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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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ANA M. GUERRERO, Claimant
Vick & Associates, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 85-04520
January 6, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Nichols' order which: (1) found that her hip, back, neck, and shoulder injury claim had not been prematurely closed; (2) affirmed a Determination Order that awarded no permanent disability; and (3) upheld the self-insured employer's partial denial of her medical services claim for chiropractic treatments. On review, the issues are premature closure, extent of permanent disability, and the compensability of claimant's chiropractic treatments.

We affirm those portions of the Referee's order concerning the premature closure and extent of disability issues. However, we reverse the Referee's order insofar as it upholds a partial denial issued prior to claim closure.

Claimant was 31 years of age at the time of hearing. In August 1984, while working for a cannery, she fell, striking the right side of her body. Dr. Webb, her treating chiropractor, diagnosed acute lumbar and cervical/dorsal strain/sprain and right rotator cuff strain. Claimant had sustained a prior compensable low back injury in August 1980, for which she continued to receive periodic chiropractic treatments from Dr. Webb. The employer accepted claimant's August 1984 injury claim and began paying for her treatments.

In October 1984 Dr. Webb reported that claimant was making favorable, but slow, progress. Yet, the time of claimant's eventual return to work was still undetermined. Dr. Webb subsequently referred claimant to Dr. Jansen, chiropractor, for physical therapy.

In January 1985 Dr. Voiss, neuropsychiatrist, performed an independent medical examination. The findings of Dr. Voiss' evaluation indicated a major psychological interference. Dr. Voiss attributed the interference to claimant's "idea" of disability which appeared to be actively and aggressively reinforced by her treating chiropractor. Dr. Voiss concluded that claimant had a conversion disorder, which was not under her voluntary control, but was also not attributable to the compensable injury. Dr. Voiss opined that claimant was not disabled as a result of her compensable injury.

In February 1985 Dr. Webb reported that claimant had been released to light duty on a trial basis. However, the employer apparently had no suitable positions available.

In March 1985 the Diagnostic Panel performed an independent medical examination. The Panel found no objective or subjective evidence of any diagnosable condition which could be attributed to the August 1984 injury. Consequently, the Panel concluded that claimant could be considered medically stationary, with no residual impairment or work restrictions. The Panel further advised that continuing chiropractic treatment was contraindicated.

After receiving the Diagnostic Panel's report, the employer issued its partial denial. Stating that claimant's compensable condition had resolved without permanent impairment, the employer asserted that the current chiropractic treatments were not necessary and reasonably related to the August 1984 injury.

Dr. Webb disagreed with the Diagnostic Panel's diagnosis and findings. In Dr. Webb's opinion, claimant was suffering ongoing symptoms attributable to the traumatic August 1984 injury. Rating claimant's permanent disability in the moderate range, Dr. Webb anticipated a future need for chiropractic care.

On July 26, 1985, the employer issued a Notice of Claim Closure. This notice was referred to the Evaluation Division, which also declined to award permanent disability.

In August 1985 claimant was examined by the Independent Chiropractic Consultants. The Consultants considered claimant's condition medically stationary, without any residual impairment attributable to the August 1984 injury. The Consultants further opined that no additional care was necessary.

In March 1986 Dr. Jansen reported that claimant's symptoms were consistent with the history of her injury. Although Dr. Webb's treatment had been effective, Dr. Jansen still did consider claimant's condition to be medically stationary. Rating claimant's disability as moderate, Dr. Jansen recommended modified work duties.

Claimant testified that since her 1980 injury she has treated with Dr. Webb. At the time of her August 1984 injury, she was receiving weekly chiropractic treatments and had been limited to modified work duties. Claimant presently experiences back pain and stiffness, which increases with activity. The pain is "still the same" as it was during the summer of 1985. Her treatments with Dr. Webb continue, approximately once or twice a week.

The Referee was persuaded that claimant's chiropractic care was not necessary and reasonable treatment attributable to her August 1984 injury. Consequently, the employer's denial of chiropractic treatment was upheld.

Following our de novo review of the medical and lay evidence, we agree with the Referee's conclusion that claimant has failed to establish the compensability of her current chiropractic care. Yet, the employer's denial of this treatment was issued prior to the closure of the claim. A partial denial of a previously accepted inseparable condition, issued while the claim is in open status, is not permissible. Roller v. Weyerhaeuser Co., 67 Or App 583 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983).

We are unable to separate the chiropractic treatments for claimant's accepted condition from those supposedly attributable to her noncompensable conditions. Thus, we conclude that the employer is precluded from denying responsibility for the treatments conducted between its March 1985 partial denial and the July 26, 1985 Notice of Claim Closure. However, the evidence does not support the compensability of claimant's chiropractic treatments conducted after the notice of closure. Accordingly, we find that the employer's "de facto" denial of responsibility for

these treatments shall be effective as of the date of the administrative claim closure.

ORDER

The Referee's order dated May 7, 1986 is affirmed in part and reversed in part. The self-insured employer's partial denial is set aside insofar as it purports to deny responsibility for chiropractic treatments conducted prior to the July 26, 1985 Notice of Claim Closure. Claimant's attorney is awarded $400 for services at the hearing level and $250 for services on Board review concerning this issue, to be paid by the employer. The employer's "de facto" denial of claimant's current chiropractic treatment is upheld. The remainder of the Referee's order is affirmed.

DONALD L. HALL, Claimant
Vick & Associates, Claimant's Attorneys
Beers, et al., Defense Attorneys
Bottini & Bottini, Defense Attorneys

WCB 85-15202, 85-11728 & 85-15201
January 6, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Pferdner's order which: (1) directed it to process claimant's injury claim to closure; and (2) assessed a penalty and attorney fees for unreasonable claims processing. On review, the insurer contends that it was not required to process the claim and that its conduct was not unreasonable.

Claimant filed an occupational injury claim, alleging that he suffered compensable injuries while involved in a physical altercation. The claim was denied and the matter proceeded to hearing. In August 1985, a prior Referee found the altercation compensable and set aside the insurer's denial. However, the insurer was not specifically directed to process the claim to closure. Instead, the Referee remanded two medical bills to the insurer for payment. This order was neither reconsidered nor appealed.

Shortly after the prior Referee's order, claimant's treating physician reported that claimant's recent problem was entirely related to the altercation. Accordingly, the physician retroactively authorized approximately one month of temporary disability benefits. When these benefits were not forthcoming, claimant requested a hearing.

The Referee concluded that the prior Referee had found the claim compensable. Yet, by ordering payment of only the two medical bills, the Referee reasoned that the prior Referee had usurped statutory claim closure functions. Because of the prior Referee's finding of compensability, the Referee held that the insurer remained responsible for processing the claim pursuant to the Workers' Compensation Law. Inasmuch as the insurer had failed to process the claim to closure, it was assessed a penalty and attorney fees.

We agree with the Referee that the claim must be processed through closure. However, we do not consider the insurer's conduct unreasonable. Thus, we reverse that portion of the Referee's order which assessed a penalty and accompanying attorney fees.

The insurer argues that the prior Referee's apparent finding that the claim was for medical bills only is res judicata and constitutes the law of the case. We disagree. Res judicata bars claims which were or could have been litigated in the prior proceeding. Collateral estoppel precludes relitigation of issues actually litigated and determined, if their determination was essential to the prior order. Consolidated Freightways v. Poelwijk, 81 Or App 311 (1986); Carr v. Allied Plating Co., 81 Or App 306 (1986).

Neither doctrine is applicable here. The issue litigated before the prior Referee was clearly compensability. Entitlement to medical services and compensation are naturally contingent upon a finding of compensability. The issues, however, are not one and the same. Thus, although some of the prior Referee's comments suggest otherwise, we find that the issues of claimant's entitlement to medical services and temporary/permanent disability compensation were not and could not have been litigated in the prior proceeding.

Furthermore, once a claim is found compensable, the responsibility for processing and payment of compensation lies with the insurer or self-insured employer. ORS 656.262(1). These responsibilities include processing the claim to closure either through the Evaluation Division, ORS 656.268(2), or by administrative means, ORS 656.268(3). A Referee's directive arguably to the contrary cannot release the insurer from its statutory obligations.

Claimant's attorney has been instrumental in obtaining, at least, the potential for increased compensation. For these efforts, claimant is entitled to an attorney's fee payable out of his subsequent award of compensation. ORS 656.386(2); OAR 438-47-010(5). Consequently, we find that claimant's attorney shall receive 25 percent of the compensation, if any, awarded upon claim closure. OAR 438-47-030. This fee shall not exceed $750. Id.

Penalties are assessed for an insurer's unreasonable delay or unreasonable refusal to pay compensation. ORS 656.262(10). Attorney fees are recoverable when an insurer unreasonably resists the payment of compensation. ORS 656.262(10); ORS 656.382(1). We have repeatedly stressed that the integrity of the workers' compensation system relies, to a great extent, on compliance with Referee orders. See Oscar L. Drew, 38 Van Natta 934, 936 (1986); Donald M. Van Dinter, 37 Van Natta 652, 655 (1985).

Considering the prior Referee's statements and instructions, we find that the insurer's failure to process the claim to closure pursuant to statutory procedures was not unreasonable. Therefore, penalties and attorney fees should not have been assessed.

Finally, we find that the "res judicata" issue was of ordinary difficulty with the usual probability of success for claimant. Accordingly, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated June 23, 1986 is affirmed in

part and reversed in part. The assessment of a penalty and accompanying attorney fees is reversed. Claimant's attorney is awarded 25 percent of the increased compensation, if any, to be awarded upon claim closure. This award shall not exceed $750. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services on Board review concerning the "res judicata" issue, to be paid by the insurer.

SHERRY LOEWEN-JOHNSON, Claimant
Brian R. Whitehead, Claimant's Attorney
David Horne, Defense Attorney

WCB 85-04114
January 6, 1987
Order Denying Motion to Set Aside Dismissal

Claimant has moved the Board for an order setting aside Presiding Referee Daughtry's Order of Dismissal dated June 9, 1986. As Board review of that order was not requested within 30 days, it has become final. ORS 656.289(3); 656.295(2). The only possible authority for setting aside the order at this time is ORS 656.278(1), the Board's own motion authority. Assuming without deciding that our own motion authority is sufficiently broad to permit us to set aside the dismissal in this case, but see ORS 656.278(5), we decline to do so.

This matter was dismissed after claimant's former attorneys lost contact with claimant and withdrew their representation after failure of their duly dilligent efforts to locate her. After claimant failed to respond to an order to show cause why the matter should not be dismissed as abandoned, the Presiding Referee entered the order claimant now, over six months later, seeks to have set aside. In her motion, claimant has not advanced any specific reason why the order should be set aside.

In our opinion, setting aside the order of dismissal is not justified. The motion is denied.

IT IS SO ORDERED.

LLOYD O. FISHER, Claimant
Emmons, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 85-13310
January 8, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of that portion of Referee Nichols' order which found that its unilateral termination of claimant's temporary disability benefits was improper. On review, the insurer argues that claimant was not entitled to temporary disability compensation during his incarceration. Claimant cross-requests review, contending that the insurer's conduct was unreasonable.

The Board affirms the order of the Referee with the following comments.

At the time of the insurer's unilateral termination of temporary disability benefits, claimant's condition was not medically stationary and his claim had neither been closed administratively nor by Determination Order. Furthermore, he had neither returned, nor been released, to regular work. Under these circumstances, we agree with the Referee's conclusion that the insurer's unilateral termination of benefits was improper. See Jackson v. SAIF, 7 Or App 109 (1971).

In affirming the Referee's order, we wish to stress that this is not a finding that claimant is entitled to temporary disability benefits during his incarceration. Rather, we are finding that the insurer's unilateral termination of benefits, although not unreasonable, was invalid. Claimant's entitlement to benefits during incarceration and the insurer's request for an offset are issues that should be addressed at the time of claim closure.

Finally, we find that this case is of ordinary difficulty with the usual probability of success for claimant. Accordingly, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated March 17, 1986 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the insurer.

TERRY D. QUEENER, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Cowling & Heysell, Defense Attorneys

WCB 86-01585 & 85-13348
January 9, 1987
Order on Reconsideration

Loggers Assurance Company has requested reconsideration of the Board's Order on Review dated December 24, 1986 which denied its request that the Board take administrative notice of certain records of the Corporation Division of the Oregon Department of Commerce and denied its request that the Board remand the case for the receipt of additional testimony. It contends that the Board's decision in this case is inconsistent with its decision in the case of Dave S. McElmurry, 38 Van Natta 1432 (WCB Case No. 85-12308; December 10, 1986).

In Dave S. McElmurry, supra, the Board remanded the case to the Referee under the rule of Parmer v. Plaid Pantry #54, 76 Or App 405 (1985) for the receipt of additional evidence concerning the progress and outcome of a California workers' compensation claim after the Referee issued her order. Loggers Assurance contends that the Board took "judicial notice" of the California workers' compensation proceeding in McElmurry and thus that it should take "judicial notice" of the Oregon Department of Commerce records in this case.

Loggers Assurance is mistaken. The Board did not take judicial or administrative notice of the California workers' compensation proceeding in McElmurry. The claimant in that case provided evidence of the progress and outcome of the California proceeding to the Board and the Board remanded the case for further development in light of events which had occurred after the issuance of the Referee's order. The issue was remand, not administrative notice.

In the present case, Loggers Assurance urges the Board to take administrative notice of the records of another agency which reflect events which allegedly took place nearly a year before the date of the hearing. Administrative notice is not appropriate under these circumstances for the reasons stated in our Order on Review. Remand is not appropriate for the receipt of this evidence because such evidence could have been offered at the time of the hearing with the exercise of due diligence.

Loggers Assurance also argues that the Board's denial of its motion to remand the case for the testimony of an absent witness conflicts with the Board's decision in McElmurry. The difference between this case and McElmurry is the availability of the proferred evidence prior to the hearing. In McElmurry the Board concluded that the disputed evidence was not reasonably available prior to the hearing with due diligence. The reasoning supporting this conclusion is stated in that order and will not be repeated here. In the present case, the Board concluded that the evidence was available before the hearing and could have been presented with the exercise of due diligence. The record indicates that the extent of counsel's efforts to procure the attendance of the absent witness was one unsuccessful phone call, if that. Nothing in Loggers Assurance Company's request for reconsideration causes us to conclude that our denial of the request for remand was incorrect.

Accordingly, Loggers Assurance Company's request for reconsideration is granted. After reconsideration, we adhere to our prior order. Rights of appeal shall run from the date of our prior order.

IT IS SO ORDERED.

DOUGLAS B. DICKENS, Claimant
Coons & Cole, Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 85-04449
January 12, 1987
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated December 19, 1986 which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. In its request, the insurer contends that we misinterpreted both the medical evidence and some of the Referee's conclusions.

The insurer's request is granted. Our previous order is withdrawn. However, following a further review of the medical and lay evidence, we remain persuaded that claimant's work activities as a heavy equipment dismantler were the major contributing cause of the worsening of his bilateral carpal tunnel syndrome.

In reaching our decision, we, like the Referee, did not totally accept or reject the findings from any one, or all three, of the electrical nerve conduction studies. The studies' findings were but a portion of the evidence we analyzed in determining the compensability of the claim. Furthermore, we concede that we could have misinterpreted the Referee's "conclusion" that claimant's daily activities were no different than his prior work activities as a deputy sheriff. The Referee's statement could also be construed as merely a recitation of a consulting physician's opinion and not an actual finding. Yet, even assuming that our previous representation was not an entirely accurate depiction of the Referee's conclusion, our ultimate decision would remain unaltered.

Accordingly, on reconsideration, we adhere to and republish our former order, as supplemented herein, effective this date.

IT IS SO ORDERED.

ENNIS M. ENTWISLE, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-12159
January 14, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Menashe's order that set aside its denial of claimant's aggravation claim and awarded penalties and attorney fees for late payment of interim compensation. The issues are aggravation, penalties and attorney fees.

The Board affirms those portions of the Referee's order that set aside SAIF's denial of claimant's aggravation claim and awarded claimant's attorney an attorney fee of $300 on the penalty issue. On the issue of penalties, however, the Board reduces the 25 percent penalty assessed by the Referee to 15 percent in accordance with the guidelines enunciated in Zelda M. Bahler, 33 Van Natta 478, 479 (1981), rev'd on other grounds, Bahler v. Mail-Well Envelope Co., 60 Or App 90 (1982).

ORDER

The Referee's order dated June 30, 1986 is affirmed in part and modified in part. That portion of the order that awarded claimant a penalty of 25 percent is modified, and claimant is awarded a penalty of 15 percent. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $300 for services on Board review in connection with the aggravation issue, to be paid by the SAIF Corporation.

