soon occur. However, my confidence is mere speculation and has no bearing on the evidence presented at the time of hearing. Pursuant to Gettman, we must focus on claimant's circumstances as they exist now, without regard to how his employability may change at some point in the future.

Claimant's scholastic and rehabilitative achievements are to be commended. However, his schooling was specifically designed as preparation for a career as an insurance adjustor or building inspector. Claimant credibly testified that his extensive job seeking efforts in those and similar areas were unsuccessful due to his lack of experience. This testimony stands unrebutted. Furthermore, claimant's physical restrictions foreclose his return to heavy, manual labor. Consequently, I am persuaded that he is presently incapable of performing work at a gainful and suitable occupation which is both within his physical limitations and one occupation for which claimant has the requisite amount of experience.

Claimant is a highly motivated individual who has demonstrated an extraordinary willingness to return to the work force. Unfortunately, vocational services apparently have led him down a "dead-end street." Although claimant possesses the requisite aptitude to perform the duties of a construction supervisor, insurance adjustor or building inspector, his lack of practical experience and physical limitations have combined to prevent him from attaining his objective. His admirable record should not prohibit him from receiving an award of permanent total disability. To conclude that claimant is not entitled to such an award not only is a disservice to claimant, but the conclusion could result in deterring other workers from excelling in their rehabilitation efforts.

For the foregoing reasons, I respectfully dissent.

JIMMY C. BUTLER, Claimant
James P. O'Neal, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-06247
June 28, 1985
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Daron's order which: (1) awarded 35% (112°) unscheduled permanent disability for a back injury, whereas a May 9, 1984 Determination Order awarded 10% (32°); and (2) upheld the SAIF Corporation's partial denial of claimant's treatment for a psychiatric condition. Although SAIF did not cross-request review, it contends that the Determination Order's award is appropriate. We have authority to consider SAIF's contention notwithstanding its failure to cross-request review. Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983).

The Board affirms that portion of the Referee's order which found that claimant's psychiatric condition was not related to his compensable injury. However, we modify claimant's permanent disability award.

Claimant was 42 years of age at the time of hearing. In October 1983 while working as a timber faller he was struck in the back by a falling tree. Dr. Streitz, treating orthopedist, diagnosed claimant's condition as lumbosacral strain syndrome with possible atypical discogenic component. All treatment has been conservative, consisting primarily of medication, rest and a general exercise program.

In April 1984 BBV Medical Service, Inc. performed an independent medical examination. Dr. Isaacson, orthopedic surgeon, issued BBV's medical report with which Dr. Berth and Dr. Fry concurred. Dr. Isaacson noted that claimant walked without a limp, had a normal gait, and was able to squat and rise without difficulty. There was some tenderness in portions of claimant's thoracic, lumbar and sacroiliac areas, but the doctor found no evidence of muscle spasms. Claimant's spinal range of motion findings were 90% of normal.

Dr. Isaacson opined that claimant suffered minimal impairment with no vocational restrictions attributable to his condition, which was diagnosed as "lumbosacral contusion by history." In the hopes of treating claimant's "adult situational maladjustment problem," Dr. Isaacson recommended that claimant return to the VA Hospital for further psychological counseling. Dr. Streitz concurred with this report "in general," but felt claimant should not return to heavy lifting, bucking or falling at that time. Dr. Streitz conceded that it was difficult to determine how much of claimant's limitations were based on a psychiatric component rather than a physical component.

Dr. Streitz last examined claimant in July 1984. At that time the doctor reported that claimant was experiencing some episodes of his leg giving way while working part time at "odd jobs." Dr. Streitz opined that claimant's prognosis was guarded and predicted that his symptoms were chronic, with the possibility of significant psychologic factors impacting his recovery.

At the time of hearing claimant had recently begun receiving treatment from Dr. Johnson, who had recommended daily physical therapy. These treatments consisted primarily of massage and sound treatments, in addition to the medication claimant has taken

as prescribed since his injury. Claimant experiences back pain approximately at belt level, with pain into the left leg and thigh. Since the injury his lifting, bending and stooping capabilities have been significantly reduced and his recreational activities severely curtailed. Claimant opined that he presently could not lift 20 pounds repeatedly.

Claimant attempted to return to work in July 1984, but was forced to stop on the third day because his legs gave way. Prior to his compensable injury he was able to perform these heavy work activities without difficulty, despite scars from bullet wounds in his left hip, a left leg which was 3/4 of an inch shorter than his right leg and a right hip which was broken in a 1981 truck accident. Claimant has received a 50% VA disability award stemming from his bullet wounds which were incurred while serving in Vietnam.

Claimant has a 10th grade education and no GED. In addition to his approximately 12 years of experience in timber falling and bucking, he has worked at plywood mills. While in the Army he worked as a tank mechanic. He has applied for mechanic work with a city bus system and for kitchen work at the VA Hospital, but has been advised that he would not be considered without a "complete release." Claimant is also interested in receiving training in welding and carpentry.

We agree with the Referee's conclusion that the Determination Order's 10% award was insufficient. However, we consider the Referee's 35% award to be excessive.

Pursuant to OAR 436-65-600 et seq., in rating the extent of claimant's disability resulting from his compensable injury we consider his age, education, work experience, adaptability, mental capacity, emotional state, labor market findings and physical impairment, including disabling pain. After completing our de novo review and considering the above guidelines, we conclude that an award of 20% unscheduled permanent disability would more appropriately compensate claimant.

ORDER

The Referee's order dated November 21, 1984 is affirmed in part and modified in part. In lieu of the Referee's permanent disability award, claimant is awarded an additional 10% (32°) unscheduled permanent disability, for a total award of 20% (64°) unscheduled permanent disability for his back injury. Claimant's attorney's fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed.

GARLAND COMBS, Claimant
Kelley & Kelley, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-05836
June 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Foster's order which directed it to reclassify claimant's left arm claim as a disabling injury and pay temporary partial disability until claim closure. On review, SAIF contends the Referee lacked jurisdiction to order the claim reclassified because claimant did not request reclassification within one year of his injury. We agree and reverse.

Claimant was 64 years of age at the time of hearing. He is employed as a minister, handyman and janitor for a community church. On May 4, 1983 claimant fell backward on a stairway, sustaining a non-displaced fracture of the distal radius and ulnar styloid of the left arm. The arm was casted and claimant returned home. Due to his inability to perform all of his maintenance duties, claimant's wife assisted him and received a portion of his salary.

Claimant prepared his injury claim and also signed the claim on behalf of his employer. On June 8, 1983 SAIF accepted the claim as a nondisabling injury. Ms. Lord, a legal operations analyst for SAIF, testified that claimant's file indicated that a notice of acceptance of the claim had been sent to claimant and to his employer and that neither notice had been returned as nondeliverable. According to Ms. Lord each notice of acceptance contains a recitation of the "worker's rights."

A copy of a notice of acceptance form was admitted into evidence. The notice defined an injury as "non-disabling" where time loss did not exceed three days and no permanent physical impairment resulted from the injury. In the event the worker felt a mistake had been made in classifying the claim nondisabling, the worker was directed to call SAIF. If objections to the classification remained, the worker was advised that a written request for reclassification could be made to the Workers' Compensation Department within one year from the date of injury. The notice also advised the worker of hearing and aggravation rights, in addition to the Workers' Compensation Board's continuing jurisdiction over the claim. The notice listed the addresses for the Workers' Compensation Department and Board, as well as a toll-free telephone number for the Department.

Claimant testified that he received a form from SAIF advising him that he was not entitled to any compensation, but he had no recollection of being informed of his hearing and appeal rights.

Claimant's cast was removed on June 8, 1983. On June 10, 1983 his treating physician, Dr. McNeilly, advised SAIF that claimant was released to regular work, but not medically stationary. Dr. McNeilly did not foresee permanent impairment, but mentioned the possibility of post-fracture arthritis. Claimant did not return to Dr. McNeilly for treatment of his wrist until July 1984. At that time claimant's complaints included moderate swelling, "considerable tingling" in the wrist, poor function, slow dexterity, and "considerably" decreased range of motion. The doctor diagnosed claimant's condition as post-traumatic arthritis. Dr. McNeilly prescribed a wrist immobilizer, removable splint and medication, with the possibility of a surgical fusion should claimant's symptoms persist. Dr. McNeilly opined that claimant's physical activity should have been limited for a period of three months following his injury.

On May 24, 1984 claimant's attorney requested that the Department reclassify the claim. The Department responded that since the request was beyond one year from the date of injury, it was precluded from acting upon the request pursuant to ORS 656.262(12) until the claim had been processed as an aggravation claim.

The Referee concluded that ORS 656.262(12) was inapplicable inasmuch as claimant's contention was not that an initially nondisabling injury had become disabling as the statute contemplates, but that his injury had always been disabling and was improperly classified. Therefore, the Referee reasoned that no time limitations to contest the improper classification had been triggered and that claimant was free to contest the classification unfettered by the one year time limit of ORS 656.262(12).

Since the Referee's order, the Board issued its Order on Review in Deborah L. Greene, 37 Van Natta 575 (1985). In Greene the claimant's back claim was accepted as a nondisabling injury since the claimant neither sought medical treatment nor missed time from work. The Board found that the insurer's denial of subsequent medical services rendered more than one year post-injury was not an attempt to deny a claim prior to closure as precluded by Safstrom v. Riedel International, Inc., 65 Or App 728 (1983) and its progeny, but instead was a denial of claimant's aggravation claim for an initially nondisabling injury as envisioned by ORS 656.262(12) and ORS 656.273(4)(b). The Board further reasoned that by receiving the notice of acceptance, the claimant had the information with which to challenge any aspect of her claim within the prescribed one year period should she have so chosen.

Portions of this case are analogous to Greene. Specifically, claimant's request for reclassification was made more than one year from the date of his injury, as was Mrs. Greene's claim for medical services. ORS 656.262(12) is applicable in either instance. As was the case with Mrs. Greene, claimant's prescribed course of action was to approach the matter as an aggravation claim according to ORS 656.273. Inasmuch as claimant prosecuted his claim as a request for reclassification to the Evaluation Division, the Division and the Referee were without jurisdiction to comply with his wishes. See Anthony A. Bono, 35 Van Natta 1, 6-8, rev'd on other grounds, 66 Or App 138 (1983), rev'd on other grounds, 298 Or 405 (1984).

Claimant's argument that the one year period for reclassification, as contained in ORS 656.262(12), does not apply to an injury which was improperly classified as nondisabling is not persuasive. The statute makes no distinction between a claim initially accepted as nondisabling which has become disabling within one year from the date of injury and an injury which appears disabling from the outset, but which was classified as nondisabling. Thus, we conclude that claimant has one year from the date of injury to contest the classification directly to the Department, regardless of whether his initially nondisabling injury has become disabling or his injury has always been disabling.

To follow claimant's contention to its natural conclusion, unless a claim was closed pursuant to ORS 656.268(3) the statute of limitations for addressing the issue of improper classification would be tolled. Accordingly, it would necessarily follow that the claim would perpetually remain in open status. Such a conclusion is contrary to the precepts of ORS 656.262(12) and 656.273(4)(b). In addition, claimant's interpretation is in disagreement with Workers' Compensation Department Bulletin No. 139 (January 29, 1984) which states that a notice of closure is

not required on claims which are initially accepted as nondisabling and where no temporary disability has been paid. Moreover, we note that ORS 656.268(3) states that a nondisabling claim "may" be closed by means of a notice of closure, it does not require formal closure. Thus, although the recitation of rights contained in the notice of acceptance appears to conform to the requirements for a notice of claim closure, the notice of acceptance need not be construed as a notice of claim closure since SAIF was under no obligation to formally close the claim.

ORDER

The Referee's order dated January 7, 1985 is reversed. Claimant's request for relief is denied.

HAROLD L. DOTSON, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-06463
June 28, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Podnar's order which awarded claimant's attorney a fee of $2,000 for services prior to hearing in obtaining acceptance of a cervical spine condition. The issue on review is the attorney's fee.

The issue at the hearing was the amount of the attorney's fee to be awarded. All other issues had been settled and both parties submitted the issue of the fee to the Referee. To set the fee, the Referee considered the thickness of the file, the number of hours worked, the diligence shown by claimant's attorney and the result for claimant.

SAIF argued that claimant's attorney should only be awarded 25% of the medical bills and that an attorney's fee award of $750 for an unrelated shoulder condition should be factored into the consideration of claimant's attorney's fee. SAIF also contended that it had accepted the cervical condition even without the attorney's services based on subsequent diagnostic testing after its denial.

On May 10, 1983 Dr. Norris-Pearce reported to SAIF that claimant had C6-7 radiculopathy confirmed by x-ray and thermogram. He opined that it was related to claimant's work and not related to claimant's shoulder condition. He recommended a myelogram and surgery. He specifically stated that a new claim should be opened.

On May 13, 1983 Dr. Golden examined claimant and found no evidence of radiculopathy on physical examination, but he took no x-rays and had no other information.

On June 24, 1983 SAIF denied the cervical spine condition. On June 27, 1983 SAIF and claimant reached a stipulated settlement regarding claimant's shoulder.

On April 11, 1984 Dr. Smith examined claimant and diagnosed C5-6 radiculopathy and recommended a myelogram and discogram. On April 24, 1984 a myelogram confirmed a disc bulge at C5-6. On July 17, 1984 Dr. Rosenbaum agreed with Dr. Smith's diagnosis and recommendation for surgery. On August 14, 1984 Dr. Smith

performed diskectomy and fusion which SAIF had indicated to the doctor would be compensable.

SAIF accepted the claim on November 9, 1984, but refused to pay claimant's attorney any fee. The dispute about the attorney's fee was submitted to the Referee on December 5, 1984.

The Board affirms the order of the Referee.

Claimant's attorney has requested a fee for defending the attorney's fee awarded by the Referee. An attorney's fee award is appropriate on review when the insurer raises the issue of the compensability of the underlying claim by way of cross appeal or by raising it in a response brief. Teel v. Weyerhaeuser Co., 294 Or 588 (1983); Judy M. Friedrich, 36 Van Natta 1210 (1984). Compensability of claimant's condition was not an issue on review, and our decision will not effect any change in compensation paid to the injured worker. No case or statute has been cited to us for the proposition that claimant's attorney is entitled to a fee for defending only the attorney's fee awarded by the Referee. It has previously been held that insurer-paid attorney's fees are not compensation to the claimant and are, therefore, to be treated differently. E.g., Robert G. Perkins, 36 Van Natta 1050 (1984) (discussion of offset for attorney's fee allowed out of compensation as opposed to non-payment of attorney's fee awarded in addition to compensation). Having no statutory authority to award a fee to claimant's attorney for defending the fee awarded by the Referee, we do not award a fee to claimant's attorney for services on Board review.

ORDER

The Referee's order dated December 12, 1984 is affirmed.

ARLISS D. INGRAM, Claimant
Kenneth Peterson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 82-06472
June 28, 1985
Order on Remand

This case is before the Board on remand from the Court of Appeals. AMFAC, Inc. v. Ingram, 72 Or App 168, rev den 299 Or 37 (1985). We have been instructed to reinstate the employer's denial of claimant's claim for carpal tunnel disease.

Now, therefore, the employer's denial of claimant's claim for carpal tunnel disease dated July 6, 1982 is reinstated and affirmed.

IT IS SO ORDERED.

HARLAN L. LONG, Claimant
Michael B. Dye, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-00149
June 28, 1985
Order on Reconsideration

Claimant has requested that we reconsider our Order on Reconsideration issued June 7, 1985 in which we allowed the SAIF Corporation to offset permanent partial disability benefits paid after the effective date of claimant's award of permanent total disability against the permanent total disability benefits. Claimant urges that any benefits paid pursuant to the Referee's order during the period that Board review was pending cannot be recovered "by offset or otherwise," relying upon ORS 656.313(2).

In Pacific Motor Trucking v. Yeager, 64 Or App 28 (1983), the Court of Appeals ruled that a claimant could not be awarded permanent partial disability benefits in addition to permanent total disability benefits. The statutes and cases relied upon by claimant in this case all contemplate a situation in which the final disposition of the claim results in a lowering of a previous award. ORS 656.313(2) prohibits recovery of erroneously paid compensation in such cases, but does not apply in cases such as this one, where the final disposition of a claim results in an increased award.

Claimant's request for reconsideration is allowed. On reconsideration we adhere to and republish our former orders.

IT IS SO ORDERED.

WESLEY L. McBRIDE, Claimant
Michael B. Dye, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 84-05143
June 28, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Michael Johnson's order which increased his award of unscheduled permanent disability for a low back injury from 20% (64°), as awarded by an October 18, 1983 Determination Order, to 45% (144°). On review, the sole issue is extent of unscheduled disability, including permanent total disability.

The Board affirms the order of the Referee with the following supplementation.

The Referee stated that the "futility" doctrine, as discussed in Butcher v. SAIF, 45 Or App 313, 317 (1980), only applied to physically incapacitated workers, but not to the so-called "odd lot" workers. Subsequent to the Referee's order the Board issued its decision in George M. Turner, 37 Van Natta 531 (May 7, 1985) which contradicts the Referee's statement. In Turner we held that a claimant may be excused from the seek-work requirement of ORS 656.206(3) as a result of medical factors and social/vocational factors.

This supplementation has no effect upon our ultimate conclusion that claimant failed to prove his entitlement to an award of permanent total disability.

ORDER

The Referee's order dated January 18, 1985, as supplemented herein, is affirmed.

VINCENT L. MEYER, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 81-06150, 80-11612 & 80-11611
June 28, 1985
Order on Remand

This case is before the Board on remand from the Court of Appeals. Meyer v. SAIF, 71 Or App 371 (1984), rev den 299 Or 203 (1985). We have been instructed to order acceptance of claimant's asbestosis claim.

Now, therefore, the SAIF Corporation's denial of claimant's claim for asbestosis dated June 26, 1981 is set aside and claimant's claim is remanded to the SAIF Corporation for acceptance and processing, including the payment of benefits, according to law.

IT IS SO ORDERED.

ANNA MILLER, Claimant
Becker, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 84-02995
June 28, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of those portions of Referee Shebley's order which set aside its denial of aggravation of claimant's finger injury and awarded 50° for 33 1/3% scheduled permanent partial disability for loss of use or function of claimant's left forearm in addition to the Determination Order dated March 9, 1984 which awarded 2.2° for 10% loss of use due to pain in claimant's middle finger on the left hand. Claimant cross-requests review but filed only a respondent's brief. By separate motion, SAIF requests authorization of an offset for interim compensation paid pending denial. The issues on review are aggravation and scheduled permanent partial disability.

On the issue of the requested offset for interim compensation, we find that the issue was not raised by pleadings or representations of counsel at or before hearing and, therefore, will not be considered on review. Clark v. SAIF, 50 Or App 139 (1981); Robert R. Delugach, 37 Van Natta 63 (1985).

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated November 30, 1984 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

DAWN O'BRIEN, Claimant
Pozzi, et al., Claimant's Attorneys
G. Howard Cliff, Defense Attorney

WCB 83-09480
June 28, 1985
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of those portions of Referee Galton's order which: (1) awarded claimant 64° for 20% unscheduled permanent partial disability in addition to claimant's prior awards of 48° for 15% unscheduled disability for injury to her neck and low back and 19.2° for 10% loss of use of her right arm; and (2) allowed additional temporary total disability for the period November 3, 1980 through April 15, 1981.

Claimant was employed as an apartment manager. Her work required not only showing apartments and collecting rent, but also such activities as moving heavy appliances, cleaning and painting. Claimant injured her low back, left hip, right shoulder, neck and upper dorsal spine in lifting incidents in 1979.

Early treatment was conservative. Claimant came under the

care of Dr. Stiger, an osteopath, in January 1980. His diagnosis included lumbosacral strain, left sacroiliitis, lumbar somatic dysfunction secondary to lumbosacral strain, right acromioclavicular strain with dysfunction of the musculature of the right scapula and left sciatic neuralgia. An April 1980 myelogram was normal.

Claimant was examined by Orthopaedic Consultants on June 25, 1980. They diagnosed lumbar spine strain with radicular symptoms but no radiculopathy identified, cervical spine strain and mild functional overlay. They opined that claimant was stationary and that she could return to her prior occupation with light to medium limitations, limiting lifting to 15 pounds repeatedly and 30 pounds occasionally.

An August 15, 1980 Determination Order was followed by a September 16, 1980 Stipulation awarding a total of 10% scheduled permanent partial disability for loss of use of her right arm and 20% unscheduled permanent partial disability. Claimant was found medically stationary as of June 25, 1980.

Claimant experienced an aggravation of her compensable condition in October 1980. Dr. Stiger hospitalized her on October 23, 1980 for back pain with radiation down her right leg. While hospitalized she was examined by Drs. Borman and Heatherington, both osteopaths. Dr. Borman suggested manipulation under general anesthesia, which Dr. Heatherington performed on October 29, 1980. In discharging claimant on October 31, 1980, Dr. Stiger reported:

> "The patient had a remarkable decrease in symptomatology following surgery. The next day she was much more comfortable and able to ambulate and sit with virtually no discomfort. Two days after the procedure she still is quite comfortable and therefore, we are dismissing her from the hospital and we are going to continue with the anti-inflammatory agents and Naprosyn, 250 mg. t.i.d. and Flexoril 1 t.i.d. and Darvocet N 100 for pain. Because she lives so far from our office we are going to put her back to work on November 3 and return to office on the 13th or sooner if necessary."

On November 7, 1980, Dr. Stiger wrote to the insurer that a recurrence of claimant's symptomatology had required her October 1980 hospitalization and that she was then under his care for her recurrent back problem.

Dr. Borman reexamined claimant on December 16, 1980. He reported that claimant stated that she felt worse ever since the manipulation during her hospitalization. Osteopathic evaluation failed to reveal any significant changes in claimant's condition, although she complained of more extensive pain. He stated:

> "This patient presents a rather difficult diagnostic problem. Based upon the present examination the subjective symptoms are not necessarily confirmed by objective testing. It would be my recommendation that the patient's industrial claim be

considered closed. It would appear that a 25 percent permanent partial disability award is quite generous for the symptoms for which the patient has been treated."

A February 1981 lumbar CT scan revealed no defects. Claimant received physical therapy beginning in February 1981. She was treated by Dr. Stiger into April 1981. Dr. Stiger reported on November 17, 1981 that he had neither determined the cause of claimant's chronic low back pain nor found any treatment that was particularly effective. He stated that by the end of December 1980 or early January 1981 her situation had become medically stationary again, and that throughout January and February 1981 her symptomatolgy remained the same. He stated that after March 11, 1981, he no longer continued to treat claimant regularly. Later in the same report, however, he opined that claimant became medically stationary about April 15, 1981.

Dr. Borman opined in February 1983 that claimant's condition became stationary on or about November 2, 1980.

Claimant was evaluated at the Northwest Pain Center in late May of 1981. Their findings included chronic cervical and low back pain without evidence of nerve root problems, psychogenic magnification of pain, hysterical conversion elements and poor incentive for reduction in pain behavior due to secondary gain. Drs. Seres and Yospe stated that although it appeared clear that the Pain Center could help claimant, she did not seem appropriately interested. They stated that this should give her attending physicians some indication of the extent of her discomfort with her present situation.

Dr. Post, an orthopedic surgeon, examined claimant in June 1981 and concluded that claimant's impairment was minimal. He stated that he could document no reason why claimant could not return to work involving prolonged sitting and standing with incidental lifting up to 40 pounds.

A July 17, 1981 Determination Order awarded temporary total disability from October 23 through November 2, 1980, and awarded no additional permanent disability.

In early 1982 claimant underwent testing at the Callahan Center. It was determined that claimant could return to light work without repetitive bending and lifting or repetitive neck turning and with lifting limited to 25 to 30 pounds. Claimant commenced bookkeeping training under an authorized training program in March 1982. The program was initially scheduled to end in February 1983. In April 1982 Dr. Stiger reported that prolonged sitting necessitated by the program was causing a great deal of pain and suggested that claimant take a less accelerated course. The program was subsequently revised. Dr. Stiger reported in November 1982 that claimant could continue to take the course at the reduced level of three to four hours a day. He stated that despite this limitation, her chances for becoming successfully employed at the occupation she was being trained for were quite good because the anticipated work would allow her to move around freely. Claimant completed the program in May 1983.

On May 20, 1983 Dr. Stiger stated that claimant's condition would permit gainful employment with the following restrictions:

(1) no more than four hours of work per day, five days per week; (2) the place of employment should be fairly close to claimant's home so that prolonged driving could be avoided; (3) no lifting over 20 pounds; and (4) the work needs to permit alternation between sitting and standing.

Claimant became employed full time as an accountant clerk in July 1983. A September 6, 1983 Determination Order again closed the claim. It awarded additional temporary disability for the training period, but awarded no additional permanent disability.

Claimant was hospitalized from November 29, 1983 to December 3, 1983 for severe low back pain. The insurer accepted this as an aggravation of the compensable condition. On May 18, 1984 Dr. Stiger opined that claimant was again medically stationary, with pain in her left leg and right shoulder, limited lumbar range of motion and tenderness in the sacroiliac joints and the musculature of the upper back. He stated that her limitations remained unchanged and that he would continue to treat her right shoulder bursitis and other medical problems.

The most recent Determination Order, dated June 15, 1984, awarded additional temporary disability from November 29, 1983 through May 18, 1984, but no additional permanent disability.

Based on claimant's demeanor at hearing the Referee found her to be a credible and reliable witness who somewhat overfocused on her physical symptomatolgy. Claimant testifed that she had no back or spine trouble before the compensable injuries. She appears to have testified that she improved temporarily just after the October 1980 hospitalization. She insists that Dr. Stiger did not tell her that she was released to work until April 1981. She testified that she could not have worked in November 1980 even had she been released. Claimant testified that she regressed again at the end of 1980 and that injections by Dr. Stiger and physical therapy in early 1981 provided some benefit; however, on cross-examination she stated that her condition did not change from December 1980 to April 1981.

Claimant testified that her current work involves filing, lifting and going through reports, making journal entries and using a telephone and computer. Generally her work permits frequent change of position, but when it does not she finds prolonged sitting very painful. She experiences muscle spasms in her right shoulder and pain in the lower left hip with radiation into the leg. She sometimes misses time from work as a result of her condition. She believes that her condition is progressively deteriorating.

The Referee found claimant entitled to temporary disability compensation benefits from October 23, 1980 through April 15, 1981. A July 17, 1981 Determination Order had awarded temporary total disability only through November 2, 1980. Claimant is entitled to temporary disability benefits until such time as she became medically stationary. See ORS 656.268. In Brad T. Gribble, 37 Van Natta 92, 97 (1985), we explained:

> "An injured worker is considered medically stationary when '[N]o further material improvement would reasonably be expected from medical treatment, or the passage of

time.' ORS 656.005(17). The question of whether claimant's condition was medically stationary . . . when his claim was closed is primarily a medical question, resolution of which is a matter of competent medical evidence. . . . It is claimant's burden to establish, by a preponderance of the evidence, that he was not medically stationary when the claim was closed. . . . We generally defer to a treating physician's opinion on the medically stationary question. . . . Deference to the treating physician's opinion, however, is only appropriate to the extent that the opinion is found persuasive."

We find helpful claimant's treating physician's November 17, 1981 report wherein he discusses claimant's condition in late 1980 and early 1981. He observed little change throughout January and February 1981. This is confirmed by claimant's own testimony. However, the physician had obvious and understandable difficulty with the legal question of when claimant became medically stationary. He offered conflicting opinions within the same report. Although we find that claimant was not medically stationary on November 2, 1980, considering the record as a whole, we are persuaded that further material improvement was not reasonably to be expected after December 16, 1980, the date claimant was reexamined by Dr. Borman. Accordingly, we modify the Referee's order to award temporary disability only through that date.

Weighing the evidence we find that claimant has mild to mildly moderate permanent physical impairment due to her compensable injuries. Claimant is 48 years old. She has a GED and bookkeeping training. She has marketable skills and is able to perform reasonably well in her current position. Considering claimant's physical impairment and weighing the pertinent social/vocational considerations, see OAR 436-65-600 et seq., we find that claimant would most appropriately be compensated for her permanent loss of earning capacity due to the compensable injuries by an award of 25% unscheduled permanent partial diability in lieu of all prior unscheduled awards. The Referee's order is modified accordingly. The Board agrees with the Referee's order insofar as it deals with claimant's scheduled disability and that portion of the order is affirmed.

ORDER

The Referee's order of August 24, 1984 is affirmed in part and modified in part. Claimant is awarded 80° for 25% unscheduled permanent partial diasbility in lieu of all prior unscheduled awards. Claimant's scheduled awards are left unchanged. That portion of the Referee's order awarding temporary total disability benefits from October 23, 1980 through April 15, 1981 is modified to award benefits only through December 16, 1980, and the offset authorization is adjusted accordingly; however, offset is not authorized for any compensation or attorney fees out of compensation paid pending Board review. Claimant's attorney's fees are also modified accordingly.

KATHY D. OWENS, Claimant
WCB 84-04111
June 28, 1985
Pridgeon & Stimac, Claimant's Attorneys
Cummins, et al., Defense Attorneys
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee McCullough's order which upheld the self-insured employer's denial of her injury claim. The issue on review is whether claimant sustained an injury arising out of and in the course of her employment. A threshold issue is presented by claimant's allegation that, after the hearing, and apparently after issuance of the Referee's order, new evidence was discovered in the form of a witness who allegedly observed claimant's injury occur. Thus, claimant requests that we remand this case to the Referee for further evidence taking on the basis of this "newly discovered evidence."

We have authority to remand the case if we determine that it has been improperly, incompletely or otherwise insufficiently developed or heard, and that remand is otherwise appropriate. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 44 (1983); Delfina P. Lopez, 37 Van Natta 164, 170 (1985). This recently discovered witness to claimant's alleged injury is clearly "newly discovered evidence," as opposed to some other form of new evidence not previously available or obtainable. Thus, the applicable standard for determining whether remand is appropriate is that enunciated in Robert A. Barnett, 31 Van Natta 172, 173 (1981), aff'd mem. 59 Or App 133 (1982): "To merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing." Delfina P. Lopez, supra, 37 Van Natta at 170.

The only explanation for claimant's failure to produce this witness, or even mention the existence of this witness, prior to or at the hearing, is the statement in claimant's request for review that she was "unable to locate this witness prior to the time of hearing." No other explanation is made, either in claimant's appellant's brief or by way of affidavit, of the nature or extent of the "due diligence" exercised by claimant to ascertain the existence or whereabouts of this witness. Therefore, we find remand is not an appropriate disposition, and claimant's request is denied. See also Ralph W. Compton, 36 Van Natta 1707 (1984); Ora M. Conley, 34 Van Natta 1698 (1982), aff'd mem. 65 Or App 229 (1983).

On the merits of the compensability issue, we agree with the Referee's analysis and conclusion that claimant has failed to establish it is more likely than not that she sustained an injury arising out of and in the course of her employment. Therefore, we affirm and adopt the Referee's order.