ARCHIE F. KEPHART, Claimant
Malagon, et al., Claimant's Attorneys
Cheney & Kelley, Defense Attorneys

WCB 81-0173M
January 14, 1987
Own Motion Order on Remand

This matter is before the Board on remand from the Court of Appeals. Edward Hines Lumber Co. v. Kephart, 81 Or App 43 (1986). We have been instructed to allow time for a response from the self-insured employer and to then reconsider our Second Own Motion Determination on Reconsideration dated August 6, 1985.

We are now in receipt of the employer's response. Having received no further response from claimant, we have proceeded with our review.

On reconsideration, we adhere to and republish our August 6, 1985 order.

IT IS SO ORDERED.

The Beneficiaries of
HERSCHELL R. PITTS (Deceased), Claimant
Richardson, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 80-03994, 82-05466
& 82-00902
January 14, 1987
Order on Remand

This matter is before us on remand from the Supreme Court. Farmers Insurance Group v. SAIF, 301 Or 612 (1986). We have been instructed to enter an order consistent with the Supreme Court's opinion that the Referee's March 14, 1983 order became final by operation of law. Pursuant to this order, the SAIF Corporation was found responsible for the claim.

Accordingly, Farmers' denial of benefits issued June 16, 1982 is upheld and SAIF's denial of benefits issued January 15, 1982 is set aside. The claim is remanded to the SAIF Corporation for acceptance, payment of attorney fees, and further processing according to law.

IT IS SO ORDERED.

BETTY L. VESSEY, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-06062
January 14, 1986
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Fink's order that awarded claimant permanent total disability in lieu of a Determination Order award of 40 percent (128 degrees) unscheduled permanent partial disability for the low back. The issue is extent of unscheduled disability, including permanent total disability.

Claimant is the former owner of a gift and card shop. She compensably injured her low back on April 20, 1983 while moving a heavy display rack. Initial treatment was conservative and claimant continued to attempt work. Ultimately, however, Dr. Waller performed a right L5-S1 microlumbar discectomy on March 21, 1984. The surgery resolved claimant's right thigh pain, but her low back pain remained. She left work to have surgery and had not returned at the time of the hearing. Following surgery, claimant was unable to continue operating her gift shop, and she filed a petition for bankruptcy in June 1984.

During mid-1984 claimant gradually increased her activity at the direction of Dr. Waller, the treating surgeon. Dr. Waller suggested that claimant avoid any employment involving repetitive lifting of more than 15 pounds. On June 28, 1984, he reported, "I think she is ready to return to work, but needs . . . assistance in the area of vocational counseling." In Dr. Waller's opinion, claimant could sit and stand for an hour at a time, four hours per day, and could walk for 1/2 hour at a time. Based on Dr. Waller's report, SAIF arranged for claimant to receive vocational assistance from Richter-Harper Services, a private vocational service provider.

The vocational provider initially determined that claimant's prognosis for a return to work was "fair to good," based on her transferable skills, apparent above average intelligence and prior work habits. Bookkeeping employment was

set as the vocational goal because of claimant's documented work experience in that area. Other clerical positions were also to be explored. Within the first month, a part-time job was found. Claimant did not submit an application, however, because of the job's location and the $5.30 per hour wage.

As reemployment efforts continued, the provider identified claimant's salary demands as an obstacle to employment. Claimant had indicated that she would need a minimum monthly net income of $1,000 to meet expenses. The provider noted that bookkeepers' salaries tended to be low, but it continued its efforts toward claimant's reemployment.

In a December 18, 1984 report, claimant's vocational counselor expressed frustration with claimant's difficulty in focusing on a suitable return-to-work goal, as well as her failure to follow through on employment search directives. The counselor tentatively decided to steer claimant away from bookkeeping and related employment because of claimant's preference for higher paying jobs.

In early 1985, the counselor developed a job for claimant at a dry cleaning shop. The job was to be part-time to start and was within the physical limitations prescribed by Dr. Waller. Dr. Waller reviewed the proposed job description and approved claimant's participation. The beginning pay was to be minimum wage, with a proposed increase to $1,300 per month three months later. Because the job required knowledge of computer techniques, the vocational provider arranged for claimant's computer certification. Although claimant agreed to become certified, both the certification and the proposed employment fell through after a series of miscommunications, some for which claimant appears to have been responsible. The proposed employer ultimately withdew his offer of employment. Claimant's vocational counselor thereafter expressed continuing frustration, noting: "[Claimant] . . . seems to be sabotaging return-to-work opportunities." The counselor warned that further failures to cooperate and participate could result in the closure of claimant's file.

Claimant was declared medically stationary by a panel of Orthopaedic Consultants on January 31, 1985. The panel rated claimant's overall impairment as moderate. The claim was later closed by Determination Order with an award of 40 percent unscheduled low back disability.

In February 1985, Dr. Waller approved a second job developed for claimant by Richter-Harper Services. Although claimant agreed to attempt the job, her continuing complaints of low back pain and requests for therapy led the vocational provider to seek Dr. Waller's opinion on claimant's need for continued medical treatment. Dr. Waller apparently responded negatively to the therapies requested by claimant and reported that claimant would have to "settle down and get back to work." Despite claimant's concerns, a direct employment program was developed and approved. Two job openings were found and claimant was offered an entry-level bookkeeping job by one of the employers. Claimant refused the job because of its low starting salary.

In April 1985, a new Richter-Harper counselor assumed responsibility for claimant's file. Because claimant's

bookkeeping skills were "not fresh" and her enthusiasm for that employment had reportedly "dwindled," the new counselor attempted to place claimant as a receptionist in a medical office. One office expressed initial interest in hiring claimant, but the high salary expectations she expressed in her interview resulted in the office hiring another applicant. Claimant's file was soon closed, with her counselor reporting:

> "After many months of placement efforts . . . it has not been possible to assist the injured worker with entry placement which meets her salary expectations of $1,000/net. Other concerns about worker's participation in the joint job placement effort had also been expressed . . . The worker is considered to possess marketable skills for employment as a receptionist/bookkeeper but has not attained employment to date because of the labor market."

Claimant testified at hearing that she was 60 years old and had a high school diploma. Her past employments included work at a ship yard, a department store and a school district before she left employment for several years to raise a family. When claimant later divorced, she worked for a short time as a secretary before purchasing her card and gift shop. She had had two prior minor compensable back injuries that resulted in medical treatment only.

Claimant testified to ongoing low back and leg pain that limits her ability to be active. She indicated that after a day of activity, her sleep is affected and she is unable to be active the next day. Her day-to-day activity consists largely of rest and sporadic light activity. When asked whether her job search efforts had resulted in offers of employment, claimant indicated that she had received two calls regarding temporary employment, both of which she rejected. She did not feel capable of doing one job and she cited personal reasons for rejecting the other.

Sue Swenson, claimant's initial Richter-Harper counselor, testified that claimant viewed herself as more disabled than did her treating doctor. She also testified regarding the several unsuccessful attempts at returning claimant to work, citing claimant's rejections of job offers as a source of frustration. On cross-examination, Ms. Swenson admitted that she had conducted no vocational tests and that claimant had arranged for her own typing and accounting training. Claimant had also been active in arranging for at least one bookkeeping job.

The Referee found claimant to be a completely credible and reliable witness. Relying largely on her testimony, the Referee found claimant to be permanently and totally disabled. He found that the medical evidence "essentially, corroborates claimant's testimony." The Referee discounted the vocational evidence, finding claimant's vocational assistance to have been ineffectual and her counselor to have "either totally misconstrued the situation or distorted the facts."

It is claimant's burden to prove that she is permanently and totally disabled, that she is willing to seek regular gainful employment and that she has made reasonable efforts to obtain such

employment.. ORS 656.206(3). Our review of the evidence persuades us that claimant has failed to sustain her burden of proof. While her testimony is probative and suggests that claimant is permanently and totally disabled, the remainder of the record is to the contrary. The treating surgeon has never suggested that claimant is unable to work. In fact, he has consistently reported that claimant is able to work, albeit with limitations. He has specifically approved her participation in two jobs, and has apparently denied her requests for additional medical therapy, reporting to claimant's counselor that claimant should "settle down and get back to work."

We disagree with the Referee's complete rejection of the vocational evidence. Although the evidence may have been more persuasive had claimant undergone vocational testing, we do not find it to be subject to rejection out of hand. Rather, the vocational record persuades us that claimant has skills transferable to the sedentary occupations approved by the treating physician. We also are persuaded by the vocational evidence that claimant rejected several viable offers of employment solely because she was dissatified with the wages associated with those offers. The repeated rejections were a direct cause of the ultimate closure of the vocational file. We find claimant's rejections to have been unreasonable, given that her participation in employment was twice approved by her physician. Claimant is not entitled to an award of permanent total disability.

At the time of the hearing, claimant had received a 40 percent unscheduled award for the low back. We find that she is entitled to an increased award. As previously noted, claimant was 60 years old at the time of the hearing. Although she has transferable skills, she is now precluded from all but sedentary employment. Her physical impairment has been rated "moderate" by Orthopaedic Consultants. After reviewing these and other pertinent social/vocational factors, we find that claimant is entitled to an increased award of 20 percent unscheduled disability, bringing her total award to 60 percent. The Referee's order shall be modified accordingly.

ORDER

The Referee's order dated February 26, 1986 is modified. In lieu of the Referee's award of permanent total disability and all prior awards, claimant is awarded 60 percent (192 degrees) unscheduled permanent partial disability for the low back. Claimant's attorney's fee shall be modified according to this order.

Board Member Lewis Dissenting

I respectfully dissent from the majority's order that reversed the Referee and found that claimant was not permanently totally disabled.

At the time of hearing claimant was 60 years old with a 12th grade education. Her only recent occupation was that of owning and operating a gift shop for nine years. Her annual income from that occupation had been $23,000 to $24,000. As a result of her injury Dr. Waller, her treating physician, had limited her to occupations with no repetitive lifting beyond 15 pounds. Further, she was to sit and stand for only an hour at a time, four hours per day, and could walk for half an hour at a

time. Dr. Waller concluded that claimant would not be able to return to her former occupation at the gift card shop and was in need of vocational retraining.

I conclude that claimant has established that she is permanently disabled due to a combination of medical and non-medical disabilities which have effectively foreclosed her from gainful employment. See Welch v. Banister Pipeline, 70 Or App 699 (1984). I also conclude that claimant has satisfied her burden of proving that she is willing to seek regular gainful employment and that she has made reasonable efforts to obtain such employment as required by ORS 656.206(3).

The majority declined to award permanent disability based primarily on the vocational reports and testimony of the vocational counselor. In doing so, the majority has directly assailed the Referee's credibility findings of both the vocational counselor and claimant. The Referee stated that he had no questions concerning claimant's credibility and found that the medical evidence corroborated her testimony. The majority concluded that her testimony was "probative", but contrary to the remainder of the record. Implicitly, the majority has disputed the Referee's credibility findings even though he was in the best position to make that determination. See Humphrey v. SAIF, 58 Or App 360 (1982).

Most significant was the majority's disregard of the Referee's finding concerning the vocational counselor's testimony and reports. After hearing the elusive testimony of the vocational counselor, the Referee stated that her testimony was not entitled to any weight as she had "either totally misconstrued the situation or distorted the facts." This finding was not totally based on demeanor, but is also supported by the record.

After the start of vocational services, bookkeeping was established as a potential occupational goal. The counselor and claimant soon discovered, however, that her skills were outdated and she needed additional training. Without the aid of her vocational counselor, claimant located and participated in computer and typing classes. She also paid for these courses. Further, claimant's only serious job opportunity came after she contacted a friend regarding possible employment at a dry cleaning shop. Unfortunately, the job never fully materialized as the employer was unable to obtain a federal wage subsidy. Significantly, the vocational counselor never aided claimant in obtaining the necessary certificate so the employer could obtain the needed wage subsidy. Despite claimant's finding this job and the vocational counselor's lack of help, the majority concluded that the counselor "developed" this job.

The vocational counselor testified at hearing that she became "frustrated" with claimant and doubted her motivation. She later concluded that claimant was attempting to "sabotage" her vocational assistance. The counselor was unable to substantiate any of these conclusions at hearing although the majority relies on them in their order. Like the Referee, I conclude that claimant was motivated to return to work and made exceptional efforts towards that goal. The vocational program did not aid claimant or make her more employable and we are obligated to base an award of permanent disability on the conditions existing at the time of hearing. Gettman v. SAIF, 289 Or 609 (1980). We can not

rely on what might have happened had claimant been given an effective vocational rehabilitation program.

I would affirm the well reasoned order of the Referee.

LINDA C. VILES, Claimant
Welch, Bruun & Green, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-11987
January 14, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The SAIF Corporation requests review of Referee Fink's order which: (1) found that claimant had established good cause for the untimely filing of her request for hearing; and (2) set aside its denial of claimant's occupational disease claim for her mental condition. On review, the issues are good cause and compensability.

We agree that claimant established good cause for the untimely filing of her hearing request concerning SAIF's denial. ORS 656.319(1)(b); Anderson v. Publishers Paper Co., 78 Or App 513 (1986); William J. Anderson, 38 Van Natta 1446 (December 15, 1986). Yet, we are not persuaded that claimant's work activities were the major contributing cause of her mental condition, or its worsening. Consequently, we reverse that portion of the Referee's order which found the claim compensable.

Claimant was 36 years of age at the time of hearing. In 1979 she began working for a college as a refund clerk. In 1982 and 1984 she sought treatment for stomach pains. However, these complaints were not attributed to mental problems. In September 1984, her husband accepted employment in Saudi Arabia. Claimant remained at her job and managed the couple's household, which consisted of two children. Her husband's move had apparently been necessitated by financial concerns, which included much of the support for her father-in-law, who had been recently incapacitated by two heart by-pass surgeries.

In January 1985 claimant was promoted to an administrative assistant position as a "Vets clerk." This position entailed the supervision of six work-study veterans. Claimant had no prior supervisory experience. Also in January 1985 her husband returned for a two-week vacation. Claimant behaved normally during his visit but was reluctant to have him return to Saudi Arabia.

After her husband's departure, claimant prepared a memo regarding the work-study veterans. She was concerned about some of the veterans tendency to study while they were assigned to work duties. The memo discussed what was expected of the veterans while they were working. The memo's distribution was met with nearly unanimous criticism. Claimant was amazed by this negative response.

On March 4, 1985, claimant was hospitalized for agitated behavior and auditory hallucinations. Apparently, she was talking in a disconnected fashion about her father, who had been dead for 23 years, and the safety of her children. In addition to her husband's Saudi Arabian employment and the pressures at home, claimant's history included her recent employment distress that had prompted her to leave work the previous week. Since her departure from work, claimant had experienced intermittent crying, auditory hallucinations, a 10-pound weight loss and insomnia.

Dr. Hensala, claimant's treating psychiatrist, ultimately diagnosed a major depressive disorder with psychotic features. This diagnosis was based on several examinations, including two separate hospitalizations. In Dr. Hensala's opinion, claimant's work activities, specifically the job change, was a major contributing factor in causing the development of her depressive condition. However, Dr. Hensala also acknowledged that another contributing factor was the absence of her husband.

Dr. Colbach, psychiatrist, performed an independent medical examination. Because of the loss of her father at a young age, Dr. Colbach opined that claimant was more sensitive to separations. Thus, Dr. Colbach felt that claimant's husband's move to Saudi Arabia had rekindled these prior problems. Although claimant's work played a part in aggravating an underlying condition, Dr. Colbach concluded that it did not provide the entire answer. In addition to claimant's job promotion, Dr. Colbach identified financial and personal pressures which could also account for the psychotic episodes.

The Referee was persuaded that claimant's new employment responsibilities were the major contributing factor in her need for psychiatric treatment. Accordingly, the claim was found compensable.

To establish compensability, claimant must prove that there were "real" work events and conditions that, when viewed objectively, were capable of producing stress and which had resulted in her mental disorder. McCarrah v. SAIF, 296 Or 145 (1983). Furthermore, she must establish that her work conditions, when compared with non-work conditions, were the major contributing cause of the disorder, or its worsening. McCarrah, supra; Weller v. Union Carbide, 288 Or 27 (1979); Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Cygi, 55 Or App 570, rev den 292 Or 825 (1982). Although claimant's testimony concerning causation is probative, it may not be persuasive when the issue involves a complex medical question. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Considering the complexity of claimant's condition, we have determined that the resolution of the causal relationship issue can best be achieved through an appraisal of the medical opinions. Although the credible lay testimony is not rejected, the medical opinions have been accorded significant probative weight.

Each medical expert supported a causal relationship between claimant's work activities and her need for medical treatment. However, each expert also considered off-the-job factors as probable contributors to her mental condition. Moreover, neither expert concluded that claimant's work conditions were the major contributing cause of her mental disorder, or its worsening. Thus, the evidence fails to meet the requisite burden of proof.

Dr. Hensala stated that the work activities, particularly the promotion, was a major contributing factor in the development of claimant's emotional breakdown. Yet, Dr. Hensala further conceded that another contributing factor was the absence of claimant's husband. Dr. Colbach discussed this latter factor,

as well as other non-work stressors, in concluding that although claimant's work contributed to the aggravation of her emotional situation, it was not the only contributor.

We are mindful that "magic words" are not necessarily essential to establish a claim's compensability. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). However, after consideration of the medical opinions, in conjunction with the credible lay testimony, we are unable to conclude that claimant's work conditions, when compared to non-work conditions, were the major contributing cause of her mental disorder, or its worsening. Consequently, we find that her occupational disease claim is not compensable.

ORDER

The Referee's order June 12, 1986 is reversed. The SAIF Corporation's denial is reinstated and upheld.

TRINIDAD V. ENCISO, Claimant
Gatti, Gatti, et al., Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 85-11430
January 15, 1987
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated December 30, 1986. On reconsideration, the insurer argues that we did not decide one of the issues raised on appeal. Specifically, the insurer contends that we failed to address its argument that, based on decisions rendered in Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986), claimant was not entitled to a Determination Order's award of temporary disability benefits after April 10, 1985.

The insurer is mistaken. This issue was addressed in the Referee's order. Thus, in affirming the order, we necessarily agreed with the Referee that claimant was entitled to temporary disability benefits as awarded by the Determination Order.

Accordingly, the insurer's request is granted. On reconsideration, we adhere to and republish our former order. Rights of appeal shall run from the date of our former order.

IT IS SO ORDERED.

STEVEN J. MARSHALL, Claimant
Steven C. Yates, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 85-09016
January 15, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The self-insured employer requests review of Referee St. Martin's order that set aside its denial of claimant's industrial injury claim for the upper back. The issue is whether claimant's injury arose out of and in the course of his employment. We reverse.

Claimant had been a relief man on a lumber mill planer crew for about four years at the time of his alleged industrial injury. Although he was uncertain regarding dates, claimant testified that he had an onset of upper back pain while working on the planer. He further testified that after work on the evening of the alleged injury, he advised his supervisor, Mr. Turcotte, of

his back pain. An incident report offered by the employer suggests that claimant's initial complaints were registered with Mr. Berger, the employer's safety supervisor, on May 30, 1985 after claimant had awakened during the previous night with back pain. Claimant did not file a Form 801 until June 17, 1985, or nearly three weeks after the alleged onset of pain. On that date claimant was taken off work by his chiropractor.

Claimant testified that Turcotte offered him lighter-duty employment, which claimant performed for two nights before a shortage of workers necessitated his returning to his regular job. Claimant testified that upon returning to his regular work, his symptoms increased to the point where his sleep was disturbed. As a result, he overslept the following afternoon and was an hour late for work. Claimant testified that on arriving at work, he advised Turcotte that medical attention would be required. Claimant ultimately sought treatment from Drs. McMahon and Buttler, chiropractors. Dr. McMahon's initial report states that claimant complained of the gradual onset of back pain, resulting from pushing and pulling on the job.

After a few weeks of chiropractic treatment, claimant was released to return to his regular employment. He was terminated on the day he returned for having falsified a portion of his original employment application. Claimant testified that he did not know that he was falsifying information at the time he filled out his application for employment.

Claimant was questioned on cross-examination regarding his personal history and work record. He admitted to having received a "verbal warning" for tardiness on the job. That formal step was preceded by other warnings. He also admitted to being taken into police custody for failing to appear in court on a drunk driving charge shortly after filing his compensation claim. He also admitted to having had a default judgment declared against him in a civil matter. All of the aforementioned events occurred around the time of claimant's alleged injury and the filing of his claim. Finally, claimant admitted to having been convicted of a felony.

Mr. Bailey, the employer's personnel director, testified that the county sheriff's office contacted the employer on June 17, 1985, the date claimant filed his claim and was taken off work by his chiropractor. The sheriff's representative was seeking to serve an arrest warrant. Claimant was taken into custody at his chiropractor's office later in the month. Bailey also testified that claimant was absent six times between February 12, 1985 and the date he complained of his injury in May.

Mr. Turcotte testified that claimant came to him on May 31, 1985 and indicated that he had apparently injured his back the night before on the job. Turcotte placed claimant on light duty and, according to Turcotte, claimant responded well. Turcotte further indicated that he observed claimant after he returned to his regular work, and that claimant appeared to be performing the job without difficulty. Claimant did not complain or show signs of disability. Approximately two weeks later, however, claimant announced that he was leaving work to seek medical attention. Turcotte indicated that after claimant left work, other employes discussed seeing claimant fishing and actively jumping from rock to rock on the river bank. No employe reported seeing claimant injured on the job or discussing it with him after the fact.

After reviewing the record, the Referee concluded:

> "In my opinion it was well established that claimant is not a paragon of virtue; however, what was at issue was whether claimant sustained a compensable on-the-job injury. There was no credible evidence introduced to support the various defense theories that claimant made a workers' compensation claim and went to see a doctor only because he wanted to evade a civil suit process server or that he wanted to evade a last warning for absenteeism or justify a tardy reporting for his shift by claiming an injury and having to see a physician."

Although the Referee acknowledged that the employer had "legitimate suspicions" that claimant was seeking an excuse for his absenteeism, he found the claim compensable.

We disagree with the Referee's findings. From the outset, it appears that the Referee initially shifted the burden of proof from claimant to the insurer. By indicating that the insurer had produced "no credible evidence" to support its defense theories, the Referee appears to have required the defense to prove that claimant's accident did not occur.

It is claimant's burden to prove that the alleged industrial incident occurred as described. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). After our review of the record, we are not persuaded that claimant has sustained his burden. Claimant's alleged injury was unwitnessed. His credibility, therefore, is of considerable importance. The Referee made no specific credibility finding, although he noted that claimant was not a "paragon of virtue." Our review of claimant's testimony leaves us unpersuaded that it is favorable to the claim. Claimant was wholly unable to remember the details of his alleged accident, and his admissions regarding prior criminal and civil problems, as well as the falsification of his employment application, do nothing to enhance his believability.

We also disagree with the Referee that the several inferences raised by the insurer regarding claimant's motivation for filing his claim are insignificant. The insurer has demonstrated that claimant had several potential reasons for submitting a claim. On or about the date of his claim filing, claimant was being sought by county authorities with regard to both civil and criminal matters. In addition, he had received several warnings from the employer regarding absences and tardiness, so that an additional tardiness could have resulted in his termination. It is not insignificant that claimant's claim arose contemporaneously with these several events, any one of whose outcome could have been affected by an excused absence from work. Thus, unlike the Referee, we are simply not persuaded that the preponderance of the evidence favors claimant's claim.

ORDER

The Referee's order dated August 4, 1986 is reversed. The insurer's denial is reinstated.

CLARA J. SPURLOCK, Claimant
Evohl Malagon, Claimant's Attorney
Foss, Whitty & Roess, Defense Attorneys

WCB 85-03381
January 15, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The self-insured employer requests review of that portion of Referee Michael Johnson's order that found it responsible for claimant's alleged bilateral carpal tunnel condition. The employer asserts that if claimant has scheduled wrist disability, it is the responsibility of another employer. We agree and reverse.

Claimant began working in 1966 as a dryer feeder for International Paper Company, the present self-insured employer. After eleven years, she began experiencing a bilateral carpal tunnel syndrome, which was ultimately accepted as a nondisabling claim. Claimant was laid off from International Paper in 1981 and was soon employed by Georgia-Pacific Corporation. After a few months with Georgia-Pacific, claimant's carpal tunnel symptoms returned. She underwent a surgical decompression of each median nerve in mid-1983 and filed claims against International Paper and Georgia-Pacific. Each employer issued a responsibility denial. International Paper was ultimately held to be responsible.

In 1983, claimant began working for a third employer, first as an office worker in Washington state and later as a clerk/motel maid in Oregon. Claimant remained employed as such at the time of the hearing. She credibly testified that her motel maid employment was very heavy work, requiring repetitive use of the hands and arms. After working as a maid for a short time, claimant's carpal tunnel symptoms returned. She soon sought medical treatment.

On March 14, 1985, a Determination Order issued on the claim for which International Paper was responsible. Claimant was awarded no permanent partial disability. She requested a hearing, asserting entitlement to an award of scheduled disability for each forearm. At hearing, counsel for International Paper issued a verbal denial of responsibility for claimant's ongoing carpal tunnel condition. Counsel asserted that claimant's most recent motel maid employment resulted in a worsening of her condition, and that under the last injurious exposure rule, International Paper should be relieved of further liability.

The hearing record was left open for the deposition of claimant's most recent treating physician, Dr. MacCloskey. In Dr. MacCloskey's opinion, claimant suffered a return of carpal tunnel symptoms while employed as a motel maid. Dr. MacCloskey also explained the process by which symptoms occur, i.e., repetitive use of the hands and wrists causes an inflamation of the median nerve's synovial lining. As inflamation increases, pressure is placed on the median nerve, causing a decreased flow of electrical impulses through the carpal tunnel.

The Referee apparently agreed with International Paper's assertion as to its right to raise the last injurious exposure rule defensively. He ultimately concluded, however, that claimant had experienced only a symptomatic worsening while working as a motel maid, and that International Paper should remain responsible for her condition.

This case is similar to SAIF v. Luhrs, 63 Or App 78 (1983), and Runft v. SAIF, 78 Or App 356 (1986). In Luhrs, the court recognized the right of an employer who is not the last one whose working conditions were potentially injurious to assert the last injurious exposure rule as a defense. See Bracke v. Baza'r, 293 Or 239, 249 (1982). The court further recognized that the success of the defense depends on the medical evidence in the given case. Luhrs, 63 Or App at 83.

In Runft, the claimant had been employed in two employments, each of which was capable of producing his asbestosis. He filed a claim with only the first employer, however. That employer asserted the last injurious exposure rule as a defense. The court noted that because the claimant had proved his disease to be work-related, the last injurious exposure rule entered the case only because the first employer asserted that a subsequent employment had been injurious. Acknowledging the first employer's right to assert the rule, and finding that the subsequent employment had, in fact, been injurious, the court found the first employer relieved of further responsibility as a matter of law. Runft, 78 Or App at 360.

As in Luhrs and Runft, the last injurious exposure rule enters the present case because of International Paper's assertion that claimant's subsequent motel maid employment was injurious. International Paper was not the last employer whose conditions could have been injurious. It therefore has the right to assert the last injurious exposure rule defense. Whether the defense succeeds will depend on the medical evidence.

We disagree with the Referee's interpretation of the medical evidence. Unlike the Referee, we find that claimant's motel maid employment actually worsened her underlying carpal tunnel condition. Although Dr. MacCloskey began his deposition testimony by suggesting that claimant's maid employment resulted in a mere symptomatic worsening, he later persuasively described the pathological mechanism by which symptoms occur. It appears from the whole of Dr. MacCloskey's testimony that symptoms would not have arisen in this claimant but for pathological changes in the tissues at or near her median nerves. In the doctor's opinion, these changes were brought about by the active use of claimant's hands and wrists in her most recent employment. Thus, that employment was actually injurious.

We find from this record that International Paper is no longer liable for claimant's carpal tunnel condition. Its verbal denial, therefore, shall be reinstated. Because the employer responsible for claimant's condition was not joined to this proceeding, the awards of scheduled permanent partial disability made by the Referee are moot.

ORDER

The Referee's order dated July 28, 1986 is reversed in part and affirmed in part. Those portions of the order that set aside International Paper Company's "de facto" denial of claimant's carpal tunnel syndrome and that awarded 10 percent scheduled permanent partial disability for each wrist are reversed. The remainder of the Referee's order is affirmed.

Reviewed by Board Members Lewis and Ferris.

The insurer requests review of Referee Quillinan's order which set aside its denial of claimant's occupational disease claim for an asthma condition. On review, the insurer contends that claimant's work exposure was not the major contributing cause of his condition, or its worsening. We agree and reverse.

Claimant was 31 years of age at the time of hearing. In March 1985 he began working as an insulation installer. His duties involved the installation of subfloor insulation, primarily for older homes. In performing his work duties, he was generally exposed to a dirty, dusty, and poorly ventilated environment. Within approximately two months, claimant developed shortness of breath and, in August 1985, sought medical treatment.

Claimant had experienced similar complaints in 1981, while he was working as an insulation installer for a previous employer. His 1981 work environment had been comparable to his 1985 work exposure. For about four to six months, claimant had received medical treatment, mainly consisting of inhalers and medication. His breathing difficulties gradually dissipated, generally coinciding with his departure from this 1981 employment.

Claimant had filed a claim for asthma stemming from this 1981 work exposure. This claim was eventually settled by means of a disputed claim settlement. For the next four years, claimant worked in a variety of jobs, some of which pertained to the insulation industry. He did not have any asthmatic symptoms during this period. However, none of these employments involved work conditions similar to those he experienced in 1981 and 1985.

Following his 1985 exposure, claimant sought medical treatment from Dr. Smulovitz, endocrinologist. Pulmonary tests revealed a moderate obstructive lung defect. Dr. Smulovitz diagnosed claimant's condition as "probably asthma, hypersensitive lung disease," which seemed to be definitely related to an allergy to dust and other flying particles that were present in his work environment. Without mentioning claimant's prior medical history, Dr. Smulovitz concluded that claimant's condition had been worsened by this recent episode.

In April 1986 an independent medical examination was performed by Dr. Bardana, allergist/clinical immunologist and Director of the Occupational and Environmental Allergy Laboratory for the Oregon Health Sciences University. A thorough medical and employment history was obtained. Claimant smoked one-half of a pack of cigarettes per day. Although he denied any exposure to prescribed medication or recreational drugs, the laboratory data recorded a substantial amount of tetrahydrocannabinol (marijuana). A battery of tests was also administered, including blood, pulmonary, and immunological. These studies demonstrated a significant reaction to housedust.

Dr. Bardana diagnosed an adult-onset of bronchial asthma in 1981, which was non-allergic in nature. In Dr. Bardana's

opinion, claimant's medical history neither supported the presence of an occupational asthma nor a preexistent asthma which was significantly worsened by work exposures. While the allergy to housedust might be a minor contributor to claimant's asthma, Dr. Bardana concluded that the major triggers were upper respiratory infections, exercise, and cigarette smoking.

The Referee found that claimant's 1985 occupational exposure to housedust was the major contributing cause of his asthma. Consequently, the insurer's denial was set aside.

To establish an occupational disease claim, claimant must prove that his work exposure was the major contributing cause of his asthma. Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570, rev den 292 Or 825 (1982). If claimant's asthmatic condition preexisted his employment, he must also prove that his work exposure caused a worsening of his underlying condition producing disability or the need for medical services. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). Although claimant's testimony concerning causation is probative, it may not be persuasive when the issue involves a complex medical question. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Considering claimant's prior medical history and the complexity of his respiratory condition, we have determined that the resolution of the causal relationship can best be achieved through an appraisal of the medical opinions. Although the lay testimony is not rejected, the medical opinions have been accorded significant probative weight.

After conducting our de novo review of the medical and lay evidence, we are not persuaded that claimant's work exposure was the major contributing cause of his asthma, or its worsening. Consequently, we conclude that his claim is not compensable.

Dr. Smulovitz, claimant's treating physician, concluded that claimant's asthmatic condition had been worsened by his work exposure. We generally accord greater weight to the opinion of the treating physician, absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). Following our review of the record, we do not find Dr. Smulovitz' opinion as persuasive as Dr. Bardana's for several reasons.

To begin, Dr. Smulovitz, an endocrinologist, conducted only pulmonary function studies. Dr. Bardana, an allergist and clinical immunologist, administered not only these tests, but blood and immunological studies as well. Secondly, unlike Dr. Bardana, Dr. Smulovitz did not provide a thorough analysis of claimant's condition and the reasoning behind the physician's ultimate conclusion. Moreover, Dr. Smulovitz neither mentioned nor discussed claimant's prior medical history or his personal habits.

In contrast to the apparently incomplete history taken by Dr. Smulovitz, Dr. Bardana provided a thorough employment, medical, and social history. This history established support for Dr. Bardana's conclusion that the major triggers of claimant's preexisting asthma were unrelated to his work environment. Dr. Bardana conceded that claimant's allergy to housedust might be a contributor to the bronchial asthma. However, Dr. Bardana did

not attribute this allergy to claimant's work environment. Furthermore, Dr. Bardana did not conclude that the allergy was the major contributing cause of any worsening of claimant's preexisting condition.

Considering claimant's prior respiratory complaints, Dr. Bardana's thorough medical opinion, and the lack of a persuasive medical opinion attributing a causal relationship between claimant's work exposure and any worsening of his condition, we find claimant's testimony insufficient to establish the compensability of his occupational disease claim.

ORDER

The Referee's order dated May 16, 1986 is reversed. The insurer's denial dated October 17, 1985 is reinstated and upheld.

SHARON K. GONZALEZ, Claimant
Gatti, Gatti, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-06718
January 16, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of that portion of Referee Foster's order, as adhered to on reconsideration, which set aside its denial of claimant's occupational disease claim for a right epicondylitis condition. On review, the insurer contends that claimant failed to establish that her work activities were the major contributing cause of her condition, or its worsening. We agree and reverse.