ORDER

The Referee's order dated September 18, 1984 is affirmed.

MARTIN J. RIDGE, Claimant
David Force, Claimant's Attorney
Coons, et al., Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-04476
June 28, 1985
Order on Reconsideration

The Board issued its Order on Review herein on June 11, 1985 reversing that portion of the Referee's order which awarded interim compensation from April 27, 1983 through June 16, 1983. 37 Van Natta 691 (1985). Claimant requests reconsideration.

The Order on Review states:

> "Since the evidence fails to establish that claimant sustained his finger injury during his authorized training program, it follows that the record fails to establish claimant 'left work,' or in this particular instance, left his authorized training program, as that phrase is used in ORS 656.210(3). Therefore, claimant has failed to establish his entitlement to interim compensation."

This language was ill-advised and requires clarification.

Interim compensation must be paid whether or not the underlying claim is compensable. Jones v. Emanuel Hospital, 280 Or 147 (1977); see also Bono v. SAIF, 298 Or 405, 408 (1984). It is payable within 14 days of notice or knowledge of the claim. ORS 656.262(4); Jones v. Emanuel Hospital, supra, 280 Or at 151. The employer/insurer is not obligated to pay interim compensation, however, to a claimant who proves not to be a subject worker. Bell v. Hartman, 289 Or 447 (1980). The mere filing of a claim by a subject worker does not trigger the duty to pay interim compensation unless the worker has "left work" as that phrase is used in ORS 656.210(3), or has otherwise suffered some diminished earning capacity. Bono v. SAIF, supra, 298 Or at 410. "Any claim for a disabling compensable injury will trigger the ORS 656.262(4) payments." Id. (Emphasis supplied.) Thus, where a claimant suffers no temporary disability and incurs medical expenses only, there is no obligation to pay interim compensation. If interim compensation is due, however, and the employer/insurer fails to comply with its obligation to make such payments within 14 days of notice/knowledge in the absence of a denial, penalties and attorney fees may be imposed if the failure to pay is unreasonable.

In this case, claimant allegedly sustained this injury to his finger sometime in mid January of 1983 while he was enrolled and actively participating in an authorized training program. During his enrollment, he received temporary total disability benefits. By letter dated March 9, 1983 claimant was informed by the Field Services Division that his authorized training program was terminated effective January 28, 1983, for his failure to attend classes. He continued to be paid temporary total disability through March 17, 1983. He first sought medical attention for his cut finger on April 21, 1983. The physician's chart note reflects that claimant informed the doctor he had dropped an object on his finger while working "in the machine shop" four weeks previously. The doctor diagnosed a lacerated extensor tendon and resultant mallot finger. He indicated that claimant would be scheduled to have the tendon reattached and that, "This should be done before too long."

The Referee found that claimant had "limited credibility" based upon the conflict between claimant's testimony that he was regularly attending his machine technology class during the time he sustained the injury in question, and the college transcript reflecting that he received no credit for any courses during that term. (Claimant had also testified that he was "sure" that his grades for that term had placed him on the "honor roll.")

The physician's chart note of April 21, 1983 constituted the claim for this finger injury and was received by SAIF April 27, 1983. As of that date, claimant's authorized training program had been officially terminated for almost seven weeks, with an effective date of January 28, 1983, for failure to attend classes since January 28, 1983. This physician's chart note/claim states a history of an injury four weeks previously, which was after claimant's training program had been terminated and long after he had stopped attending classes. There is no indication on the face of the claim whether this cut finger had any disabling effects. The suggestion is that, although the injured finger interfered with some use or function of the hand, it in no way prevented use of the hand. SAIF denied the claim on June 16, 1983, i.e. within 60 days of notice or knowlege; however, no interim compensation payments were made prior to the denial.

We adhere to the conclusion stated in our Order on Review that claimant has failed to establish his entitlement to interim compensation. Our prior order suggests that we reached this conclusion because claimant failed to establish that he sustained this injury during his authorized training program. Such a rationale would be inconsistent with Jones v. Emanuel Hospital, supra, which establishes that interim compensation is due and payable regardless of the compensability of the underlying claim. What we meant to state, but failed to, is that the record fails to establish that, as a result of this injury, claimant sustained "time loss," an inability to work, or a diminution of his earning power. It appears that the most that was required as a result of claimant's cut finger at any time prior to SAIF's denial was medical treatment. Thus, no interim compensation was, or is, due claimant.

ORDER

On reconsideration of the Board's Order on Review dated June 11, 1985, the Board modifies and supplements that order as provided herein. Except as modified and supplemented, the Board adheres to its prior order, which hereby is republished effective this date.

LAURENCE E. SAXTON, Claimant
Evohl Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-10671
June 28, 1985
Order on Reconsideration

The Board issued its Order on Review herein on June 11, 1985, reversing those portions of the Referee's order which set aside as premature a Determination Order dated August 29, 1983 and awarded claimant an additional award of unscheduled disability for injury to the low back. The Board affirmed that portion of the Referee's order which imposed a penalty and associated attorney's fee for the SAIF Corporation's failure to pay interim compensation in connection with an aggravation claim. Claimant requests

reconsideration of our order insofar as it fails to award an insurer-paid attorney's fee on Board review for prevailing on the issue of penalties/attorney fees. In support of his request, claimant cites the Court of Appeals' recent decision in Shoulders v. SAIF, 73 Or App 811 (1985).

Neither ORS 656.382(2), 656.386(1) nor Shoulders v. SAIF, supra authorize an award of attorney fees in this proceeding. SAIF raised three issues: two "compensation" issues and one penalty/attorney fee issue. Claimant, as respondent, prevailed only on the penalty/attorney fee issue and lost on the "compensation" issues. Under these circumstances, claimant is not entitled to a fee for services on Board review. Van DerZanden v. SAIF, 60 Or App 316, 321 (1982); Korter v. EBI Companies, Inc., 46 Or App 43, 54 (1980); Dewey R. Begley, 36 Van Natta 1078, 1079 (1984).

ORDER

On reconsideration of the Board's Order on Review dated June 11, 1985, the Board adheres to its prior order, which hereby is republished effective this date.

DONALD A. TEEM, Claimant
Evohl F. Malagon, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 84-06660
June 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Daron's order which found that temporary disability compensation would not commence until claimant entered the hospital for back surgery. On review, claimant contends he is entitled to temporary disability from the date his compensable condition worsened.

Claimant was 50 years of age at the time of hearing. In September 1977, while working as a choker setter, he was struck by a falling tree, sustaining injuries to his head, neck, upper back and lower back. Since his compensable injury claimant has undergone neck and rib resection surgery and his claim has been reopened on numerous occasions for further medical treatment and vocational rehabilitation. His claim was initially closed by a March 22, 1979 Determination Order which awarded him 35% (112°) unscheduled permanent disability. As of February 20, 1981, the last arrangement of compensation, claimant had received a total of 100% (320°) unscheduled permanent disability.

In November 1982 claimant came under the care of Dr. Dunn. Following several examinations and diagnostic procedures, Dr. Dunn subsequently recommended that claimant undergo lumbar and cervical surgery. In April 1983 Dr. Dunn referred claimant to Dr. Luce for a second opinion. Although no report from Dr. Luce appears in the record, Dr. Dunn's June 1983 chart note indicates that Dr. Luce did not agree with the proposed surgery. In October 1983 claimant participated in an inpatient pain treatment program, which also involved psychological consultation and therapy. At the time of claimant's discharge from the program, Dr. O'Connell, psychologist, opined that claimant's prognosis remained guarded.

Dr. Dunn referred claimant to Dr. Smith, neurosurgeon, who examined claimant on February 23, 1984. On February 29, 1984 Dr. Smith opined that claimant had both a cervical and lumbar lesion which were symptomatic and the cause of his continuing complaints. Dr. Smith stated that there was "little question that he has cervical spondylosis at C6-7 and this is probably significant and may, because of the fusion of the two above levels, have advanced significantly over the past 2-3 years." In addition, claimant's 1978 and 1983 studies "strongly" suggested a significant lesion of lumbar stenosis at the L4-5 level. Dr. Smith concluded that there was ample evidence in claimant's history and studies to justify surgical exploration and decompression of the low back. Dr. Smith recommended a repeat CT scan of the lumbar area and a complete myelogram.

In March 1984 claimant's attorney requested that SAIF commence temporary disability payments retroactive to February 29, 1984, the date of Dr. Smith's report. Claimant's attorney also requested SAIF's approval for surgery.

Claimant was hospitalized from March 11 to March 13, 1984, at which time the myelogram and CT scan were performed. The final diagnosis was cervical spondylosis with nerve root compression and lumbar spondylosis with lateral recess and foraminal stenosis. On April 12, 1984 Dr. Smith requested authorization to proceed with surgery.

On May 8, 1984 Dr. Hardiman, orthopedist, performed an independent medical examination. Although Dr. Hardiman noted abnormal x-ray findings in both claimant's neck and low back, the doctor concluded there were no good objective physical findings to support a surgical approach. Dr. Hardiman predicted that claimant would not return to work, even if surgery was performed.

On May 10, 1984 SAIF paid temporary disability retroactive to April 12, 1984. Claimant received temporary disability until June 22, 1984, the date SAIF denied his request for surgery. Claimant did not receive temporary disability compensation for the period between February 23, 1984 and April 12, 1984.

Dr. Smith disagreed with Dr. Hardiman's opinion. Dr. Smith concluded that any chance of claimant's returning to work was dependent on the satisfactory resolution of his complaints. Dr. Smith recommended that claimant be referred to Dr. Cruickshank, neurosurgeon. Stating that the only positive physical findings of an objective nature were mild limitation of motion in the cervical and lumbosacral area, Dr. Cruickshank did not recommend surgery. The doctor further opined that claimant's condition remained essentially medically stationary and only palliative treatment was necessary.

In October 1984 claimant was examined by Dr. Poulson. Dr. Poulson concluded that claimant had a "full blown pain syndrome" which required "Pain Clinic" treatment. In Dr. Poulson's opinion anything done mechanically or surgically would be without good results.

The Referee concluded that claimant's condition had worsened since February 1981, the last arrangement of compensation. This worsening had led to further diagnostic procedures for his neck

and low back complaints, which had culminated in Dr. Dunn's and Dr. Smith's recommendations for surgery. However, inasmuch as no physician had verified claimant's inability to work, the Referee concluded that claimant was not entitled to temporary disability until he entered the hospital for surgery.

We agree with claimant's contention that he should receive temporary disability as of February 23, 1984, the date of Dr. Smith's initial examination. Consequently, we modify the Referee's order.

In reaching our conclusion we find guidance from the Court of Appeals' decision in Clark v. SAIF, 70 Or App 150 (1984). In Clark, the claimant's treating physician issued a report stating that the claimant's condition had continued to worsen and that surgery was recommended. The Board found that the claimant had failed to prove an aggravation claim, concluding that the claimant's condition remained medically stationary and that the claim need not be reopened until the surgery was performed. The Court of Appeals reversed, stating that the issue was not whether the claimant should or would undergo surgery, but that the issue was had the claimant's compensable condition worsened since the last arrangement of compensation. The Clark court reasoned that although the treating physician appeared to subsequently retract his surgery recommendation, the physician never changed his opinion that claimant had worsened as of the date of the physician's initial report.

Dr. Smith does not expressly state that claimant's condition had worsened. However, the general thrust of his initial report certainly advances that conclusion. Dr. Smith's original impressions that claimant's cervical spondylosis may have significantly advanced in the preceding two to three years and that claimant's history and studies amply demonstrated the need for low back surgery were subsequently borne out by further examinations and procedures. At least these impressions were apparently verified to SAIF's satisfaction since it does not question the Referee's conclusions that claimant's condition had worsened and that claimant was entitled to the proposed surgery. Just as the physician in Clark, Dr. Smith never retreated from his initial opinion. The fact that he proposed further diagnostic procedures and consultations does not detract from his consistent diagnosis that claimant's back condition had significantly advanced and that surgery was an appropriate, as well as a potentially curative, treatment.

Although we have reservations concerning whether claimant's condition had worsened, SAIF does not contest that portion of the Referee's order. Therefore, the issue becomes claimant's entitlement to temporary disability compensation. We interpret Clark to be controlling. Consequently, the claim should be reopened effective February 23, 1984, the date of Dr. Smith's initial examination.

The Referee awarded claimant's attorney a $1,500 fee for "prevailing on a rejected claim." We conclude that this award adequately compensates claimant's attorney for his "efforts expended" and "results obtained" at the hearing level. OAR 438-47-010; 438-47-020. This award applies not only to the services rendered concerning the claim's "conditional reopening," but for the services rendered regarding the determination of the

actual date for claim reopening. We consider claimant as having "finally prevailed" at this level on the claim reopening aspect of this case. Therefore, he is entitled to an insurer-paid fee for services at the hearing and Board levels. ORS 656.386(1). Because we consider the Referee's award of fees adequate remuneration for services rendered at hearing, we will award only an additional fee for services on review.

ORDER

The Referee's order dated December 10, 1984 is modified in part. The claim is remanded to SAIF Corporation for acceptance, effective February 23, 1984, until closure pursuant to ORS 656.268. SAIF is granted an offset for temporary disability compensation previously paid between April 12, 1984 and June 22, 1984. 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.

LEO UPDIKE, Claimant
Welch, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 83-08825 & 83-08826
June 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Daron's order that granted claimant an award of permanent total disability. The issue is extent of disability.

Claimant was 58 years of age at the time of the hearing and had been employed as a timber faller and bucker for approximately 30 years. Claimant made a claim for back pain by submitting Form 801 to his employer on or about July 16, 1982. The Form 801 does not include any narrative description of a specific incident as bringing about the pain. Dr. Bornstein, claimant's initial treating chiropractor, diagnosed a moderate lumbosacral strain, indicating on Form 827 that claimant had injured his back while bucking and limbing trees.

Claimant began treating with Dr. Norwyn R. Newby, neurosurgeon, on August 12, 1982. After his examination of claimant, Dr. Newby diagnosed lumbar spondylosis and right foraminal stenosis at L5-S1. He prescribed 10 days absolute bedrest and antispasmodic medications. At the end of August 1982 Dr. Newby released claimant to return to his regular work. However, claimant was again taken off work after ten days. SAIF accepted the claim on September 14, 1982.

In addition to Dr. Newby, claimant has been examined by Dr. Sulkosky, an orthopedic surgeon, a panel of the Orthopaedic Consultants, Dr. Raaf, a neurosurgeon, and Dr. Medved, the medical examiner at the William A. Callahan Center. The medical consensus is that claimant suffers from degenerative arthritis of his entire spinal column, degenerative disc disease, a chronic lumbar strain and a dorsal wedging roundback deformity developed during adolescence. The consensus also is that the work-related contribution to claimant's condition has resulted in a mildly moderate impairment. No physician has recommended that surgery would improve claimant's condition, and the Orthopaedic Consultants specifically opined that surgery was contraindicated.

Claimant has received two Determination Orders. On

February 9, 1983 claimant was awarded 112° for 35% of the maximum allowable unscheduled permanent partial disability for his back condition. On January 12, 1984 a second Determination Order closed an aggravation claim with no additional permanent partial disability award. The second order no doubt relied upon Dr. Newby's December 12, 1983 report in which he opined that claimant was medically stationary and had suffered no additional impairment beyond that compensated by the 35% award.

No physician who has treated or examined claimant has suggested that he is incapacitated from working due solely to his physical condition. Indeed claimant's treating physician evidently believed that claimant was no more disabled in December 1983 than he was in February 1983 when he received a 35% disability award.

The Referee found claimant to be permanently and totally disabled based upon the combination of his physical condition and the relevant social and vocational factors that comprise the so-called "odd-lot doctrine." See, e.g., Wilson v. Weyerhaeuser, 30 Or App 403 (1977). The Referee's decision appears to flow from the following statement in his order:

> "This is one of those cases where it appears to me that the combination of problems from his pre-existing physical conditions, his lack of education and aptitudes and his very limited vocational experience puts him into that category where it is incumbent upon the employer to positively come forward to show a specific job or jobs at which claimant can and will be employed, the rule of evidence referred at times as the odd-lot doctrine, if permanent total disability is to be avoided. Employer has failed to do that in this instance." (Emphasis supplied.)

This statement is clearly contrary to ORS 656.206(3), which states:

> "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."

Applying the correct statement of the burden of proof, it is not "incumbent upon the employer to positively come forward to show" anything. The Referee impermissibly shifted the burden of proof, and his finding of permanent total disability cannot stand for that reason.

We note that on Board review claimant has specifically stated that he does not rely upon the Referee's statement of the burden of proof. Claimant urges that under the correct standard, he is nonetheless permanently and totally disabled. SAIF concedes that claimant is more seriously disabled than a 35% award would indicate, but that he is not permanently and totally disabled. On de novo review, we agree with SAIF that claimant did not carry his burden of proof under the correct statement of that burden.

In all cases involving issues of permanent total disability or unscheduled permanent partial disability, the fact finder must consider the combined effects of physical disability and relevant social and vocational factors. The result reached depends upon whether the combination of factors "permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation . . ." (ORS 656.206(1)(a) - permanent total disability) or merely interferes with the worker's "ability to obtain and hold gainful employment in the broad field of general occupations . . ." (ORS 656.214(5) - permanent partial disability).

There is evidence in the record that claimant has made 78 job contacts between January 10, 1984 and August 14, 1984. Claimant points to this admittedly laudable effort as support for his assertion that he has met the "job search" requirement of ORS 656.206(3). We find this assertion premature. In order to activate the requirement that claimant show reasonable efforts to obtain employment, claimant must cross the threshold of proof that the combination of physical and social/vocational factors permanently incapacitates him from performing work. We find that it does not, although we agree that the combination does seriously affect claimant's earning capacity.

The Orthopaedic Consultants and Dr. Raaf both rated claimant's impairment as mildly moderate. Claimant was 58 years old at the time of the hearing. He has a ninth grade education with no GED. He is now limited to light to sedentary work activity, where he formerly regularly performed heavy work. His work experience has been limited to timber falling and bucking and like activities in the woods. We find that less than ten percent of the labor market is, in all probability, open to claimant. Combining all of these factors in light of the guidelines of OAR 436-65-600 et seq., we find that claimant would be most appropriately compensated by an award of 224° for 70% of the total allowable compensation for unscheduled permanent partial disability for injury to his low back, in lieu of all other awards for permanent partial disability.

ORDER

The Referee's order dated September 24, 1984 is modified to award claimant 224° for 70% unscheduled permanent partial disability for injury to his low back, in lieu of and not in addition to all other awards for permanent partial disability. Claimant's attorney's fee award shall be adjusted accordingly.

DONALD M. VAN DINTER, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Schwenn, et al., Defense Attorneys
Meyers & Terrall, Defense Attorneys
Lindsay, et al., Defense Attorneys

WCB 81-05303, 82-06302, 82-07084, 82-09038, 83-02631, 83-06962, 83-06963 & 83-06964
June 28, 1985
Order of Abatement

The Board has received Fireman's Fund Insurance Company's Motion for Reconsideration of our Order on Review dated May 31, 1985.

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.

W. CRAIG WALKER, Claimant
Carney, Buckley & Kasameyer, Claimant's Attorneys
Horne & Meserow, Defense Attorneys
Tooze, Kerr, et al., Defense Attorneys

WCB 84-00767 & 84-03849
June 28, 1985
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The Hartford requests review of Referee Pferdner's order that set aside its denial of claimant's medical services claim for low back surgery. The issue is responsibility for the low back surgery as between The Hartford and Wausau Insurance Companies. The Hartford also objects to a $1,450 attorney fee awarded to claimant's attorney, and to the Referee's order requiring it to pay for a physician's deposition.

The Board affirms and adopts the order of the Referee. We have found claimant's participation on Board review to be active and meaningful and, therefore, award a carrier-paid attorney fee. See Robert Heilman, 34 Van Natta 1487 (1982). In awarding this fee we take note that claimant's attorney is not entitled to a fee for that portion of his effort expended toward defending the attorney fee awarded by the Referee, because there is no statutory or other basis for such a fee award. See Harold L. Dotson, 37 Van Natta 759 (June 27, 1985).

ORDER

The Referee's orders dated December 17, 1984, December 19, 1984 and December 31, 1984 are affirmed. Claimant's attorney is awarded $400 for services on Board review, to be paid by The Hartford.

MICHAEL R. HARMAN, Claimant
Hayner, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

WCB 82-02979 & 82-03232
May 1, 1985
Order of Abatement

The SAIF Corporation has requested that we reconsider our Order on Remand entered April 3, 1985 to the extent that the order fails to allow SAIF to recover as an overpayment permanent partial disability benefits paid after the date claimant was declared permanently and totally disabled. In order to allow sufficient time for claimant to respond to SAIF's motion, our previous Order on Remand is hereby abated. Claimant's response should be received within ten days from the date of this order.

IT IS SO ORDERED.

RAYMOND C. NORGAARD, Claimant
Pozzi, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 83-09014
April 12, 1985
Order of Abatement

The self-insured employer has moved the Board for an order abating our Order on Review issued March 18, 1985 in order that issues related to this claim may be decided by the Hearings Division at a hearing presently scheduled for April 16, 1985. In the interest of avoiding piecemeal litigation, the motion is granted.

Now, therefore, the Order on Review entered herein on March 18, 1985 is hereby abated pending completion of the hearing in Case No. 84-10649 and entry of the Referee's Opinion and Order in said case.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ROBERTS,
Plaintiff,
v.
GRAY'S CRANE & RIGGING, INC. et al,
Defendants and Third-Party Plaintiffs/Appellants,
v.
EMERICK CONSTRUCTION CO. et al,
Third-Party Defendants and Fourth-Party Plaintiff,
v.
DISDERO STRUCTURAL INCORPORATED,
Fourth-Party Defendant/Respondent.

(A8206 03882; CA A31447)

Appeal from Circuit Court, Multnomah County.

Charles S. Crookham, Judge.

Argued and submitted December 7, 1984.

J. Randolph Pickett, Portland, argued the cause for Defendants and Third-Party Plaintiffs/Appellants Gray's Crane & Rigging, Inc., and Earl Goll. With him on the briefs were Sandra Hansberger and Don G. Swink, Portland.

Jas. Jeffrey Adams, Portland, argued the cause for Fourth-Party Defendant/Respondent Disdero Structural Incorporated. With him on the brief was Mitchell, Lang & Smith.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

This is a wrongful death action involving the exclusive liability provision of the Workers' Compensation Act. ORS 656.018. The issue is whether that statute voids the indemnity agreements entered into between the parties to this appeal. Defendants/third party plaintiffs appeal a judgment entered on an order dismissing their amended third party complaint, which sought enforcement of the indemnity agreements against fourth party defendant, a subject employer under the Workers' Compensation Act.[1] We hold that the agreements are void under ORS 656.018 and, therefore, we affirm.

For the sake of clarity, defendants/third party plaintiffs will be referred to as "Gray's Crane" and fourth party defendant will be referred to as "Disdero." The Emerick/

[1] The judgment on Gray's Crane's third party claim contains the findings and recitations required by ORCP 67B that make it a final appealable judgment.

Mattson Construction Co., a general contractor, "Emerick," subcontracted with Disdero to construct a new roof on Civic Stadium in Portland. Disdero is a subject employer under the Workers' Compensation Act. It leased a crane and crane operators from Gray's Crane. The lease agreements executed in January and February, 1982, provided that Disdero would indemnify Gray's Crane for all claims for death or injury to persons, including Disdero's employes, arising in any manner out of Disdero's use of the crane.

One of Disdero's employes was killed when the crane hit a beam, which struck another beam, which fell on the employe. Plaintiff, the personal representative of the employe's estate, brought this wrongful death action against Gray's Crane for negligence in operating the crane. Gray's Crane filed a third party complaint against Emerick, seeking contribution. Emerick then filed a fourth party complaint against Disdero for indemnity or contribution. Gray's Crane moved to amend its third party complaint to include a claim against Disdero based on the indemnity provisions of the lease agreements. Disdero opposed the motion on the ground that the indemnity agreements were void under ORS 656.018, which provides generally that an employer's duty to provide workers' compensation coverage shall be its exclusive liability

for injuries to its workers and that all agreements to the contrary are void. The trial court allowed Gray's Crane's motion to amend its third party complaint and then, treating Disdero's motion as a motion to dismiss under ORCP 21A, dismissed that third party complaint.

Gray's Crane appeals that dismissal. It argues that ORS 656.018 does not apply to express indemnity agreements. It further argues that, if the statute does apply, it unreasonably interferes with the freedom to contract protected by Article I, section 20, of the Oregon Constitution and the Fourteenth Amendment to the United States Constitution and denies Gray's Crane a remedy in violation of Article I, section 10, of the state constitution.[2] We hold that the indemnity agreements are void under ORS 656.018(1)(c), that the statute suffers from none of the alleged constitutional infirmities and, therefore, that the trial court correctly dismissed the complaint.

Under the Workers' Compensation Act, a subject employer's duty to maintain coverage for its subject workers, ORS 656.017(1), is its exclusive liability for injuries to those workers. ORS 656.018. Before amendment in 1977, ORS 656.018(1) provided:

> "Every employer who satisfies the duty required by subsection (1) of ORS 656.017 is relieved of all other liability for compensable injuries to his subject workmen, the workmen's beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries, except as specifically provided otherwise in ORS 656.001 to 656.794."

[2] Gray's Crane also argues that the statute violates the equal protection provisions of the state and federal constitutions. We decline to address that challenge, because it was not raised in the trial court. *Kane v. Tri-Co. Metro. Transp. Dist.* 65 Or App 55, 58 n 3, 670 P2d 178 (1983), *rev den* 296 Or 411 (1984).

In *U.S. Fidelity v. Kaiser Gypsum*, 273 Or 162, 539 P2d 1065 (1975), the Supreme Court held that the statute did not bar an action for common law indemnity by a third party against an employer, when the third party's liability to an injured worker had resulted from a breach of an express or implied independent duty owed by the employer to the third party. On the same day that *Kaiser Gypsum* was decided, the Supreme Court held that the statute did not bar an indemnity

action by a third party against an employer under an express contract of indemnity. *Gordon H. Ball v. Oregon Erect. Co.*, 273 Or 179, 539 P2d 1059 (1975). The court noted that "[t]here is no indication that the legislature in enacting ORS 656.018(1) intended to preclude an employer from *voluntarily* contracting with a third party to indemnify it for damages paid to an injured employee." 273 Or at 185. (Emphasis in original.)

In 1977, ORS 656.018 was amended. Or Laws 1977, ch 804, § 3a. The statute now provides:

> "(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to 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.
>
> "(b) This subsection shall not apply to claims for indemnity or contribution asserted by a corporation, individual or association of individuals which is subject to regulation pursuant to ORS chapter 757 or 760.
>
> "(c) *Except as provided in paragraph (b) of this subsection, all agreements or warranties contrary to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void.*" (Emphasis supplied.)

The statute was amended to overturn the holding of *U.S. Fidelity v. Kaiser Gypsum, supra. Boldman v. Mt. Hood Chemical Corporation,* 288 Or 121, 124, n 1, 602 P2d 1072 (1979). The legislative history of the amendment indicates that it was equally intended to abrogate the holding of *Gordon H. Ball v. Oregon Erect. Co., supra.*

Contrary to Gray's Crane's contention that "there is nothing on the face of the language of ORS 656.018(1)(a) which bars *express* indemnity agreements," the statute clearly bars such agreements. The best evidence of the purpose of a statute is its language. *Whipple v. Howser,* 291 Or 475, 479-80, 632 P2d 782 (1981). Subsection (1)(a) provides that the employer's duty to provide workers' compensation coverage shall be its exclusive liability for injuries to its workers and specifically protects the employer from third party claims for

contribution or indemnity. Subsection (1)(c) provides that *all* agreements or warranties to the contrary entered into after July 19, 1977, are void. Under the plain, unambiguous language of the statute, the indemnity agreements in this case, executed in 1982, are void. In the light of the 1977 amendments to the statute, Gray's Crane's reliance on *Kaiser Gypsum* and *Gordon H. Ball* is misplaced.

Gray's Crane argues that, if the statute renders void the indemnity agreements, it unreasonably interferes with the right to contract guaranteed by Article I, section 20, of the Oregon Constitution:

> "No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens.—"

In support of its argument, Gray's Crane cites cases which state that the right to contract is both a property right and a liberty protected by Article I, section 20, with which the legislature cannot unreasonably interfere: *General Electric Co. v. Wahle,* 207 Or 302, 319, 296 P2d 635 (1956); *Crouch v. Central Labor Council,* 134 Or 612, 618, 293 P 729 (1930); *George et al. v. City of Portland et al.,* 114 Or 418, 424, 235 P 681 (1925). In *George,* the court stated that the freedom to contract is not an absolute, but a qualified right, and is therefore subject to reasonable restraint in the interest of the public. In *General Electric Co.* 207 Or at 326, the court stated that the Oregon Fair Trade Act, as it applied to nonsigners of contracts executed pursuant to it, constituted "an unnecessary and unreasonable interference with an individual's constitutional right of contract and of property in violation of Art I, § 20, of the Oregon Constitution, and of the due process clause of the federal constitution." The court discussed the state's power to impinge upon the right to contract:

> "The enactment of the Fair Trade Act can be justified only upon the theory that it constitutes a reasonable and proper exercise of the inherent police power residing in the state. The police power is broad and far-reaching, and it is difficult, if not impossible, definitely to fix its bounds. Yet an exercise of the police power can never be justified unless it is reasonably necessary in the interests of the public order, health, safety, and welfare. The legislature is not the final judge of the limitations of the police power, and, because the legislative action must be reasonably necessary for the public benefit, the

> validity of all police regulations depends upon whether they can ultimately pass the judicial test of reasonableness." 207 Or at 320. (Citation omitted.)

Gray's Crane argues that under these cases ORS 656.018 is unconstitutional, because it is not reasonably necessary for the public benefit.

The continuing vitality of the analysis used in those cases is questionable. At one time a supposed right to contract was protected by the Due Process Clause of the Fourteenth Amendment, which provides that no state shall deprive any person of life, liberty, or property without due process of law. The U.S. Supreme Court has since abandoned that analysis. *See Williamson v. Lee Optical Co.,* 348 US 483, 75 S Ct 461, 99 L Ed 563 (1955); *Nebbia v. New York,* 291 US 502, 54 S Ct 505, 78 L Ed 940 (1934). The cases cited by Gray's Crane treat Article I, section 20, as a due process provision and therefore hold that it, like the Due Process Clause of the Fourteenth Amendment, protects the right to contract from unreasonable interference by the state. However, Article I, section 20, is not a due process provision: it does not mention "life," "liberty," "property" or "due process of law." *See* Linde, *Without "Due*

Process" Unconstitutional Law in Oregon, 49 Or L Rev 125, 140-43 (1970). In fact, as both the Supreme Court and this court have recently stressed, this state's constitution has no due process clause. *State v. Clark,* 291 Or 231, 235, n 4, 630 P2d 810, *cert den* 454 US 1084 (1981); *State v. Stroup,* 290 Or 185, 200, 620 P2d 1359 (1980); *State v. Lyon,* 65 Or App 790, 795, 672 P2d 1358 (1983). Therefore, it is doubtful that the Oregon Supreme Court today would interpret Article I, section 20, as it was interpreted in the cases cited by Gray's Crane.