Claimant was 38 years of age at the time of hearing. For the past seven years, she has worked as head instructor for a hair salon. Approximately 50 to 60 percent of her time has involved demonstrations of hair styling techniques to students of the salon. The remainder of the time she has either taught theory or performed office work. In addition to these activities, claimant was also employed as a hair stylist for a second employer. This employment, which entailed approximately 15 hours per week, extended from November 1984 to March 1985.

In the past, claimant has experienced right upper extremity problems. In November 1976 she was examined by Dr. Bown, her family physician, complaining of right shoulder pain while moving her arm at work. Dr. Bown prescribed medication, heat, and rest for claimant's "myositis and bursitis." In May and June 1979 this treatment was repeated for her recurring right shoulder complaints. In December 1983 claimant fell while leaving her home, landing on her right side. No fractures were detected, but she was tender around the shoulder joint. In May 1984 claimant returned to Dr. Bown, complaining of right elbow pain. Although she attributed her problem to the December 1983 fall, Dr. Bown concluded that she was experiencing a "classic" tennis elbow, unrelated to the injury. In July 1984 claimant sought treatment from Dr. Miller. She continued to relate her right elbow and shoulder pain to her December 1983 fall. Diagnosing tennis elbow, Dr. Miller administered a steroid-compound injection.

In March 1985 claimant sought medical treatment from Dr. Poulson, orthopedist. She complained of a tender right elbow, attributing her complaints to her constant and repetitive motions as a hairdresser. Dr. Poulson diagnosed tennis elbow and agreed that claimant's condition was related to her repetitive work activities.

In July 1985 Dr. Button, upper extremity surgeon, performed an independent medical examination. Claimant denied any specific injury to her right side. However, Dr. Button noted the December 1983 fall and subsequent treatments. Diagnosing lateral epicondylitis, Dr. Button did not attribute claimant's condition to her work activities. Instead, Dr. Button suspected that the December 1983 fall had triggered claimant's present symptoms.

In his years of experience, Dr. Button had not found tennis elbow to be an occupationally related condition for barbers or hair stylists. Furthermore, considering claimant's instructor duties, Dr. Button reasoned that she was not engaged in sustained repetitive activities. Assuming that claimant's elbow symptoms were related to her hair styling activities, Dr. Button concluded that it would be much more likely that her other job as a hair stylist would be the cause since these activities were more sustained and repetitive.

In August 1985 claimant was examined by Dr. Stevens, orthopedist. Claimant associated her right elbow complaints with her repetitive work activities as a hairdresser. Her prior medical or employment history was neither mentioned nor discussed. Diagnosing epicondylitis and tendinitis, Dr. Stevens related claimant's condition to her repetitive work activities.

Dr. Poulson testified by way of deposition. It was his understanding that claimant worked eight hours per day, engaging in repetitive work activities. Dr. Poulson was unaware that claimant was an instructor or that she had worked in a second hair stylist job from November 1984 to March 1985. If claimant's work activities were not steady and sustained, Dr. Poulson stated that it would be less likely that her condition was work related.

Based on claimant's history and upon a videotape of an instructor's duties, Dr. Poulson concluded that the right elbow symptoms were "compatible to a degree" with claimant's work activities. However, Dr. Poulson conceded that:

> "[I]t's hard for me to tell because some people have a predilection for this sort of thing, and what her other outside activities are, I don't know, because I didn't go into them, so you know, your question is very difficult."

The Referee found that claimant testified in a straight forward manner. Persuaded by this testimony and the opinion of Dr. Poulson, the Referee concluded that claimant's work activities were the major contributing cause of her right elbow condition. Consequently, the insurer's denial was set aside.

To establish an occupational disease claim, claimant must prove that her work activities were the major contributing cause of her right elbow condition. Dethlefs v. Hyster Co., 295 Or 298 (1983); SAIF v. Gygi, 55 Or App 570, rev den 292 Or 825 (1982). If claimant's condition preexisted her employment, she must also prove that her work activities caused a worsening of her underlying condition producing disability or the need for medical services. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). Although claimant's testimony concerning causation is probative, it may not be

persuasive when the issue involves a complex medical question. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Considering claimant's prior complaints and second employment, we have determined that the resolution of the complex causal relationship between her work activities and right elbow condition can best be achieved through an appraisal of the medical opinions. Although the credible lay testimony is not rejected, the medical opinions have been accorded significant probative weight.

After conducting our de novo review of the record, we are not persuaded that claimant's work activities were the major contributing cause of her right elbow condition, or its worsening. Accordingly, we conclude that her claim is not compensable.

Dr. Poulson initially related claimant's condition to her work activities. Yet, this opinion, like Dr. Stevens' opinion, was based on the inaccurate impression that claimant was engaged in these activities on a full-time basis. Furthermore, the physicians were apparently unaware of claimant's second job as a hair stylist. Inasmuch as these opinions were based on an inaccurate and incomplete history, they are entitled to little probative weight. Miller v. Granite Construction Co., 28 Or App 473 (1977). Once Dr. Poulson received a more complete history, he opined that claimant's symptoms were "compatible to a degree" with her work activities. We consider this opinion to be couched in terms of possibilities and, as such, insufficient to establish claimant's requisite burden of proof.

We find Dr. Button's opinion persuasive. Based on his years of experience, Dr. Button had not found tennis elbow to be related to the work activities of barbers and hair stylists. Moreover, we are persuaded that claimant's duties as an instructor had not involved the sustained repetitive work activities which were arguably necessary to cause her condition. Finally, even if claimant's condition was related to her hair styling activities, we find that it was just as likely, if not more, that her symptoms were attributable to the more sustained activities of her second job.

After consideration of claimant's previous off-the-job complaints, the work activities of her second job, Dr. Button's persuasive opinion, and the lack of a persuasive medical opinion supporting a causal relationship between her work activities and her right elbow condition, we find claimant's credible testimony insufficient to establish the compensability of her claim.

ORDER

The Referee's order dated March 13, 1986, as adhered to May 2, 1986, is reversed. The insurer's denial is reinstated and upheld.

NOLA L. MALONEY, Claimant
Malagon & Moore, Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 85-14136
January 16, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of those portions of Referee Wilson's order that: (1) refused to authorize an offset of overpaid temporary disability compensation; (2) assessed penalties and attorney fees for unreasonable delay in submitting claimant's claim for closure; and (3) increased claimant's award of permanent partial disability for her low back from the 10 percent (32 degrees) awarded by Determination Order to 20 percent (64 degrees). The issues are offset, penalties, attorney fees and extent of permanent disability.

The Board affirms the order of the Referee on the penalties, attorney fees and extent of disability issues. Claimant's attorney is entitled to a reasonable employer-paid attorney fee on the extent issue for services on Board review. See ORS 656.382(2); Shoulders v. SAIF, 300 Or 606, 609-10 (1986). On the remaining issue, we reverse.

The Referee refused to allow the employer to offset overpaid temporary disability against the permanent disability award because much of the overpayment resulted from the employer's unreasonable delay in submitting the claim for closure.

We conclude that the offset should have been allowed. Regardless of the cause of the overpayment, an overpayment did occur and claimant received temporary disability compensation to which she had no legal entitlement. Allowing the offset would in no way have deprived claimant of any compensation due her. The only purpose that we can see in refusing to allow the offset, other than providing a windfall for claimant, was to penalize the employer for its unreasonable delay in closing the claim. We conclude that the penalty and attorney fee provisions of ORS 656.262(10) are sufficient to remind an employer of its claims processing responsibilities. The employer will be authorized to offset the overpaid temporary disability compensation against any future permanent partial disability compensation awarded for this claim. See Forney v. Western States Plywood, 66 Or App 155, 159-60 (1983), aff'd, 297 Or 628 (1984); Donald D. Mills, 37 Van Natta 219, 220 (1985).

ORDER

The Referee's order dated July 8, 1986 is affirmed in part and reversed in part. That portion of the order that refused to authorize an offset of overpaid temporary disability compensation is reversed and the employer is authorized to offset overpaid temporary disability compensation in the amount of $1,051.52 against any future permanent partial disability compensation awarded on this claim. The remainder of the order is affirmed. Claimant's attorney is awarded $600 for services on Board review in connection with the issue of extent of disability, to be paid by the self-insured employer.

DARYL SIMS, Claimant
Peter O. Hansen, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 85-08642
January 16, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Shebley's order that upheld the insurer's partial denial relating to claimant's low back. The insurer cross-requests review of that portion of the order that granted claimant an award of 10 percent (32 degrees) unscheduled permanent partial disability for his right shoulder. The issues are the compensability of claimant's low back condition and the extent of his right shoulder disability.

Claimant began experiencing pain in his right shoulder, right arm and chest after work on April 30, 1985. Three days later, claimant filed a claim stating that he had probably been injured when he was carrying a garbage can and a fellow employe dropped a heavy stack of magazines in it while claimant was looking in another direction. Claimant sought treatment from Dr. Day, a family practitioner, for his upper body complaints and also received several treatments for low back pain.

On May 28, 1985, claimant entered the hospital for treatment of Codeine addiction. Claimant had injured his low back in a nonindustrial setting three years previously, had received Codeine-containing medication in treatment of this injury and had developed a dependency on the drug. The records of claimant's week-long stay in the hospital contain several references to complaints of low back pain. These complaints were attributed by various attending doctors either to a "recent back injury" or to an "old back strain."

On discharge from the hospital, claimant was referred to Dr. Geist, an orthopedist. After a physical examination and X-rays on June 13, 1985, Dr. Geist diagnosed a muscular low back strain which he attributed to the incident at work on April 30, 1985 and degenerative disc disease at L3-4 which he attributed to claimant's earlier nonindustrial accident. On July 9, 1985, the insurer issued a partial denial relating to claimant's low back condition.

Claimant was examined by a panel of the Orthopaedic Consultants on November 7, 1985. On physical examination, the panel noted complaints of low back pain, but with regard to claimant's shoulder noted "a full range of unrestricted painless motion." The panel diagnosed a muscle strain of the shoulder, resolved and back pain of unspecified etiology, not related to the incident at work on April 30, 1985. The panel found both conditions medically stationary and stated that neither condition had resulted in any permanent impairment.

Dr. Geist disagreed with the Orthopaedic Consultants report to the extent that it failed to diagnose disc narrowing at L3-4, but otherwise had no basic disagreement. Dr. Day indicated that he agreed with the report. The claim was closed by Determination Order dated January 15, 1986 with no award of permanent partial disability.

Approximately two months later, in a letter to claimant's attorney, Dr. Day indicated that his staff had treated

claimant on several occasions for low back pain following the incident at work on April 30, 1985 and stated that this incident had been a material contributing factor in claimant's need for low back treatment.

Dr. Keist wrote claimant's attorney at about the same time. He stated that he was uncertain whether the incident at work on April 30, 1985 had affected claimant's low back condition and recommended that Dr. Day be consulted on this question.

In a deposition taken on May 14, 1986, Dr. Day conceded that he had never actually diagnosed a low back injury when he treated claimant in May 1985, but indicated that claimant's low back had been treated by his physical therapy staff.

The only other reference in the record to the cause of claimant's alleged low back injury is in a letter dated May 16, 1986 from a family practitioner, Dr. Reynolds, to claimant's attorney. Dr. Reynolds stated that claimant had been treated briefly in late July 1985 by a doctor who was no longer with his office. Claimant had given this doctor a history of injuries to his right shoulder and low back on April 30, 1985. Based upon the records he reviewed, Dr. Reynolds thought that it was probable that the treatment provided by his office had related to industrial injuries to claimant's shoulder and low back on April 30, 1985.

At the hearing, claimant testified that about an hour after the garbage can incident at work, he began to experience severe pain in his shoulder, arm and neck. He also indicated that he felt some pain in his low back which gradually worsened during the next few days. He stated that he sought treatment from Dr. Day for his shoulder, which was the major problem at that time, but also told Dr. Day that his back was hurting. Claimant went on to testify that at the time of the hearing he continued to experience severe and relatively constant pain in his right shoulder, right arm and low back.

The Referee upheld the partial denial relating to claimant's low back because claimant had a preexisting low back problem and claimant's low back pain had been slow in developing after the April 30, 1985 incident. He rejected Dr. Day's opinion that the incident at work was a material contributing factor to the low back treatment provided by Dr. Day's physical therapy staff and accepted the conclusions expressed in the Orthopaedic Consultants report. On the issue of the extent of claimant's right shoulder disability, the Referee found claimant's testimony of significant impairment of his right shoulder "in stark juxtaposition to [the] expert medical opinions." He nonetheless awarded claimant 10 percent (32 degrees) unscheduled permanent partial disability for shoulder pain.

After our de novo review of the record, we conclude that claimant did sustain a muscular strain of his low back as a result of the incident at work on April 30, 1985. This conclusion is supported by the reports of Drs. Day, Keist and Reynolds. We also conclude, however, that this muscular strain had resolved without permanent impairment by the time that the Orthopaedic Consultants issued its report on November 7, 1985 and that claimant's ongoing complaints after that time related solely to his preexisting degenerative disc disease as diagnosed by Dr. Geist. We, therefore, set aside the insurer's partial denial to the extent

that it denied medical treatment and temporary disability prior to November 7, 1985, but uphold the partial denial thereafter.

With regard to the extent of disability for claimant's right shoulder, the medical evidence in the record does not support the conclusion that claimant sustained any permanent impairment as a result of the April 30, 1985 industrial accident. Claimant's testimony is indicative of some level of permanent impairment if accepted at face value, but after our de novo review of the record, we do not so accept it. We, therefore, reverse that portion of the Referee's order that awarded claimant 10 percent (32 degrees) unscheduled permanent partial disability for his right shoulder.

ORDER

The Referee's order dated June 30, 1986 is affirmed in part and reversed in part. That portion of the order that upheld the insurer's partial denial relating to claimant's low back is reversed in part. Claimant did sustain a compensable injury to his low back on April 30, 1985 which was medically stationary without permanent impairment on November 7, 1985. The insurer's partial denial is upheld after this date. Those portions of the order that awarded claimant 10 percent (32 degrees) unscheduled permanent partial disability for his right shoulder and awarded claimant's attorney an associated attorney fee are reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $800 for services at the hearing in connection with the partial denial and $400 for services on Board review, to be paid by the insurer.

JAMES W. HOWARD, Claimant
Michael Erwert, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 86-11692
January 20, 1987
Interim Order of Remand

Claimant requested Board review of Referee Wasley's order which was issued October 29, 1986. The hearing in this matter had been held by means of an October 23, 1986 teleconference, which was electronically recorded. In accordance with ORS 656.295(3), a transcription of the proceedings was requested. In the course of preparing the transcript, it has become apparent that the recording is incomprehensible. Thus, the recording is inadequate for purposes of Board review.

Pursuant to ORS 656.295(5), should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction or other necessary action. Considering the aforementioned circumstances, we conclude that remand is an appropriate action.

Accordingly, this matter is remanded to the Referee with instructions to reconvene a hearing. The limited purpose of this hearing is to obtain as complete a record as is possible of the proceedings that occurred during the October 23, 1986 teleconference. No new or additional evidence should be taken.

The Board retains jurisdiction over this matter. Upon completion of the reconvened hearing, the Referee shall obtain a transcription of the oral proceedings which shall be forwarded to the Board within thirty (30) days of the hearing date. Once the Board receives the transcript, copies will be provided to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

MINA L. BROOKS, Claimant
Gatti, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-03579 & 85-07115
January 23, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Garaventa's order which: (1) upheld the self-insured employer's partial denial of her medical services claim for bilateral carpal tunnel syndrome; and (2) declined to assess penalties and accompanying attorney fees for the employer's allegedly unreasonable failure to provide timely reimbursement for travel expenses. In its respondent's brief, the employer requests clarification of a portion of the Referee's order which pertains to the employer's unreasonable processing of the medical services claim. On review, the issues are compensability, penalties, and attorney fees.

The Board affirms the order of the Referee with the following comments concerning the issue of the employer's unreasonable failure to timely process claimant's medical services claim.

A portion of the Referee's opinion suggests that the employer should not only be penalized for a late denial of claimant's chiropractic bills, but should also be held responsible for all of the bills which it received more than 60 days prior to its denial. However, it is apparent that this was not the Referee's ultimate conclusion. The Referee's order specifically directs that a penalty and accompanying attorney fees for the employer's late denial be assessed against the aforementioned bills. The order does not direct that the bills themselves be satisfied. Moreover, the chiropractic treatments upon which these outstanding bills were based are not compensable. Thus, claimant should not be reimbursed for noncompensable medical services.

ORDER

The Referee's order dated November 8, 1985 is affirmed.