Those cases, however, have not been expressly overruled. Assuming that the analysis of those cases remains valid, we hold that ORS 656.018 is not unconstitutional under Article I, section 20, because it is reasonably necessary to maintain the balance in the Workers' Compensation Act. The legislative history of the 1977 amendments to ORS 656.018 reveals that the legislature amended the statute to restore the exclusive liability protection former ORS 656.018(1) was understood to afford the employer before to *U.S. Fidelity v. Kaiser Gypsum, supra,* and *Gordon H. Ball v. Oregon Erect. Co,*

supra. The legislature was concerned that third party indemnity claims against employers would circumvent and undermine the exclusive liability provision. Obviously, if employers were liable for such claims, workers' compensation would no longer be their exclusive liability. The legislature also expressed concern about the costs and prolonged litigation threatened by such claims.

The identical problem arose in the context of the Longshoremen's and Harbor Workers' Compensation Act and was resolved in 1972 when Congress amended the act to prohibit express contractual indemnity. 33 USC § 905(b). That problem was discussed in *Hurst v. Triad Shipping Co.,* 554 F2d 1237, 1243 (3rd Cir), *cert den* 434 US 861 (1977):

> "With [*Ryan Co. v. Pan-Atlantic Corp.*, 350 US 124, 76 S Ct 232, 100 L Ed 133 (1956), upholding indemnity actions by the third party-shipowner against the employer-stevedore], the shipowners' burdens were eased, but the purpose of the Longshoremen's Act was entirely thwarted. Under the Act, the stevedore's duty to pay compensation to injured longshoremen regardless of fault was supposed to be 'exclusive and in place of all liability of such employer to the employee.' *Ryan* permitted the circumvention of this exclusivity provision by allowing third parties to seek indemnification from the stevedore. Hence, the balance established by the 1927 Act was disrupted. Stevedores faced not only the certainty of administrative workmen's compensation payments, but also the prospect of indemnifying shipowners for damages awarded longshoremen in third-party suits.
>
> "Because of this double liability, stevedores' insurance rates ran as high as forty dollars per one hundred dollars of payroll. Despite the high premiums, compensation rates under the Act remained quite low; a great percentage of each premium dollar went toward expenses of litigation. The administrative scheme envisioned by the draftsmen of the 1927 Act had been rendered grossly inefficient, and the maritime industry suffered concomitantly. Moreover, the skyrocketing numbers of *Sieracki-Ryan* cases burdened the federal courts.

"The 1972 amendments to the Longshoremen's Act were designed to correct these problems. Under amended section 905(b), the roundabout evasion of the Act's exclusivity provision was ended." (Footnotes omitted.)

Given the compelling reasons for the legislature's amendment of ORS 656.018, we hold that the statute does not unreasonably interfere with any freedom to contract, which may exist under the state constitution.

Next, Gray's Crane contends that the statute denies it a remedy in violation of Article I, section 10, of the Oregon Constitution, which provides in relevant part:

"[E]very man shall have remedy by due course of law for injury done him in his person, property, or reputation.—*[sic]*"

Prospectively declaring void certain types of agreements is not a deprivation of a remedy within the meaning of that section. The statute abrogates the right to enter into certain agreements; it does not deprive any person of a remedy. It is a legislative regulation of contracts, which, as we have stated above, is valid. Therefore, the statute does not violate Article I, section 10.

Finally, Gray's Crane challenges the statute as being an unreasonable interference with the right to contract protected by the Fourteenth Amendment to the federal constitution. Because we have found that the legislation is a reasonable means to restore the integrity of the exclusive liability provision, that challenge must fail, assuming that it is appropriate at all. *Williamson v. Lee Optical Co., supra; Day-Brite Lighting, Inc. v. Missouri,* 342 US 421, 72 S Ct 405, 96 L Ed 469 (1952); *West Coast Hotel Co. v. Parrish,* 300 US 379, 57 S Ct 578, 81 L Ed 703 (1937); *Nebbia v. New York, supra.*

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Roy M. Hoke, Claimant.

HOKE,
Petitioner,

v.

LIBBY, McNEIL & LIBBY,
Respondent.

(82-09021; CA A30609)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 17, 1984.

J. Michael Alexander, Salem, argued the cause for petitioner. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.

Deborah Sather MacMillan, Portland, argued the cause for respondent. With her on the brief was Moscato & Byerly, Portland.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Order modified to reinstate award of $1,000 attorney fee and penalty at referee hearing level; affirmed as modified.

RICHARDSON, P. J.

Claimant petitions for review of an order of the Workers' Compensation Board upholding the denial of his aggravation claim. We modify the order to clarify the issues of attorney fees and penalties and otherwise affirm.

To establish an aggravation claim, a claimant must prove by a preponderance of the evidence a worsening of his condition since the last award or arrangement of compensation and a causal relation between that worsening and his compensable injury. ORS 656.273(1); *Brewer v. SAIF,* 59 Or App 87, 89-90, 650 P2d 947 (1982). Claimant has not sustained his burden of proving that his compensable low back injury has worsened since the last determination order was issued on April 4, 1982. The objective medical evidence shows no such worsening. Claimant was hospitalized in the summer and December, 1982, for flare-ups of pain. Objective medical evidence is not necessarily required to establish an aggravation claim, *Garbutt v. SAIF,* 297 Or 148, 151-52, 681 P2d 1149 (1984), and the worker's subjective complaints may or may not sustain his burden of proof. *Garbutt v. SAIF, supra.* However, in the light of the objective medical evidence which indicates that there has been no worsening, claimant's subjective complaints of increased pain are not sufficient to carry his burden in this case. *Jacobson v. SAIF,* 36 Or App 789, 585 P2d 1146, *rev den* 284 Or 521 (1978).

There is some confusion concerning the issues of attorney fees and penalties. The referee overturned the denial of the aggravation claim and awarded claimant $750 in attorney fees for overcoming that denial. The referee also decided that the insurer should have paid for claimant's December, 1982, hospitalization and awarded $1,000 in attorney fees and a penalty for its refusal to do so. The Board reversed the referee on the aggravation issue and, because employer did not contest the issue, affirmed the referee's decision that the insurer was responsible for payment of the December, 1982, hospitalization. The Board stated that, because it was reinstating the denial of the aggravation claim, the issues of attorney fees and penalties were moot. That statement is incorrect; $1,000 in attorney fees and the penalty were assessed for the insurer's unreasonable refusal to pay for the hospitalization rather than for any unreasonable denial of

the aggravation claim. We therefore affirm the Board's order insofar as it reinstates the denial of the aggravation claim and affirms the insurer's responsibility for payment of the December, 1982, hospitalization. Because the denial of the aggravation claim is reinstated, claimant is not entitled to the $750 in attorney fees that the referee awarded for overcoming that denial. We modify the order to affirm the award of $1,000 in attorney fees and the penalty for the insurer's unreasonable refusal to pay for claimant's hospitalization.

Order modified to reinstate award of $1,000 attorney fee and penalty at referee hearing level; affirmed as modified.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Ray A. Whitman, Claimant.

WHITMAN,
Petitioner - Cross-Respondent,

v.

INDUSTRIAL INDEMNITY COMPANY,
Respondent - Cross-Petitioner,
EBI COMPANIES et al,
Respondents - Cross-Respondents.

(83-00043, 83-00726; CA A32263)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 16, 1984.

Allen T. Murphy, Jr., Portland, argued the cause for petitioner - cross-respondent. With him on the brief was Richardson & Murphy, Portland.

Scott M. Kelley, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Cheney & Kelley, P. C., Portland.

Jerald P. Keene, Portland, argued the cause for respondents - cross-respondents. With him on the brief was Roberts, Reinisch & Klor, P. C., Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Reversed on petition; referee's order on penalties and attorney fees reinstated; affirmed on cross-petition.

VAN HOOMISSEN, J.

Claimant seeks review of a Workers' Compensation Board order that reversed a referee's order that assessed penalties and attorney fees against Industrial Indemnity for an unreasonable delay in accepting his claim. Industrial Indemnity cross-petitions from that part of the Board's order that affirmed the referee's order that claimant had incurred a new injury for which it is the responsible insurer. We review *de novo*.

At all relevant times, claimant was employed by Western Concrete Pumping. He injured his back in 1978. EBI was Western's insurer at that time. He injured his back again in 1981. Industrial Indemnity was Western's insurer at that time. Initially, EBI treated claimant's second back injury as an aggravation claim. EBI paid time loss benefits from October, 1981, to January, 1982, when it denied responsibility. When Industrial Indemnity received notice of the claim in January, 1982, it began paying time loss benefits. It did not pay claimant's hospital bills, and it failed to accept or deny the claim until December, 1982, at which time it requested a 307 order designating a paying agent *under* ORS 656.307.

The referee found in relevant part:

> "4) The entire claims handling process by Industrial Indemnity has caused this claimant to be denied medical treatment by his treating physician, left him in limbo for some 11 months and caused him to be dunned by credit agencies for non-payment of hospital bills.
>
> "I find that the appropriate penalty for this conduct is a payment to claimant of 25 percent of all compensation due him from the 60th day after Industrial Indemnity had notice or knowledge of the claim until the date of the request for the 307 Order. It is this Referee's understanding and I so find that Industrial Indemnity had notice or knowledge of this claim on January 20, 1982. The date of the request for the 307 Order is December 30, 1982. The above penalty applies to compensation due claimant even if he has in fact received it.
>
> "I find further that Industrial Indemnity shall pay to the claimant an amount equal to 25 percent of the Emanuel Hospital bill as and for unreasonable conduct in the payment of that bill.

> "I find further that Industrial Indemnity shall pay to the claimant's attorney the sum of $1500 as and for a reasonable attorney fee for his efforts in representing his client on all issues in this matter."

The Board agreed with the referee's responsibility determination. However, it held that Industrial Indemnity was not subject to penalties:

"Industrial failed to accept or deny claimant's claim until December 30, 1982, well beyond the sixty-day requirement of ORS 656.262(6). We held in *Norman J. Gibson,* 34 Van Natta 1583 (1982), and *Eugene Thomas,* 35 Van Natta 16 (1983), that in situations involving an unreasonably delayed denial the insurer would be penalized for violation of this statutory duty regardless of its payment of interim compensation. We interpreted the 'then due' language of ORS 656.262(10) (formerly ORS 656.262(9)) to mean that when a denial was unreasonably late a penalty would be imposed and calculated upon the interim compensation paid between the sixtieth day and the date of the denial. *Norman J. Gibson, supra,* 34 Van Natta at 1584; *Eugene Thomas, supra,* 35 Van Natta at 18. In apparent reliance upon these decisions, the Referee imposed a penalty based upon all compensation due claimant until December 30, 1982, regardless of payment.

"The Court of Appeals recently reversed that portion of our order in *Thomas* which imposed a penalty and attorney's fee, and in so doing, cast considerable doubt upon our interpretation of the 'then due' language in ORS 656.262(10) as expressed in *Gibson. EBI Companies v. Thomas,* 66 Or App 105 (1983). Although the court's statements appear to be dicta, the clear message is that in situations such as this, where the insurer unreasonably delays acceptance or denial of a claim but nevertheless complies with its separate and distinct duty to pay interim compensation during the period of delay, the insurer is not subject to a penalty for unreasonably delaying acceptance or denial pursuant to ORS 656.262(6), because there are no amounts 'then due' upon which a penalty can be assessed within the meaning of ORS 656.262(10). 66 Or App at 111."

The Board interpreted ORS 656.262(6):

" 'Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice of [sic] knowledge of the claim. *Pending acceptance or denial of a claim, compensation payable to a claimant does not include*

the costs of medical benefits or burial expenses. The insurer shall also furnish the employer a copy of the notice of acceptance. * * *' ORS 656.262(6).

"The underscored sentence was added to ORS 656.262(6) by Oregon Laws 1981, chapter 874, § 4, with an effective date of July 1, 1981 (Oregon Laws 1981, chapter 874, § 23). For injuries occurring on and after the effective date of this enactment, the insurer is not obligated to pay medical bills on an interim basis pursuant to ORS 656.262(4). ORS 656.202(2); *SAIF v. Mathews,* 55 Or App 608 (1982). Because there is no obligation to pay medical services on an interim basis, such medical services cannot constitute compensation 'then due' within the meaning of the penalty provision of ORS 656.262(10).

"Industrial has been found responsible for claimant's September 15, 1981 new injury. ORS 656.262(6) was in effect in its present form on that date. Accordingly, claimant was not entitled to be paid compensation in the form of medical services pending acceptance or denial of his new injury claim by Industrial. It follows, therefore, that no penalty can be imposed." (Emphasis supplied.)

The Board concluded that, because the referee's award of attorney fees included a penalty associated fee pursuant to ORS 656.382(1),[1] the Board's elimination of the penalties required elimination of the attorney fees.

We agree with the Board's determination of responsibility. We also agree that, under these facts, there were no "amounts then due" as to the temporary total disability on which a penalty could be assessed. ORS 656.262(10); *see EBI Companies v. Thomas*, 66 Or App 105, 672 P2d 1241 (1983). We conclude, however, that the language in ORS 656.262(6) excepting payment of medical benefits or burial expenses pending acceptance of a claim refers, for the purposes of the penalty provisions of ORS 656.262(10), to the 60-day period referred to in ORS 656.262(6). Any other interpretation effectively would eviscerate an insurer's duty promptly to pay

medical bills arising from a *bona fide* claim. Accordingly, we reinstate that part of the referee's opinion assessing a 25 percent penalty on the hospital bill. We remand to the Board for redetermination of the attorney fees.

Reversed on petition; referee's order on penalties and attorney fees reinstated; affirmed on cross-petition.

[1] ORS 656.382(1) provides:

"(1) If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney's fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

No. 186 April 10, 1985 119

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David C. Christensen, Claimant.

CHRISTENSEN,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(83-00378; CA A31399)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 15, 1985.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Jeff Bennett, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

Claimant seeks review of an order of the Workers' Compensation Board that upheld the referee's determination that claimant's ulcerative colitis is not a compensable occupational disease. On *de novo* review, we affirm.

It is undisputed that, during the period of 1979 through 1983, claimant experienced extraordinary stress in his job as president of the Bonneville Automobile Insurance Agency. In 1982, claimant's business went through some very stressful litigation, and he experienced severe stomach pain and gastrointestinal problems. At the onset of symptoms, he went to his regular physician, Dr. Perkins, an internist, who has been treating claimant since 1972 for diabetes. Dr. Perkins referred claimant to Dr. Wrigley, a gastroenterologist, who diagnosed ulcerative colitis, an inflammatory bowel disease. Claimant filed a claim for an occupational disease, which was denied by SAIF on the ground that the stomach disease was not work-related.

The only issue is whether claimant's work-related stress was the medical cause of the ulcerative colitis. At the hearing, Dr. Perkins was the only doctor to testify. He stated that, in his opinion, based on a reasonable medical probability, claimant's stress was a "major contributing cause to the onset and/or aggravation of" the ulcerative colitis. He testified that claimant seemed very satisfied with his personal life and did not appear to be under a great deal of stress in that regard. He was of the opinion that the stress of claimant's job had thrown his diabetes out of control, which had exacerbated the stomach condition. On cross-examination, the doctor admitted that he had not consulted medical journals within the last ten years regarding the cause of ulcerative colitis and that the underlying cause of the disease is unknown. Dr. Perkins did not explain how stress might have medically caused the stomach ailment, other than to state that the onset of symptoms of ulcerative colitis coincided with job stress. No testimony was offered in support of the theory that the diabetes aggravated the colitis.

SAIF submitted a letter written by Wrigley:

> "* * * Despite numerous theories in the literature which purport that stress is related to the cause of ulcerative colitis,

> the actual cause of ulcerative colitis remains unknown. In spite of Mr. Christensen's firm belief that the litigation began his illness, I am unable to state this to be the case medically. I could easily believe that there is some relatonship between the onset of his illness and the litigation, but I am unable to state that this is the cause of his disease."

SAIF also consulted Dr. Girod, an internist, who reported that the cause of ulcerative colitis is unknown and that there is no medical evidence to support the contention that stress can cause the disease.

In addition, Dr. Katon, an associate professor of medicine at the Oregon Health Sciences University, Division of Gastroenterology, at SAIF's request, reviewed claimant's history, the reports of Girod and Wrigley, and medical texts and literature. He submitted a written general opinion regarding the cause of ulcerative colitis:

> "* * * Although in the 1940s and 50s it was felt by some that there might be a link between psychological stress and ulcerative colitis, this theory has been largely abandoned by most authorities. * * *
>
> "* * * * *
>
> "The exact etiology of ulcerative colitis is at present unknown and there is at present an intense amount of research in this area. Possible mechanisms include bacterial factors, viral factors, immunological factors, genetic, and possibly psychogenic as well. However, the present body of evidence is against a clear-cut link between psychological factors and the onset of ulcerative colitis. There is likewise no clear-cut evidence that stress will exacerbate the symptoms of ulcerative colitis although this sometimes seems to be the case for an occasional patient seen in our practice.
>
> "Your third question is much easier to answer in this regard. I am not aware of any evidence that links diabetes mellitus or insulin use as a contributing factor in ulcerative colitis. * * *"

On this record, we conclude, as did the referee and the Board, that claimant has failed to prove medical causation by a preponderance of the evidence.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Tillman E. Price, Claimant.

PRICE,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(83-00575; CA A32934)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 15, 1985.

David H. Blunt, Salem, argued the cause and filed the brief for petitioner.

Jeff Bennett, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed in part; reversed in part, and remanded for determination of penalty.

BUTTLER, P. J.

Claimant's widow[1] seeks review of an order of the Workers' Compensation Board, which modified the referee's award by denying claimant penalties for SAIF's denial of an aggravation claim. On *de novo* review, we reverse.

In March, 1979, claimant sustained a compensable right ankle injury. His subsequent low-back condition was determined to be compensably related to that injury and required disc surgery at the L4-5 level. In October, 1982, claimant again experienced back pain. He underwent a myelogram, followed by more surgery at the same L4-5 level. The myelogram report, received by SAIF on December 10, 1982, provided a statement of findings and a diagnosis of a "[h]uge recurrent herniated nucleus pulposus anterior right anterolateral and right direct lateral at L4-5." In a memo dated December 28, 1982, SAIF's consultant, Dr. Brown, went to considerable lengths to explain his opinion that the original 1979 injury was not the cause of claimant's back problem and that the earlier surgery should not have been compensable. He stated that he had reviewed all previous medical reports relating to the original injury. He summarized those reports and concluded:

> "It is my opinion that the disc was not herniated at the time of the injury, that there was no medical evidence to substantiate this and that the Referee interjected his own feelings about the case rather than on medical facts. Although we can not change the Referee's opinion there is no medical evidence that the injury of 1979 herniated the disc resulting in the first operation. There is also no medical evidence that the injury in 1979 caused the same disc and/or the next disc to herniate three years later."

Dr. Brown did not state an opinion as to whether the present herniated disc was a worsening of the earlier disc herniation, which had been held to be compensable. He merely reiterated his belief that the original back problem was not compensable. On the basis of the myelogram report and Dr. Brown's memo, SAIF denied the aggravation claim on January 5, 1983. On January 12, 1983, SAIF received a letter from Dr. White,

claimant's treating physician, stating that the herniated disc was definitely related to the 1979 injury.

Claimant requested a hearing, seeking compensation, attorney fees and a penalty for SAIF's "unreasonable denial" of the claim. The referee found the claim to be compensable and awarded a penalty, stating that SAIF's refusal to accept the claim was unreasonable, because it was based solely on a medical report which merely disputed the compensability of

[1] Claimant died after the request for hearing and before final disposition of the request. His widow was substituted as the petitioner pursuant to ORS 656.218(3).

the 1979 injury. Further, the referee found that SAIF had acted unreasonably in not reinvestigating the denied claim after receiving the letter from Dr. White. On review, the Board affirmed the referee's decision on compensability but concluded that no penalty was authorized, because SAIF had not acted unreasonably in denying the claim on the basis of the information that it had at the time it issued the denial.

At the time of the filing of the claim, *former* ORS 656.262(9) provided:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."[2]

A penalty may be imposed only if the insurer's conduct in denying compensation was unreasonable. If SAIF, after reviewing the evidence, had a legitimate doubt as to its liability, its conduct was not unreasonable. *Norgard v. Rawlinsons,* 30 Or App 999, 1003, 569 P2d 49 (1977).

Claimant argues that SAIF acted unreasonably in refusing to pay compensation after receiving the myelogram report.[3] We cannot say that the myelogram report was sufficient in and of itself to eliminate doubt as to SAIF's liability. Although the report notes a "recurrent" herniated disc, it does not mention or explain the cause of the recurrence. Neither

does it state that there was a worsened condition arising out the original injury. ORS 656.273. SAIF, however, does not contend that the report was not an aggravation claim. It treated it as one and denied it on the basis of Dr. Brown's report.

It is that report, however, which calls into question the legitimacy of SAIF's doubt as to its liability. Dr. Brown's report does not deal with the relationship between the original back surgery and claimant's current problem, except, possibly, for the last sentence: "There is no medical evidence that the injury in 1979 caused the same disc and/or the next disc to herniate three years later." That opinion, from all that appears in the report, is based on the doctor's insistence that claimant's original back surgery should not have been compensable. It does not state that claimant's present condition is not an aggravation of his back problem that was found to be compensable, notwithstanding Brown's disagreement. That conclusory statement is not a reasonable basis for the denial of the aggravation claim. SAIF's liability for the original back injury had been previously litigated and was not open to question. *See Waldrop v. J. C. Penney Co.,* 30 Or App 443, 567 P2d 576 (1977). SAIF acted unreasonably in basing its denial on a medical opinion which was, in effect, an argument against the compensability of the original back condition. The Board erred in determining that no penalty was authorized.

Affirmed in part; reversed in part, and remanded for determination of penalty.

[2] ORS 656.262(9) was renumbered as ORS 656.262(10) by Or Laws 1983, ch 816, § 7.

[3] Claimant does not argue that SAIF should have considered Dr. White's January 12, 1983, letter in determining whether it would allow the claim. Because SAIF did not have the letter in its possession at the time of the denial, its conduct cannot be evaluated as if it did. *Mt. Mazama Plywood Co. v. Beattie,* 62 Or App 355, 661 P2d 109 (1983).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gary R. Thomas, Claimant.

THOMAS,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE,
Respondent.

(81-02240; CA A31226)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed February 21, 1985. Former opinion filed January 23, 1985, 71 Or App 837, 695 P2d 100.

Richard A. Lee, Eugene, for petition.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reconsideration granted; former opinion withdrawn; Board's order reversed insofar as it affirmed referee's opinion and order refusing to consider medical evidence of claimant's anxiety reaction; affirmed otherwise; remanded for further proceedings not inconsistent with this opinion.

BUTTLER, P. J.

Claimant filed a petition for review in the Supreme Court, ORAP 10.05, which we treat as a petition for reconsideration. ORAP 10.10. We affirmed, without opinion, the Workers' Compensation Board's disallowance of compensation for, among other claims, an anxiety reaction or syndrome. We grant the petition.

Claimant suffered a compensable injury when he received a severe electric shock while working on power lines. In the original judicial review, claimant focused on his contention that the Board erred in not remanding the case for the taking of additional evidence; he also contended that the Board erred in affirming the referee's order. In his petition for review, he focuses on what appears to be an error of law committed by the referee in failing to consider certain medical evidence in determining whether claimant's anxiety reaction was causally related to his compensable injury.

The record reflects no less than three medical opinions that diagnose an anxiety reaction or syndrome. Dr. Bert, who treated claimant for neck and shoulder discomfort, stated in a letter to the insurer dated April 30, 1980, that claimant had "some impairment based upon anxiety and pain of perhaps 15 percent." Dr. Wagner, an examining physician, stated in a letter to claimant's attorney, June 27, 1980:

"Last, but not least, the patient's concern over his physical disability has caused great anxiety. He acknowledges the interaction of this anxiety with his lack of improvement."

Orthopaedic Consultants, in a letter to the insurer dated January 26, 1981, diagnosed "anxiety reaction, severe; bordering on conversion reaction." The opinions of those doctors regarding claimant's anxiety reaction were not contradicted. The reports repeatedly state that there is an absence of objective evidence for the many subjective symptoms which claimant continued to experience.

The referee found claimant's testimony regarding his symptoms credible; however, he concluded that claimant had failed to meet his burden of proof on the issue of anxiety reaction, because there was no psychiatrist's or psychologist's report in the record, which the referee believed was necessary

to verify the diagnosis of anxiety reaction and to establish causation:

"The record certainly suggests that the claimant has psychological problems—and that those problems may account for the increasing variety of subjective complaints. A 'severe anxiety syndrome' may be the correct diagnosis. However, there is no opinion from a psychologist or psychiatrist in this record. I believe that an opinion from such an expert would be necessary to both verify that diagnosis *and* establish that the condition was the result of the electrical shock injury. * * *" (Emphasis in original.)

The Board appears to have agreed with that assessment of the record.

The Supreme Court, in *Barrett v. Coast Range Plywood,* 294 Or 641, 661 P2d 926 (1983), held that evidence of functional overlay must not be ignored simply because the evidence does not consist of expert psychological evaluation; a physician or surgeon is not incompetent to testify as an expert merely because he or she is not a specialist in the particular branch of the profession involved in the case. As pointed out, there is medical evidence in this case that claimant had an anxiety reaction to the industrial injury that caused subjective symptoms. If the injury was a material contributing cause of claimant's anxiety resulting in disability, the condition is compensable. Because the referee refused to consider that evidence on the ground that the doctors were not specialists on this subject, the case must be remanded.

Petition for reconsideration granted; former opinion withdrawn; Board's order reversed insofar as it affirmed referee's opinion and order refusing to consider the medical evidence of claimant's anxiety reaction; affirmed otherwise; and remanded for further proceedings not inconsistent with this opinion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Kim B. Kitchel, Claimant.

AGRIPAC, INC.,
Petitioner,

v.

KITCHEL,
Respondent.

(83-01162; CA A34058)

Judicial review from the Workers' Compensation Board dismissed by order dated January 17, 1985.

On respondent's petition for attorney fees filed February 5, 1985.

James L. Edmunson, Eugene, and Malagon & Associates, Eugene, for the petition.

Paul J. DeMuniz and Garrett, Seideman, Hemann, Robertson & DeMuniz, P. C., contra.

Before Warden, P. J., and Van Hoomissen and Young, Judges.

WARDEN, P. J.

Petition for attorney fees denied.

WARDEN, P. J.

The issue in this case is whether a workers' compensation claimant is entitled to an award of attorney fees for legal services performed in response to an employer's petition for judicial review that is dismissed on the claimant's motion. Claimant relies on ORS 656.382(2):

> "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 in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal." (Emphasis supplied.)

The precise question is whether in dismissing employer's petition for judicial review on claimant's motion this court has found that the compensation awarded to claimant should not be disallowed or reduced.

In *SAIF v. Bond,* 64 Or App 505, 669 P2d 332 (1983), in which an insurer's appeal was dismissed on its own motion, we held that "in enacting ORS 656.382(2), the legislature intended that a claimant receive a reasonable attorney's fee paid by the employer or insurer when the claimant prevails,

whether on the merits or because the appeal is dismissed, because the result is the same."

We now overrule the holding in *Bond* on the basis of the Supreme Court's decision in *SAIF v. Curry*, 297 Or 504, 686 P2d 363 (1984). In *Curry* the issue was whether, under ORS 656.382(2), a claimant was entitled to attorney fees for work done in response to an insurer's petition for review in the Supreme Court that was ultimately denied. As stated by Judge Lent:

> "The question is to determine if our denial of review fits the statutory predicate for awarding attorney's fees if this '* * * court *finds* that the compensation awarded to claimant should not be disallowed or reduced * * *.' ORS 656.382(2)." (Emphasis in original.) 297 Or at 508.

After reviewing earlier court decisions, particularly *Bracke v. Baza'r*, 294 Or 483, 658 P2d 1158 (1983), and legislative history concerning the 1983 amendments to ORS 656.382(2), the court concluded

> "that the intent of the legislature in passing the 1983 amendments to ORS 656.382(2) was to allow attorney's fees in Supreme Court cases only when this court actually allows an employer's petition for review and *decides that theretofore awarded compensation should not be disallowed or reduced.*" 297 Or at 510. (Emphasis supplied.)

In its review of the legislative history the court took note that

> "the committee considered, but rejected, a proposal that would have allowed an award of attorney fees to a claimant's attorney who works on an appeal initiated by an employer or insurer, but which is dismissed on the employer/insurer's motion prior to a decision." 294 Or at 510.

Being unable to find any meaningful distinction between the issue in this case and that in *Curry*, we overrule our holding in *SAIF v. Bond, supra*, and hold that, when an employer or insurer's petition for judicial review is dismissed without a finding "that the compensation awarded to a claimant should not be disallowed or reduced," the claimant is not entitled to an award of attorney fees.

Petition for attorney fees denied.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Eugene A. Page, Claimant.

JELD-WEN, INC.,
Petitioner - Cross-Respondent,

v.

PAGE,
Respondent - Cross-Petitioner.

(80-05763, 80-07722; CA A31401)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 15, 1984.

Brian L. Pocock, Eugene, argued the cause and filed the briefs for petitioner - cross-respondent.

Mark Andrew Lange, Salem, argued the cause and filed the brief for respondent - cross-petitioner.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Jeld-Wen, Inc., seeks review of an order of the Workers' Compensation Board which held that claimant's psychological condition is related to his compensable physical injury. Claimant cross-petitions, arguing that the referee's award of 50 percent unscheduled disability for his back injury should not have been reduced by the Board to 40 percent. We affirm.

Claimant suffered a compensable injury to his neck, left shoulder and arm on May 8, 1979, when he slipped on a ladder and caught himself with his left hand. He later suffered a compensable injury to his low back on December 20, 1979, when he was pushing a heavy load of door skins.

In April, 1982, claimant was hospitalized for paranoid psychosis. On July 15, 1982, employer denied responsibility for his psychological condition with respect to either the May or December, 1979, injuries. Claimant's hospitalization stemmed from his belief that, since late 1981, employer or its insurance department had hired individuals to follow and spy on him. There was no evidence that Jeld-Wen ever actually had hired anyone to maintain surveillance of claimant. Both the referee and the Board concluded that claimant's psychiatric condition was compensably related to his physical injuries.

The parties are in substantial disagreement as to what standard applies to determine whether claimant's psychiatric condition is compensably related to his physical

injuries. Jeld-Wen argues that claimant must establish that one of the 1979 injuries was the major contributing factor in the development of his psychological condition, relying on *McGarrah v. SAIF,* 296 Or 145, 675 P2d 195 (1983), and *Elwood v. SAIF,* 67 Or App 134, 676 P2d 922 (1984), *rem'd for further proceedings* 298 Or 429, 693 P2d 641 (1985), *decision on remand* 72 Or App 771, ___ P2d ___ (1985). Neither of those cases is applicable to the facts in the case at bar. Both are occupational disease cases that deal with the problem of establishing whether a claimant's psychological condition stems from actually existing mental stresses which were related to his employment and were the major contributing factor in causing the disability. Occupational disease cases concerning the psychological effects of mental stress involve

unique proof problems and have a distinct set of standards from those applicable to the present case.

A claimant asserting the compensability of a psychiatric condition following an industrial injury must prove by a preponderance of the evidence that the work-related injury was a material cause of the condition, or, if the claimant's mental condition predated the injury, that the injury worsened that preexisting condition. *See Partridge v. SAIF,* 57 Or App 163, 167, 643 P2d 1358, *rev den* 293 Or 394 (1982). We conclude that claimant sustained his burden. There is no evidence of a paranoid psychosis in his medical history before the compensable accident. His paranoid delusions related to his employer or its insurance department and their perceived attempts to deny him compensation for his physical injuries. Thus, it appears that his work-related injury was the initial seed for his perception of persecution. It is also clear that the appearance of symptoms of his psychological disease followed his compensable physical injury and that he required medical services.

Dr. Thompson, claimant's treating psychiatrist, concluded that his paranoid psychosis did not precede, and was directly related to, his work injuries. The doctor considered claimant's personal and medical history, his family life and information gleaned through the course of his treatment in arriving at the conclusion that stress associated with his work injuries caused his psychological disease.

Dr. Koutsky testified for employer that, in his opinion, "paranoia is a progressive illness that is most likely a hereditary condition." He reviewed material on claimant provided by employer and interviewed claimant on one occasion. He acknowledged that there is no evidence in claimant's medical history before the injuries that indicates a psychotic condition. It was his opinion that claimant's work injuries were not "a major contributing factor" to his psychological illness and that "the physical injury would at most be a precipitating stress to an already preexisting condition." In a letter of July 8, 1982, Dr. Koutsky inferred that claimant's illness preexisted his work injuries from his understanding of the general nature of the illness and from his belief that claimant "has not responded to antipsychotic medication and good psychiatric treatment * * *." The basis of his opinion is

somewhat undercut by his testimony on November 3, 1982, that claimant appeared to be better and "that the treatment program, from a psychiatric viewpoint, appears to be a successful one as it continues." In addition, Dr. Koutsky's opinion that claimant's physical injuries were not a major causative factor in his paranoia may have been influenced by his "personal opinion, that compensation of this variety tends to prolong mental, and emotional disabilities, standing in the way of successful recovery and rehabilitative efforts."

We are not persuaded by Dr. Koutsky's testimony. His opinion that claimant's work-related injuries were not "a major contributing factor" to his psychological illness is not helpful. It is addressed to the occupational disease standard and does not address the question whether the work injury was a material cause. Furthermore, his opinion that claimant had a preexisting condition which was not made worse by his work injuries appears to be based on his concept of the nature of psychological disorders rather than on an examination of claimant. His opinion that claimant had a preexisting mental disorder is not persuasive in the light of his admission that nothing in claimant's prior medical history indicates a psychiatric disorder and that the condition did improve with treatment.

There is no question that claimant's psychological condition was stable before his injuries. The appearance of symptoms of paranoid psychosis in 1982 was most likely associated with either the onset or worsening of his psychotic condition. We find Dr. Thompson's opinion that claimant's psychosis was caused by his work injuries and subsequent related events persuasive. It is clear from this evidence that the compensable physical injury was a material factor in causing his psychological disorder. Claimant has established by a preponderance of the evidence that his psychological condition is compensably related to his compensable physical condition.

On claimant's cross-petition, we find on *de novo* review that the Board's award of 40 percent unscheduled permanent partial disability for claimant's back condition is adequate.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ivy E. Miller, Claimant.

MISSION INSURANCE CO.,
Petitioner - Cross-Respondent,

v.

MILLER,
Respondent - Cross-Petitioner,
STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent - Cross-Respondent.

(82-04811, 82-10905; CA A30742)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 9, 1984.

Marianne Bottini, Portland, argued the cause for petitioner - cross-respondent. On the brief were Bruce A. Bottini, and Bottini & Bottini, Portland.

Richard T. Kropp, Albany, argued the cause for respondent - cross-petitioner Miller. With him on the brief was Emmons, Kyle, Kropp, Kryger & Alexander, P. C., Albany.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent - cross-respondent SAIF. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

On petition, affirmed as to attorney fees; otherwise reversed and referee's order reinstated; affirmed on cross-petition.

ROSSMAN, J.

Mission Insurance Company (Mission), as workers' compensation insurer for Action Ambulance, Inc. (Action Ambulance), seeks review of a Board order which held that Action Ambulance is solely responsible for claimant's compensable injury. On *de novo* review, we reverse, except as to the award of attorney fees.

The issue is the responsibility of two part-time employers for claimant's compensable injury. The facts are not disputed. Action Ambulance and Action Welding, Inc. (Action Welding) are separate companies, each owned equally by Ray Moore and Edith Moore. Action Welding was formed to supply oxygen and other medical supplies to Action Ambulance and other customers. The books of Action Welding were kept separately, and assets were separately owned. The two corporations used the same office space, warehouse,

bookkeeper and manager. They shared one telephone, with three lines.

In June, 1980, claimant began working for Action Ambulance as a part-time ambulance driver. In October, 1980, he began working part-time as a delivery truck driver for Action Welding. The two jobs totalled 40 hours per week. At the time of the injury, claimant earned $200 per month from Action Ambulance and $700 per month from Action Welding. He worked primarily for Action Ambulance on Tuesdays and Fridays, and primarily for Action Welding on Mondays, Wednesdays and Thursdays. However, the record indicates that, despite claimant's primary assignment to one company on certain days, he was always available and "on call" for the other, as needed. He performed services for each company on all days, taking the jobs with the greater priority. For example, while driving the Action Welding delivery truck, he was always on call for the ambulance, wore his ambulance uniform and carried ambulance equipment with him.

In the fall of 1981, the companies encountered financial difficulties and the bank assumed *de facto* receivership, consolidating the funds of both companies into the Action Ambulance account. All checks were written on the Action Ambulance account, with the exception of one vacation pay check to claimant dated December 15, 1981. Action Welding's coverage with SAIF was terminated on October 1, 1981, for

nonpayment of premiums. The company did not acquire a replacement policy. Action Ambulance retained its coverage through Mission.

On Friday, December 18, 1981, claimant was working primarily for Action Ambulance when he received an urgent call from an Action Welding customer for a tank of oxygen. He was not needed on the ambulance and decided to deliver the oxygen. In loading the oxygen into the Action Welding truck, he ruptured a disk in his low back.

Mission initially accepted the claim and paid it as if claimant were fully employed by Action Ambulance. Later, Mission notified claimant that it was reducing claimant's benefits to the level of a part-time employe. At a hearing on the matter, SAIF represented Action Welding as a non-complying employer.

The referee held that Action Ambulance and Action Welding were "joint" employers, equally responsible for claimant's injury. Mission was ordered to pay benefits based on full-time employment, and SAIF was ordered to reimburse Mission for 50 percent of the expenses. The Board reversed, holding that Action Ambulance was the only employer.

Mission argues that Action Welding is the sole responsible employer, because claimant was performing an Action Welding task at the time of the injury. In the alternative, Mission argues that Action Welding and Action Ambulance were "dual" employers and responsible for the injury in proportion to the salary paid by each. We conclude that Action Ambulance and Action Welding were joint employers, jointly responsible for claimant's injury.

This court has recognized that it is possible for an employe to have two employers for the purposes of workers'

compensation. *Robinson v. Omark Industries, Inc.*, 46 Or App 263, 611 P2d 665 (1980). In resolving responsibility disputes between two or more employers, the classifications of "dual" and "joint" employment are useful. The two terms are aptly described in 1C Larson, Workmen's Compensation Law, § 48.40 (1982):

> "Joint employment occurs when a single employee, under contract with two employers, and under the simultaneous control of both, simultaneously performs services for both

> employers, and when the service for each employer is the same as, or is closely related to, that for the other. In such a case, both employers are liable for workmen's compensation.
>
> "Dual employment occurs when a single employee, under contract with two employers, and under the separate control of each, performs services for the most part for each employer separately, and when the service for each employer is largely unrelated to that for the other. In such a case, the employers may be liable for workmen's compensation separately or jointly, depending on the severability of the employee's activity at the time of injury."

A joint employe is subject to the simultaneous control of two employers and performs simultaneous and related services for each. Dual employment is characterized by separate control and separate performance of unrelated services.

In this case, the owners and managers of Action Ambulance and Action Welding are the same, and claimant was subject to their simultaneous control. Claimant performed services for the companies simultaneously, in the sense that, even if claimant was working primarily for one employer, he was always on call for the other, as needed. Both companies benefited from claimant's unique "on call" status and from his availability to perform priority tasks. That, more than any other factor, leads us to conclude that claimant was a joint employe.

In concluding that Action Ambulance was the only employer, the Board apparently relied on the fact that the payrolls of both corporations were drawn on the Action Ambulance account. We do not find that factor to be controlling, however. The use of one bank account was required by the bank. The consolidation of accounts did not result in a dissolution of Action Welding or the merger of the two companies. They remained separate legal entities and were functioning as such at the time of the injury. Both are therefore fully responsible.

Petitioner raises as error the Board's award of attorney fees to claimant for services performed before the Board on review. It is clear that claimant is entitled to attorney fees under the provisions of ORS 656.386(1) for successfully defending his award of compensation as a full-time employe.

Claimant has cross-petitioned, prompted by his concern that he be compensated as a full-time employe in the event that the court treats this case as a dual employment situation. Our holding inherently provides for the result sought by claimant.

We reinstate the referee's determination that Action Welding and Action Ambulance are jointly liable for claimant's compensable injury. Mission is to pay claimant's benefits and temporary total disability at the rate computed on the basis of claimant's combined salary from Action Ambulance and Action Welding. SAIF shall reimburse Mission for 50 percent of its expenses.

On petition, affirmed as to attorney fees; otherwise reversed and referee's order reinstated; affirmed on cross-petition.

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184 April 10, 1985 No. 197

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David F. Barrett, Claimant.

BARRETT,
Petitioner,

v.

D & H DRYWALL et al,
Respondents.

(81-02757; CA A29349)

Judicial Review from Workers' Compensation Board.

On respondents' petition for reconsideration filed November 21, 1984. Former opinion filed September 26, 1984. 70 Or App 123, 688 P2d 130.

Scott H. Terrall, Portland, for petition.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Petition for reconsideration allowed; former opinion withdrawn; affirmed.

ROSSMAN, J.

Employer and EBI Companies filed a petition for review in the Supreme Court, ORAP 10.05, which we treat as a petition for reconsideration. ORAP 10.10. In our former opinion, 70 Or App 123, 688 P2d 130 (1984), we reversed the Workers' Compensation Board and held that a claimant's preexisting medical condition is an element to be considered in determining the extent of unscheduled permanent partial disability, even though the claimant is unable to establish that the underlying condition was worsened or otherwise affected by the compensable industrial injury. We now withdraw our former opinion and affirm.

An award of permanent partial disability is to be rated on the basis of "the permanent loss of earning capacity

due to the compensable injury." ORS 656.214(5).[1] In determining loss of earning capacity attributable to an industrial injury, impairments not related to the injury are not considered. This is in contrast with a determination of permanent total disability, which requires the consideration of preexisting disability. ORS 656.206(1)(a).[2]

The facts as found by the referee, the Board and this court are that claimant's preexisting degenerative low back condition was not worsened by the compensable industrial injury. In our former opinion, we erroneously held that the

referee and the Board should have considered the preexisting back condition as an element of claimant's loss of earning capacity. On reconsideration, we conclude that the Board properly refused to consider the preexisting condition.

On *de novo* review, we also consider claimant's second assignment of error that he is permanently and totally disabled and affirm the Board.

Petition for reconsideration allowed; former opinion withdrawn; affirmed.

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[1] ORS 656.214(5) provides:

"In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, training, skills and work experience. The number of degrees of disability shall be a maximum of 320 degrees determined by the extent of the disability compared to the worker before such injury and without such disability. For the purpose of this subsection, the value of each degree of disability is $100."

[2] ORS 656.206(1)(a) provides:

"As used in this section:

"(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."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Arliss Ingram, Claimant.

INGRAM,
Petitioner,

v.

AMFAC, INC.,
Respondent.

(84-3-280; CA A31666)

Appeal from Circuit Court, Umatilla County.

J. F. Olsen, Judge.

Argued and submitted November 19, 1984.

Kenneth D. Peterson, Jr., Hermiston, argued the cause and filed the brief for petitioner.

Mildred J. Carmack, Portland, argued the cause for respondent. With her on the brief were Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

NEWMAN, J.

Reversed and remanded.

NEWMAN, J.

This case is a companion to *AMFAC, Inc. v. Ingram*, 72 Or App 168, 694 P2d 1005 (1985). Claimant appeals a circuit court order that dismissed her attorney's "Motion to Determine Claimant's Attorneys Fees." The attorney filed the motion within 30 days after the Workers' Compensation Board reversed the referee, holding that claimant's occupational disease claim was compensable and fixing her attorney fees. ORS 656.386(1); OAR 438-47-040(2). The attorney disagreed with the *amount* of fees that the board set. At the time of the motion in the circuit court, employer had already filed a petition for review in this court in *AMFAC, Inc. v. Ingram, supra.* The circuit court ruled that it lacked jurisdiction to consider the motion. We reverse.

Initially, employer had denied this claim. Claimant requested a hearing, and the referee held her claim compensable. On employer's motion for reconsideration, the referee held the claim noncompensable. Claimant appealed to the Board and prevailed on the merits. Employer then petitioned for review, and we reversed the Board and held the claim noncompensable. *AMFAC, Inc. v. Ingram, supra.*

ORS 656.388(2) provides:

> "If an attorney and the referee or board or appellate court cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge of the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

It provides a claimant a remedy to challenge the *amount* of attorney fees that the Board sets, if the attorney "forthwith" submits the matter to the presiding judge of the circuit court. We have held that "forthwith" means within 30 days of the Board's order. *SAIF v. Culwell*, 65 Or App 332, 671 P2d 759 (1983), *rev den* 296 Or 411 (1984).[1]

At the time of the motion in the circuit court, it had jurisdiction to determine the amount of the award for attorney fees. Claimant had prevailed before the Board, which had set attorney fees for services up to and including the Board level.

[1] We do not decide whether claimant could have appealed to this court the amount of the fees that the Board had set, *compare Button v. SAIF*, 45 Or App 295, 298, 608 P2d 206, *rev den* 289 Or 107 (1980), with *Bentley v. SAIF*, 38 Or App 473, 481, 590 P2d 746 (1979), or whether she could have raised that issue by cross-petition in *AMFAC, Inc. v. Ingram, supra.*

Concededly, none of the statutes which authorize attorney fee awards in workers' compensation cases—ORS 656.382, ORS 656.386(1) and ORS 656.388(1)—allows an award to claimant if she does not finally prevail. *See Brown v. EBI Companies*, 289 Or 905, 618 P2d 959 (1980); *SAIF v. Paresi*, 62 Or App 139, 142 n 1, 660 P2d 684, *rev den* 295 Or 259 (1983). She may, however, finally prevail in *AMFAC, Inc. v. Ingram, supra*, on Supreme Court review.[2] The circuit court erred in dismissing the attorney's motion for lack of jurisdiction. It should have determined the *amount* of attorney fees for services up to the Board level.

Reversed and remanded.

[2] ORS 656.382(2) provides for an award of attorney fees

"[i]f 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 * * *."

In *AMFAC, Inc. v. Ingram, supra*, employer initiated the request for referee reconsideration and for Court of Appeals review. The referee and this court found that claimant is not entitled to compensation. In neither instance did the reviewing body find that "the compensation awarded to a claimant should not be disallowed or reduced."

ORS 656.386(1) provides for an award of attorney fees if a claimant "finally prevails" in a proceeding after a denial of compensation. Claimant has not "finally prevailed" in *AMFAC v. Ingram, supra*, and will not unless the Supreme Court on review reverses the decision on compensability. *See also* OAR 438-47-060.

ORS 656.388(1) provides for an award of attorney fees "[i]n cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board * * *."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Edward J. LaRoque, Claimant.

FMC CORPORATION,
Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY et al,
Respondents.

(81-11384, 81-11347; CA A28601)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed November 28, 1984. Former opinion filed 70 Or App 370, 689 P2d 1046.

Mildred J. Carmack, Portland, for petition.

Before Buttler, Presiding Judge, Warren and Rossman, Judges.

BUTTLER, P. J.

Reconsideration granted; former opinion adhered to as amplified and clarified.

BUTTLER, P. J.

FMC Corporation has petitioned the Supreme Court for review of our decision. 70 Or App 370, 689 P2d 1046 (1984).

We treat the petition as one for reconsideration. ORAP 10.10(1). We grant the petition in order to clarify and amplify the opinion, but adhere to our former opinion.

Our opinion accurately stated that this case involves a single employer and that the dispute is between the employer's former workers' compensation insurer and the employer in its self-insured capacity about responsibility for claimant's occupational disease. However, the analysis was phrased as if it were a contest between two employers, and the authorities cited involved the issue of which of two or more employers was responsible for the claimant's disability. What is lacking is a transitional explanation that the application of the last injurious exposure rule is the same in cases involving successive insurers (including a self-insured employer) as it is in those involving successive employers. Lacking that explanation, the opinion is confusing, because it gives the impression that the employer *qua* employer may not be liable. There is no question here that FMC is liable as the employer of claimant; the issue is whether it must pay the claim as a self-insured employer or whether its former insurer must pay it. We proceed with that explanation.

Davidson Baking v. Ind. Indemnity, 20 Or App 508, 532 P2d 810, *rev den* (1975), involved a claim for a hearing loss allegedly incurred during a 20-year period of employment at Davidson Baking. Each of the three insurers that had covered the company's compensation liability during the relevant period denied the claim. The referee, the Board and the circuit court concluded that the claimant had suffered a compensable disability and that the last carrier was responsible. On *de novo* review this court affirmed compensability of claimant's condition as an occupational disease. The other issues were whether the claim had been timely filed and, if so, which of the carriers was responsible. The court decided, first, that the contemporary version of ORS 656.307 authorized the Board to make a determination of responsiblity among the single employer's

successive insurers.[1] Turning to the timeliness and responsibility issues, this court, rather summarily, determined that the claim was timely filed on the ground that "[t]o hold that disability from an occupational disease may mature in stages

[1] ORS 656.307, *amended by* Or Laws 1979, ch 839, § 8, provided:

"(1) Where there is an issue regarding:

"(a) Which of several subject employers is the true employer of a claimant worker;

"(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

"(c) Responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries; or

"(d) Joint employment by two or more employers,

the director shall, by order, designate who shall pay the claim, if the claim is otherwise compensable. Payments shall begin in any event as provided in ORS 656.262(4). When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved. Any failure to obtain reimbursement from an insurer or self-insured employer shall be recovered from the Administrative Fund.

"(2) No self-insured employer or an insurer shall be joined in any proceeding under this section regarding its responsibility for any claim subject to ORS 656.273 unless the issue is entitled to hearing on application of the worker.

"(3) The claimant shall be joined in any proceedings under this section as a necessary party, but may elect to be treated as a nominal party."

would place an unfair burden on the workman with respect to the timely filing of claims." 20 Or App at 515.[2]

On the responsibility question, we adopted the rule in *Mathis v. SAIF*, 10 Or App 139, 499 P2d 1331 (1972), involving a workman who had been exposed to asbestos over a 31-year period in several employments, and applied the "last injurious exposure" rule derived from 3 Larson, Workmen's Compensation Law § 95.21 (1971).

The Supreme Court did not review either *Mathis* or *Davidson Baking*. The issues of the procedures and the basis for allocating responsibility between successive carriers for a single employer or between a carrier and a subsequently or

previously self-insured employer did not arise again until *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980). The claimant there had worked for Forest Fiber from 1966 until 1977. Until April 1, 1976, the employer had been a "contributing employer"[3] covered by SAIF. When the claim was made in September, 1976, the employer was a "direct responsibility employer."[4] The claim was filed with the employer, and no claim was ever submitted directly to SAIF. For reasons that do not appear in the opinion, apparently no action was taken on the claim until January, 1978, when the employer's carrier at the time of the claim, Employee Benefits Insurance Company, denied it as noncompensable.

The claimant requested a hearing, and the referee, at claimant's request, brought in SAIF as a defendant with EBI. The claimant took no position as to which of the carriers was responsible, and each of the carriers attempted to show that the other was responsible. Ultimately, the Board held that neither carrier was liable, which meant that the claimant would receive no compensation for his hearing loss, which all the parties agreed was job-related.[5]

Given that peculiar posture of the case, it is not particularly surprising that the Supreme Court found a way to give the claimant another opportunity to obtain compensation. The court said at the very beginning of its analysis: "The petitioner in this case presents the same problem as the occupational disease claimant who at different times held jobs with several employers, each of which involved exposure to conditions which might cause the disease." 288 Or at 341. That statement contains the same confusion that is contained in our original opinion in this case, which we propose to clarify. It seems fairly obvious that Inkley's problem was by no means the same as in a successive employer case, for his *only* burden was to show a causal relationship between conditions

[2] ORS 656.807(1) now reads:

"(1) Except as otherwise limited for silicosis, asbestosis and asbestos-related diseases, all occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer within five years after the last exposure in employment subject to the Workers' Compensation Law and within 180 days from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease whichever is later."

[3] Now called a "carrier-insured employer." ORS 656.017(1)(a).

[4] Now called a "self-insured employer." ORS 656.017(1)(b).

[5] It remains a mystery how at every stage of the case the legal fact of the *employer's* liability was overlooked.

in his place of employment and his illness. In fact, just two pages after the quoted statement the court said, 288 Or at 343: "When only one employer is involved, the claimant must show

a causal relationship between workplace conditions and his illness." When *Inkley* was decided, ORS 656.307, *supra* n 1, provided:

> "(1) Where there is an issue regarding:
>
> "* * * * *
>
> "(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;
>
> "* * * * *
>
> the director shall, by order, designate who shall pay the claim, if the claim is otherwise compensable. Payment shall begin in any event as provided in ORS 656.262(4). When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved. * * *
>
> "* * * * *
>
> "(3) The claimant shall be joined in any proceedings under this section as a necessary party, but may elect to be treated as a nominal party."

Why that statutory procedure was not followed, given that all parties agreed that the claimant's hearing loss was job-related, does not appear in the case. ORS 656.307 is not even mentioned.

Having started with the proposition that the problem was the same as in the case with successive employers, the court turned to this court's opinion in *Mathis v. SAIF, supra,* and adopted the last injurious exposure rule. Subsequently, in *Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982), the court analyzed the last injurious exposure doctrine as encompassing a rule of liability and a rule of proof, noting that (at least with respect to the rule of proof) it applies in the single employer situation the same as in the case of successive employers. 293 Or at 246. *See also Grable v. Weyerhauser Co.,* 291 Or 387, 631 P2d 768 (1981). *Inkley v. Forest Fiber Products, supra,* imported the last injurious exposure rule into the single employer, successive carriers situation.

That rule is applicable to this case, but we emphasize that FMC, as employer, is liable for claimant's occupational disease. It was claimant's only employer, and the conditions that could have caused his occupational disease existed during

Liberty Mutual's coverage and while FMC was self-insured. We adhere to our original opinion that FMC has not demonstrated that it was impossible for conditions at its plant to have caused claimant's disease while it was self-insured and, therefore, FMC, as a self-insured employer, is responsible for the payment of compensation under the last injurious exposure rule.

Reconsideration granted; former opinion adhered to as amplified and clarified.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

BROWN,
Respondent,
v.
BUNCH TIRE BAILER, INC. et al,
Appellants,
ARMSTRONG,
Respondent.
(40 972; CA A31868)

Appeal from Circuit Court, Washington County.

Jon B. Lund, Judge.

Argued and submitted January 18, 1985.

Brian W. O'Brien, Portland, argued the cause and filed the brief for appellants.

Richard D. Wasserman, Assistant Attorney General, Salem, argued the cause for respondent William J. Brown, Director, Workers' Compensation Department. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

No appearance for respondent Steve Armstrong.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Reversed.

GILLETTE, P. J.

This is an appeal from an order granting summary judgment in favor of plaintiff, the Director of the Workers' Compensation Department (Department), and directing defendant, Bunch Tire Bailers, Inc. (Bunch Tire), to reimburse the State Accident Insurance Fund Corporation for certain sums that were paid to a claimant who was injured while allegedly employed by defendant. We reverse.

On January 30, 1978, Bunch Tire received a notice of a "Proposed and Final Order" issued by the Compliance Division of the Department on December 15, 1977, declaring Bunch Tire a noncomplying employer. *See* ORS 656.017, 656.023, 656.027. The notice informed Bunch Tire that a hearing could be requested if it disagreed with the Division's findings.[1] Bunch Tire requested a hearing; receipt of the request was acknowledged by the Hearings Division of the Workers' Compensation Board by a letter dated March 15, 1978. Although the letter stated that scheduling and notice of a hearing would "issue in due course," Bunch Tire did not hear from the Hearings Division until nearly a year later, on March

[1] The Compliance Division had investigated defendant as the result of a claim filed by the claimant in this case. Claimant alleged that he was an employe of Bunch Tire and had been injured while working for it.

5, 1979. At that time, the Hearings Division sent a letter to defendant and asked for a "status report on [the] case"; Bunch Tire did not reply. On April 5, 1979, the Hearings Division sent another letter, asking Bunch Tire to respond to the letter of March 5, 1979; Bunch Tire again did not answer.

Approximately 17 months after Bunch Tire had originally requested a hearing, the Hearings Division issued an order, dated August 31, 1979, requiring Bunch Tire to show cause within 30 days why the "case should not be dismissed as abandoned." Bunch Tire did not answer the order, and the Hearings Division consequently dismissed the case on October 2, 1979.

Before and during the events described, the claimant in this case (Armstrong) had filed a claim for an industrial injury allegedly suffered while in the employ of defendant. The claim was sent for processing to SAIF and was accepted. Following acceptance, SAIF paid $5,799.45 to claimant and,

pursuant to ORS 656.054,[2] sought to recover from defendant the amount expended. Defendant refused to reimburse the Department or SAIF, arguing that a final determination had not been entered regarding its status as an employer. Plaintiff then brought this action in circuit court to recover the sum allegedly owed. The court granted plaintiff's motion for summary judgment; a judgment was entered directing defendant to reimburse plaintiff in the amount of $5,407.88. This appeal followed.

The dispositive issue in this case is whether a valid final order was issued declaring defendant to be a noncomplying employer under ORS 656.740. If a proper final determination of defendant's status was not made, the case must be reversed. Defendant's principal argument is that the order declaring it to be a noncomplying employer never took effect and that entry of summary judgment in favor of plaintiff was therefore in error. We agree with defendant that the order did not become a final order.[3]

ORS 656.740(1) (*amended by* Or Laws 1983, ch 816, § 14) provides, in pertinent part:

> "A person may contest a proposed order of the director declaring that person to be a noncomplying employer * * * by filing with the department, within 20 days of receipt of notice thereof, a written request for a hearing. Such a request need not be in any particular form, but shall specify the grounds upon which the person contests the proposed order * * *."[4]

ORS 656.740(3) provides, in pertinent part:

> "A hearing relating to a proposed order declaring a person to be a noncomplying employer * * * *shall be held* by a referee of the board's Hearing Division; but a hearing shall not be granted unless a request for hearing is filed within the period

[2] ORS 656.054(3) provides, in pertinent part:

> "In addition to, and not in lieu of, any civil penalties, * * * all costs to the Industrial Accident Fund of a claim * * * shall be a liability of the noncomplying employer. * * * The director shall recover such costs from the employer."

[3] Bunch Tire seeks support under the APA, ORS 183.310 *et seq*, for its argument that the order is not a final order. However, the APA was not made applicable to this kind of proceeding until 1983 and therefore was not binding on the Department at the time the order was issued. Or Laws 1983, ch 816, § 14.

[4] It is undisputed that Bunch Tire complied with the statute in a timely fashion and that the Department acknowledged receiving the request for a hearing.

> specified * * * and if a request for hearing is not so filed, the order * * * as proposed shall be a final order of the department and shall not be subject to review by any agency or court." (Emphasis supplied.)

The unambiguous language of the statute mandates a hearing by a referee if a request for hearing is not filed within 20 days. Only if a request is not filed will an order automatically become final. Because defendant filed a request, thereby fulfilling its obligation under the statute, the proposed order of noncompliance did not become final, unless the Department was otherwise authorized to escape from complying with the statute.

The Department argues that Bunch Tire failed to respond to the order to show cause and that the case was thus properly dismissed as abandoned. The Department apparently relies on OAR 436-83-310 for its position, but that reliance is misplaced. OAR 436-83-310 was promulgated by the Board in 1975 and provides:

> "A request for hearing may be dismissed for want of prosecution *where the party requesting the hearing occasions a delay of more than 90 days without good cause.*" (Emphasis supplied.)

At the time Bunch Tire requested a hearing, it was a practice of the Board to issue orders to show cause under the rule to dispose of matters pending consideration or resolution which had not seen any activity for an extended period of time. If there was no response to the order, the case would be dismissed. If a new request for a hearing was submitted, that was considered satisfactory compliance with the order. *See Fulgham v. SAIF,* 63 Or App 731, 734-35, 666 P2d 850 (1983). We hold that the dismissal of the case in issue was error on this record.

OAR 436-83-310 vests the Board, and thus the Hearings Division, with authority to dismiss a party's request for hearing for want of prosecution, "where *the party requesting the hearing occasions a delay* of more than 90 days without good cause." (Emphasis supplied.) There is no evidence in the record to indicate that Bunch Tire was in any way responsible for the delay in setting the hearing. On the contrary, other than the initial acknowledgement of Bunch Tire's request for a hearing, it was the Hearings Division that failed to contact

Bunch Tire until nearly one year later. The Board, in promulgating OAR 436-83-310, limited its discretion and must act in accordance therewith. *See Wyers v. Dressler,* 42 Or App 799, 807-08, 601 P2d 1268 (1979). Without a showing that defendant was responsible for any delay, the Hearings Division exceeded this self-imposed limitation in dismissing Bunch Tire's request for a hearing.

It follows that Bunch Tire has not been shown to be a noncomplying employer and, because it has not, there was no predicate for the trial court's grant of summary judgment to the Department.

Reversed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
RICHARD F. ERZEN, Claimant.

EBI COMPANIES et al,
Petitioners - Cross-Respondents,
v.

ERZEN,
Respondent - Cross-Petitioner.

(82-01698; CA A32492)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 22, 1985.