WILLIAM E. CARR, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 83-05764 & 83-07625
January 23, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Carr v. Allied Plating Co., 81 Or App 306 (1986). In a portion of our previous order, we affirmed the Referee's holding that, although claimant had established his aggravation claim against Allied Plating Co., the claim was barred by the doctrine of res judicata. The court found that we "erred in holding that the 1982 aggravation claim against Allied was barred by res judicata." Carr, supra., 81 Or App at 310. Consequently, the court reversed and remanded that portion of our previous order.

Accordingly, the May 20, 1983 denial issued by Argonaut Insurance Companies', on behalf of Allied Plating Co., is set aside and this matter is remanded to Argonaut for acceptance and payment of compensation according to law.

IT IS SO ORDERED.

ROY W. HAMMETT, Claimant
Kilpatricks & Pope, Claimant's Attorneys
Mitchell, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorneys

WCB 84-06239 & 83-09271
January 23, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Golden West Homes v. Hammett, 82 Or App 63 (1986). The court has mandated that we enter an order holding the SAIF Corporation responsible for claimant's current low back condition. We have also been instructed to determine whether claimant's December 1982 fall from a scaffold constituted a new injury or an aggravation of a 1980 injury. In either event, SAIF shall be responsible. Hammett, supra., 82 Or App at 68.

In an aggravation/new injury context, allocation of responsibility is dependent on whether claimant's current condition is a continuation of his original injury or the result of a subsequent exposure that independently contributed to his condition in a material way. Ceco Corp. v. Bailey, 71 Or App 782, 785 (1985). To shift responsibility from a prior employer/insurer, the evidence must establish that a subsequent work exposure independently contributed to the causation of the disabling condition, i.e., to a worsening of the underlying condition. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

Following our further review of this record, we are persuaded that claimant's December 1982 fall from the scaffold independently contributed to the causation of his disabling back condition, i.e, to a worsening of his underlying condition. Consequently, we find that claimant suffered a new injury as a result of his December 1982 fall.

Accordingly, this claim is remanded to the SAIF Corporation for acceptance and processing in accordance with law. SAIF is further directed to process this claim as a new injury.

IT IS SO ORDERED.

WAYNE A. HAWKE, Claimant
Emmons, et al., Claimant's Attorneys
Cliff, Snarskis & Yager, Defense Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Acker, et al., Defense Attorneys
Breathouwer, et al., Defense Attorneys
Moscato, et al., Defense Attorneys
Mitchell, et al., Defense Attorneys

WCB 83-04843, 83-04210, 83-03016, 83-03382, 83-03320,83-03319,83-03318, 83-03317, 83-03316, 83-03321, 83-12004 & 83-07043
January 23, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated December 30, 1986. Claimant contends that his attorney is entitled to an attorney fee on Board review because compensability was an issue at the hearing and was still a potential issue on Board review even though responsibility was the sole issue raised on Board review by the insurers. No order has been issued in this case pursuant to ORS 656.307. In support of his position, claimant cites Shoulders v. SAIF, 300 Or 606 (1986) and Western Pacific Construction Co. v. Bacon, 82 Or App 135 (1986). Claimant's request for reconsideration is granted.

In Shoulders v. SAIF, supra, the court held that the claimant's attorney was entitled to attorney fees under ORS

656.382(2) for services on Board review when the insurer requested review of a Referee's order finding four medical conditions compensable and the Board affirmed the compensability of only two of the conditions. Compensability was clearly raised on Board review in Shoulders and hence that case is inapplicable to the present case.

In Western Pacific Construction Co. v. Bacon, supra, the court reinstated an award of attorney fees for services at the hearing level which the Board had set aside. In setting aside the award of attorney fees, the Board had assumed that responsibility was the sole issue at the hearing. The court found that compensability also was at issue at the hearing and thus reinstated the award of attorney fees granted by the Referee. Again, attorney fees were awarded for services relating to the issue of compensability.

We note that in Bacon the Board made no award of attorney fees for services on Board review. See Erwin L. Bacon, 37 Van Natta 205, 208 (1985). The court did not order that an attorney fee be awarded for services on Board review and thus tacitly approved the Board's action. See Western Pacific Construction Co. v. Bacon, supra, 82 Or App at 138. If anything, therefore, Bacon supports the Board's action in the present case.

Our previous order is withdrawn. After reconsideration, we adhere to and republish our previous order, effective this date.

IT IS SO ORDERED.

DELBERT R. HUTCHINSON, Claimant
Aitchison, Imperati, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Rankin, McMurry, et al., Defense Attorneys

WCB 83-09115 & 84-00965
January 23, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162 (1986). We have been instructed to determine an attorney fee for the SAIF Corporation's late denial. Because there was no compensation then due on which to base a penalty, the court found that claimant was not entitled to a penalty for SAIF's tardy denial of his claim. Hutchinson, supra., 81 Or App at 164.

Attorney fee awards are based on efforts expended and results obtained. OAR 438-47-010(2). In determining the reasonableness of attorney fees, several factors must be considered. These factors generally include: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985).

Following our review of the record and after consideration of the aforementioned factors, we find that a reasonable attorney fee for claimant's attorney's services in connection with SAIF's late denial is $100.

ORDER

Claimant's attorney is awarded a reasonable attorney fee of $100 for services in connection with the late denial, to be paid by the SAIF Corporation.

PATRICK K. RICHARDS, Claimant
Duncan & Lusk, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 82-11053
January 23, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Richards v. Argonaut Insurance Companies, 80 Or App 428 (1986). The court has mandated that Argonaut accept claimant's aggravation claim for a right knee injury. Accordingly, Argonaut's denial dated November 11, 1982 is set aside and this matter is remanded to Argonaut for acceptance and payment of compensation according to law.

IT IS SO ORDERED.

REGINA E. CAIN, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Rankin, McMurry, et al., Defense Attorneys

WCB 85-14593
January 27, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee William Peterson's order that: (1) declared its partial denial of temporary total disability compensation invalid and ordered payment of compensation beginning April 12, 1985 and continuing through the date of the next proper closure; (2) assessed a 25 percent penalty and an associated attorney fee for the insurer's alleged unreasonable refusal to pay temporary total disability compensation; (3) set aside its denial of claimant's claim for certain prescription medications; and (4) assessed a 25 percent penalty and an associated attorney fee for the insurer's alleged unreasonable denial of those prescription medications. The issues are claimant's entitlement to temporary total disability compensation, the compensability of prescription medications and penalties and attorney fees.

We affirm those portions of the Referee's order that set aside the insurer's denials of temporary total disability compensation and prescription medications. We also agree with the Referee's assessment of a penalty and attorney fee for the insurer's denial of claimant's claim for medications. We disagree, however, with the Referee's assessment of a penalty and attorney fee for the insurer's partial denial of claimant's temporary total disability compensation. We, therefore, reverse that portion of the Referee's order.

Claimant sustained a compensable low back strain in March 1985. Shortly after she began treating with Dr. Giesbrecht, claimant's chart notes made consistent reference to her long-standing bilateral knee condition, as well as back pain. Claimant filed a claim for her back strain on March 6, 1985 and one for her knee condition on April 15, 1985. Dr. Giesbrecht took

claimant off work beginning April 12, 1985, although he did not specify in his work release whether it was related to claimant's back strain or her knee condition.

The insurer then sent claimant to Dr. Rosenbaum for an independent medical examination. Dr. Rosenbaum discovered osteoarthritis in claimant's back and knees and suggested that it was due to claimant's longstanding obesity, rather than her compensable injury. He also opined that claimant's major problem was her knee condition. Based on Dr. Rosenbaum's report, the insurer issued two denials; one for the bilateral knee condition and the other a partial denial of claimant's osteoarthritis condition. Upon claimant's request that her back condition be reclassified as disabling, the insurer submitted the claim to the Evaluation Division. Claimant was subsequently examined by Dr. Waldram, who identified claimant's bilateral knee problem as the "large" factor leading to her having left work in April 1985. Dr. Waldram also related claimant's current back condition to the compensable injury.

Claimant requested a hearing on the insurer's denials. In her October 24, 1985 Opinion and Order, Referee Neal affirmed the insurer's bilateral knee claim denial. She also found claimant's then-current back claim to be related to her compensable strain, rather than the osteoarthitis. The Referee further determined that because claimant's claim "may result in an award of compensation," the claim should be reclassified as disabling. The Referee made no determination regarding claimant's entitlement to temporary total disability to date and did not order past payment in that regard. Finally, Referee Neal noted that claimant's treating physician had never authorized temporary total disability for claimant's low back condition.

On November 1, 1985, or approximately one week after the Referee's order was published, Dr. Giesbrecht issued a report indicating that claimant had been taken off work in April 1985 primarily because of her back condition, rather than her knee problems. He also indicated that claimant should be receiving temporary disability compensation. Dr. Waldram then issued a report stating his opinion that claimant had likely left work in April because of her knee problems. The insurer did not pay temporary total disability compensation, and claimant requested a hearing. That issue, among others, was heard by the present Referee.

Referee Peterson concluded that, as a result of claimant's back problems, she had never been released by Dr. Giesbrecht to return to regular work. He, therefore, concluded that claimant was entitled to temporary total disability compensation retroactive to the date she left work in April 1985. While recognizing the initial confusion as to whether claimant had been taken off work because of her knee condition or her back condition, the Referee held that the insurer had a duty to pay compensation within 14 days of its receipt of Dr. Giesbrecht's November 1, 1985 report. He further held that the insurer's failure to pay was unreasonable.

We agree that the insurer must pay claimant temporary total disability compensation retroactive to April 12, 1985. We find, however, that the insurer's failure to commence payment after its receipt of Dr. Giesbrecht's November 1985 letter was not

unreasonable. Although Dr. Giesbrecht was claimant's treating physician and his November report was, therefore, of considerable importance, it must also be remembered that the November report was the first in which Dr. Giesbrecht had specifically tied claimant's April 1985 release from work to her back strain. Up to and through the time of Referee Neal's order, it appeared that claimant had been taken off work due to her knee problem, which was ultimately found noncompensable. The Referee specifically found that claimant had not been authorized time loss because of her back strain. Further, while Dr. Giesbrecht subsequently did tie the April work release to claimant's back, Dr. Waldram disagreed, indicating that claimant's primary problem in April was her knees. Dr. Rosenbaum also indicated after the Opinion and Order was published he had never considered claimant's back problem to be disabling.

From these conflicting and convoluted facts, we find that the insurer had a reasonable doubt as to its duty to pay temporary total disability compensation after its receipt of Dr. Giesbrecht's November 1985 report. The insurer had not been ordered to commence payment by Referee Neal, and Dr. Giesbrecht's later opinion was controverted by two physicians who had examined claimant before the Referee's order. The insurer's action was not unreasonable.

ORDER

The Referee's order dated February 2, 1986 is reversed in part and affirmed in part. That portion of the order that assessed penalties and attorney fees for the insurer's alleged unreasonable failure to pay temporary total disability compensation is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $600 for services concerning the insurer's denials on Board review, to be paid by the insurer.

DURWOOD L. DUBAY, Claimant
Kevin Mannix, Attorney

WCB 86-04463
January 27, 1987
Order of Dismissal

The claimant has requested review of the Referee's Opinion and Order dated December 15, 1987. The Board received claimant's request January 15, 1987, 31 days after the date of the Referee's order. Therefore the request is not timely filed.

ORDER

Claimant's request for review is hereby dismissed as being untimely filed.

WAYNE N. GENTRY, Claimant
Nichols & Bogardus, Claimant's Attorneys
Edward C. Olson, Defense Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-07892 & 85-08969
January 27, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

North Pacific Insurance Company requests review of Referee Mongrain's order which: (1) set aside its denial of claimant's medical services claim for a low back condition; and (2) upheld the SAIF Corporation's denial of his "new injury" claims for the aforementioned condition. On review, the sole issue is responsibility.

We affirm the order of the Referee with the following comments.

In finding North Pacific responsible, the Referee concluded that North Pacific had successfully rebutted the presumption that the second injury independently contributed to claimant's condition. In conducting his analysis, the Referee applied the so-called Kearns rebuttable presumption from Industrial Indemnity Company v. Kearns, 70 Or App 583 (1984). Such an analysis was inappropriate. The Kearns presumption applies in cases involving multiple accepted injuries involving the same body part. Stanley C. Phipps, 38 Van Natta 13 (1986). It does not apply when, as is the case here, the question is whether a claim is compensable as an aggravation of an old injury or as a new contributory incident.

In an aggravation/new injury context, allocation of responsibility is dependent on whether claimant's present condition is a continuation of his original injury or the result of a subsequent incident that independently contributed to his condition in a material way. Ceco Corp. v. Bailey, 71 Or App 782, 785 (1985). To shift responsibility to a subsequent employer/insurer, the evidence must establish that the subsequent incident independently contributed to the causation of the disabling condition, i.e., to a worsening of the underlying condition. See Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). If the second incident merely aggravates the effects of the first and results in a second period of disability without independently contributing to claimant's condition, the first insurer remains responsible. Smith v. Ed's Pancake House, 27 Or App 361 (1976).

Following our de novo review of the medical and lay evidence, we find that claimant's work activities while SAIF was on the risk did not independently contribute to the causation of his disabling condition, i.e., to a worsening of his underlying condition. Rather, the evidence establishes that, at most, the aforementioned activities increased his symptoms, which resulted in a further period of disability. Consequently, we agree with the Referee that North Pacific remains responsible for claimant's condition.

ORDER

The Referee's order dated March 26, 1986 is affirmed.

MARGARET L. GRAY, Claimant
Kenneth D. Peterson, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-02692
January 28, 1987
Order of Dismissal

On January 16, 1987, claimant mailed his request for Board review of the Referee's December 17, 1986 order. At that time, the Referee had issued his Abeyance Order, thereby setting aside the December 17, 1986 order. Since the Referee's order has been set aside, we conclude that the request for Board review is premature.

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

IT IS SO ORDERED.

KATHLEEN A. OVERDEY, Claimant
Kulongoski, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Reviewed by Board Members Ferris and Lewis.

WCB 86-05492
January 28, 1987
Order on Review

The self-insured employer requests review of Referee Podnar's order that: (1) found that the employer had miscalculated claimant's rate of temporary total disability compensation; and (2) assessed a 25 percent penalty and associated attorney fee for the alleged improper calculation. The issues are the proper rate of claimant's compensation, penalties and attorney fees. We reverse.

Claimant was hired by the employer as an on call radiology clerk on November 4, 1985. Claimant understood that she would first be oriented to her new position during two to three weeks of training, and that during training she would work 40 hours per week. Claimant further understood that she would work irregular hours as an on call employe thereafter.

Claimant testified that she was interviewed by Mr. Tomlinson before being hired, and that she told Tomlinson that she needed to work 40 hours per week in order to make ends meet. Claimant testified that although Tomlinson did not promise her a 40-hour work week, he implied that she could work up to 40 hours per week by working in the employer's various branch locations.

Claimant injured her low back during the first week of her orientation period. The employer's claims processing agent calculated claimant's temporary total disability compensation rate based on the employer's estimation that claimant would average 12 hours per week on call, once her orientation period ended. Sometime after claimant received her first payment of compensation, she alleged that her rate should have been calculated based on a 40-hour work week. After claimant requested a hearing, the processing agent recalculated claimant's compensation based on a 26-week average of hours worked by similarly situated on call radiology clerks. It ultimately arrived at an average of 16.15 hours per week. Thereafter, claimant was paid at the newly calculated rate and was given a lump sum payment equal to the previously underpaid compensation. Claimant renewed her request for hearing, continuing to allege that her compensation rate should be based on a 40-hour work week.

Ms. Hickenlooper testified that as the employer's senior personnel assistant, she initially interviewed claimant for the on call position. Ms. Hickenlooper testified that she fully explained the on call nature of the position to claimant and that claimant understood that work hours would be irregular after the orientation period ended. After Ms. Hickenlooper interviewed claimant, she sent claimant's application to Tomlinson, the assistant supervisor of the radiology unit.

Tomlinson testified that upon interviewing claimant, the on call nature of the position was again explained. Tomlinson reiterated to claimant that she could not expect to work regular hours. He mentioned the possibility of claimant's working at other facilities operated by the employer, but he made no guarantees with regard to the number of hours claimant could

work. Tomlinson testified that even though radiology clerks enter employment working 40 hours per week during orientation, they are considered on call from the outset because of the ultimate on call nature of their jobs.

The Referee found that because claimant was "regularly at work five days during the week in which she was injured," her compensation rate should be based on her daily wage, multiplied by five. The Referee further found:

> "To base the wage upon any other form of averages for other employees is not necessary and works to disadvantage claimant and flies in the face of the reality that she was regularly employed five days that week." (emphasis added).

ORS 656.210(2) provides that when a worker is "regularly employed" five days a week, the worker's weekly wage is to be ascertained by multiplying the daily wage at the time of the injury by five. OAR 436-60-020(4)(a) provides that the rate of compensation for on call workers with "unscheduled, irregular or no earnings shall be computed on the wages determined in the following manner:

> "Use average weekly earnings for past 26 weeks, if available, unless periods of extended gaps exist, then use no less than the last 4 weeks of employment to arrive at average. For workers employed less than 4 weeks use intent at time of hire as confirmed by employer and worker."

The Referee apparently concluded that because claimant was working eight hours per day, five days per week at the time of her injury, her compensation rate should be frozen as of the specific time of the injury, without regard to her regular work schedule thereafter. The Referee did not discuss the above-cited administrative rule.

We disagree with the Referee's analysis and find that the administrative rule controls. There is no dispute that claimant was hired as an on call employe whose work hours would be irregular after an initial orientation period. There is also no dispute that claimant had been employed for less than four weeks at the time of her injury. Under OAR 436-60-020(4)(a), therefore, claimant's compensation rate is to be determined by looking to the intent of the parties at the time of hire.

We find that the employer's intent was to employ claimant first on a 40-hour work week for a limited orientation period, and thereafter on a schedule like that of other on call employes, i.e., approximately 16 hours per week. Claimant's intent was to work as many extra hours as possible. There is no persuasive evidence, however, that she made arrangements with the employer to regularly work 40 hours per week; she knew her hours would be irregular. We find, therefore, that the intent of the parties most closely resembles that to which the employer testified at hearing and that claimant's "regular" employment was, in fact, intended to be irregular. We also find that the employer's method of calculating claimant's compensation was

reasonable under the circumstances. See Jerry L. Jennings, 37 Van Natta 704, 705 (1985). The Referee's order shall be reversed.

ORDER

The Referee's order dated August 15, 1986 is reversed.

The Beneficiaries of
WAYNE L. RAGSDALE (Deceased), Claimant
Pozzi, et al., Claimant's Attorneys
Lester Huntsinger, Defense Attorney

WCB TP-86011
January 28, 1987
Third Party Distribution Order

Claimant, Teli Ragsdale, as representative for the estate of the aforementioned deceased worker, has petitioned the Board for an order distributing the proceeds of a third party recovery obtained by settlement of a civil action against allegedly negligent third parties. Claimant requests that the settlement proceeds be distributed pursuant to ORS 656.593(3). Specifically, claimant contends that the SAIF Corporation, as paying agency, is not entitled to proceeds from the settlement because the actions of its insured, the Oregon Department of Transportation (ODOT), were a material cause of the worker's death.

The deceased, an employee of ODOT, died as a result of injuries sustained when he was run over by a dump truck on a construction site. Claimant initiated a civil action against both the manufacturer and distributor of the truck's chassis. The manufacturer/installer of the dump box and accessories was also named as a defendant. The action was based on claimant's contention that the dump truck had been sold without adequate rear vision and with no audible back-up alarm.

Each of these safety devices is required by the Oregon Safety Code. The safety code provides that equipment without adequate rear vision will have an audible back-up alarm or will be backed up using a ground guide. No ground guide was in use when the accident occurred. Following an investigation of the incident, the Accident Prevention Division issued a citation which classified the violation as "Serious."

All of the third party defendants raised an affirmative defense that they were not liable because ODOT had specified the dimensions of the rear vision devices and had ordered the truck without an audible back-up alarm. With SAIF's approval, claimant settled the third party action with all defendants for the sum of $48,500.

A conflict has now arisen because SAIF asserts its entitlement to a statutory distribution of the settlement proceeds pursuant to ORS 656.593. SAIF's current claim costs amount to $35,745.56, while it has reserved an additional $151,916.44. Claimant maintains that the proceeds should be distributed in a "just and proper" manner pursuant to ORS 656.593(3). Considering ODOT's negligence, claimant argues that preventing SAIF from sharing in the proceeds would be a just and proper distribution.

Claimant cites several cases from other jurisdictions which support, to one degree or another, the proposition that an employer or its insurer are not entitled to proceeds of the settlement of a third party action where the employer's negligence caused the injury or death. However, current Oregon law is contrary to claimant's contention.

Claimant's proposition was discussed by the Supreme Court in Boldman v. Mt. Hood Chemical Corporation, 288 Or 121, 129-32 (1980). In Boldman, the court held that an employer's culpability in the cause of a worker's death was irrelevant for purposes of ORS 656.593. The court noted that the legislature had made no distinction between an employer whose fault contributed to the worker's death or injury and an employer who was free of fault. Seeing no justification for grafting onto the statute this substantial exception, the Supreme Court concluded that ORS 656.593 granted an insurer's lien in either situation. The Boldman court further concluded that the "just and proper" language in ORS 656.593(3) referred to the relationship between the paying agency and the worker/dependent, and did not concern the employer's culpability.

We followed this line of reasoning in Peter R. Warner, 37 Van Natta 419, 420 (1986). In Warner, we concluded that the statutes governing distribution of the proceeds of a third party recovery drew no distinction between an innocent employer and one whose alleged negligence is partly, or even solely, the cause of a worker's injury.

Finding no significant distinction between the aforementioned cases and the present situation, we are unpersuaded by claimant's contention. Consequently, her petition for a disposition of proceeds pursuant to ORS 656.593(3) is denied.

Accordingly, we conclude that the proceeds of claimant's third party recovery shall be distributed according to ORS 656.593(1).

IT IS SO ORDERED.

DOUGLAS V. TEMPLER, Claimant
Jerry Gastineau, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-07823
January 28, 1987
Order Denying Motion to Dismiss

Claimant has moved to dismiss the SAIF Corporation's request for Board review on the ground that the request was untimely. The 30th day after the date of the Referee's order was January 11, 1987, a Sunday. The request was mailed on Monday, January 12, 1987. The request was timely. See ORS 174.120; Brett W. Bertrand, 38 Van Natta 1046 (1986). Accordingly, the motion to dismiss is denied.

IT IS SO ORDERED.

ROBERT MARK, Claimant
Merrill Schneider & Assoc., Claimant's Attorneys
Lester Huntsinger, Defense Attorney

Own Motion 85-0561M
January 30, 1987
Own Motion Order of Dismissal

Claimant has requested that the Board exercise its own motion authority and either award him permanent disability or refer this matter for hearing to consider the issue of the extent of his permanent disability resulting from his July 14, 1982 compensable injury. The April 8, 1983 Determination Order to which claimant objects was not timely appealed and has become final by operation of law. Furthermore, claimant's aggravation

rights under ORS 656.273 have not expired. Consequently, the Board lacks jurisdiction to consider this matter under its own motion authority. ORS 656.278(2). Accordingly, claimant's request is dismissed.

IT IS SO ORDERED.

JOHN R. PATTERSON, Claimant
Velure & Bruce, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 85-0628M
January 30, 1987
Second Own Motion on Reconsideration

The Board issued an Own Motion Order on Reconsideration on June 24, 1986 whereby the SAIF Corporation was directed to pay for certain medical bills resulting from claimant's September 10, 1964 compensable injury. Claimant has requested further consideration of that portion of our order which awarded an attorney fee equal to 25 percent of the additional compensation granted by the order, not to exceed $350.

Claimant contends that his attorney fee should not be paid from his award of medical expenses. Rather, he asserts that his fee should be paid by SAIF in addition to his compensation.

Pursuant to OAR 438-47-070(1), if a proceeding is commenced under ORS 656.278(1) by an insurer, and compensation previously awarded is not reduced or is increased, the Board shall allow a reasonable attorney fee payable by the party requesting the proceeding in addition to compensation. On the other hand, if a proceeding is initiated on the Board's own motion because of a request from a claimant and an increase in compensation is awarded, the Board shall approve for claimant's attorney a reasonable fee payable out of any increase awarded by the Board. OAR 438-47-070(2).

An insurer's refusal to voluntarily pay benefits and its submission of the matter to the Board does not amount to an insurer's request for own motion relief. Bernie Hinzman, 35 Van Natta 739, 1374 (1983). Where the request for relief stems from claimant's request for additional compensation and not from an insurer's request to reduce or disallow a previous award, the attorney fee is payable out of, and not in addition, to the increased award. Hinzman, supra.

Here, SAIF referred to the Board claimant's request to reopen his claim for the payment of medical benefits. Although it opposed claimant's request, SAIF did not request that claimant's previous compensation be reduced or disallowed. Inasmuch as claimant has prevailed on a portion of his request for relief, he is entitled to an attorney fee. However, this fee is payable out of his increased award, not in addition to his compensation. See OAR 438-47-070(2); Hinzman, supra.

Accordingly, we grant claimant's request for reconsideration. On reconsideration, we adhere to our prior order on reconsideration.

IT IS SO ORDERED.

KAREN J. BATES, Claimant
William E. McCann, Claimant's Attorney
Brian L. Pocock, Defense Attorney
Dan Steelhammer, Defense Attorney

WCB 85-15422 & 85-15423
February 5, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Aetna Casualty Co. requests review of those portions of Referee Nichols' order which: (1) set aside its denial of claimant's aggravation claim for a neck and shoulder condition; (2) upheld the SAIF Corporation's denial of her "new injury" claim for the aforementioned condition; and (3) awarded claimant an insurer-paid attorney's fee for overturning Aetna's denial of responsibility. On review, the issues are responsibility and attorney fees.

Following our de novo review of the medical and lay evidence, we find that claimant's subsequent work activities while employed by SAIF's insured did not independently contribute to the causation of her disabling condition, i.e., to a worsening of the underlying condition. See Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). Rather, the evidence establishes that claimant's subsequent work activities aggravated her continuing problem, resulting in a period of disability. See Crowe v. Jeld-Wen, 77 Or App 81 (1985). Accordingly, we affirm that portion of the Referee's order which found Aetna responsible for claimant's aggravation claim.

We modify that portion of the Referee's order which awarded an insurer-paid attorney fee to be paid by Aetna. We agree that claimant is entitled to an insurer-paid fee. However, we find that the fee should be paid by SAIF.

In issuing its denial, Aetna contended that claimant's subsequent work activities for SAIF's insured were the material contributing cause of her increased symptoms and time loss. Aetna did not deny the compensability of claimant's condition. Rather, it was merely denying responsibility for her current treatment.

Thereafter, claimant filed a "new injury" claim with SAIF's insured. SAIF denied the claim, contending that there was insufficient evidence to justify a relationship between claimant's current condition and her work activities with SAIF's insured. In addition, SAIF questioned whether claimant was a subject worker and whether the claim was timely filed. Based on these grounds, SAIF denied not only responsibility for claimant's current condition, but also compensability.

Aetna requested designation of a paying agent pursuant to ORS 656.307. However, SAIF continued to assert the timeliness defense. Therefore, no .307 order was forthcoming.

The Referee found SAIF's denial on timeliness grounds unreasonable. Since SAIF had failed to adequately investigate the matter and because its position had prevented claimant from receiving compensation, the Referee concluded that SAIF's conduct was unreasonable. Accordingly, a penalty and a $400 attorney fee were assessed against SAIF. Furthermore, finding Aetna responsible for claimant's condition, the Referee awarded a $1200 attorney fee for claimant's attorney's assistance in setting aside Aetna's denial.

In a responsibility case, where the issue of compensability has been resolved, a claimant is generally considered a nominal party. Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 571 (1985); Stanley C. Phipps, 38 Van Natta 13, 16 (1986). As such, a claimant has not "actively and meaningfully participate[d]," as that phrase is used in OAR 438-47-090(1), and an attorney fee is generally not awarded for services at the hearing level. Phipps, supra. However, where ancillary issues pose a threat to a claimant's entitlement to compensation, an attorney fee award is appropriate. See, e.g., Nat. Farm Ins. v. Scofield, 56 Or App 130 (1982); Jerry W. Wine, 38 Van Natta 470 (1986).

SAIF's denial prevented the issuance of a .307 order. Thus, responsibility was not the sole issue at hearing. Morecver, SAIF's denial clearly threatened claimant's ability to ultimately obtain compensation. Under these circumstances, claimant is not considered a nominal party and has "actively and meaningfully participate[d]." Consequently, she is entitled to an insurer-paid attorney's fee for services at the hearing level. See ORS 656.386(1).

Pursuant to ORS 656.386(1), in all cases involving accidental injuries where a claimant finally prevails from an order or decision denying the claim for compensation, a reasonable attorney fee shall be allowed. The attorney fees for this section shall be paid by the insurer or self-insured employer. id. Where a claimant overcomes an insurer's denial of compensability, even though another insurer is found responsible for compensation, the insurer that denied compensability is responsible for claimant's attorney fee. See Ronald J. Broussard, 38 Van Natta 59, 61 (1986), aff'd mem. Western Employers Insurance v. Broussard, 82 Or App 550 (1986).

We agree that Aetna is responsible for claimant's compensation. Yet, Aetna only denied responsibility for claimant's current condition. It was SAIF's denial of compensability which prompted claimant's active and meaningful participation at the hearing. Under these circumstances and in reliance upon Broussard, we find that SAIF should be responsible for the attorney fee award.

Although claimant is entitled to an insurer-paid attorney's fee to be paid by SAIF, we consider a $1200 award to be excessive. Accordingly, we modify the Referee's award of attorney fees.

Attorney fee awards are based on efforts expended and results obtained. OAR 438-47-010(2). In determining the reasonableness of attorney fees, several factors must be considered. These factors include: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; and (6) the results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985).

In reaching our conclusion regarding the reasonableness of claimant's attorney fee, we are mindful that she has already been awarded a $400 attorney fee for SAIF's unreasonable conduct

in relying upon its timeliness defense. After considering the efforts expended and the results obtained in claimant's overturning SAIF's denial of compensability, we conclude that an attorney's fee of $600 is a reasonable award for services rendered at the hearing level.

Inasmuch as claimant's entitlement to compensation was not at issue on Board review, no attorney fee is awarded. Wayne A. Hawke 39 Van Natta 31 (January 23, 1987), Phipps, supra.

ORDER

The Referee's order dated July 16, 1986 is affirmed, modified, and reversed. The SAIF Corporation's denial is set aside insofar as it denies or purports to deny the compensability of claimant's neck and shoulder condition. The remainder of SAIF's denial is upheld. In lieu of the Referee's $1200 attorney fee award to be paid by Aetna Casualty Co., claimant's attorney is awarded $600 for services at the hearing concerning the compensability issue. This attorney fee award shall be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

CLINTON P. JOHNSON, Claimant
Carney, et al., Claimant's Attorneys
David Horne, Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 85-06431, 85-07389, 85-09383 & 85-09384
February 5, 1987
Second Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated December 17, 1986. The insurer's request, postmarked January 22, 1987, was received January 23, 1987.

Pursuant to ORS 656.295(8), a Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. The time within which to appeal an order continues to run, unless the order has been abated, stayed, or "republished." See International Paper Co. v. Wright, 80 Or App 444 (1986).

Inasmuch as the Board's order issued December 17, 1986 and since the order has neither been appealed, abated, stayed, or "republished," it became final by operation of law on January 16, 1987. Consequently, the Board lacks jurisdiction to consider the insurer's request.

IT IS SO ORDERED.

DELBERT D. KLIEVER, Claimant
Emmons, et al., Claimant's Attorneys
David O. Horne, Defense Attorney

Own Motion 86-0004M
February 5, 1987
Own Motion Determination Rescinded

Claimant has requested reconsideration of our order dated January 6, 1986 that closed his April 17, 1974 injury claim without awarding compensation. Claimant contends that we lacked jurisdiction to consider this matter. On reconsideration, we agree.

This claim was initially closed by a September 23, 1976 Determination Order. The claim was subsequently reopened and closed by a June 29, 1979 Determination Order. Claimant's timely request for hearing from this Determination Order currently remains pending before the Hearings Division. (WCB Case No. 79-06403). The insurer concedes that claimant is entitled to a hearing concerning the 1979 Determination Order.

Inasmuch as the aforementioned Determination Order was timely appealed and since claimant's request for hearing from that order has not yet been heard, we conclude that we lack jurisdiction to exercise our own motion authority. The issues raised in this own motion request will be considered when claimant's pending hearing is held. Accordingly, our January 6, 1986 Own Motion Determination is rescinded and this matter is dismissed.

IT IS SO ORDERED.

JUDITH A. KNISKERN, Claimant
Duncan, Lusk & Strock, Claimant's Attorneys
Roberts, et al., Defense Attorneys
Cliff, Snarskis & Yager, Defense Attorneys

WCB 84-03141 & 84-04311
February 5, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Industrial Indemnity Company requests review of Referee Fink's order that: (1) found it, rather than Royal Insurance Company, responsible for claimant's de Quervain's disease, carpal tunnel syndrome and thoracic outlet syndrome; (2) awarded claimant's attorney an insurer paid attorney fee of $3,000; and (3) awarded claimant a 25 percent penalty and his attorney a fee of $250 for a procedurally improper denial. The issues are responsibility, penalties and attorney fees.