R. Kenney Roberts, Portland, argued the cause for petitioners - cross-respondents. On the briefs were Jerald P. Keene and Roberts, Reinisch & Klor, Portland.

Donald Winfree, Portland, argued the cause and filed the brief for respondent - cross-petitioner.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Affirmed.

GILLETTE, P. J.

Petitioners, Homecraft Construction Company, Inc. (Homecraft), and EBI Companies (EBI), seek judicial review of an order of the Workers' Compensation Board affirming a referee's determination that claimant is covered by the Workers' Compensation Laws. Respondent's cross-petition requests reversal of the referee's denial of a penalty sought by respondent against EBI. We affirm.

In January, 1981, claimant formed a partnership under the name of E & M Construction (E & M) with his brother and another person. E & M engaged primarily in the framing of new houses and had no employes to assist the partners in their work. In October, 1981, E & M entered into an agreement to perform labor for Homecraft. The agreement consisted of a bid form prepared by E & M which, although verbally accepted by which Homecraft, was not signed by the parties until a later date and was kept in Homecraft's office files. At the time the agreement was entered into, ORS 656.027(7) provided that "[a]ll workers are subject to [the Workers' Compensation Law] except * * * [s]ole proprietors and partners." (*Amended by* Or Laws 1983, ch 579, § 3). Although partners were therefore not considered "subject workers," members of a partnership could elect to become subject workers under ORS 656.128[1] and could thereby become eligible to receive workers' compensation benefits.

[1] ORS 656.128(1) provides, in pertinent part:

"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."

Partnerships could also bring their members under the umbrella of protection provided by the Workers' Compensation Law through a limited exception created under ORS 656.029. Pursuant to that section, any "person," defined by ORS 656.005(21) to include a partnership, to whom a contract is let for the performance of labor, could be considered a subject worker. Specifically, the version of ORS 656.029 in effect at the time provided, in pertinent part:

> "(1) If any person engaged in a business and subject to this chapter as an employer lets a contract involving the performance of labor and * * *

> "(2) If the person to whom the contract is let performs the work without the assistance of others, that person is subject to this chapter as a subject worker of the person letting the contract *unless that person and the person letting the contract jointly file with the insurer or self-insured employer a declaration stating that the services rendered under the contract are rendered as those of an independent contractor.* * * *" (*Amended by* Or Laws 1983, ch 397, § 1 and Or Laws 1983, ch 579, § 2a.) (Emphasis supplied.)

There is no dispute that claimant, as a partner in E & M, was a nonsubject worker under ORS 656.027(7). However, E & M, as a partnership, came within the scope of ORS 656.029(2), because it was "let a contract" by Homecraft, a subject employer, for the performance of labor and performed its framing work for Homecraft "without the assistance of others." The plain language of ORS 656.029(2) thus makes it clear that claimant was a subject worker eligible to receive benefits *unless* a declaration of status declaring E & M an independent contractor was jointly filed by the parties with EBI, Homecraft's insurer.[2]

Testimony given before the referee by a claims supervisor for EBI and the president of Homecraft indicates that there were no documents filed with EBI regarding the original agreement or manifesting acknowledgment by the parties of E & M's status as an independent contractor.[3] Because no joint declaration was filed with EBI, we hold that claimant is a subject worker under ORS 656.029(2) and affirm the Board.

On cross-petition, claimant seeks reversal of that portion of the Board's order affirming the referee's denial of a penalty under ORS 656.262(9), which provides, in pertinent part:

> "If the insurer * * * unreasonably delays or unreasonably refuses to pay compensation, * * * the insurer * * * shall be

> liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed * * *." (*Amended by* Or Laws 1983, ch 809, § 1 and Or Laws 1983, ch 816, § 7.)

[2] Homecraft is not a self-insured employer.

[3] Although ORS 656.029 was amended in 1981 to provide that the filing of a joint declaration created a rebuttable presumption that a person is an independent contractor, we agree with the Board's conclusion that the failure to file did not create a contrary presumption. As the Board said:

> "Where there has been no filing of the joint declaration there is no presumption, either rebuttable or conclusive, that arises. The statute simply operates to make the person performing the work without the assistance of others the subject worker of the person letting the contract."

Taking into consideration the fact that ORS 656.029 was a relatively new statute,[4] lacking in relevant interpretations, as well as the existence of conflicting provisions such as ORS 656.027(7), which excluded partnerships, we believe that EBI reasonably could have had some doubt regarding claimant's status as a subject worker. Accordingly, we agree with the Board that EBI's refusal to pay compensation was not unreasonable and that the imposition of a penalty under ORS 656.262(9) was properly denied.

Affirmed.

[4] ORS 656.029 was enacted two years before its application to the facts of this case. Or Laws 1979, ch 864, § 2.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James W. Thomason, Claimant.

THOMASON,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(79-05982; CA A32255)

Judicial review from the Workers' Compensation Board.

Argued and submitted November 14, 1984.

A. Duane Pinkerton, II, Burns, argued the cause for petitioner. With him on the brief were Cramer & Pinkerton, Burns.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General.

No appearance by respondent Blue Mt. TV Cable Co.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

NEWMAN, J.

Order modified to award 160 degrees for 50 percent unscheduled permanent partial disability for 1977 injury; affirmed as modified.

NEWMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board that awarded him 40 percent unscheduled permanent partial disability for his 1977 com-

pensable injury.[1] *See* ORS 656.214(5). Claimant assigns as errors that the Board reduced the referee's award from 60 percent to 40 percent and in so doing misapplied ORS 656.222. We modify the order to award claimant 50 percent unscheduled permanent partial disability and affirm the order as modified.

Claimant, age 45, fell from a ladder on November 1, 1977, while employed as a television lineman, a job he had held for more than 18 years. He suffered a cervical-dorsal sprain (an "unscheduled" injury) and related pain. In 1970, claimant had suffered a similar compensable injury. Initially he had received 10 percent unscheduled permanent partial disability for the 1970 injury. A determination order in July, 1976, increased that award to 20 percent.

From 1977 to 1981, claimant held several jobs, but his physical condition forced him to give them up. During each of the following two years, claimant did light-to-moderate full-time work nine months of the year for the Forest Service as a warehouse maintenance supervisor.[2] He had to bid for the Forest Service job each year. He testified that he did less physical labor than the job description required and that for approximately ten days each month he felt no pain, but that on the other days he was on medication and had to go home from work on four or five days each month because of pain. The job did not require him to work during the three winter months. He testified that he would not have been able to handle the job then because of more arduous winter responsibilities, such as snow removal.

OAR 436-65-600 to 608 are guidelines for the Workers' Compensation Division to rate the extent of a claimant's unscheduled permanent disability, based on arithmetic values

assigned to factors of impairment, age, education, work experience, adaptability, intelligence, psychological condition and labor market. Although the referee and Board considered the guidelines, the referee did not assign any specific value to any factor and the Board only assigned a specific value, 15 percent, to "impairment."[3] Consequently, the record does not disclose precisely how the referee and the Board determined the extent of claimant's permanent partial disability from the 1977 injury.

On our *de novo* review, we use the guidelines "only when the record discloses the manner in which the Board used them, and then only to the extent their intrinsic persuasiveness assists us in performing our independent assessment function." *Fraijo v. Fred N. Bay News Co.*, 59 Or App

[1] A July, 1978, determination order gave claimant 15 percent unscheduled disability. He filed a request for hearing on July 12, 1979, but the hearing was not held until April 5, 1983. The parties had agreed to await the outcome of claimant's third-party action.

[2] The record does not show where claimant has worked since 1983.

[3] The Board stated:

> "Based on the Orthopedic Consultants' finding that claimant's impairment related to his 1970 injury was mild, we find that claimant's impairment relating to his neck was 15% prior to his 1977 injury. We further find that claimant's total impairment following his 1977 injury is 30%. Therefore, we find that claimant's impairment resulting from the 1977 injury is 15%."

260, 269, 650 P2d 1019 (1982); *accord Harwell v. Argonaut Insurance Co.*, 296 Or 505, 510, 678 P2d 1202 (1984); *see also* ORS 656.214(5); ORS 656.298(6). We conclude that 70 percent is the total extent of claimant's injury-related permanent disability *after* the 1977 injury.[4]

Under ORS 656.214(5), the award of compensation for claimant's unscheduled permanent partial disability "due to the [1977] compensable injury" is "determined by the extent of the disability compared to the worker before such injury and without such disability." The award of disability to claimant for his 1970 injury does not necessarily show the level of his disability just before the 1977 injury. In determining the amount of the disability award for the 1977 injury, ORS 656.222 requires *consideration* of the prior related injury

and the prior disability award, but does not require a mechanical offset. *Green v. State Ind. Acc. Com.*, 197 Or 160, 251 P2d 437, 252 P2d 545 (1952).[5]

We conclude that the extent of claimant's unscheduled permanent partial disability immediately *before* the 1977 injury was 20 percent. The 1976 determination order fixed the extent of his unscheduled disability from the 1970 injury at that amount. Neither the parties, the referee nor the Board assert, and the evidence does not show, that the amount just before the 1977 injury was otherwise. We are not bound to an arithmetical calculation, but we conclude that claimant suffered a 50 percent permanent loss of earning capacity due to the 1977 compensable injury and that 50 percent unscheduled permanent partial disability for the 1977 injury is an appropriate award. ORS 656.214(5), ORS 656.222.

Claimant also assigns as error that the Board misapplied ORS 656.222 because, he asserts, that statute does not apply to cases of unscheduled permanent partial disability. We disagree. *See* page 3 and n 5, *supra; see also Cain v. State Ind. Acc. Comm.*, 149 Or 29, 42, 37 P2d 353, 359 (1934); *see generally American Bldg. Maint. v. McLees*, 296 Or 772, 774,

[4] The Board misapplied the guideline on "impairment," *see* OAR 436-65-602(a), when it assigned a value to "impairment" (15 percent) after the 1977 injury which was the difference between claimant's "impairment" after (30 percent) and before (15 percent) that injury. The effect of this error was to count "impairment" before the 1977 injury twice—once in determining the extent of disability from the 1970 injury and again in determining the extent of disability from the 1977 injury.

[5] ORS 656.222 provides that the award for the last injury shall be made "with regard to the combined effect of his injuries and his past receipt of money for such injuries." *Green v. State Ind. Acc. Com., supra*, held that ORS 656.222 does not require a strict arithmetical offset of the amount of a prior award of disability. The court concluded, quoting from the trial court's opinion:

> " 'It appearing to the Court from the stipulation of counsel for the respective parties that a qualified medical expert if called would testify that *with regard to the combined effect of plaintiff's disabilities sustained in the accident of August 18, 1949 and his disabilities sustained in his accident of 1943 and his past receipt of money for such disabilities the plaintiff as the proximate result of the further accidental injury to his back on August 19, 1949 is suffering a permanent partial disability equivalent to 50 per cent* loss of function of an arm, or 66 degrees. It follows from the conclusions reached by the Court with respect to the law as hereinabove expressed that plaintiff is entitled to an award of 66 degrees in the within action.' " 197 Or at 168. (Emphasis supplied.)

See also Cascade Steel Rolling Mills v. Madril, 62 Or App 598, 661 P2d 564, *rev den* 295 Or 541 (1983); *Cascade Steel Rolling Mills v. Madril*, 57 Or App 398, 644 P2d 655 (1982); OAR 436-65-800(2).

679 P2d 1361 (1984); *Nesselrodt v. Compensation Department*, 248 Or 452, 455, 435 P2d 315 (1967).

Order modified to award 160 degrees for 50 percent unscheduled permanent partial disability for the 1977 injury; affirmed as modified.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dickie A. Comstock, Claimant.

INTERNATIONAL PAPER COMPANY,
Petitioner,

v.

COMSTOCK,
Respondent.

(82-07496; CA A32907)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 20, 1985.

Paul L. Roess, Coos Bay, argued the cause for petitioner. With him on the brief was Foss, Whitty & Roess, Coos Bay.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Dale C. Johnson, and Malagon & Associates, Eugene.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Employer seeks review of an order of the Workers' Compensation Board which affirmed the referee's decision that claimant's worsened cervical condition is compensable. Claimant injured his back while working for employer. He subsequently left that employment, became self-employed and elected not to be covered by workers' compensation insurance. During his self-employment, he experienced increased back problems and underwent corrective surgery.

The referee and the Board determined that the test for compensability found in *Grable v. Weyerhaeuser Company*, 291 Or 387, 631 P2d 768 (1981), is the appropriate rule. Employer argues that the last injurious exposure rule explained in *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 675 P2d 1044 (1984), should be applied, even though claimant was self-employed and not covered by workers' compensation insurance. It concedes that we rejected an identical contention in *Peterson v. Eugene F. Burrill Lumber*, 57 Or App 476, 645 P2d 567 (1982), *aff'd* 294 Or 537, 660 P2d 1058 (1983), but argues that that case is wrong and should be overruled. We are not persuaded by employer's arguments.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Susie F. Ragan, Claimant.

RAGAN,
Petitioner,

v.

FRED MEYER, INC.,
Respondent.

(82-00988; CA A32140)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 15, 1985.

Willard E. Merkel, Portland, argued the cause for petitioner. With him on the brief were Donald E. Beer, and Galton, Popick & Scott, Portland.

Jerald P. Keene, Portland, argued the cause for respondent. On the brief were Craig A. Staples, Leslie J. Mackenzie and Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks judicial review of an order of the Workers' Compensation Board affirming the referee's award of 52.5 degrees for loss of her right forearm. She also seeks review of a previous Board order which affirmed the denial of her request for surgery. Employer moved to dismiss the petition for review insofar as it relates to the latter order.

We first address the motion to dismiss. Claimant sustained a compensable injury to her right wrist when she slipped and fell on her right hand. The injury occurred on April 6, 1980, and she filed a claim for compensation on April 9, 1980. A series of determination orders resulted in an award of 52.5 degrees for loss of her right forearm on March 3, 1981. On March 2, 1981, employer received a letter from claimant's doctor requesting authorization for surgery on her right wrist. Employer denied the request for surgery for the reason that the condition for which surgery was requested was not related to the industrial injury.

Claimant requested review of the determination order and of employer's denial of the request for surgery. The referee overturned employer's denial but held that claimant was not entitled to additional temporary total disability. The referee withheld review of the extent of disability until after the surgery was completed and claimant's condition was reevaluated.

Claimant appealed to the Board, contending that the

claim should be reopened and that she was entitled to temporary total disability benefits. Employer contended that the referee's decision overturning its denial of authorization for surgery was erroneous. The Board reversed the referee, upheld the denial and remanded to the referee for determination of the extent of disability of the compensable part of the claim. The order on remand was issued May 27, 1983. Claimant did not appeal the Board's order, and the referee subsequently, on September 29, 1983, issued an order affirming the determination order.

On October 6, 1983, claimant appealed the referee's order to the Board, contending that the award of compensation was insufficient, and requested that the Board reconsider its earlier order upholding employer's denial of claimant's

request for surgery. The Board affirmed the referee's award of compensation. Regarding the request for reconsideration, the Board said:

> "* * * We are not certain, however, whether we have authority to reconsider our prior order. *See Price v. SAIF,* 296 Or 311, [675 P2d 479] (1984). Assuming, without deciding that we have such authority, we adhere to our prior order."

Claimant petitioned for review of the Board's order affirming the award of compensation and the order of May 27, 1983, upholding employer's denial of surgery.

Employer moved to dismiss the petition for review of the May 27, 1983, order, citing *Price v. SAIF,* 296 Or 311, 675 P2d 479 (1984). It argues that *Price* held that an order upholding a partial denial is appealable and that, therefore, claimant's petition for review was untimely, because it was filed more than 30 days after the Board's order was issued.

Claimant contends that she sought reopening of her claim for surgery, that the Board's order in effect denied reopening of the claim and that that is not the same as upholding a partial denial. Consequently, claimant argues, *Price* is inapplicable. In the alternative, she contends that the Board's order of May 27, 1983, was issued before the Supreme Court's decision in *Price* and that she did not seek review of the Board's order because of our decision in *Jones v. SAIF,* 49 Or App 543, 619 P2d 1342 (1980), which held that such orders were not appealable. She contends that *Price* should not be applied retroactively to deny her review.

Price v. SAIF, supra, involved procedural facts markedly similar to those involved in the case under review. The claimant had suffered a low back strain at work. His claim was accepted, and he received treatment for a compensable injury. After he returned to work, he experienced chest pains. SAIF denied that portion of his claim relating to the chest pains. Claimant appealed the denial of compensability of his chest pains and the extent of disability of his low back injury. The referee overturned SAIF's denial of the claim for chest pains. On review of the referee's order, the Board reversed the order and upheld the denial. It then remanded the claim to the referee for determination of the extent of disability of the back condition. Claimant filed a petition for review in this court, and we dismissed the petition as premature.

On review, the Supreme Court noted that partial denials of a portion of a single claim are a recognized procedure in workers' compensation practice. The court held that the Board's affirmance of a partial denial finally determines that issue and is appealable, even though determination of the extent of disability of the compensable portion of the claim is still in litigation. The court noted that nothing further could be accomplished regarding the denied portion of the claim by the referee on remand.

We do not agree with claimant that there are material distinctions between *Price* and the case at issue. In *Price,* the Board upheld SAIF's partial denial that the claimant's chest pains were related to his compensable back injury. Here, the Board affirmed employer's partial denial of a relationship between claimant's wrist condition for which surgery was requested and her compensable injury. The portion of the Board's order affirming the partial denial could have been appealed. That much is clear from the decision in *Price.*

It does not necessarily follow that claimant must have petitioned for review of the affirmance of the partial denial within 30 days as required by ORS 656.295(8) in order to preserve an appellate challenge to the Board's decision. The Board's order did not dispose of all of the claim; it was remanded to the referee for determination of the extent of disability. The Supreme Court in *Price* upheld the right of the claimant to appeal a final determination of part of the claim; it did not discuss whether or hold that a claimant's appeal rights expired within 30 days of the order. ORS 656.295.

An appeal of the portion of the Board's order remanding the claim to the referee would have been premature. *Jones v. SAIF, supra.* Claimant could wait until the claim was finally determined to appeal and raise all issues relating to the claim. In the circumstances of this case, it is claimant's option to appeal the partial denial or await final determination of the balance of the claim.

A claimant can properly raise all issues respecting the claim in an appeal from an order which finally disposes of the claim. This claimant is not foreclosed from review of the partial denial because she awaited final determination of the balance of the claim and did not seek review of the partial

denial at the earlier opportunity that *Price v. SAIF, supra,* states she had. Employer's motion to dismiss is denied.

On the merits of the appeal of the Board's decision upholding employer's partial denial, we have reviewed the record and concur with the Board's decision which demonstrates an exhaustive analysis of the conflicting medical opinions. We also agree with the Board that the referee was correct in his determination of the extent of disability.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joyce Groshong, Claimant.

GROSHONG,
Petitioner,

v.

MONTGOMERY WARD COMPANY et al,
Respondents.

(81-05961; CA A31287)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 16, 1984.

Edward J. Harri, Albany, argued the cause for petitioner. On the brief were J. David Kryger and Emmons, Kyle, Kropp, Kryger & Alexander, Albany.

Cynthia S. C. Shanahan, Portland, argued the cause for respondents. With her on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Reversed; referee's order reinstated.

GILLETTE, P. J.

In this workers' compensation case, claimant seeks judicial review of an order of the Workers' Compensation Board that reduced a referee's permanent partial disability award from 60 percent to 35 percent. Her principal argument is that the Board erred in admitting documentary evidence offered by the employer after hearing. We reinstate the referee's award.

Extensive repetition of the facts would not aid bench or bar. *See Hoag v. Duraflake,* 37 Or App 103, 585 P2d 1149, *rev den* 284 Or 521 (1978). Suffice it to say that claimant suffers significant impairment from a back injury suffered while in respondent's employ. The injury has required two lower back surgeries.

The referee, who heard claimant testify about the extent of her disability and found her to be a credible witness, awarded her 60 percent permanent partial disability. Respondent then sought Board review. Attached to its brief to the Board were materials from the *Dictionary of Occupational Titles,* often called "DOT." Claimant made timely objection to consideration of the DOT materials. The Board overruled the objection. We set out its opinion at some length:

> "In its brief, the employer has discussed the disability rating guidelines found at OAR 436-65-600, *et seq.,* has included photocopied pages from the *Dictionary of Occupational Titles,* 4th Edition, 1977, and has discussed Appendix A

of Selected Characteristics of Occupations defined in the *Dictionary of Occupational Titles* (1981). The latter two sources have been used to justify the figures the employer uses in its application of the disability rating guidelines.

"Claimant has moved to strike the employer's brief, stating that the employer has improperly supplied the Board with evidence that was not submitted at hearing. *See generally* ORS 656.295(5). Claimant states that the photocopied pages which show the job descriptions of 'sales clerk' and 'stock clerk' were not introduced as evidence at hearing and, therefore, it is improper for the Board to consider such 'evidence' on review. We deny claimant's motion to strike.

"The federal publication entitled *Dictionary of Occupational Titles,* 4th Edition, 1977, is a resource regularly used by the Workers' Compensation Board and the Workers' Compensation Department as an aid in determining the extent of

permanent disability. The Employment Division has available a computer printout which has broken down each one of the job descriptions found in the *Dictionary of Occupational Titles* into various categories. Three of the most regularly used categories are those which determine the specific vocational preparation (SVP) required for a particular job, the general education development (GED) required for a particular job and the strength (STR) required for a particular job. The numerical values assigned in those categories are then applied to the appropriate rules at OAR 436-65-600, *et seq.* which, in turn, yield a number which aids in arriving at a figure indicating the claimant's disability. By supplying the Board with job descriptions from the *Dictionary of Occupational Titles* (which the employer felt reflected the job claimant was performing at the time of her injury), the employer is providing no more information than the Board itself would have relied on in the regular course of its duties.

"In another case, *Thomas C. Whittle,* WCB Case No. 80-05189, 36 Van Natta ___ (decided this date), we discussed the subject of offical notice by the Board in the context of extra-record medical texts. We held that, to the extent we would ever consider such extra-record material as substantive evidence, we would only do so where the material facts in question were capable of certain verification or not subject to reasonable dispute. *See also* ORS 40.065(2); *Dennis Fraser,* 35 Van Natta 271 (1983).

"We regularly refer to the *Dictionary of Occupational Titles,* and *we generally cite it in our orders when we have relied upon it as substantive evidence. In effect it has become a standard reference that we use in evaluating permanent disability.* We consider the information contained in the *Dictionary of Occupational Titles* to constitute facts which are 'capable of immediate and accurate demonstration by resort to easily accessible sources of indisputable accuracy.' McCormick, *Handbook of the Law of Evidence,* 763 (2d ed. 1970). Accordingly, the *Dictionary of Occupational Titles* is properly subject to official notice by the Board as a standard reference in evaluating permanent disability.

"Whether or not we agree that the employer has supplied the *most appropriate* job descriptions found in the *Dictionary of Occupational Titles* is another matter. However, in this case, we do agree with the insurer that claimant's job at the time of her injury appears to have been a combination of sales clerk and stock clerk found in the *Dictionary of Occupational Titles* at 290.477-014 and 222.387-058. We have utilized the

computer analysis of those jobs in the SVP, GED and STR categories as an aid in the evaluation of the extent of claimant's permanent disability. Similarly, we see no problem with the employer's discussion of Appendix A of the Selected Characteristics of Occupations defined in the *Dictionary of Occupational Titles.* This appendix explains the categories that are broken down in the Employment Division computer printout.

"In conclusion, we are denying claimant's motion to strike because the *Dictionary of Occupational Titles* and Appendix A of Selected Characteristics of Occupations defined in the *Dictionary of Occupational Titles* are essential resources in interpreting the guidelines set out at OAR 436-65-600, *et seq.* Since those resources are regularly used by the Workers' Compensation Board, as well as the Workers' Compensation Department, we do not find it inappropriate that the employer discussed these resources without having formally admitted them into evidence at the hearing. The employer presented this material as part of its appellant's brief, and claimant had the opportunity to respond. Accordingly the procedural requirements discussed in *Dennis Fraser, supra,* have been met." (Emphasis supplied.)

Review by the Board is statutorily limited to evidence found in the record from the hearing below. ORS 656.295(5). We have held that the Board has no authority to hear "additional evidence not admitted at the hearing and not a part of the record." *Gallea v. Willamette Industries,* 56 Or App 763, 768, 643 P2d 390 (1982). As noted in *Gallea,* under ORS 656.295(5) the Board is limited to remanding to the referee for further evidence taking if the case has been improperly, incompletely or otherwise insufficiently developed.

Respondent has offered two justifications for the Board's use of the DOT. First, it argues that DOT is not evidence but, rather, a part of "the law of the Oregon Workers' Compensation System as embodied within the Oregon Administrative Rules." That is not correct; there is no reference to the DOT in the rules, much less specifically in OAR 436-65-608, on which respondent relies.[1]

Second, respondent relies on the Board's approach of taking official notice of the DOT. The Board's order states

that it was taking official notice of the DOT as substantive evidence of facts capable of certain verification or not subject to reasonable dispute. The Board's order then goes on to categorize claimant on the basis of the DOT and mechanically apply calculations based on this reference to the guidelines for determining disability found in OAR 436-65-600 *et seq.*

Respondent cites *Bend Millwork v. Dept. of Revenue,* 285 Or 577, 592 P2d 986 (1977), which discusses judicial notice, to support the Board's use of the DOT. The Supreme Court did say there that notice of special dictionaries giving the "true significations" of words "used in those fields of thought and endeavor which we descibe as being 'scientific,' especially in the mathematical sciences" was proper. 285 Or at

[1] By noting that the DOT has not been adopted by rule, we do not decide whether it could (or should) be.

583. The court cautioned, however, that, "[a]s we leave those fields, * * * self-restraint must be exercised in order to avoid the taking of evidence from a source not subject to confrontation and cross-examination." 285 Or at 584. Considering the reliance placed on DOT by the Board, going beyond the mere definition of technical words, self-restraint regarding judicial notice in this instance would have been appropriate.

The reasoning behind limiting the Board's—or any agency's—review to the record was stated in *Rolfe v. Psychiatric Security Review Board,* 53 Or App 941, 633 P2d 846 (1981):

> "The vice of receiving these 'facts' as evidence outside of the hearing is that it deprives petitioner of an opportunity to challenge them. Without presentation at a hearing, petitioner has no way of showing that these facts—which carry much weight—either are not well founded or are not relevant to his case for some distinguishing reason." 53 Or App at 951.

We also quoted Schwartz, *Administrative Law* 358 (1976):

> " '[E]xclusiveness of the record is at the core of the right to a fair hearing. Without that principle the hearing itself can be but a sham. * * * The hearing itself becomes only an administrative town meeting rather than the adversary proceeding required by due process.' " 53 Or App 951.

The Board's action here accomplished precisely what *Rolfe* and Schwartz condemn: It accepted as pivotal facts that the claimant was given no opportunity to contest, cross-examine or refute.

By using extra-record evidence in the form of the DOT, the Board has substituted a further mechanical calculation for the guidelines laid down in OAR 436-65-600 *et seq.* This court has already cautioned against the too rigid application of the rules in establishing the level of permanent partial disability. *See Fraijo v. Fred N. Bay News Co.,* 59 Or App 260, 650 P2d 1019 (1982). In an effort perhaps to insure uniformity in awards, the Board's action in effect shortcircuited the hearing process mandated by law by denying claimant a chance to rebut DOT data, the application of which to her may depend on factors not foreseen by the authors of the DOT, in an adversarial hearing. If the Board believed that the case was improperly developed factually, it should have remanded for further evidence taking. ORS 656.295(5). Failing that, it was improper for the Board to take judicial notice of the DOT or otherwise to use it in deciding the case.

Rejection of the Board's approach to the evidence also leads us to reject its assessment of the extent of claimant's disability. On that point, we find the referee's decision well reasoned and persuasive. It is reinstated.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Russell Carter, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner,

v.

CARTER,
Respondent.

(81-05764; CA A31320)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 18, 1985.

Donna Parton Garaventa, Assistant Attorney General, Salem, argued the cause for petitioner. With her on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Michael Haines, Salem, argued the cause and filed the brief for respondent.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Affirmed.

GILLETTE, P. J.

SAIF petitions for review of a Workers' Compensation Board order requiring SAIF to accept an exacerbation of claimant's multiple sclerosis (MS) condition as compensable. We affirm.

Claimant works for the Field Services Division of the Workers' Compensation Department. In 1980 and 1981, he was a supervisor in the Portland area. He has had MS since 1974 and has been a patient of Dr. Swank since 1975. He had several exacerbations of the disease in 1976 and 1977 but was essentially stable from then until February, 1981. Early in 1981, the Portland newspapers reported allegations that claimant, a State Senator and the head of the Workers' Compensation Department had received favors from a vendor of rehabilitation services; the implication was that claimant had sent injured workers to the vendor's program for improper reasons. The allegations led to grand jury and Ethics Commission investigations. Those investigations took up much of claimant's time during the first half of 1981 and subjected him to considerable stress. The charges also received a large amount of publicity, increasing claimant's stress. Even before the allegations surfaced, claimant had worked 10-hour days and frequent weekends; his perfectionism caused problems between him and those he supervised.

Claimant's MS began to be exacerbated in February, 1981, producing numbness in his arms, hands and legs. At the time of the hearing he had improved but continued to have residual numbness in his left hand and right fingertips and pain in his upper thighs. The weight of the testimony is that an exacerbation of MS leaves one or more lesions along neural pathways, resulting in a permanent neurological deficit, and that a patient will never recover to the pre-exacerbation condition. Although exacerbations are to be expected in the course of the disease, each produces a worsening of the underlying condition as defined in *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979). A particular exacerbation is therefore compensable if it is caused by something related to the patient's work. The issue here is whether claimant's 1981 exacerbation was causally connected to his work-related stress.

We have dealt with the effect of stress on MS exacerbations, and with Swank's position as an expert, twice previously. In *Abbott v. SAIF*, 45 Or App 657, 609 P2d 396 (1980), we found that the claimant, who was also a patient of Swank, had shown that stress had exacerbated her MS. Although three neurologists testified to the contrary, and although it was a close case, we found Swank's opinion that stress was the cause was more persuasive, because he was the treating physician and because he had more expertise in treating MS than did the other neurologists. In *Giesbrecht v. SAIF*, 58 Or App 218, 648 P2d 70 (1982), we found that the claimant had not shown that heat caused an exacerbation of his MS. Four physicians had testified that it did not, but the referee had accepted Swank's opinion that it did because we had found Swank persuasive in *Abbott v. SAIF, supra*. As we pointed out in *Giesbrecht*, our decision on the value of a particular expert's testimony can only be a decision for the particular case. Each case must stand on its own. "[T]he contribution of one expert's opinion to the preponderance of evidence in one case has no bearing on the relative weight of the same expert's opinion in another case with a different mix of medicial opinions." 58 Or App at 219.