The Board affirms and adopts the order of the Referee with the exception of that portion of the order that awarded claimant's attorney an insurer-paid attorney fee of $3,000 for services prior to and at the hearing. The responsibility issue in this case was actively litigated by the insurers under an order issued pursuant to ORS 656.307. Claimant's attorney is not entitled to an insurer-paid attorney fee under these circumstances. Petshow v. Farm Bureau Insurance Co., 76 Or App 563, 571 (1985), rev den 300 Or 722 (1986); Stanley C. Phipps, 38 Van Natta 13, 15-16 (1986). We conclude, however, that claimant's attorney was instrumental in securing the issuance of the .307 order and that claimant's attorney is entitled to a fee out of claimant's compensation for services rendered prior to hearing. Mark L. Queener, 38 Van Natta 882 (1986). We conclude that a fee of $1,000 is appropriate.

ORDER

The Referee's order dated April 21, 1986 is affirmed in part and modified in part. That portion of the order that awarded claimant's attorney an insurer-paid attorney fee of $3,000 is modified. Claimant's attorney is awarded a fee of $1,000 to be paid from claimant's compensation. The remainder of the order is affirmed.

STAN M. MONTGOMERY, Claimant
Malagon & Moore, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 85-08541
February 5, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Quillinan's order which affirmed a July 12, 1985 Determination Order insofar as it declined to award unscheduled permanent disability for a back injury. On review, claimant contends that he is entitled to an unscheduled permanent disability award.

Following our de novo review of the medical and lay evidence, we are not persuaded that claimant has suffered a permanent loss of earning capacity as a result of his compensable back injury. See ORS 656.214(5). Consequently, we affirm the order of the Referee.

In conducting our review, the insurer's untimely filed respondent's brief was not considered. OAR 438-11-015 (2),(3); 438-11-035 (1)(b). (Temporary rule, effective November 1, 1986).

ORDER

The Referee's order dated May 9, 1986 is affirmed.

NANCY A. ROTH, Claimant
Bischoff & Strooband, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-00720
February 5, 1987
Order of Dismissal

The self-insured employer has requested review of Referee Myers' Interim Order that withdrew a prior Order of Dismissal, thereby reinstating claimant's request for hearing. We have reviewed the request for review on our own motion to determine whether the Referee's order is reviewable. Zeno T. Idzerda, 38 Van Natta 428 (1986).

A Referee's order that denies a request to dismiss a request for hearing is not a reviewable order. James D. Whitney, 38 Van Natta 628 (1986); Paul W. Bryan (Dec'd), 37 Van Natta 1431 (1985).

Accordingly, the request for review is dismissed. This case is remanded to the Hearings Division for further processing.

IT IS SO ORDERED.

MICHAEL J. THOMAS, Claimant
Malagon & Moore, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 84-10897
February 5, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Baker's order which: (1) assessed penalties and accompanying attorney fees for its failure to timely pay "interim compensation" as directed by a prior Referee's order; and (2) declined to authorize recovery of the "interim compensation," as well as a prematurely paid penalty and attorney fee. On review, the insurer contends that its conduct was not unreasonable and that it should be entitled to recover the aforementioned payments.

We reverse that portion of the Referee's order which assessed penalties and attorney fees.

In January 1984 claimant filed a claim, contending that his work exposure to solvents had caused his hematuria condition. The insurer's denial was appealed. After a June 1984 hearing, a prior Referee upheld the denial. However, relying on then prevailing law, Bono v. SAIF, 66 Or App 138 (1983), the prior Referee awarded interim compensation, penalties, and accompanying attorney fees. The insurer subsequently requested Board review.

In October 1984 claimant requested another hearing, contending that the insurer had failed to timely comply with the prior Referee's order. The day after the filing of claimant's request, the insurer paid not only the interim compensation, but also the penalty and accompanying attorney fee.

In March 1985 the Board reversed the prior Referee's order. Michael J. Thomas, 37 Van Natta 252 (1985). Relying on the Supreme Court's decision in Bono v. SAIF, 298 Or 410 (1984), the Board found that claimant had not left work as a result of the condition for which he had filed his claim. Therefore, he was not entitled to interim compensation, penalties, or attorney fees.

Thereafter, claimant's subsequent hearing request was heard by Referee Baker. The insurer's failure to timely pay the "interim compensation" as ordered by the prior Referee was found unreasonable. Accordingly, a penalty and accompanying attorney fee were assessed. In addition, Referee Baker found no authority for directing the recovery of the "interim compensation" or the insurer's prematurely paid penalty and attorney fee. Consequently, the insurer's request for recovery of these payments was denied.

Subsequent to the Referee's decision, the Board issued its order in Terry L. Hunter, 38 Van Natta 134 (1986). In Hunter, we concluded that the "interim compensation" ordered by a Referee's order was payable solely by virtue of the Court of Appeals' interpretation of ORS 656.262(4) regardless of claimant's work status. Thus, these payments were not temporary total disability compensation due under ORS 656.210. Since the Supreme Court's decision in Bono v. SAIF, supra., had terminated the existence of such compensation, we reasoned that this was not the type of compensation that must be paid under ORS 656.313(4) pending further review. Consequently, we held that the insurer was justified in refusing to pay this compensation pending review of a Referee's order.

Here, as in Hunter, the interim compensation ordered paid by the prior Referee's order was based on the Court of Appeals' interpretation of ORS 656.262(4). As such, this interim compensation was not temporary disability compensation due under ORS 656.210 and was not required to be paid pending further review pursuant to ORS 656.313(4). Since this compensation need not have been paid pending review, we conclude that the insurer's payment of this compensation during appeal of the prior Referee's order was neither late nor unreasonable. Accordingly, a penalty and accompanying attorney fee were not justified.

We affirm that portion of the Referee's order which declined the insurer's request to recover the "interim

compensation" payments, as well as the prematurely paid penalties and attorney fees. The insurer has cited no authority, and we have found none, which empowers us to direct the immediate recovery of these payments. The only avenue for recovery would appear to be through obtaining permission for a future offset. See Forney v. Western States Plywood Co., 66 Or App 155, 159 (1983), aff'd 297 Or 628 (1984). However, inasmuch as the claim has been found noncompensable, there will be no future permanent disability awards against which these alleged overpayments could be offset. Thus, further discussion of this issue would be of no benefit since we would be engaging in a purely academic exercise.

Although claimant has technically prevailed on this "recovery" issue, he is not entitled to an insurer-paid attorney fee. We reach this conclusion because the amounts that the insurer sought to recover are not "compensation" for purposes of ORS 656.382(2). See Saxton v. SAIF, 80 Or App 631 (1986); Hunter, supra. Consequently we have not found that compensation awarded to claimant should not be disallowed or reduced. See ORS 656.382(2).

Finally, we decline claimant's request to assess a penalty pursuant to ORS 656.382(3). This statute only applies where a Referee finds that an insurer's request for hearing is initiated for the purpose of delay, another vexatious reason, or without reasonable ground. Inasmuch as claimant requested the hearing and did not raise this issue at that time, the statute is inapplicable. In any event, considering the complexity of this procedural matter and our ultimate conclusion, we would not find the insurer's appeal without merit.

ORDER

The Referee's order dated April 12, 1985 is reversed in part and affirmed in part. That portion which assessed a penalty and attorney fees is reversed. The remainder of the Referee's order is affirmed.

RICHARD L. WINE, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 85-0548M
February 5, 1987
Second Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on Reconsideration on September 24, 1986 whereby claimant was granted an increased award equal to 48 degrees for 15 percent unscheduled disability for injury to his low back. Claimant has asked the Board to award penalties and associated attorney fee for an alleged unreasonable delay in payment of compensation on the part of SAIF Corporation.

Claimant has indicated that the permanent partial disability payment due on October 24, 1986 was not made until October 31, 1986, one week later. Compensation for permanent partial disability ordered paid by a litigation order is due within 30 days from the date of the order. OAR 436-60-150 (5)(b). SAIF Corporation has offered no explanation for the delay in payment of benefits. We conclude that a penalty is warranted.

SAIF Corporation is ordered to pay to claimant a penalty of 25 percent of the permanent partial disability compensation due

as a result of the Board's September 24, 1986 order. Claimant's attorney is awarded a reasonable attorney fee of $150 to be paid by SAIF in addition to compensation and the penalty.

IT IS SO ORDERED.

BRUCE A. MARSH, Claimant
Bloom, Marandas & Sly, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 83-08985
February 9, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Thye's order that: (1) determined that his claim for a head injury was not prematurely closed; (2) concluded that he had not suffered an aggravation; (3) declined to award temporary disability from January 25, 1982 through July 19, 1983 or after August 9, 1983; and (4) concluded that he lacked jurisdiction to rate claimant's unscheduled permanent disability. Should we conclude that the Referee was without jurisdiction to consider the appeal from the Determination Order, claimant requests that we exercise our Own Motion authority to grant relief. The issues are premature claim closure, aggravation, temporary disability, jurisdiction and extent of unscheduled permanent disability.

Claimant suffered a compensable injury in December, 1976, after falling and striking his head on a concrete wall. At that time, claimant was working framing houses. He suffered a concussion and post-traumantic cephalgia. The claim was closed by a December 1977 Determination Order that awarded no permanent disability.

In February 1981 claimant developed a post-traumatic seizure disorder related to his 1976 injury. He suffered from both grand mal and temporal lobe seizures and was diagnosed as having a moderately severe hydrocephalus. By January 1982 claimant's seizures and related headaches had been controlled through the use of a medication called Tegretol. His condition was permanent and he was not to return to occupations involving heights or dangerous machinery. Dr. Reimer, a neurologist, estimated permanent impairment at 15 percent, noting that claimant could have difficulties in the job market depending on how well his seizures could be controlled. In February 1982, claimant complained of one to three small seizures per month, accompanied by headaches, some vision distortion and slowed speech. A February 1982 Determination Order awarded claimant 20 percent unscheduled permanent disability.

In July 1982 claimant was enrolled in an authorized training program to be a Mechanical Engineering Technician. By April 1983 the program was terminated due to claimant's poor performance. Claimant felt that his poor performance was related to reduced memory retention. As a result, Dr Reimer referred claimant for evaluation by a clinical psychologist, Dr. Dewey. Dr. Dewey performed numerous tests and noted that claimant demonstrated reduced IQ scores compared to tests performed in 1982 at the Callahan Center. However, Dr. Dewey was unable to correlate the reduction directly to claimant's injury. Claimant also scored poorly in the memory portion of the test and Dr. Dewey concluded that this was a result of frontal lobe impairment.

Dr. Dewey recomended that claimant's school load be reduced to accommodate his inability to absorb new information and allow for the reading and rereading of material. Dr. Reimer also recommended that claimant's school load be reduced.

In April 1983 claimant's authorized training program was terminated for the development of a new program. A Determination Order was issued on August 9, 1983 that awarded claimant no additional permanent disability. Claimant timely appealed from this Determination Order. A second authorized training program was started in October 1983 to train claimant in surveying. In October 1984 claimant was again examined by Dr. Reimer who noted that he complained of writing down the wrong numbers while at work. Dr. Reimer stated that claimant remained medically stationary. After the successful completion of the new training program, a fourth Determination Order was issued in November 1984 that awarded claimant no additional permanent disability. Claimant reported having seizures in January 1985, but Dr. Reimer stated that claimant's condition remained stationary.

Claimant testified that he had been working as a county survey technician on a temporary basis for two and half years. He still has occasions where he suffers headaches, mildly blurred vision and a feeling of disassociation, all of which he associates with the beginnings of a seizure. He has small seizures about once a week, which will pass if he has an opportunity to lie down for a brief nap. Over time, his ability to function with the seizures has improved. The grand mal seizures occur in his sleep about twice per month. He still has trouble comprehending what he reads, particularly technical data. In order to control the seizures, claimant continues to take medication which causes hair loss, occasional nausea, and sleepiness. Due to his periods of disassociation and fear of seizures, he uses caution when driving an automobile and on occasion will limit his driving.

We affirm those portions of the Referee's order concerning the premature closure, aggravation, and temporary disability issues. However, we reverse that portion of the Referee's order that concluded he lacked jurisdiction to determine the extent of claimant's unscheduled disability.

When a claim is opened during the time claimant still has appeal rights pursuant to ORS 656.268(6)(Formerly ORS 656.268(5)), closure of that claim carries with it the right of appeal whenever issued. Coombs v. SAIF, 39 Or App 293, 300 (1979). Moreover, after completion of an authorized training program, ORS 656.268(5) provides that a new determination be made based on the medical and other evidence existing at that time. Hanna v. SAIF, 65 Or App 649 (1983); Wayne D. Cooper, 38 Van Natta 913 (1986); Jeffrey P. Hough, 37 Van Natta 1253 (1985).

Claimant received his first Determination Order on December 23, 1977. As a result, his aggravation rights expired on December 23, 1982. ORS 656.273(4)(a). However, in July of 1982 his claim was reopened for an authorized training program and was subsequently closed by an August 1983 Determination Order. The order was timely appealed. Within one year of this order, the claim was again reopened for another vocational rehabilitation program. A November 1984 Determination Order eventually reclosed the claim. This order was also timely appealed. Thus, the timely appeal of either of these orders would entitle claimant to a

hearing. Accordingly, we find that the Referee had jurisdiction to rate the extent of claimant's permanent disability.

We also conclude that the record is sufficiently developed that we can rate claimant's unscheduled permanent disability without remand.

In rating claimant's permanent disability, we consider his physical impairment, which includes his credible testimony concerning his pain, physical limitations and relevant social and vocational factors as set forth in OAR 436-30-380 et. seq. We do not apply these rules as rigid mechanical calculations that are determinative of the final result. Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). Following our de novo review of the medical and lay evidence, and considering the aforementioned guidelines, we conclude that claimant is entitled to an additional 20 percent permanent disability for a total of 40 percent unscheduled permanent disability.

ORDER

The Referee's order dated June 11, 1986 is affirmed in part and reversed in part. That portion of the order that found the Referee lacked jurisdiction to rate claimant's unscheduled permanent disability is reversed. Claimant is awarded an additional 20 percent (64 degrees) unscheduled permanent disability for a total, to date, of 40 percent (128 degrees) unscheduled permanent disability. Claimant's attorney is allowed 25% of the additional compensation granted by this order, not to exceed $3,000, as a reasonable attorney fee. The remainder of the Referee's order is affirmed.

The Beneficiaries of
CLINTON S. McGILL (Deceased), Claimant
Benziger & Karmel, Claimant's Attorneys
Allen G. Owen, Defense Attorney

WCB 82-01436
February 9, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. McGill v. SAIF, 81 Or App 210 (1986). The court has mandated that the SAIF Corporation accept the claim for death benefits.

Accordingly, SAIF's denial dated January 28, 1982 is set aside and this matter is remanded to SAIF for acceptance and payment of compensation according to law.

IT IS SO ORDERED.

ALLAN T. SHEPHERD, Claimant
Robert L. Chapman, Claimant's Attorney
Foster & Purdy, Defense Attorneys
Robert H. Fraser, Defense Attorney

WCB 86-03810 & 86-07450
February 11, 1987
Order Denying Motion to Dismiss

Mid-Century Insurance Company has moved the Board for an order dismissing Universal Underwriter Insurance's request for Board review of the Referee's December 8, 1986 order. Mid-Century contends that Universal's January 5, 1987 notice of appeal improperly stated that Universal was appealing on behalf of Mid-Century's insured. Further, Mid-Century argues that Universal's January 7, 1987 amended notice of appeal, as filed with the Board, was only a conformed copy.

Universal's amended notice of appeal rectified the apparent deficiencies present in its initial notice of appeal. In addition, the amended notice of appeal was mailed on January 7, 1987, the 30th day after the date of the Referee's order. Therefore, the request for Board review was timely. ORS 656.289(3); OAR 436-11-035. Finally, the amended notice of appeal filed with the Board is not a conformed copy.

Accordingly, the motion to dismiss is denied.

IT IS SO ORDERED.

JOHN A. GRAHAM, Claimant
Noreen Saltveit, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Lindsay, et al., Defense Attorneys

WCB 84-01383 & 84-03399
February 12, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Graham v. Schnitzer Steel Products, 82 Or App 162 (1986). The court agreed with our prior conclusion, John A. Graham, 37 Van Natta 933 (1986), that United Pacific Insurance Company was not responsible for claimant's present back condition under either an occupational disease or a new injury theory.

However, we have been instructed to consider claimant's contention that his present back condition is an aggravation of a 1980 compensable injury for which the SAIF Corporation is responsible. We conclude that no further action by the Hearings Division is required for a final decision.

Following our further review of the medical and lay evidence, which includes claimant's noncredible testimony, we are not persuaded that claimant's present low back problem represents a worsened condition resulting from his 1980 compensable injury. Consequently, the record fails to establish the compensability of claimant's aggravation claim. See ORS 656.273(1).

ORDER

The SAIF Corporation's denial dated January 30, 1984 is reinstated and upheld.