Again in this case, Swank's position on MS is disputed by other neurologists, and again we must evaluate his position in the context of a specific claim and a specific record.[1] Swank is the former head of the Neurology

[1] One difficulty we have in this case comes from the nature of the testimony, particularly from the limited cross-examination of the medical witnesses. All of the physicians referred, in general terms, to studies, published and unpublished, which supported or illustrated their testimony. However, counsel did not ask the physicians to refer to studies by title, name of author or journal and date of publication, nor did counsel on cross-examination ask them to comment on specific publications which might contradict or cast doubt on their testimony. No relevant studies were placed in the record. Counsel made little attempt to test the methodology of the studies which were discussed. The issue we must decide is primarily whether stress *can* cause an exacerbation of MS. That is a question of scientific knowledge. In answering it, empirical data, explained by knowledgeable experts, would be more valuable than the opinion of a treating or examining physician. Testimony based on research, and sophisticated probing of that testimony by reference to specific research findings and methodologies, is more important in deciding this kind of question than are unsupported opinions of physicians, however detailed or clearly stated. In the absence of such testimony we are left to pick and choose among the experts, relying on their apparent credentials and the persuasiveness of their presentations. We are unable to determine as well as we would wish what scientific authority is behind the experts' opinions or to compare those opinions to research results.

Department of the University of Oregon Medical School (now Oregon Health Sciences University). Although he retired from that position when he reached the mandatory retirement age, he continues an active medical practice, limited to the treatment of MS. He has conducted long-term studies on groups of MS patients, including one group that he has followed for over 30 years. In his opinion, which he first developed in the 1940's, MS is the result of an excessively high level of blood fat; the heart of his treatment, therefore, is a low fat diet. He also previously used whole blood transfusions and presently uses plasma infusions during an exacerbation.

Swank appears to be almost alone in the profession in his view of the cause of the disease. The other neurologists who testified stated that the cause of MS is unknown but that the best theories are that it is either the result of a slow virus or of an auto-immune response. The only available treatment for an exacerbation, they testified, is palliative, except that steroids appear to help clear up vision problems. In part because of their view that there is no effective treatment, the other neurologists have relatively few MS patients, while Swank has 800 or 1000 at any one time. Although Dr. Watson did not believe that Swank's treatment can arrest the disease, he considers Swank's program excellent palliative care and encourages his MS patients who ask about it to go to Swank.

The evidence is similarly divided on whether stress can cause MS to exacerbate. In a letter, Dr. Stolzberg questioned whether stress is definable or objectively measurable and stated that claimant's exacerbation was not related to his work. In his testimony, Dr. Snodgrass denied that stress can cause an exacerbation. He pointed to a study showing no greater MS incidence in soldiers exposed to combat than in soldiers who never saw action.[2] Watson questioned how a mental condition such as stress could have a physical effect on nerve pathways. He recognized that some studies show a relationship between *physical* stress and MS exacerbations. Swank stated unequivocably that stress can cause exacerbations and that it in fact caused claimant's. He relied partly on

the opinions of other neurologists and partly on a study he conducted of 12 divorcing women. The study showed that 10 of the 12 women experienced exacerbations in the course of their divorces and that the two who did not were the only ones who were independently secure financially.

All of the objective evidence in this case is flawed. The study of veterans is not in the record, and we cannot evaluate it beyond Snodgrass' summary. The expert opinions on which Swank relied are apparently all several decades old. He apparently made no attempt to evaluate the degree of stress the divorcing women he studied had experienced in any objective fashion or to compare them to a control group.[3] Watson, although denying that mental stress could play a role, accepted physical stress as a possible contributor.[4] All the physicians recommended rest for a patient during an exacer-

[2] Snodgrass did not mention the source of this study. He spent a number of years working in veteran's hospitals early in his career, and he may have learned of the study during that work. Neither he nor any other expert who testified claimed to have done a thorough search of the relevant medical literature or to be presenting the results of such a search at the hearing.

bation, which indicates some feeling that a reduction in stress might be helpful.

The question of whether mental stress can cause MS exacerbation is, on this record, close.[5] Swank seems to be opposed to the generality of the profession on the cause of MS, but he also has had far more experience with the disease than has any of the other witnesses. His experience with the disease gives his opinion on the relationship between mental stress and exacerbations considerable weight. We find, on the evidence before us, that it is more probable than not that mental stress can cause MS to exacerbate. That being the case, we accept the opinion of Swank, claimant's treating physician, and find it more probable than not that claimant's work-related stress caused his 1981 exacerbation. His claim as to that exacerbation is compensable.[6]

Affirmed.

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[3] We say "apparently," because the cross-examination did not probe into Swank's study in any depth.

[4] Stolzberg's denial of the existence of mental stress gives his opinion little value in this context.

[5] It is also, of course, a medical, rather than a legal, question. However, the answer is relevant to claimant's claim, and we must therefore resolve it for the purposes of this case on the record before us. We necessarily do so without prejudice to future medical developments or to previous medical developments of which we have not been made aware and which may be presented in a future case.

[6] We do not, by this ruling, express any opinion as to the compensability of future exacerbations, if they occur.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Terri E. Becker, Claimant.
E. W. ELDRIDGE, INC. et al,
Petitioners,
v.
BECKER,
Respondent.
(81-08634, 81-08635; CA A32179 (Control))

In the Matter of the Compensation of
Robert E. Becker, Claimant.
E. W. ELDRIDGE, INC. et al,
Petitioners,
v.
BECKER,
Respondent.
(81-08636, 81-08637; CA A32180)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 22, 1985.

R. Kenney Roberts, Portland, argued the cause for petitioners. On the brief were Jerald P. Keene and Roberts, Reinisch & Klor, Portland.

Alan M. Scott, Portland, argued the cause for respondents. With him on the brief were Jill Backes and Galton, Popick & Scott, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Affirmed.

GILLETTE, P. J.

Petitioners, E. W. Eldridge, Inc. (Eldridge), and EBI Companies (EBI), seek judicial review of an order of the Workers' Compensation Board (Board) affirming two opinions of a referee which had held them responsible for separate claims submitted by respondents Terri Becker and Robert Becker for injuries received while in the employ of a subcontractor performing work for Eldridge. The subcontractor's compensation coverage had lapsed. We affirm.

Claimants were employed as dump truck drivers by D & F Trucking (D & F), a corporation engaged in general subcontract work. In November, 1980, Eldridge let a contract to D & F under which D & F was to deliver and unload quarry materials for Eldridge at a job site in Kelso, Washington. At the time the parties entered the contract, D & F had workers' compensation insurance for its employes through SAIF, but that insurance apparently lapsed on December 31, 1980. D & F obtained workers' compensation coverage in Washington.

On March 31, 1981, claimants both suffered compensable injuries[1] arising from the same incident at the Kelso job site. Separate claims were filed with SAIF, EBI and the State of Washington. Each of the claimants' three claims was subsequently denied, and claimants requested a hearing on their Oregon claims.

After the hearing, the referee concluded, in separate orders, that the claims were governed by Oregon Workers' Compensation Law and that claimants were subject workers of Eldridge under Oregon's statutory employer law. ORS 656.029; *see EBI Companies v. Erzen*, 73 Or App 256, ___ P2d ___ (1985). *Cf. former* ORS 656.124 (*repealed by* Or Laws 1965, ch 285, § 95). As a result, Eldridge was held responsible for the payment of all workers' compensation benefits to claimants through its insurer, EBI. The Board affirmed.

Petitioners first assign as error the Board's interpretation of ORS 656.029 as imposing on an "employer who lets a contract" (*i.e.*, a prime contractor) the responsibility of monitoring "the person to whom the contract was let" (*i.e.*, a

subcontractor)[2] for the purpose of assuring that the latter maintains workers' compensation insurance coverage for its employes. A result of the Board's interpretation is that an

[1] Compensability is not at issue in this appeal.

[2] These designations are only for the sake of clarity and convenience. We do not purport by this opinion to limit the scope of the statute solely to prime contractor-subcontractor relationships; the issue of whether the statute applies to subcontractor-subsubcontractor relationships is not before us.

uninsured subcontractor's employe injured on the job is a "subject worker" of the prime contractor for the purposes of workers' compensation and, thus, is entitled to benefits through the prime contractor's insurer.

The version of ORS 656.029 (*amended by* Or Laws 1981, ch 725, § 1; Or Laws 1981, ch 854, § 4; Or Laws 1983, ch 397, § 1; and Or Laws 1983, ch 579, § 2a) in effect at the time claimants' injuries occurred provided:

> "(1) 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.
>
> "(2) If the person to whom the contract is let performs the work without the assistance of others, that person is subject to this chapter as a subject worker of the person letting the contract unless that person and the person letting the contract jointly file with the insurer or self-insured employer a declaration stating that the services rendered under the contract are rendered as those of an independent contractor."

It is clear from a reading of the statute that a prime contractor is to be responsible for persons deemed "subject workers" under the provisions of the Workers' Compensation Laws. It is equally clear, however, that the prime contractor may avoid responsibility if certain conditions are met. *See EBI Companies v. Erzen, supra.*

Subsection (1), applicable here, removes responsibility from the prime contractor if the subcontractor qualifies as either a "direct responsibility employer" or a "contributing employer." As the former, the employer is self-insured and warrants that it will be personally responsible for compensation benefits. *See* ORS 656.407 (*amended by* Or Laws 1981, ch 854, § 27). As the latter, an employer furnishes workers' compensation coverage through an insurance carrier. *See former* ORS 656.411 (*repealed by* Or Laws 1981, ch 854, § 1). At the time it subcontracted with Eldridge, D & F qualified as a contributing employer under ORS 656.029.

Petitioners argue that the language of the statute, "has qualified," imposes responsibility on the prime contractor to verify a subcontractor's insurance coverage only at the time a contract is let and that the prime contractor is thus relieved from responsibility if an injury occurs at some later date when the subcontractor has become uninsured. They argue that there is no duty to monitor subcontractors to see that insurance is maintained and that to impose such a duty would be an unfair burden. However, the legislative history of ORS 656.029 and the policy of the Workers' Compensation Law do not support petitioners' claims.

The impetus behind the introduction and passage of

ORS 656.029 was the desire to eliminate "phony partnerships" and other business entities organized to evade responsibility under the Workers' Compensation Law. Minutes, Senate Committee on Labor, Consumer and Business Affairs, p 7 (Feb. 27, 1979 — Statement of Senator Kulongoski). Legislators recognized the seriousness of the problem and strove to correct it by enacting legislation which would encourage employers either to obtain insurance on their own, demand proof of insurance coverage from subcontractors or negotiate a waiver of responsibility through the filing of a declaration of independent contractor status. Minutes, Senate Committee on Labor, Consumer and Business Affairs, pp 4-7 (Feb. 27, 1979). Because the primary goal of all workers' compensation legislation is the protection of employes, we agree with the Board that imposing liability on the party best able to shoulder the burden both financially and logistically, *i.e.*, the prime contractor, achieves this goal and furthers the intent of the legislature. We hold, therefore, that ORS 656.029

is to be applied in the light of the circumstances at the time a worker is injured, rather than the time the contract was let.

Petitioners argue that the imposition of a monitoring function on contractors will encourage unscrupulous or careless subcontractors either to cancel their insurance coverage after entering the contract or to let their coverage lapse. We believe, as did the Board, that the referee identified an answer to this objection which may be currently in practice or which at least deals with petitioners' concerns: The prime contractor need only obtain from the subcontractors it does business with, proof of coverage *and* assurance that such coverage will be maintained until the contract is performed. The prime contractor is in the best position to require compliance with its demands, as it controls the selection of its subcontractors.[3] This position receives support from one noted commentator:

> "The purpose of this legislation was to protect employees of irresponsible and uninsured subcontractors by imposing ultimate liability on the presumably responsible principal contractor, who has it within his power, in choosing subcontractors, to pass upon their responsibility and insist upon appropriate compensation protection for their workers." 1C Larson, *Workmen's Compensation Law* 9-12, § 49.11 (1980 ed.).

The parties did not cite, but our research has disclosed, another section of the Workers' Compensation Law which, we believe, reflects the legislative policy that the prime contractor be ultimately liable for workers' compensation coverage. At the time of claimants' injury, ORS 656.556 (*amended by* Or Laws 1981, ch 854, § 38) provided:

> "If any person lets a contract and the person to whom the contract was let, while performing the contract, engages as an employer subject to ORS 656.001 to 656.794 at the plant of the person letting the contract, upon premises owned, leased or controlled by such person *or upon premises where such person is conducting his business, the person letting the contract shall be liable to the Industrial Accident Fund for the payment of all contributions which may be due such fund on*

[3] It would seem that employer-subcontractors normally also would be encouraged to provide coverage to avoid a finding of noncompliance under the Workers' Compensation Law, which would subject them to sanctions, such as a penalty. *See* ORS 656.052, 656.054.

account of the performance of the contract or any subcontract thereunder." (Emphasis supplied.)

The statute plainly made a prime contractor responsible for the payment of a subcontractor's "contributions" due the Industrial Accident Fund if certain circumstances existed. Pursuant to ORS 656.504-.505 and 656.508 (*amended by* Or Laws 1981, ch 854, §§ 33, 34 and 35), "contributions" consisted of the monthly payment or premium for workers' compensation insurance coverage. *See also* Skelton, *The 1965 Oregon Workmens' Compensation Law: A New Model for the States,* 45 Or L Rev 40, 51 (1965). The legislature's obvious intention to make the prime contractor liable for a subcontractor's monthly payments clearly reinforces the conclusion of the Board that the prime contractor should be ultimately responsible for a workers' insurance coverage in the event the subcontractor is uninsured at the time of the injury, and we so hold.

Petitioners next assign as error the Board's determination that the contract between Eldridge and D & F was for "labor" rather than for the delivery of "materials." Petitioners argue that the contract entered into between the parties in this case involved a "materials" contract and that ORS 656.029 is therefore inapplicable, because it only operates where a contract is let "involving the performance of labor." We agree with the Board that petitioners' characterization of the contract must be rejected, because the terms and nature of the contract clearly involved "the performance of labor."

Affirmed.

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638 May 22, 1985 No. 276

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Betty L. Williams, Claimant.

WILLIAMS,
Petitioner,

v.

GATES, McDONALD & COMPANY,
Respondent.

(80-10620; CA A32940)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 1, 1985.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Associates, Eugene.

Cynthia S. C. Shanahan, Portland, argued the cause for respondent. With her on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Affirmed.

GILLETTE, P. J.

Claimant seeks judicial review of a Workers' Compensation Board order that found that her memory loss and mild dementia are not causally related to her compensable upper back injury. We affirm.

Claimant was injured in March, 1978, while working for Owens Illinois Corporation in a job which required repetitive lifting. She saw a series of physicians after the injury. They prescribed conservative treatment, but she continued to have severe pain in her right shoulder and arm. She was ultimately referred to Dr. Misko, a neurosurgeon, who recommended a discectomy and spinal fusion at the C5-6 level. In his preoperative examination he noticed a bruit[1] in her right carotid artery. He also learned that she had had an incident of amaurosis, or temporary blindness, in her right eye. He attributed that incident to the carotid artery defect. It would be necessary to retract, or move, the right carotid artery in the course of the spinal fusion surgery. The condition which Misko found indicated that there might be unreasonable dangers in doing so with the artery in its current condition. Misko therefore first performed a right carotid endarterectomy, removing the plaque buildup from inside the artery, in September, 1979. He then performed the discectomy and fusion in October, 1979.

Soon after the endarterectomy, claimant began noticing a loss in her short-term memory; she also experienced other symptoms, which were ultimately diagnosed as mild dementia.[2] The medical evidence on the cause of claimant's mental problems is not wholly satisfactory. We conclude, however, on the basis of our review of the evidence, that the most probable explanation is that claimant suffered either a mild stroke or a temporary loss of oxygen to her brain in the course of or as a result of the endarterectomy. We therefore

find that claimant's memory loss and dementia were caused by that operation.

Our finding on the cause of claimant's symptoms requires us to determine whether the endarterectomy is the result of claimant's compensable injury. As a matter of chronology, she had the operation when she did because it was a necessary prelude to the discectomy and fusion; the latter operation was clearly related to her injury. However, the

[1] A bruit is an unusual sound caused by the turbulent flow of blood through the artery at a point where it is constricted.

[2] These problems do not clearly appear in claimant's medical and psychological records until about two years after the operation. However, she and her family testified at the hearing that she first exhibited the symptoms soon after the endarterectomy. The referee accepted that testimony as credible; the Board did not reverse those findings. We have no basis for disagreeing with the referee on this point.

chronology does not end the inquiry. Misko, in a letter of June 3, 1983, stated:

> "It is true that Betty Williams developed amaurosis and a right carotid bruit. It is also true that because of the necessity of retracting the carotid artery and because of the symptoms, we performed a right carotid endarterectomy prior to a cervical discectomy and interbody fusion for her industrial injury.
>
> "However, *it is also true that, independent of her industrial injury, this patient should have had a right carotid endarterectomy.* It was, in fact, her industrial injury which brought her to the attention of physicians who diagnosed her case of carotid stenosis resulting in amaurosis. It was necessary to perform this procedure prior to her cervical discectomy." (Emphasis supplied.)

We understand Misko's letter to state that claimant should have had the endarterectomy, whether or not she had the spinal surgery. The condition which required that operation was not one which claimant could have safely ignored if it had not been for the fusion; the amaurosis was a sign that she needed treatment. The problem with her carotid artery was not going to disappear. There is no causal connection between her compensable injury and the underlying carotid artery constriction, and there is no causal connection between her compensable injury and the surgery to repair that constriction. There is only a purely fortuitous chronological connection. That chronological connection is insufficient to make the aftereffects of the endarterectomy compensable.

The endarterectomy itself is compensable, of course, because it was a necessary prelude to the spinal surgery. However, the fact that a physican had to provide independently required treatment in order to treat the compensable

injury does not by itself alone make the long-term consequences of the independently required treatment compensable.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wayne A. Volk, Claimant.

VOLK,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Respondent.

(83-04354; CA A32948)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 1, 1985.

Quintin B. Estell, Salem, argued the cause and filed the brief for petitioner.

Philip Schradle, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief was Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

GILLETTE, P. J.

Reversed; referee's order reinstated.

GILLETTE, P. J.

Claimant seeks judicial review of an order of the Workers' Compensation Board which denied his claim for penalties and attorney fees for SAIF's allegedly premature closure of his case and termination of his temporary total disability and medical benefits. The referee had awarded penalties and attorney fees. Claimant asserts that SAIF terminated benefits before his attending physician released him for a return to his regular employment and before there was a determination order finding him medically stationary. SAIF therefore acted, claimant argues, before it had the legal right to do so. We agree that SAIF's actions were improper and reinstate the referee's order.

Claimant works in heavy construction. He injured his back in July, 1982. He received chiropractic treatment from Dr. Nickila for that injury. In October, 1982, SAIF referred him to Dr. Murphy, an orthopedist, for evaluation. In November, Nickila referred him to Dr. Buza, a neurosurgeon, for consultation. Buza ordered certain tests and continued to follow claimant's progress after the original examination; however, Nickila remained claimant's primary treating physician. Claimant's condition improved with continued treatment. Nickila had released him for light duty work on October 4, 1982, before either medical examination. In January, 1983, Nickila stated that claimant was medically stable but continued to be available only for light work. Because claimant's

employer had no light duty work available, claimant did not actually return to work.

Murphy saw claimant a second time on February 25, 1983. In his report, dated March 7, 1983, he stated that claimant had improved sufficiently to return to his regular work. He did not say that claimant was then medically stationary, but he believed "that 4 to 6 weeks *after he returns to his job,* he may be declared medically stationary. An impairment should be rated at that time. I would anticipate none." (Emphasis supplied.) Murphy also said that claimant "should be evaluated periodically after he returns to work to determine that he is indeed able to perform his construction work." SAIF sent a copy of Murphy's report to Buza, who responded on April 11, 1983, that he concurred with Murphy

> "that the patient can return to regular work, that is, within 4-6 six weeks after Dr. Murphy has seen the patient which is

> about the 7th of April, and at the time of this letter. I believe that he is medically stationary *if there has [sic] not been any interim changes since he was last seen at this office.*" (Emphasis supplied.)

Neither Murphy nor Buza considered claimant medically stationary at the last time they saw him; they only believed that he would probably be stationary at some later date. Both implicitly assumed that claimant would return to work for a trial period before being found medically stationary. Nevertheless, SAIF terminated claimant's benefits on April 7, 1983. Its action in doing so was unreasonable for two reasons. First, it acted before claimant's attending physician—Nickila—approved his return to his regular employment and before the issuance of a determination order. Second, it unreasonably misread Murphy's and Buza's statements as unequivocal findings that claimant was stationary rather than as predictions that he probably would be stationary if he had no difficulties after several weeks of his normal work.

ORS 656.268(2) provides in part:

> "If the attending physician has not approved the worker's return to the worker's regular employment, *the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized* following examination and the medical reports submitted to the Evaluation Division under this section." (Emphasis supplied.)

The "attending physician" is the "doctor or physician who is primarily responsible for the treatment of a worker's compensable injury." ORS 656.005(13). Nickila was claimant's attending physician. He had not released claimant to return to his regular employment. There was no determination order until May 12, 1983. SAIF was without authority to terminate claimant's benefits before then. *See Scheidemantel v. SAIF,* 68 Or App 822, 824-25, 683 P2d 1028, *modified* 70 Or App 552, 690 P2d 511 (1984).

Even if SAIF's closure were proper procedurally, it was wrong in substance. There is no substantial evidence to support SAIF's conclusion that claimant was medically stationary and that he had no permanent disability. Before an

insurer may close a claim without a determination order, it must reach both conclusions. If there is no substantial evidence in support of those conclusions, the insurer is liable for a penalty if it closes the claim without a determination order. ORS 656.268(3).[1] Although Nickila indicated in January that claimant was medically stationary, he released claimant only for light work and stated that claimant had periods of remission and exacerbation of his problem. If SAIF accepted Nickila's opinion, it must necessarily have concluded that there would be permanent partial disability.

Neither do the reports of the other physicians support SAIF's action. Murphy and Buza did not find claimant stationary when Nickila did. Indeed, they did not find him *presently* stationary at all. Murphy's report suggested a probable future stability, but he clearly was predicting the future rather than describing a present condition. In addition, his prediction was based on claimant's returning to his regular work without problems in the interim. SAIF knew that claimant had not returned to work and that Nickila had not released him to do so. Buza's report simply agreed with Murphy's, and Buza was unaware of what might have happened to claimant in the period since he last saw him. SAIF had no basis for concluding that claimant was *both* medically stationary and had suffered no permanent disability. SAIF is liable for the penalty provided in ORS 656.268(3) for a premature closure and is liable for an award of attorney fees.[2]

Reversed; referee's order reinstated.

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[1] ORS 656.268(3) provides, in pertinent part:

"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."

[2] The record contains considerable evidence about the the reasons for the various physicians' opinions and about developments after SAIF closed the claim. The parties argue the effect of that evidence. It is irrelevant to the issue on appeal, which is whether SAIF had substantial evidence to act as it did. The answer to that question necessarily depends on what SAIF knew at the time it acted.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation
of Lawrence M. Sullivan, Claimant.

SULLIVAN,
Petitioner,

v.

ARGONAUT INSURANCE COMPANY,
Respondent.

(81-06349; CA A31255)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1984.

Kenneth D. Peterson, Jr., Hermiston, argued the cause and submitted the brief for petitioner.

LaVonne Reimer, Portland, argued the cause for respondent. With her on the brief were Lindsay, Hart, Neil & Weigler, Portland.

Before Joseph, Chief Judge, and Warden and Newman, Judges.

WARDEN, J.

Affirmed.

WARDEN, J.

Claimant petitions for review of an order of the Workers' Compensation Board reversing the referee and reinstating a determination order that he claims was issued prematurely. In the alternative, he claims that the Board erred in not reopening his claim for aggravation. We affirm.

Claimant sustained injuries when he fell at work in September, 1980. The primary injury was to his left knee, although he also sustained a cracked rib and claimed a back injury. Insurer accepted the claim, and Dr. Corbett performed knee surgery. On March 31, 1981, the doctor declared claimant medically stationary. On April 28, 1981, a determination order of the Workers' Compensation Department awarded claimant compensation for temporary total disability from September 9, 1980, to March 31, 1981, and scheduled permanent partial disability for a 15 percent loss of the left leg. He received no permanent partial disability award for any other injury. Claimant requested a hearing.

In July, 1981, claimant sought to reopen his claim because of problems with his back, which he maintained also resulted from his 1980 fall. Insurer responded with a letter which said, in part:

> "This is to advise you that we are respectfully denying responsibility for your back problems and circulation loss under the Workers' Compensation Laws, as we do not feel

that these problems resulted from your original injury and did not arise out of nor in the course and scope of your employment.

"This partial denial does not affect your original knee injury and cracked rib injury, which is still in an accepted state."

The referee set aside the 1981 determination order on the ground that

"the back condition was not stationary, at that point in time, as evidenced by the medical reports both before and after the publication of the Order. In addition, although Dr. Corbett had indicated that the left knee was medically stationary, prior to the Determination Order being published, his subsequent reports indicate a worsening of that condition * * *."

The referee also set aside the denial of claimant's back injury claim. The Board affirmed the referee's order setting aside the denial but reversed the order setting aside the determination order as premature and remanded the claim to the referee to consider the extent of disability from both the knee and the back injuries.

Claimant argues that the Board erred in reinstating the determination order. We agree with the Board that claimant failed to prove that his injury-related conditions were not stationary at the time of closure. At the hearing, claimant sought to have the claim reopened on the ground that his knee had *worsened* after the claim closure. The referee agreed, reasoning that worsening of the knee less than a year after the determination order justified reopening "without the necessity of a formal aggravation claim." The Board properly reversed that decision, citing *Roy McFerran, Jr.*, 34 Van Natta 621 (1982), *aff'd without opinion, McFerran v. SAIF*, 60 Or App 786, 655 P2d 230 (1982). Claimant does not defend the referee's reasoning.

On review, claimant takes the position that his knee condition *improved* after claim closure and that his knee condition therefore could not have been "medically stationary" as defined by ORS 656.005(17):

" 'Medically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time."

A subsequent change in a claimant's condition may not be used to second-guess informed medical opinion relied on at the time a claim was closed. *See Alvarez v. GAB Business Services, Inc.*, 72 Or App 524, 696 P2d 1131 (1985); *Maarefi v. SAIF*, 69 Or App 527, 531, 686 P2d 1055 (1984). The Board properly reinstated the determination order as to both the back and the knee.

Claimant's second assignment is that the Board erred in not reopening his back claim on the basis of aggravation. Claimant's entire argument in support of the assignment is:

"The Board affirmed the referee's reversal of the denial. Logically it follows that as an integral part of reversing the denial the claim must be reopened also. If claimant were stationary on April 28, 1981, then Dr. Smith's report provides justification, in conjunction with claimant's aggravation

claim for reopening, for opening the case after the April 1981 closure. Clearly claimant was suffering significant back difficulties when he saw Dr. Smith." (Citations omitted.)

Claimant, however, had not made a valid claim for aggravation. He relies on Dr. Smith's letter of June 5, 1981, as a claim. In that letter the doctor merely noted that claimant had said that he had experienced back trouble since the accident. He did not state that the original injury resulted in any worsening of the back condition after the claim was closed, nor did he indicate a need for further medical services or compensation because of the original injury. The doctor's letter is not a claim for aggravation under ORS 656.273(3).

Affirmed.

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768 May 22, 1985 No. 292

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Terri L. Kuhn, Claimant.

KUHN,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(83-01668; CA A33124)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 13, 1985.

A. J. Morris, Eugene, argued the cause for petitioner. With him on the brief were Hoffman, Morris, Giustina and Fox, Eugene.

Ann Farmer Kelley, Assistant Attorney General, Salem argued the cause for respondent. With her on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Gillete, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Reversed; referee's order reinstated.

VAN HOOMISSEN, J.

Claimant petitions for review of a Workers' Compensation Board order that affirmed SAIF's denial of her aggravation claim. ORS 656.273. The issue is whether she met her burden of proving her aggravation claim. On *de novo* review, ORS 656.298, we conclude that she did. We reverse and reinstate the referee's order.

Claimant compensably injured her low back in March, 1981. During the course of treatment, it was determined that she had a congenital condition described as a pronounced lumbar lordosis and prominently curved sacrum. She was diagnosed as having a lumbosacral strain superimposed on those congenital abnormalities. A determination order was issued, but it contained no award of permanent disability. She appealed. The referee was persuaded by the opinion of Dr. Wong, claimant's attending physician, that she was entitled to an award of 10 percent permanent partial disability. The referee implicitly rejected the opinion of Dr. McHolick, SAIF's consulting physician, who stated that claimant had suffered no permanent impairment as a result of her injury. SAIF did not petition for Board review of the referee's order.

In 1982, claimant returned to Dr. Wong, complaining of low back and intermittent right leg pain. Dr. Wong reported that her condition had become aggravated. He diagnosed "chronic lumbosacral strain - exacerbation." He noted that, since he had last seen her, she had moved twice and given birth to a child.

Dr. Wong reported:

> "Therefore, in my medical opinion, while the lumbar lordosis may have made her more susceptible to low back injury, it was the initial injury of March 12, 1981, which precipitated the symptoms. It is my opinion that her present condition has worsened since March 12, 1982 *[sic]*. I do believe the aggravation is a continuing, on-going problem related to her initial injury."

Dr. McHolick, who examined claimant for SAIF in July, 1983, reported:

> "At this time, as previously, I still see no evidence of major neurologic or orthopedic problems other than congenital

> abnormality of horizontal sacrum, vertical lumbosacral joint, and severe lumbar lordosis, none of which would I attribute to the single contusing injury in question. I do not believe at the present time her problem could relate to that contusing injury but is on a developmental basis. I wonder how much of this is a fixation and possibly psychiatric or psychological testing and evaluation might be in order in this instance."

SAIF denied the aggravation claim.

Claimant testified that her symptoms had occurred intermittently since the injury; that she had experienced no low back symptoms prior to the injury; and that she was hospitalized in February, 1983, because of a severe aggravation of her low back pain. Once again, the referee found Dr. Wong's opinion more persuasive. He discounted Dr. McHolick's opinion, because he had continued to operate on the assumption that claimant's industrial injury had caused her no permanent disability. The referee reasoned that that issue had already been resolved and could not be relitigated. The referee set aside SAIF's denial of claimant's aggravation claim. SAIF petitioned for Board review.

Relying on our opinion in *Giesbrecht v. SAIF,* 58 Or App 218, 648 P2d 70 (1982), the Board first determined that it was improper for the referee to find Dr. Wong's opinion more

persuasive simply because another referee had found Dr. Wong more persuasive in a previous hearing. In *Giesbrecht,* we stated that "the contribution of one expert's opinion to the preponderance of evidence in one case has no bearing on the relative weight of the same expert's opinion in another case with a different mix of medical opinions." 58 Or App at 219. We held that it was error for the referee to consider himself bound by the opinion of one expert solely because this court had found that expert's opinion persuasive in a *different* case. The Board's reliance on *Geisbrecht* was misplaced. We are concerned here with the *same* case.

The Board stated:

> "We thus assess the relative weight of the medical opinions in this record. First, it is not at all clear that claimant's condition is worse now than it was at the time of the last award of compensation; claimant's current symptoms seem to mirror her symptoms at the time of the prior extent-of-disability hearing, and there is no persuasive evidence of any objective change in claimant's condition since that prior hearing. Second, even assuming there has been a worsening, we are not persuaded by Dr. Wong's opinion of a causal link to claimant's rather minor industrial injury. The record indicates a number of other as plausible explanations or more plausible explanations for claimant's current symptoms, specifically her congenital spinal defects, the birth of her child and her move to Seattle and back."[1]

We conclude that claimant has met her burden of proving her aggravation claim. Her condition worsened, and the worsening was causally related to her industrial injury. Dr. Wong's opinion is supportive on both issues. *See Hamlin v. Roseburg Lumber,* 30 Or App 615, 567 P2d 612 (1977). Additionally, she testified that her condition was severely aggravated. Her subjective complaints are probative on the question whether there was an aggravation of a compensable condition. *Garbutt v. SAIF,* 297 Or 148, 151, 681 P2d 1149 (1984); *Hoke v. Libby, McNeil & Libby,* 73 Or App 44, 46, ___ P2d ___ (1985). Dr. McHolick has steadfastly maintained that claimant's condition is entirely due to her congenital abnormalities. Although he was entitled to reiterate his original conclusion, it conflicts with the law of the case, which is that permanent disability resulted from her industrial injury. As a legal matter, it is wrong. *Price v. SAIF,* 73 Or App 123, ___ P2d ___ (1985); *see also SAIF v. Forrest,* 68 Or App 312, 315, 680 P2d 1031 (1984). Therefore, his conclusion must be discounted.

We are unpersuaded by the argument that claimant's worsened condition resulted from her giving birth to a child or from her moving. The Board terms those as "plausible explanations or more plausible explanations for claimant's current symptoms * * *." We conclude that those explanations are mere speculation; they cannot defeat claimant's claim.

Reversed; referee's order reinstated.

[1] Dissenting Board Member Lewis, stated:

> "I cannot agree with the majority's implication that the Referee reasoned that Dr. Wong's opinion has to be found more persuasive in this proceeding because another Referee found his opinion more persuasive in another proceeding. I interpret the Referee's reasoning to be that he would not accept Dr. McHolick's opinion over Dr. Wong's because Dr. McHolick's fundamental impression is that claimant has no impairment as a result of her industrial accident, which is contrary to the law of this case that claimant has 10% permanent disability."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Thomas D. Parker, Claimant.

PARKER,
Petitioner,

v.

NORTH PACIFIC INSURANCE CO.,
Respondent.

(80-10438; CA A32833)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 13, 1985.

Jill Backes, Portland, argued the cause for petitioner. With her on the brief were Gary M. Galton and Galton, Popick and Scott, Portland.

William H. Walters, Portland, argued the cause for respondent. With him on the brief were Brian B. Doherty and Miller, Nash, Wiener, Hager and Carlsen, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

Claimant seeks review of a final order of the Workers' Compensation Board entered on remand after a previous review in this court. 66 Or App 118, 672 P2d 1248, *rev den* 296 Or 536 (1984). Initially, claimant appealed a denial by North Pacific Insurance Company (North Pacific) of three aggravation claims which arose after a wrestling incident on February 4, 1980. The referee found that claimant had failed to prove that the industrial injury was a material contributing cause of the condition and upheld North Pacific's denial. The Board affirmed. We reviewed the Board's decision in the light of *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), and remanded that portion of the Board's order affirming North Pacific's denial of the three aggravation claims for reconsideration. On remand, the Board found that Parker had wilfully withheld from his treating physician any mention of the wrestling incident and that that intentional omission was within the exceptions to the rule in *Bauman* against backup denials. We affirmed.

Our previous opinion states the facts:

> "[Claimant] first suffered a compensable back sprain on July 25, 1979. Insurer accepted the claim on August 19, 1979. Claimant returned to work at a lighter job in December, 1979. The Evaluation Division issued a determination order on March 3, 1980, that held that he was entitled to temporary total disability for the 1979 injury from July to November, 1979, but not an award of permanent partial disability.

"In early February, 1980, claimant again injured his back. On February 13, 1980, his treating physician wrote insurer:

" 'Mr. Thomas Parker was seen in my office on February 4, 1980, for a reoccurrence of back pain. The symptoms were similar to his previous back injury. He has had no other back injury since.'

"On the basis of this letter, insurer accepted the February incident as an aggravation and paid time loss benefits. Claimant was released to return to work on April 28, 1980.

"On August 5, 1980, and again on November 24, 1980, claimant suffered off-the-job back injuries, the first while playing softball and the second while reaching into the trunk of his car. Insurer accepted both as aggravation claims. A determination order closed all three aggravation claims on May 5, 1981, and on the basis of a report by an examining

physician that claimant was medically stationary on February 23, 1981, awarded claimant time loss for periods through February 23, 1981.

"On March 5, 1981, insurer received information from a second treating physician indicating that claimant's injury in February, 1980, occurred while claimant was 'wrestling' with his wife. On May 22, 1981, insurer contacted that doctor by telephone to obtain additional information. On July 2, 1981, the doctor affirmed to insurer that 'it is medically probable that Mr. Parker's wrestling activities caused the time loss and medical treatment he was incurring prior to and after his visit with [me] on September 24, 1980.' Insurer then denied compensability of the February, 1980, injury, and responsibility for all benefits and treatments from and after that date. Insurer asserted that recent medical evidence showed that the February, 1980, injury was a new injury and that it and the two subsequent injuries were not aggravations of the 1979 injury."

As a threshold matter, it appears that the Board misapplied the standard of proof. It concluded that, when an insurer alleges one of the *Bauman* exceptions, its burden is to go forward with "some evidence" of fraud, misrepresentation or other illegal activity. After the Board's opinion in the present case, we considered the burden of proof issue in *Parker v. D.R. Johnson Lumber Co.*, 70 Or App 683, 687, 690 P2d 1087 (1984), and stated:

"[A] backup denial of an accepted claim must be supported by proof of fraud, misrepresentation or other illegal activity; it is then the employer's burden to prove, *by a preponderance of the evidence,* those grounds for a denial. If the employer does so, the claimant may, nevertheless, proceed to prove, by a preponderance of the evidence, the compensability of the claim." (Emphasis added.)

North Pacific's burden is to prove claimant's misrepresentation by a preponderance in order to support its backup denial. On *de novo* review, we conclude that it has met that burden. Claimant testified that he informed Dr. Walker of the wrestling incident in question. However, in a letter to claimant's attorney in response to a specific inquiry whether claimant had mentioned any wrestling incident during his office visit on February 4, 1980, Dr. Walker stated that he had not. Claimant further testified that he had informed North Pacific's claims manager of the wrestling incident. The claims

manager testified that he had not. We agree with the Board that the claims manager's testimony was not to the effect that he merely failed to recall the specific incident. Rather, he denied the truth of claimant's statements that he had related the incident at issue. We agree with the referee and the Board that these witnesses are more credible than claimant. A failure to disclose a previous injury is a type of misrepresentation contemplated by the *Bauman* exceptions. *Skinner v. SAIF,* 66 Or App 467, 470,674 P2d 72 (1984).[1]

Affirmed.

[1] Claimant did not contend that, notwithstanding any alleged misrepresentation, his claim was nonetheless compensable. *See Parker v. D.R. Johnson Lumber Co., supra,* 70 Or App at 687.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Mercedes Evans, Claimant.

FRED MEYER, INC.,
Petitioner,

v.

BENJAMIN FRANKLIN SAVINGS & LOAN et al,
Respondents.

(82-04068, 82-10141; CA A32087)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 13, 1985.

Patric J. Doherty, Portland, argued the cause for petitioner. With him on the brief were Karli L. Olson and Rankin, McMurry, VavRosky and Doherty, Portland.

Gail M. Gage, Salem, waived appearance for respondent Mercedes Evans.

William H. Stockton, Hillsboro, argued the cause and filed the brief for respondents Benjamin Franklin Savings and Loan and United Pacific Insurance Co.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

This workers' compensation case involves the issue of which of two employers is responsible for claimant's occupational disease claim. ORS 656.802 - 656.807. The Board affirmed a referee's order that found petitioner to be the responsible employer. Fred Meyer seeks judicial review of the

Board's order and order on reconsideration. We review *de novo* and affirm.

The parties do not dispute the referee's findings of fact. Fred Meyer's argument is that the medical evidence establishes that claimant's work activities while employed by respondent Benjamin Franklin Savings and Loan aggravated or exacerbated her underlying chronic myofascitis condition. If it does, under *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982), responsibility shifts to Benjamin Franklin, the second employer.

In 1967 and 1970, claimant was involved in motor vehicle accidents and, on both occasions, suffered acute cervical strains. Dr. Eckhardt, an orthopedist, treated her conservatively, and she recovered without any residual impairment or disability. In 1975, claimant was employed by Fred Meyer as a grocery checker. In December, 1976, as a result of problems associated with the overhead use of her arms and lifting, she returned to Dr. Eckhardt. He diagnosed chronic myofascitis in the right suprascapular area, causing nerve impingement that resulted in abnormal sensations in the right forearm and right hand. She was again treated conservatively and returned to work in February, 1977. In May, she quit her job at Fred Meyer. In June, Dr. Eckhardt reported that claimant was developing carpal tunnel syndrome.

From November, 1977, through January, 1978, claimant was evaluated at the Disability Prevention Center. Dr. Azavedo diagnosed a chronic cervico-dorsal strain and concluded that claimant had a slight permanent physical impairment. In May, 1978, a determination order awarded temporary total disability and a 5 percent unscheduled permanent partial disability, chargeable to Fred Meyer. In June, 1978, claimant enrolled in a vocational rehabilitation program to be trained as a kindergarten teacher. Some of the tasks necessary for that training, however, activated her symptomatology. She completed the program and, in July, 1980, a

second determination order awarded additional temporary total disability benefits.

Claimant's vocational counselor referred her to Job Seekers, who in turn referred her to Benjamin Franklin for employment. In October, 1980, Benjamin Franklin hired her as a teller. Dr. Eckhardt had recommended that she avoid teller work, which required her to stand most of the time. She handled financial transactions, filed and typed at a computer terminal. Three months after she commenced employment, she noticed that her symptomatology had returned. Additionally, for the first time she noticed that riding in certain car seats made her nauseated. In June, 1981, she was examined by Dr. Gritzka. He reported that she had activated her cervical sprain by prolonged forward flexion. On June 10, claimant quit work at Benjamin Franklin.

Claimant subsequently filed an aggravation claim against Fred Meyer and an occupational disease claim against Benjamin Franklin. Both employers denied responsibility. Benjamin Franklin also asserted that claimant had failed to file her claim timely. The referee concluded that Fred Meyer was the responsible employer:

"Claimant's original claim at Fred Meyer resulted in permanent impairment and disability for which she received an unscheduled permanent partial disability award. Her treating doctor placed certain specific working restrictions and limitations upon her. Dr. Eckhardt recognized claimant would encounter predictable problems if she nonetheless attempted to perform those activities which would result in a flare-up of her symptomatology. * * * [I]t is clear claimant's work activities at Benjamin Franklin were related to her need for continuing medical care and treatment. But any such activities inevitably would have led to continued medical care. *SAIF Corp. v. Baer*, 60 Or App 133 (1982). Finally, I conclude that there is no persuasive medical evidence supporting Fred Meyer's contention that claimant's employment activities at Benjamin Franklin contributed to the *causation* of the disabling condition. *SAIF Corp. v. Brewer*, 62 Or App 124 (1983); *Boise Cascade Corp. v. Starbuck*, 61 Or App 631 (1983); *Perdue v. SAIF*, 53 Or App 117 (1981)." (Emphasis in original.)

The Board adopted the referee's opinion and affirmed.

Essentially, Fred Meyer argues that the medical evidence shows that claimant's work at Benjamin Franklin "aggravated" her chronic myofascitis in her upper back and neck. *Bracke v. Baza'r, supra*, states the test:

"A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer." 293 Or at 250.

Therefore, the issue is whether claimant's work at Benjamin Franklin affected the extent of her continuing underlying disease. The court in *Bracke* analyzed that question by examining the evidence to determine whether the subsequent employment "aggravated or exacerbated" the underlying disease. 293 Or at 250.

We conclude that the evidence does not preponderate that claimant's work at Benjamin Franklin affected the extent of her chronic myofascitis. Relying on Dr. Eckhardt's reports, Fred Meyer argues that the medical evidence is "undisputed" that claimant's occupational disease was "aggravated." While those reports do use the terms "aggravated" and "worsening," when they are taken as a whole, it is apparent that Dr. Eckhardt was referring to an increase in symptomatology, something about which he had warned claimant before she accepted the job at Benjamin Franklin. Her statements that she seemed to have more limitations after her work at Benjamin Franklin, although probative, do not demonstrate that the *extent* of her chronic myofascitis was worsened as a result of the later employment.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John A. Shoulders, Claimant.

SHOULDERS,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(80-06247; CA A31403)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 14, 1984.

James L. Edmunson, Eugene, argued the cause for petitioner. On the brief were Christopher D. Moore, and Malagon & Associates, Eugene.

Jeffrey Bennett, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed as to compensability; reversed and remanded for an award of attorney fees.

ROSSMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board, which held that his vertigo and tinnitis were not compensable and refused to award him attorney fees.

Claimant suffered a compensable injury to his knee in July, 1978, when he was struck by a tree limb. SAIF accepted the claim for the injury, and on July 22, 1980, a determination order was issued granting 15 percent permanent partial disability. Thereafter, claimant developed numerous conditions, including phlebitis, an ulnar nerve lesion, tinnitis, vertigo and thrombophlebitis. SAIF denied claims for each, and claimant requested a hearing. The referee found that the phlebitis, tinnitis, vertigo and thrombophlebitis were compensable and awarded attorney fees. SAIF appealed, and the Board affirmed the referee as to the phlebitis and thrombophlebitis but reversed as to the tinnitis and vertigo. The Board declined to award attorney fees for the Board appeal.

On *de novo* review, we affirm the Board as to the denial of vertigo and tinnitis and hold that the conditions were not causally related to the industrial injury. The only issue which merits discussion is the Board's refusal to award attorney fees.

Claimant argues that he is entitled to an award of attorney fees under ORS 656.382(2), which provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant *should not be disallowed or reduced,* the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney's fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal." (Emphasis supplied.)

That provision requires the insurer or employer to pay reasonable attorney fees if, on review by the Board, requested by it, the "compensation awarded" is not disallowed or reduced. We have held that a claimant must prevail on the compensation issue in order to be entitled to an award of attorney fees under ORS 656.382(2). *Korter v. EBI Companies, Inc.,* 46 Or App 43,

53, 610 P2d 312 (1980), *remanded on other grounds* 290 Or 301, *on remand* 51 Or App 206, 625 P2d 668 (1981).

Claimant argues that an award of attorney fees is proper under ORS 656.382(2), because he prevailed before the Board on two of the four compensation issues which were appealed to the Board by SAIF. We have held that an award of attorney fees was proper under that subsection when the Board affirmed the compensation awarded but found against the claimant on other issues not related to compensation. *Bahler v. Mail-Well Envelope Co.,* 60 Or App 90, 652 P2d 875 (1982) (Board reduced penalty only, but sustained referee's award of compensation); *Mobley v. SAIF,* 58 Or App 394, 648 P2d 1357 (1982) (Board reduced award of attorney fees, but did not reduce the compensation awarded).

Here, however, there had been no award of compensation at the time of employer's appeal to the Board. The referee had found four conditions compensable and had remanded those claims to SAIF for acceptance and further processing under ORS 656.268. A referee's finding of compensability is not the same as an award of compensation, or benefits, as the term is defined by ORS 656.005(9).

We hold that the provisions of ORS 656.382(2) require the payment of attorney fees by the employer or insurer only when compensation benefits have been awarded and have not been disallowed or reduced on the employer's or insurer's appeal.

The stated restriction is not applicable to ORS 656.386(1), which we hold authorizes an award of attorney fees in this case:

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

This subsection somewhat backhandedly deals with a prevailing claimant's right to attorney fees at each level of an appeal

involving a rejected claim. If the claimant prevails finally on a rejected claim before the referee or in a review by the Board, reasonable attorney fees are to be allowed. If the claimant prevails finally before this court or the Supreme Court on a rejected claim from an order or decision denying the claim, attorney fees are to be allowed. The actual "claims" in this case were a series of medical reports mailed to SAIF from March, 1979, to May, 1982, documenting the various conditions. In March, 1979, claimant's phlebitis was diagnosed. In May, 1980, a doctor identified vertigo and tinnitis. All three conditions were denied in a single letter dated July 2, 1980. The thrombophlebitis was diagnosed and reported to SAIF in early 1982 and denied on June 25, 1982. Claimant prevailed finally before the Board on the originally rejected phlebitis and thrombophlebitis claims. He is therefore entitled to reasonable attorney fees on those claims for successfully defending the referee's determination of compensability at the Board level.

Affirmed as to compensability; reversed and remanded for determination of attorney fees.

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20 June 5, 1985 No. 307

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Willi A. Arndt, Claimant.

ARNDT,
Petitioner,

v.

NATIONAL APPLIANCE CO.,
Respondent.

(81-08483; CA A32266)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 11, 1985.

Joseph C. Post, Forest Grove, argued the cause and filed the brief for petitioner.

Marshall C. Cheney, 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; referee's order reinstated.

BUTTLER, P. J.

Claimant seeks review of a Workers' Compensation Board order reducing the referee's award of permanent total disability to 75 percent unscheduled back and psychiatric

disability. On *de novo* review, we conclude that claimant meets the statutory criteria for permanent total disability; therefore, we reverse the Board and reinstate the referee's order.

Claimant was employed as a sheet metal worker and welder for employer for 21 years. He suffered a compensable low-back injury in 1975 while lifting 120 pounds. As a result, he underwent surgery for the removal of a "huge" herniated disc at L5-S1 and lamina at L5. Although he returned to work seven months later, he continued to have back pain. A determination order that was not appealed awarded 5 percent unscheduled disability. He began to experience right leg pain in 1976 with numbness in his right foot, together with low-back pain. A second laminectomy was performed in September, 1976, by Dr. Raaf, a neurosurgeon, for the removal of an inferior-articular facet and lamina from L5 right; in addition, Dr. Gripekoven, an orthopedic surgeon, performed a fusion of L5-S1. Claimant returned to work within six months, but soon began to experience back pain. By a determination order of February 2, 1978, he was awarded an additional 15 percent unscheduled disability.

In June, 1979, claimant was compensably injured a second time while lifting a 200 pound compressor.[1] His back pain increased, and he again noticed numbness in his right leg and little toe. For a short time, he experienced pain in his left leg. He was hospitalized for treatment and a myelogram. In a letter to the insurer dated July 19, 1979, Dr. Gripekoven stated:

> "* * * He has had recurrent problems which have become increasingly disabling. There has been no specific reinjury of his back; however, the physical demands of his work are constantly aggravated *[sic]* his preexisting condition.
>
> "I feel that his condition has deteriorated and that his symptoms are now at a level where it is unrealistic for him to continue with his present occupation. Unfortunately, the only specific treatment we can offer is symptomatic with appropriate protection of the back and medication. * * *"

An x-ray performed on August 5, 1979, showed "post-operative changes." On December 4, 1979, Dr. Shipps, a roentgenologist, noted that an x-ray of claimant's back showed degenerative changes in the cervical spine. On December 10, 1979, a myelogram was performed, showing post-surgical changes and degenerative cervical disc disease. Dr. Raaf's report, dated December 12, 1979, states that a comparison of a myelogram performed before the 1976 surgery with the myelogram of December 10, 1979, showed "no essential difference in the configuration of the pantopaque column * * *." The report concluded that "it does not seem reasonable to me that any further operative procedure on the patient's lumbar spine would be of any value." The report further notes:

> "Following the pantopaque myelogram on December 10, 1979, the patient complained a great deal of low back pain and pain in his neck. I told Mr. Arndt that I did not think that the pain in his neck was connected with the industrial injury of February 18, 1975, or the back strain which he sustained on

[1] A hearing was held in which it was determined that the 1979 incident constituted a new injury, rather than an aggravation, which placed responsibility on employer's carrier at that time.

June 24, 1979. I think the neck pain is due to degenerative disc disease in the cervical spine and is an independent problem."

In a report of September 8, 1981, Orthopaedic Consultants noted a moderate degree of functional disturbance.

Claimant did not return to work after the 1979 injury and has not worked since. He continues to experience pain in his lower back and right leg and numbness in the right foot. Dr. Raaf recommended treatment at Northwest Pain Center; however, the insurance carrier has not authorized such treatment. Orthopaedic Consultants also recommended the Pain Center, but Dr. Colbach, the carrier's consulting psychiatrist, recommended against it, because he thought that claimant would resist it too much.

In a report dated July 19, 1979, following the second injury, Dr. Gripekoven stated that claimant was not able to tolerate the physical demands of welding and should seek "a more protected environment." He also reported that it would be difficult for claimant to find different employment because of his age and limitations as to his ability to use the English language. Dr. Colbach, the carrier's consulting psychiatrist,

found claimant to be of "limited intelligence and very limited education" and concluded that claimant was totally disabled unless he were to receive "some sort of retraining."

At the time of the hearing, claimant was 54 years old. He was born in Poland, lived for a short time in Germany and immigrated to the United States in 1956. He has difficulty speaking and reading English and is unable to write English. He has had a total of six years of education in Poland and Germany and no additional education in the United States. His work experience includes welding, construction, railroad work, papermill work, dog training and janitor work. He testified that after his 1975 injury he could engage in all of his accustomed activities. Since his 1979 injury, however, he sleeps poorly, only two to three hours at a time, and his activities are very limited. He finds it difficult to do even light work, such as feeding his pigeons and rabbits. He now claims to be permanently and totally disabled. A determination order of November, 1981, awarded 35 percent unscheduled disability as a result of the 1979 injury. After hearing, the referee found that claimant was permanently and totally disabled.

The Board reversed the finding of permanent total disability. It expressed difficulty understanding how claimant's 1979 injury could have had such a devastating impact on his physical condition, considering his recovery and return to work after the "more serious" 1975 injury. It is apparent, however, that the Board recognized the seriousness of his present physical disability; it awarded 75 percent unscheduled disability resulting from the 1979 injury.

The Board correctly stated that claimant suffers from several physical conditions that are not properly part of the disability calculation, if only the disability resulting from the 1979 injury is in issue. Those conditions include claimant's liver, gallbladder and intestinal problems, which apparently are nondisabling, and the degenerative cervical disc disease. Only the last condition, however, did not manifest itself until after the 1979 injury, and, therefore, could not be

taken into account in this proceeding. The Board focused on claimant's neck pain, and then stated:

> "We infer that the majority (but not all) of claimant's limitations and difficulties are probably due to his 1975 and/or 1979 industrial injuries. *On the other hand, it is safe to*

> *assume that some of claimant's limitations are due to non-compensable conditions, like his cervical disc disease.*" (Emphasis supplied.)

Although medical reports indicate that claimant complained of neck pain at one time, it is not apparent from the record that claimant's cervical disc disease was ever disabling, and there is no evidence that it caused disability at the time of hearing. The Board's assumption that some of claimant's limitations are due to the cervical disc disease is, therefore, not supported by the record.

In discussing employer's argument that claimant's failure to seek work precludes an award of permanent total disability, the Board discussed the "futility exception":

> "As indicated above, we think it is clear that claimant has various forms of physical impairment that were neither caused by his 1979 injury nor are preexisting disability *[sic]* that we can consider under ORS 656.206(1)(a). We are frankly unsure how the futility exception should be applied in this kind of situation; we assume that we should focus only on whether claimant's compensable impairment (i.e., cognizable impairment under ORS 656.206(1)(a)) makes seeking work futile, not whether claimant's total impairment makes seeking work futile. Just before claimant's 1979 injury, his compensable impairment did not prevent him from working at a fairly strenuous job. *We do not think the incremental impairment caused by the 1979 strain-type injury, although difficult to understand on this record, is of a magnitude that would make seeking work futile.* * * *" (Emphasis supplied.)

The Board concluded that ORS 656.206(3)[2] precludes an award of total disability, because it was not futile for claimant to seek work. It is correct that the degenerative cervical disc disease may not be considered under that section; as indicated, however, that condition was not disabling. The other conditions preexisted the 1979 injury and, whether compensable or not, must be considered in determining whether he is permanently and totally disabled and whether it would be futile for him to seek work. ORS 656.206(1)(a); *Livesay v.*

SAIF, 55 Or App 390, 637 P2d 1370 (1981); *Butcher v. SAIF*, 45 Or App 313, 608 P2d 575 (1980). The "incremental impairment" caused by the 1979 injury may not have been of a magnitude that would make seeking work futile, but if claimant's total impairment after that injury was such that he could not work, he will not be required to seek work. In such a case, the worker's total impairment might be greater after the second injury than might be estimated by adding the worker's

[2] 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."

preexisting impairment to the hypothetical "incremental impairment" caused by the second injury. This synergistic effect makes it pointless to speak in terms of "incremental impairment" in a discussion of permanent total disability.

Here, the record indicates that claimant's physical and psychological condition is extremely limiting, and there is no evidence that his limitations are the result of anything but the residual effects of the 1975 injury and the 1979 injury. Claimant is unable to sit or stand for long periods of time and must rest after any activity. He is unable to drive and can sit only on one buttock. No doctor has released him for work since the 1979 injury. It is clear from the record that he is not capable of returning to work as a welder or to any other job requiring back strength.

Claimant's limited education, mental capacity and work experience also significantly reduce his employability, as the insurer has implicitly recognized by not offering vocational assistance or pain center treatment, as recommended.

The insurer's consulting psychiatrist confirmed that claimant is totally disabled without retraining. No retraining has been offered, and no one has suggested any kind of work that claimant might be able to perform. We conclude that claimant is permanently and totally disabled. Whether retraining is feasible has not yet been determined. We evaluate the extent of disability as of the time of hearing. *Gettman v. SAIF,* 289 Or 609, 616 P2d 473 (1980).

Reversed; referee's order reinstated.

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64 June 5, 1985 No. 315

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Leia D'Lyn, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION,
Petitioner - Cross-Respondent,
v.
D'LYN,
Respondent - Cross-Petitioner.

(82-00864, 82-03225; CA A31592)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 22, 1985.

Darrell E. Bewley, Salem, argued the cause for petitioner - cross-respondent. With him on the brief were Dave Frohnmayer and James E. Mountain, Jr., Salem.

Robert K. Udziela, Portland, argued the cause for respondent - cross-petitioner. With him on the brief were David A. Hytowitz, and Pozzi, Wilson, Atchison, O'Leary and Conboy, Portland.

Before Gillette, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

SAIF petitions for judicial review of a Workers' Compensation Board order which found that claimant was a subject worker at the time of her 1981 hospitalization and that her employment activities were the major cause of her condition. ORS 656.128(1). The dispositive issue is whether claimant effectively communicated to SAIF her election to be covered as a sole proprietor. On *de novo* review, we conclude that she did and affirm.

Claimant is a licensed real estate broker. Before the onset of her psychosis, she began working for Willister Court Apartments as a resident apartment manager. There is no dispute that, as to Willister Court, claimant was a subject employe covered under the Workers' Compensation Act. Her supervisor at Willister Court was JoAnn Davis. Claimant and Davis, a licensed real estate sales agent, decided to go into the apartment management business together. They formed a new business entity under the assumed business name of D Plus Properties. This business relationship put claimant in the position of being Davis' supervisor, although Davis was still claimant's supervisor at Willister Court, where claimant continued working.

In early November, 1981, claimant contacted SAIF to obtain workers' compensation coverage for herself and Davis. She was informed by SAIF that it would cost $60 to open the account, $71 to cover Davis as an employe and $154 to cover herself as a sole proprietor. On November 6, claimant completed SAIF's application form and sent SAIF a check for $285. SAIF cashed the check. SAIF's application form provides:

> "This application does not provide personal coverage to an individual owner, partners or bona-fide corporate officers. If this additional coverage is needed a special application will be provided upon request."

Claimant testified that she received no other forms from SAIF and that she would have submitted any forms that SAIF required.

On November 18, SAIF sent claimant a letter informing her that coverage was effective November 12. The letter also stated in general terms that owners and partners were not

covered. Claimant testified that she had not seen that letter before the hearing. On November 24, SAIF sent claimant another letter. It stated:

> "Individual proprietors or partners are personally covered only if their names appear as a payroll description above."

The payroll description read: "Real Estate Agency—Agent/Salespersons." Claimant testified that she assumed that her coverage was in force, because that description fit her. SAIF did not send her the "personal election" form which it contends is necessary to extend coverage to a sole proprietor.

On December 3, claimant was hospitalized for treatment of an acute psychotic episode. On December 8, she filed this workers' compensation claim. SAIF denied the claim on the ground that she had not filed a personal election application. It also refunded her premium. The parties agree that, if claimant is covered as the owner of D Plus Properties, her illness is compensable. SAIF concedes that it was aware from the outset that claimant wanted coverage as a sole proprietor.

The referee concluded that SAIF was estopped to deny that claimant is a subject worker. The Board affirmed that conclusion, but not on the estoppel theory. The Board concluded that claimant's application, together with certain notations made thereon by SAIF employes, constituted an effective personal election for coverage. We agree.

Under ORS 656.027(7), sole proprietors are "nonsubject workers," who do not come within the protection of the Workers' Compensation Act. However, they may elect to be protected. ORS 656.128 provides in relevant part:

> "(1) Any person who is a sole proprietor, or a member of a partnership, may make written application to an insurer to become entitled as a subject worker to compensation benefits. Thereupon, the insurer may accept such application and fix a classification and an assumed monthly wage at which such person shall be carried on the payroll as a worker for purposes of computations under this chapter.
>
> "(2) When the application is accepted, such person thereupon is subject to the provisions and entitled to the benefits of this chapter. The person shall promptly notify the insurer whenever the status of the person as an employer of subject workers changes. Any subject worker employed by such a person after the effective date of the election of the

> person shall, upon being employed, be considered covered automatically by the same guaranty contract that covers such person."

The Board reasoned:

> "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."

We agree with the Board's opinion and adopt it.

Claimant cross-petitions for judicial review of the Board's conclusion that her psychological illness was not due to her employment at Willister Court Apartments. Claimant conceded at oral argument that, should she prevail in this court on SAIF's petition, her cross-petition would be moot.

Affirmed on petition and cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

KISTNER,
Appellant,
v.
BLT ENTERPRISES, INC. et al,
Respondents.
(L82-01877; CA A32357)

Appeal from Circuit Court, Douglas County.

Donald H. Sanders, Judge.

Argued and submitted January 4, 1985.

Claud Ingram, Eugene, argued the cause for appellant. With him on the brief were Bick and Monte, P. C., Eugene.

Robert M. Atkinson, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Richardson, Presiding Judge, and Warden and Newman, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Plaintiff appeals a judgment for defendants in this action for personal injuries. The court first tried defendants' affirmative defense that plaintiff's exclusive remedy was under the Workers' Compensation Law. *See* ORS 656.018. It held, and defendants assign that holding as error, that plaintiff was an employe of defendants[1] and not an independent contractor, because defendants had the right to direct and control plaintiff's services. ORS 656.005(14),(18).[2] We affirm, although for different reasons.

There was evidence from which the court, as the trier of fact, could find these facts. Plaintiff and his wife, as partners, owned and operated a farm under the assumed business name of "Diamond L Stables." Their bank account

[1] One of defendants, Vuksich, is not an employer but an employe of the other defendants. ORS 656.018(3), however, extends an employer's exemption from liability to its employes.

was in the partnership name. The partnership raised livestock, rented horses, provided picnic facilities and provided hayrides. Defendants' advertising agent contacted plaintiff on defendants' behalf to provide hayrides for family day promotions at six of their restaurants. Although defendants only wanted a team of mules and a wagon, the partnership would not provide them unless plaintiff selected the driver. Plaintiff

believed that the mules were temperamental and that it was necessary for the driver to know how to handle them. Defendants orally contracted with the partnership for six days of hayrides at a daily rate of between $50 and $65 for the mules, wagon and driver, plus an additional ten cents a mile for transportation from the farm. The partnership was to provide the mules, the wagon and the driver.

On the day of the accident plaintiff, and occasionally his wife, drove the mule team. While he was driving the mules, a sign of defendants fell and startled the mules out of control, and plaintiff, consequently, was injured. Defendants paid the partnership $65 for services on the date of the accident pursuant to the contractual arrangement. Plaintiff and his wife put the money in the partnership bank account.

At the time of the accident, ORS 656.029 provided:

> "(1) 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.
>
> "(2) If the person to whom the contract is let performs the work without the assistance of others, that person is subject to this chapter as a subject worker of the person letting the contract unless that person and the person letting the contract jointly file with the insurer or self-insured employer a declaration stating that the services rendered under the contract are rendered as those of an independent contractor.

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[2] The court's opinion stated:

"The primary issue to be resolved is whether or not plaintiff was/is an employee rather than an independent contractor.

"I agree the statutory definition must control. Counsel have cited and referred to *Lockard v. The Murphy Co.*, 49 Or App 101. *The Ponderosa Inn, Inc. v. Employment Division*, 63 Or App 183, is the most recent case I have found.

"These cases turn upon the degree of persuasion. As I understand the rule, the 'relative nature of the work test' does not have controlling application until and unless the case cannot be resolved by determining whether there was a right to control. The evidence [of] the intentions of the parties in their agreement and conduct must control.

"Based upon the evidence presented and weighing the credibility of the witnesses, in my opinion, the evidence preponderates that the agreement of these parties included that defendant had the right to control, and to the extent defendant deemed necessar[y] it did in fact exercise such right to control over plaintiff. To the extent that plaintiff (and/or his wife) were exercising expertise in handling the wagon and mules, their conduct is, in my view, no different than the expertise of the truck driver in *Lockhard* and the musicians in *The Ponderosa Inn, Inc.*, both of whom were likewise found to be employees rather than independent contractors."

"(3) A person who files the declaration of status as an independent contractor is not eligible to receive benefits under this chapter unless the individual has obtained coverage for such benefits pursuant to ORS 656.128.

"(4) The filing of a declaration of status pursuant to this section creates a rebuttable presumption that the person is an independent contractor."

"Person" includes partnership. ORS 656.005(21).

Defendants did not file jointly with the partnership, or with plaintiff or his wife, the declaration described in ORS 656.029(2). That statute applies to this case. Defendants are

engaged in business and are subject to the Workers' Compensation Law as an employer. They let the contract to the partnership, which performed the work without the assistance of others.[3] The contract was one "involving the performance of labor," the driving of the mules.[4]

In the absence of a joint notice of independent contractor status, plaintiff is deemed to be defendants' subject worker. *See EBI Companies v. Erzen,* 73 Or App 256, 698 P2d 534 (1985); *see also Didier v. S.I.A.C.,* 243 Or 460, 414 P2d 325 (1966); *Berry v. S.I.A.C.,* 238 Or 39, 393 P2d 184 (1964); *Love v. Northwest Exploration Co.,* 67 Or App 413, 417, 678 P2d 754 (1984). The Workers' Compensation Law, therefore, is plaintiff's exclusive remedy. ORS 656.029(2); 656.018. We need not consider whether plaintiff was defendants' subject worker within the definitions of ORS 656.005(14),(28). When it enacted ORS 656.029, the legislature intended to eliminate the need to decide in each case whether a person is a subject worker or an independent contractor. *See Love v. Northwest Exploration Co., supra,* 67 Or App at 417. The trial court reached the right result. *See Drulard v. LeTourneau,* 286 Or 159, 172, 593 P2d 1118 (1979).

Affirmed.

[3] The parties agree that the work of the partnership was performed "without the assistance of others." ORS 656.029(2). The work of a partner for the partnership is not the assistance of an "other." *See EBI v. Erzen, infra.* We note that defendants' employes assisted plaintiff and his wife by supervising children who rode or were waiting for rides. The requirement that plaintiff and his wife perform the work "without the assistance of others" is not negated if those who assist are employes of the party who lets the contract. Moreover, even if plaintiff and his wife performed *with* the assistance of others, there is no evidence that the partnership was a carrier-insured employer or self-insured employer. Accordingly, plaintiff would, under those circumstances, be defendants' subject worker under ORS 656.029(1), and the result here would be the same.

[4] ORS 656.124, the predecessor to ORS 656.029, was amended in 1957 to apply simply to contracts "involving the performance of labor." The previous requirement was that "the principal purpose of [the employment] is the performance of labor." A contemporary account of the statutory change notes that:

"Under the section, as now amended, it is no longer necessary to inquire into the 'principal purpose' of the employment; it is sufficient if there is a contract 'involving the performance of labor.'

"* * * * *

"The principal effect of the amendment is to extend the benefits of the act to persons who have heretofore been regarded as independent contractors * * *." "A Survey of Oregon Legislation Enacted in 1957," 37 OLR 67, 86 (1957).

ORS 656.124 was repealed in 1965. ORS 656.029 was enacted in 1979.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation
of Sharon J. Anders, Claimant.

SOUTHWEST FOREST INDUSTRIES,
Petitioner on Review,

v.

ANDERS,
Respondent on Review.

(82-10,877; CA A33032; SC S31192)

In Banc

On review from the Court of Appeals.*

Argued and submitted January 29, 1985.

H. Scott Plouse, Cowling & Heysell, Medford, argued the cause for petitioner on review.

Charles H. Seagraves, Jr., Myrick, Coulter, Seagraves, Myrick & Adams, Grants Pass, argued the cause for respondent on review.

LENT, J.

Affirmed.

* Appeal from order of the Workers' Compensation Board. Court of Appeals order dismissing appeal filed September 26, 1984. Reconsideration denied November 2, 1984.

LENT, J.

Two primary issues are presented: (1) Whether ORS 19.028[1] is applicable to "filing with the clerk of the Court of Appeals the original notice of appeal" under ORS 656.298(3).[2] (2) Whether "serving, by registered or certified mail, a copy of the notice of appeal" on the Workers' Compensation Board (Board) under ORS 656.298(3) within 30 days of the order from which appeal[3] is taken is essential to acquisition of jurisdiction by the Court of Appeals. We hold that both issues are to be answered in the affirmative.

[1] ORS 19.028 provides:

"Filing a notice of appeal or petition for review in an appeal or petition for review to the Court of Appeals or the Supreme Court may be accomplished by mail. The date of filing such notice or petition shall be the date of mailing, provided it is mailed by registered or certified mail and the appellant has proof from the post office of such mailing date. Inclosure with the mailed notice of the appropriate filing fee shall be considered timely deposit of that fee. Proof of mailing shall be certified by the appellant and filed thereafter with the court to which the appeal is taken."

[2] In pertinent part ORS 656.298(3) provides:

"The judicial review shall be commenced by serving, by registered or certified mail, a copy of a notice of appeal on the board and on the parties who appeared in the review proceedings, and by filing with the clerk of the Court of Appeals the original notice of appeal with proof of service indorsed thereon. * * *"

[3] ORS 656.295(8) provides that an order of the Board is final unless within 30 days a party "appeals to the Court of Appeals for judicial review pursuant to ORS 656.298." ORS 656.298(1) provides that within the time limit specified in ORS 656.295 a party may request "judicial review of the order with the Court of Appeals."

The Board mailed an order on July 23, 1984. The employer desired to appeal and on August 22, exactly 30 days later, mailed to the clerk of the Court of Appeals a petition for judicial review,[4] which was not received by the clerk until August 23, *i.e.*, 31 days after the Board's order was mailed. The petition has endorsed on it the certificate of counsel for the employer that on August 22 he had served each of the parties and their counsel by true copies sent by certified mail. Absent from the certificate of service was any claim of service on the Board.[5]

On its own motion the Court of Appeals dismissed the appeal for "lack of jurisdiction as untimely served on Workers' Compensation Board," citing *Stevens v. SAIF*, 27 Or App 87, 555 P2d 480 (1976).

The employer petitioned for review, erroneously asserting that the Court of Appeals had dismissed the appeal "on the grounds that it lacked jurisdiction to review the matter under ORS 19.028 and 19.033(2)." The error in that assertion lies in the fact that the Court of Appeals stated that the authority for dismissal was *Stevens v. SAIF*, 27 Or App 87, 555 P2d 480 (1976), and that decision and the case on which it relies, *Zandbergen v. Johnson*, 24 Or App 151, 544 P2d 587 (1976), contain no mention of either ORS 19.028 and 19.033(2).

The petition for review also asserted that although the Court of Appeals' action might have been required by our decision in *Modoc Lumber Co. v. EBI Companies*, 295 Or 598, 668 P2d 1225 (1983), in which we relied in part on ORS 19.028 and 19.033, we had stated just weeks before in *SAIF v. Maddox*, 295 Or 448, 667 P2d 529 (1983), that ORS chapter 19 was not applicable to appeals from the Board to the Court of Appeals in workers' compensation cases. We allowed review to resolve the contradiction in those two decisions of this court.

After we had allowed review, we questioned whether there was an independent ground for holding that the Court of Appeals was without jurisdiction, namely, the failure to have the petition for judicial review filed with the clerk of the Court of Appeals until the 31st day following mailing of the Board's order. It is our duty to raise a want of jurisdiction on our own motion. *See*, for example, *Ragnone v. Portland School District No. 1J*, 289 Or 339, 613 P2d 1052 (1980), and *Johnson v. Assured Employment*, 277 Or 11, 588 P2d 1228 (1977). Accordingly, we directed questions to the parties concerning the issue of want of jurisdiction on this ground.

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[4] Because the terminology of ORS 656.295(8) and 656.298 is imprecise, we shall use the terms "petition for judicial review," "request for judicial review," and "notice of appeal" interchangeably.

[5] In this court the employer's counsel has asserted that he did serve the Board by certified mail, but there is nothing in the record before the Court of Appeals to show that service. The record on review is the record before the Court of Appeals. ORAP 10.15(6). Rather than supporting the assertion of counsel, the record forwarded to the Court of Appeals by the Board pursuant to ORS 656.298(4) and (5) contains a copy of the petition for judicial review bearing the Board's stamp showing receipt on September 21 with counsel's certificate that he had deposited the copy in the mail on September 20 and that it had been sent by certified mail. This mailing was 29 days after the Board's order became final under ORS 656.295(8).

FILING THE NOTICE OF APPEAL

It is undisputed that the notice of appeal was not delivered physically to the clerk of the Court of Appeals within 30 days after the date of the mailing of the Board's order. The question is whether "filing" with the clerk may be accomplished at the time of mailing by reason of ORS 19.028. The text of that statute so provides. Legislative history indicates the same.

ORS 19.028 has its genesis in Senate Bill 812 in the 1979 legislative session. As originally introduced, the bill was concerned with appeals from circuit court to the Court of Appeals and would have amended ORS 19.026 by adding a subsection:

> "(4) Filing of the notice of appeal with the clerk may be accomplished by mail addressed to the clerk. If the most expeditious form of delivery by mail, other than special delivery, is used, the notice of appeal shall be considered filed on the day of mailing, and enclosure with the mailed notice of the appropriate filing fee shall be considered timely deposit of that fee under ORS 19.035."

Witnesses in support of the bill before the Senate Committee on Judiciary described the problems faced by lawyers practicing in the more distant parts of the state. They pointed out that although notices of appeal might be mailed in time ordinarily to arrive timely at the clerk's office, mail delay could cause a notice of appeal to arrive untimely and result in dismissal for want of jurisdiction. Such lawyers either had to mail well in advance or go to the extra expense of having the notice physically delivered in Salem. They contended that they were thus penalized for practicing away from Salem.

Other witnesses pointed out that the problem arose not only in appealing court cases but in seeking judicial review of administrative agency decisions. In particular, a lawyer who practiced in the workers' compensation field recounted an unhappy experience of his law firm, which had mailed a notice of appeal from a Board order to the clerk of the Court of Appeals and a copy to the Board. The Board received the copy on Friday, the 30th day; however, although the notice of appeal was received by state mail employees on the same day, the notice was not physically delivered to the clerk of the court

until the following Monday, resulting in dismissal of the appeal.

Following this testimony, the Senate Committee adopted amendments that removed the subject of the bill from ORS 19.026 and created a new section which became Oregon Laws 1979, chapter 297, section 1, now codified as ORS 19.028. We conclude from the text and from this history that ORS 19.028 is applicable to filing a notice of appeal under ORS 656.298(3).[6]

In *SAIF v. Maddox, supra,* we considered a contention of SAIF that the Board lost jurisdiction of a case completely after notice of appeal had been filed in the Court of

Appeals for judicial review of a certain Board order. SAIF particularly cited to us ORS 19.033(1) and 19.190(1), which are not concerned with the subject addressed by ORS 19.028. We held that a particular provision in the Workers' Compensation Law, ORS 656.313, rather than ORS 19.033(1) and 19.190(1), was dispositive. Unfortunately, in rejecting the application of the particular subsections of ORS chapter 19 cited to us by SAIF, we made too broad a statement when we said:

> "Our examination of ORS chapter 19 satisfies us that it has no application to appeals from administrative tribunals. Throughout ORS chapter 19 reference is made to appeals from the trial courts, never to appeals from an administrative agency. The workers' compensation statutory scheme contains its own provisions governing appeals. ORS 656.298, for example, specifically instructs litigants how to process an appeal to the Court of Appeals and sets forth the scope of that court's review."

295 Or at 452-453. We now disapprove that statement as it relates to ORS 19.028.

The tenor of our opinion in *Modoc* indicated that several sections of ORS chapter 19 were applicable to workers' compensation appeals. That was unfortunate in light of our then very recent decision in *Maddox*. While our statement in *Maddox* of the inapplicability of chapter 19 to workers' compensation appeals was too broad, the decision in *Modoc* ignored the judicial review provisions of the Workers' Compensation Law.

Rather than decide too much or too little in the case at bar, we here hold that the appellate scheme provided in ORS 656.295 and 656.298, as supplemented by ORS 19.028, governs in this case.

COMPLIANCE WITH ORS 19.028

We now turn to deciding whether the employer here satisfied the requirements of ORS 19.028. As we noted earlier, the employer acknowledged that under *Modoc* the Court of Appeals probably had properly dismissed. The employer challenges our decision in *Modoc*, however, and the rule of appellate procedure promulgated pursuant to that opinion. In *Modoc* the notice of appeal was mailed by certified mail to the clerk of the Court of Appeals on the 30th day and the mailing envelope "had affixed to it two post office forms used for certified mail and for securing a return receipt," but no date stamp was secured from the post office and the notice was not received by the clerk until the next day, just as in the case at bar. In contesting dismissal, the appellant presented a letter from the postmaster to the effect that the letter must have

[6] We are mindful of our observation, made in an earlier case, that "statements before legislative committees by persons not members of the legislature may have little or no significance." *Henthorn v. Grand Prairie School Dist.*, 287 Or 683, 691 n. 5, 601 P2d 1243 (1979). We understand as well the caution that must be used in relying on such statements. *See* 2A Sands, Sutherland Statutory Construction 318, § 48.10 (4th ed 1984). This court has never, however, held that such statements are of no value. On the contrary, we have regularly availed ourselves of testimony given in legislative hearings in order to make a determination of legislative intent based on the fullest possible record. *See, e.g., Henthorn v. Grant Prairie School Dist., supra; Sager v. McClenden*, 296 Or 33, 672 P2d 697 (1983); *Davis v. Wasco IED*, 286 Or 261, 593 P2d 1152 (1979). *Compare, Kessler v. Weigandt*, 299 Or 38, 46-47, ___ P2d ___ (1985), in which we rejected an opinion of a witness as to the effect of a bill because the opinion was mistaken.

been mailed on the 30th day to reach the clerk on the 31st day. The respondent argued that the letter from the postmaster did not constitute "proof from the post office of such mailing date." The respondent argued that the required form of proof from the post office was not specified in the statute and this court must decide what the statute meant in that respect.

We noted the possible ambiguity inherent in the statutory requirement that the appellant "has" proof from the post office of the mailing date.

> "We understand the phrase 'has proof' to refer to the time of mailing, but again it is not inconceivable that a party might

> read the statute to mean that the party must have the proof of mailing 'thereafter' when it certifies the proof and files it with the court."

295 Or at 602. We held that there was some uncertainty in the statutory text and that the text could and should be clarified by the Oregon Rules of Appellate Procedure. For disposition of the case in *Modoc* we held

> "that the present appeal should be reinstated. This holding will not serve to justify any similar ex post facto proof of the date of any filing made after the effective date of a rule of appellate procedure on the point."

295 Or at 603.

Rule 2.06 was thereafter added to the Oregon Rules of Appellate Procedure, adopted effective as of January 4, 1984, and read as follows:

> "A notice of appeal, a petition for judicial review or a petition for review in the Supreme Court may be filed by mail. If the date of mailing is relied upon as the date of filing under ORS 19.028, acceptable 'proof from the post office' shall be a receipt stamped by the post office showing the date mailed and the certified or registered number. The receipt must be submitted to the Case Records Division in the State Court Administrator's office with accompanying certification that shows service on opposing counsel."

The rule is now found as ORAP 1.35(1)(b)(i):

> "(b) Filing may be accomplished by mail and shall be complete on deposit in the mail in the following circumstances:
>
> > "(i) all notices of appeal and petitions for judicial review if mailed in accordance with ORS 19.028. If the date of mailing is relied upon as the date of filing under ORS 19.028, acceptable 'proof from the post office' shall be a receipt stamped by the United States Postal Service showing the date mailed and the certified or registered number. The receipt shall be submitted to the State Court Administrator, Case Records Division, with proof of service."

The employer in the case at bar concedes that it cannot satisfy the rule for want of the "receipt stamped." The employer contends that the appellate courts had no authority to adopt a rule which narrows the statutory text requirement

of "proof from the post office." Otherwise put, the employer contends that the statute permits it to prove by any available evidence that it mailed the notice on a particular date, and the

appellate courts have no power to limit the kind of evidence sufficient to prove the fact of the date of mailing.

As we stated in *Modoc*, we desired to promulgate a rule that would clarify the arguably ambiguous text of ORS 19.028. The rule was designed to save the time of litigants and of the appellate courts by stating a method of "proof from the post office" easily achieved by the litigant and easily administered by the courts. Whether the Court of Appeals and this court[7] have power to limit the mode of "proof" to which ORS 19.028 speaks need not be answered in this case.

We return to the text of ORS 19.028. In *Modoc* we suggested that "has proof" probably spoke to the time of mailing, and we warned that once a rule of procedure were adopted our decision in *Modoc* would not justify ex post facto proof of mailing. We now squarely hold that the statute requires that the litigant obtain proof at the time of mailing in order to satisfy the statutory requirement that the litigant "has" proof. The petitioner in *Modoc* had not the benefit of the decision in *Modoc*, and the warning therein, and we believed that justice required reinstating the appeal. That is not true in the case at bar. Lawyers for litigants were warned in *Modoc*, which was handed down September 7, 1983. Additional warning in the form of Rule 2.06 became effective January 4, 1984. The mailing in the case at bar occurred almost a year after the decision in *Modoc* and some seven months after the effective date of the rule.

We hold that the petition for judicial review was not timely filed with the clerk of the Court of Appeals.[8]

JURISDICTION

Petitioner next contends that filing within 30 days of the date of the Board's order is not essential to Court of

Appeals jurisdiction of a request for judicial review under ORS 656.295(8) and 656.298. The employer's argument is constructed from the fact that the law formerly used the word "jurisdiction" with respect to judicial review, but that word is no longer found in ORS 656.298. The employer points out that ORS 19.033(2) specifically provides that in appeals from circuit or district court to the Court of Appeals timely service and filing of the notice of appeal "is jurisdictional and may not be waived or extended." Because, argues the employer, there is no like terminology in the Workers' Compensation Law, the legislature must have intended that a defect in filing is not jurisdictional:

> "In short, if the Legislature intended that defects in the filings of Workers' Compensation appeals were to be jurisdictional, it has certainly proved that it is capable of drafting the necessary language to make them jurisdictional. It has not done so * * *."

In 1913 the legislature enacted a workers' compensation law, Or Laws 1913, ch 112. That law provided for appeal from the decision of the State Industrial Accident Commis-

[7] The Oregon Rules of Appellate Procedure (ORAP) are promulgated by both the Supreme Court and the Court of Appeals.

[8] The employer has directed our attention to House Bill 2205 introduced in the present legislative session at the request of the Judicial Department. The bill would amend ORS 19.028 but not in any particular that would affect what we hold in this case.

sion to the circuit court. Section 32 provided in pertinent part:

> "No such appeal shall be entertained unless notice of appeal shall have been served by mail or personally upon some member of the commission within 30 days following the rendition of the decision appealed from * * *."

The provision does not use the word "jurisdiction."

In 1917 section 32 was amended, Or Laws 1917, ch 288, § 18, to provide that a claimant might appeal from the "final action" of the Commission "within thirty days." The word "jurisdiction" does not appear. The word "jurisdiction" appeared for the first time when section 32 was amended in 1919, Or Laws, ch 397, § 1. The amended section gave "any beneficiary" 30 days after a commission final action to appeal to the circuit court and

> "It shall be sufficient to give the circuit court jurisdiction that a notice be filed with the clerk of said court to the effect that an appeal is taken * * *."

In 1921 the legislature returned to the section, by then codified as O.L. § 6637, amending it to allow 60 days from commission final action to appeal but not changing the just

quoted text concerning circuit court "jurisdiction." Or Laws 1921, ch 311, § 10.

In 1925 the legislature forsook the word "jurisdiction" and amended the section to shorten to 30 days the time for appeal to the circuit court:

> "Such appeal shall be perfected by filing with the clerk of the court a notice of appeal in the form of a complaint as provided in civil actions at law, and by serving a copy thereof by registered mail on the commission."

Or Laws 1925, ch 133, § 8.

In 1933 the section was again amended. Or Laws 1933, ch 455, § 1, without changing the language of the 1925 amendment. In 1935 the legislature again amended the section, Or Laws 1935, ch 178, § 1, but did not change the 1925 language, which failed to mention the word "jurisdiction." The section, by then codified as section 102-1774, OCLA, was again amended in 1945, Or Laws 1945, ch 303, § 1, but there was no change in the 1925 language.

When the legislature enacted Oregon Revised Statutes in 1953, the right of appeal was addressed in ORS 656.286 and 656.288, with the preservation of the same 30 day period from the time of the commission's final order but a change in language as to perfection of the appeal. Then ORS 656.288(2) provided:

> "The appeal shall be perfected by filing with the clerk of the [circuit] court a complaint, as provided in civil actions at law, and by serving a copy thereof by registered mail on the commission."

The word "jurisdiction" was still absent. The section was amended by Oregon Laws 1957, chapter 288, section 1, without any change in that sentence.

In the wholesale revision of the law relating to workers' compensation in 1965, ORS 656.288 was repealed,

and sections 35a and 36 were enacted, Or Laws 1965, ch 285. Section 35a(8) provided:

> "An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the circuit court for judicial review pursuant to section 36 of this 1965 Act. * * *"

Section 36 provided:

> "(1) Any party affected by an order of the board may, within the time limit specified in section 35a of this 1965 Act, request judicial review of the order with the circuit court * * *.
>
> "* * * * *
>
> "(3) The judicial review shall be commenced by serving, by registered or certified mail, a copy of a notice of appeal on the board and on the other parties who appeared in the review proceedings, and by filing with the clerk of the circuit court the original notice of appeal with proof of service indorsed thereon. * * *"

Those sections were codified as ORS 656.295(8) and 656.298(1) and (3), respectively. Except for the change from the circuit court to the Court of Appeals of the judicial review function, there have been no subsequent pertinent modifications of the 1965 legislation.

The word "jurisdiction" has not appeared in the legislative scheme for judicial review of administrative agency action since 1925. We now turn to appellate court decisions concerning "jurisdiction" vis-a-vis timeliness.

Although timeliness was not the particular issue, this court noted in *Graves v. State Industrial Acc. Com.*, 112 Or 143, 223 P 248 (1924), that because the right of judicial review was purely statutory, conformance to statutory requirements was essential to appellate tribunal jurisdiction. *See also Liimatainen v. State Indus. Acc. Com.*, 118 Or 260, 246 P 741 (1926). This is nothing more than a particular application of the rule that appellate jurisdiction springs from statute and that except for statutory authority this court and the Court of Appeals have no power to address the merits of a claim. *See Ragnone v. Portland School District No. 1J*, 289 Or 339, 613 P2d 1052 (1980).

In *Jackson v. State Industrial Acc. Com.*, 114 Or 373, 235 P 302 (1925), the worker attempted to appeal to the circuit court from an order of the Commission, but he did not file his notice of appeal in the circuit court until after the 60 day period specified for appealing by O.L. § 6637. This court quoted from an earlier decision, *Demitro v. State Industrial Acc. Com.*, 110 Or 110, 112, 223 P 238 (1924):

> "The whole scheme of the Workmen's Compensation Law is purely statutory, and not according to the course of the common law. It is elementary that in acquiring jurisdiction in pursuit of a statutory remedy, the requirements of the enactment must be complied with strictly."

114 Or at 377. This court then held that the circuit court was without jurisdiction. This court did not even refer to the word

"jurisdiction" then in O.L. § 6637 but quoted only the part of the statute requiring that an appeal be taken within 60 days.

In another case, *Bergerson v. State Indus. Acc. Com.*, 121 Or 314, 253 P 1052 (1927), concerning events governed by the statute while it still contained the word "jurisdiction," this court decided that the circuit court was without jurisdiction of an appeal that was untimely filed without any reference to statutory text other than the 60 day limit for appeals from commission orders.

After the statute had been amended in 1925 wherein the word "jurisdiction" was removed from the text and the 30 day limit restored, a claimant did not file her notice of appeal and complaint in the circuit court until the 31st day. This court stated:

> "The only question presented in this case is, did the respondent perfect her appeal within the time required by statute?
>
> " 'Within thirty days after a copy of the final order of the commission upon such application for rehearing has been mailed claimant, as herein provided, or within thirty days after rehearing is deemed denied under section 49-1842, claimant may appeal to the circuit court * * *. Such appeal shall be perfected by filing with the clerk of the court a notice of appeal in the form of a complaint as provided in civil actions at law, and by serving a copy thereof by registered mail on the commission.' Oregon Code 1930, § 49-1843.
>
> "It will be observed the statute requires the filing of a notice of appeal in the form of a complaint and by serving a copy thereof by registered mail on the commission. Both of these acts must be done, that is, the complaint must be filed and served within the thirty days in order to give the circuit court jurisdiction."

Sevich v. State Ind. Acc. Com., 142 Or 563, 565, 20 P2d 1085 (1933).

In *Gerber v. State Ind. Acc. Com.*, 164 Or 353, 101 P2d 416 (1940), applying the statute that did not contain the word "jurisdiction" but did require that an appeal be taken to the circuit court within 30 days of the Commission's final order, this court held that the circuit court had no jurisdiction of an appeal filed in the circuit court more than 30 days after the final order.

The foregoing review of cases spanning a period of time during which the statutes did contain the word "jurisdiction" and did not contain the word demonstrates that this court has consistently held that perfecting an appeal within the statutory time limits is the key to jurisdiction in the court and that the presence or absence of the word has never been considered important.

It is against this background of judicial action that we view the 1965 version of the Workers' Compensation Law. The legislative course granting judicial review by filing a notice of appeal in court within a prescribed time limit was continued. There is nothing to indicate that the legislature meant that filing within the time limit was no longer to be essential to the court's jurisdiction. We have stated

"that amendatory acts do not change the meaning of preexisting language further than is expressly declared or necessarily implied."

Fifth Avenue Corp. v. Washington Co., 282 Or 591, 597-598, 581 P2d 50 (1978).

Under ORS 656.295(8) the Board's order becomes final "unless within 30 days * * * one of the parties appeals * * * pursuant to ORS 656.298." No later than midnight on the 30th day the order is final, both internally and externally. Finality can be avoided only by taking certain action within the 30 days. One such essential action is filing the notice of appeal with the clerk of the Court of Appeals.

The employer here has failed to file the notice of appeal with the clerk of the Court of Appeals until the 31st day. Just as in the case of the claimant who failed to file until the 31st day in *Sevich v. State Ind. Acc. Com.*, *supra*, the court has no jurisdiction over the merits of this appeal.

SERVICE ON THE BOARD

The Court of Appeals, *sua sponte*, dismissed this appeal for failure to serve the Board as required by ORS 656.298(3). The same reasoning employed by this court from the time of *Demitro v. State Industrial Acc. Com.*, *supra*, forward, that jurisdiction in the court springs from the statute and that strict compliance with the statute is necessary to the court's jurisdiction, will lead to the affirmance of the Court of Appeals' action on the ground it chose.

Again, the Board's order becomes final not later than the end of the 30th day unless appeal is taken "pursuant to ORS 656.298." ORS 656.298(3) specifies that one of the acts that an appellant must do to "commence" judicial review is to serve a copy of the notice of appeal on the Board[9] and file the notice of appeal "with proof of service indorsed thereon." The original notice of appeal (petition for judicial review) eventually filed by this employer contained no such indorsement.

This is an alternative basis of affirming the decision of the Court of Appeals that the appeal should be dismissed.

Affirmed.

[9] *Compare Sevich v. State Ind. Acc. Com.*, 142 Or 563, 565, 20 P2d 1085 (1933), where we stated that *both* timely filing of the notice of appeal *and* serving a copy on the Commission were necessary to court jurisdiction.

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