DENNIS E. BERLINER, Claimant
Malagon & Moore, Claimant's Attorneys
Foss, et al., Defense Attorneys
George Goodman, Defense Attorney

WCB 85-12191
February 19, 1987
Order on Review

Reviewed by the Board en banc.

Based on the affidavits submitted, the record herein, and in the interests of substantial justice, we are persuaded that our October 8, 1986 order in this matter was not mailed to claimant and claimant's attorney. Consequently, that order has not become final. ORS 656.295(8); Armstrong v. SAIF, 67 Or App 498 (1984). Since our prior order has not become final, we have jurisdiction to republish it, which we hereby do as follows.

The self-insured employer requests review of Referee Baker's order that disallowed an allegedly unauthorized offset and awarded penalties and attorney fees. The issue is offset.

Claimant compensably injured both knees and his low back in May 1975 and subsequently developed psychological problems. Claimant received treatment for his conditions and returned to work in August 1983. The employer continued to pay temporary disability benefits after claimant returned to work and an overpayment of more than $7,000 resulted. In a letter dated March 23, 1984, the employer informed claimant that it would request authorization to offset the overpayment against any permanent partial disability awarded when the claim was closed.

The claim was closed by Determination Order dated December 17, 1984 with awards of scheduled and unscheduled permanent partial disability. The typed body of the Determination Order contained express authorization for "[d]eduction of overpaid temporary disability, if any, from unpaid permanent disability." The employer applied claimant's permanent disability awards toward its overpayment and by letter dated January 3, 1985, informed claimant that the overpayment still stood at more than $2,700.

Claimant appealed the December 1984 Determination Order and Referee Pferdner increased the permanent disability awards for claimant's right knee and low back. The employer did not request that Referee Pferdner authorize further offset of the overpaid temporary disability compensation and the Referee did not address the issue in his Opinion and Order or in a subsequent Order on Reconsideration. By letter dated two days after the date of the Order on Reconsideration, the employer informed claimant that the additional permanent disability compensation awarded by Referee Pferdner had been applied to further reduce the overpayment. Claimant requested a hearing, alleging that this offset was unlawful.

Claimant's request came to hearing before Referee Baker. Referee Baker concluded that the offset was without authority, ordered the employer to pay the additional permanent disability compensation awarded by Referee Pferdner without offset and assessed penalties and attorney fees. On Board review, the employer contends that the authorization granted by the December 1984 Determination Order continued after its initial offset and permitted the later offset against the additional permanent disability compensation awarded by Referee Pferdner. We agree with the employer and reverse Referee Baker's order.

Offsets are permissible only when authorized by the Evaluation Division, a Referee, the Board or a court. Forney v. Western States Plywood, 66 Or App 155 (1983), aff'd 297 Or 628 (1984); Pauline V. Bohnke, 37 Van Natta 146 (1985) aff'd, United Medical Laboratories v. Bohnke, 78 Or App 671 (1986) (per curium). In the present case, the Evaluation Division authorized the employer to offset overpaid temporary disability compensation against unpaid permanent disability compensation. That authorization continued after the initial offset because the amount of the overpaid temporary disability compensation exceeded the value of the permanent disability awards granted at that time. We conclude, therefore, that the offset taken by the employer was proper and that penalties and attorney fees were not warranted for the employer's action.

ORDER

The Referee's order dated February 14, 1986 is reversed.

Board Member Lewis, dissenting:

I would affirm the Referee's order and, therefore, I respectfully dissent.

Claimant was injured in 1975. Claimant returned to work in August 1983. In March 1984 the self-insured employer notified claimant that it intended to seek recovery of allegedly overpaid temporary disability compensation out of future awards of compensation. The first Determination Order was published in December 1984. The employer sought and obtained authorization to offset overpaid temporary disability compensation out of permanent disability compensation awarded by the Determination Order. The overpayment exceeded the value of the permanent disability compensation awarded by the Determination Order.

Claimant requested a hearing on the issue of the extent of his permanent partial disability. There is no response from the employer in the record. The Referee's Opinion and Order recited that the only issue at the hearing was the extent of claimant's permanent disability. Claimant requested reconsideration and on reconsideration the Referee republished his order without modification. The Referee did not authorize an offset of overpaid temporary disability compensation out of compensation awarded. The employer notified claimant that because there was still an overpayment of temporary disability compensation that it would offset the overpayment out of the current award of compensation and out of the mileage reimbursement claims presented after the hearing. The employer produced no evidence that it sought authorization of an offset by the Referee against any additional compensation that might have been awarded. The employer did not seek a reconsideration of the order to allow the Referee to consider authorization of an offset once additional compensation had been awarded.

The employer argues that its notice to claimant that it wished to recover the overpaid temporary disability compensation was the equivalent of raising the issue at hearing. There is no evidence that the issue of authorization of an offset was ever considered by the Referee at the hearing on extent of disability. The employer argues that the authorization by the Evaluation Division of the Workers' Compensation Department remains in effect until the overpayment is fully recovered and that it should not be necessary for the employer to request an offset out of each award of compensation.

I am not persuaded by the employer's argument. I believe that the policy stated by the Court of Appeals in Forney v. Western States Plywood, 66 Or App 155, 159-60 (1983), affirmed, 297 Or 628 (1984), requires that the employer seek and obtain authorization of any offset out of each award of compensation. I believe that the issue of an offset out of an award by a Referee must be raised as an issue for consideration by that Referee or by a reviewing body subsequent to the award. I do not believe that an initial authorization of an offset by the Evaluation Division out of an award of compensation carries with it the implied authority to offset future awards by a Referee, the Board, or the court without notice or hearing on the issue of the offset. For this reason I would affirm the Referee's order, and I, therefore, respectfully dissent.

CHESTER W. PARR, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 86-0400M
February 19, 1987
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and award temporary total disability benefits as a result of an October 30, 1972 injury for which the SAIF Corporation was responsible. Claimant's aggravation rights have expired.

On January 14, 1987, we affirmed a Referee's order which found that claimant's current condition was unrelated to a 1985 injury claim, also insured by SAIF. Consequently, SAIF's denial of responsibility for claimant's medical services under the 1985 claim was upheld. Chester W. Parr, 39 Van Natta ___ (January 14, 1987). Claimant has appealed the aforementioned order.

We deny claimant's request for own motion relief. An own motion request will not be acted on while other administrative or judicial remedy is available. OAR 438-12-005(1)(a).

Inasmuch as claimant is presently seeking judicial review of our prior order on review concerning responsibility for his current condition, his request for own motion relief regarding this same condition will not be acted on. However, after completion of the judicial review process, claimant may repetition the Board to exercise its own motion relief pertaining to the 1972 injury.

IT IS SO ORDERED.

EILEEN M. PHILIP, Claimant
Coons & Cole, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 82-08702
February 19, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Myers' order that awarded claimant permanent total disability and a penalty and attorney fee for its late payment of medical bills. The issues are permanent total disability, penalties and attorney fees.

The Board affirms that portion of the Referee's order which concerned the issue of permanent total disability, but modifies the award of penalties and attorney fees.

Claimant suffered an injury on June 26, 1984 for which she incurred medical bills. In October 1984 the insurer denied the claim as being unrelated to her accepted industrial injury. Subsequently, the insurer rescinded its denial and accepted claimant's new injury. We are unable to determine the date of the acceptance. On May 13, 1985 claimant's attorney sent a letter requesting payment of $1,527.43 of unpaid medical bills. The letter acknowledged that payment of $3,548.73 had been made in April 1985. Claimant again requested payment of the medical bills in August 1985. The insurer responded to the August request for payment stating that it had never received any bills beyond those paid in April 1985.

The Referee concluded that all the bills mentioned in

claimant's May 13, 1985 letter were untimely paid and therefore assessed penalties and attorney fees. We disagree and modify the award of penalties and attorney fees.

Since we are unable to determine the date of the insurer's acceptance, we cannot determine if the payment of medical bills in April 1985 was untimely. We, therefore, are unwilling to assess a penalty against the bills for $3,548.73. However, claimant requested payment of the $1,527.43 unpaid balance of the medical bills both in May and August 1985. Further, the medical bills themselves indicate that this balance remained outstanding at the time the insurer made its initial payment in April 1985. We conclude that the insurer received the medical bills and failed to timely pay the balance. Consequently, claimant is entitled to a 25 percent penalty assessed against the unpaid portion of the medical bills.

We also modify the attorney fee awarded for this issue. In determining the reasonableness of attorney fees, the factors considered are: (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. Barbara A. Wheeler, 37 Van Natta 122 (1985). We conclude that $300 is a reasonable attorney fee for services on this issue.

Further, we find the permanent total disability issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated June 9, 1986 is affirmed in part and modified in part. In lieu of that portion of the order that awarded a 25 percent penalty for the medical bills identified in claimant's May 13, 1985 letter, claimant is awarded a 25 percent penalty assessed against $1,527.43 and a $300 attorney fee. The remainder of the order is affirmed. Claimant's attorney is awarded $600 for services on Board review concerning the permanent total disability issue, to be paid by the insurer.

MYRON W. RENCEHAUSEN, Claimant
Hayner, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 84-12397, 85-13561 & 85-14595
February 19, 1987
Order on Reconsideration

The self-insured employer has requested reconsideration of that portion of our Order on Review dated December 18, 1986 that awarded claimant a $300 attorney fee for prevailing on an employer-initiated request for review. The employer contends that because claimant filed no respondent's brief on review, no attorney fee should have been awarded. To allow sufficient time to consider the employer's request and claimant's response, we abated our order. On reconsideration, we modify our award of attorney fees.

The employer requested review of the Referee's order and filed an appellant's brief in support of its position. Claimant cross-requested review, but his second request for an extension of

time for filing his brief was denied. We ultimately affirmed the Referee's order without opinion. Because the request for review was employer-initiated, we awarded claimant an attorney fee for services on Board review.

The employer objects to the award of attorney fees, contending that because claimant did not participate in briefing in this forum, no fee should have been awarded. The employer cites Betty J. McMullen, 38 Van Natta 21 (1986), and like cases for its proposition. In McMullen, an insurer requested review and the claimant filed a cross-request. Neither party filed a brief. We affirmed the Referee's order but did not award the claimant an attorney fee because of her failure to file a brief on review. The claimant subsequently requested reconsideration, and in Betty J. McMullen, 38 Van Natta 117 (1986), we held that under ORS 656.382(2), the claimant was entitled to a fee despite her having not filed a brief on review. However, we also concluded that the statute gave us authority to set the level of the fee. Finding that the fee should be "rather modest," we awarded the claimant an attorney fee of $150. McMullen, 38 Van Natta at 118.

We followed this line of reasoning in Dan W. Hedrick, 38 Van Natta 208 (1986). In Hedrick, no briefs were filed, but claimant presented motions and other documents in response to the employer's request for review. Citing our order on reconsideration in McMullen, we concluded that ORS 656.382(2) mandated an insurer/employer-paid attorney fee in such situations. Reiterating that we had been delegated the authority to determine the amount of the fee, we awarded an attorney fee of $550. Our decision in Hedrick has recently been affirmed without opinion by the Court of Appeals. Weyerhaeuser Company v. Hedrick, 83 Or App 275 (1987).

In McMullen, no brief was filed by either party. We found that fact significant in that the claimant had nothing to which to respond on review. Here, the employer filed a brief and claimant did not timely respond. We find that distinction significant, as well, in that there were points and authorities to which the present claimant could have responded so as to assist us in our process of review. Yet, in accordance with our reasoning in Hedrick and McMullen, we find that the distinction affects the amount of the fee we may award, not whether we may refuse to award one at all. ORS 656.382(2) clearly and unambiguously provides for an insurer/employer-paid attorney fee where claimant prevails over an employer-initiated request for review. See Shoulders v. SAIF, 300 Or 606 (1986). The administrative rule promulgated from the statute merely invests us with the authority to set the amount of the fee. OAR 438-47-010. We cannot deny the award of fees in the first instance.

Accordingly, on reconsideration, we continue to find that claimant was entitled to an employer-paid fee on review. However, considering the circumstances of claimant's participation, his award of attorney fees is modified. In lieu of our prior award of attorney fees, claimant is awarded $100 for his attorney's services on Board review. Except as herein modified, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

JANE E. SULLIVAN, Claimant
Bert E. Joachims, Claimant's Attorneys
David Jorling, Defense Attorney

WCB 85-07574
February 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Tenenbaum's order that: (1) reduced claimant's 25 percent (80 degrees) unscheduled permanent disabiity award for a back injury to 15 percent (48 degrees); (2) found the claim was not prematurely closed; (3) assessed a 15 percent penalty and $50 attorney fee for the late payment of $536.46 of temporary disability; (4) awarded a 25 percent attorney fee assessed against unpaid temporary disability in December 1984; (5) awarded a $500 penalty for improper claim closure; (6) declined to assess a penalty and attorney fee for the employer's incorrect calculation of time loss benefits; and (7) concluded that the employer had not unilaterally offset temporary disability benefits. The issues are extent of unscheduled permanent disability, premature claim closure, temporary disability, improper offset of temporary disability, penalties and attorney fees.

The Board modifies the Referee's award of penalties and attorney fees.

The claim was closed by a Notice of Closure dated April 1, 1985. Subsequently, claimant requested that the Evaluation Division consider her claim for an award of permanent disability. As a result, a Determination Order issued awarding claimant 25 percent (80 degrees) unscheduled permanent disability. As part of her hearing request, claimant requested a penalty for unreasonable claim closure pursuant to ORS 656.268(3). The Referee found that the notice of closure was unreasonable and awarded the minimum penalty of $500. Claimant seeks a greater penalty and a related attorney fee.

We agree that a penalty was proper, but modify the amount of the penalty and also award a related attorney fee.

ORS 656.268(3) states in relevant 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."

The Referee found no temporary disability owing between the April 31, 1985 Notice of Closure and the May 10, 1985 Determination Order. She also concluded that the 25 percent permanent disability awarded claimant was not compensation owing

between the notice of closure and the determination order within the meaning of ORS 656.268(3). Therefore, she found no amounts owing and awarded only the minimum penalty.

We disagree. We find that the award of permanent disability should have been considered for the assessment of a penalty.

If an employer fails to timely seek claim closure pursuant to 656.268(2), claimant is entitled to a penalty for the unreasonable delay in the payment of compensation. Georgia Pacific v. Awmiller, 64 Or App 56 (1983); Lester v. Weyerhaeuser, 70 Or App 307 (1984). In Lester, the employer's failure to timely submit the claim for closure resulted in a delay in the payment of permanent partial disability. The court found this delay to be unreasonable and held that claimant was entitled to a penalty and attorney fee pursuant to ORS 656.262(10).

Similarly, in the present situation, there was a delay in the payment of claimant's permanent disability due to the improper notice of closure. As a result, claimant is entitled to a penalty assessed against all compensation determined to be owing between the notice of closure and the Determination Order. We interpret compensation to include the 25 percent permanent disability awarded by the May 10, 1985 Determination Order. The inclusion of the permanent disability for the assessment of the penalty is consistent with the other improper closure cases and the requirement that compensation be paid promptly. ORS 656.262(2). Further, we conclude that claimant is entitled to an attorney fee pursuant to 656.382(1) for services on this issue. We find $500 to be a reasonable attorney fee.

At hearing, claimant asserted for the first time that her temporary total disability had been calculated at an incorrect rate. Since the employer had no prior notice of this issue, the record was left open to afford them an opportunity to respond. Subsequently, the employer verified the incorrect rate and acknowledged that claimant was owed $2,743.28 in temporary disability benefits. Because the employer did not have notice that claimant was challenging the rate of temporary total disability until hearing, the Referee concluded that it did not unreasonably resist the payment of compensation and that no penalty was appropriate. Claimant asserts that she is entitled to a penalty and attorney fee.

We agree with the Referee that no penalty was warranted as there was no unreasonable resistance to the payment of temporary disability. However, we do conclude that claimant's attorney is entitled to an attorney fee. This fee shall be paid out of compensation. ORS 656.386(2). We find that claimant's attorney is entitled to 25 percent of increased compensation up to $200.

Claimant also sought a penalty and attorney fee for eight days of compensation she alleged was not paid in December 1984. The employer conceded that claimant was entitled to temporary disability for this period. As no explanation was provided for the employer's failure to pay the temporary disability, the Referee awarded an attorney fee equivalent to 25 percent of the compensation due for the eight day period. We modify the order to reflect that in addition to the attorney fee,

claimant is also entitled to a penalty equivalent to 25 percent of the temporary disability for this eight day period.

The Board affirms the remaining portions of the Referee's order.

ORDER

The Referee's order dated July 9, 1986 is affirmed in part and modified in part. In lieu of that portion of the order that awarded a $500 penalty for unreasonable claim closure, claimant is awarded a penalty of 25 percent of the unscheduled permanent disability granted by the May 10, 1985 Determination Order. Claimant's attorney is awarded $500 as a reasonable attorney fee for services on this issue. For services in obtaining increased temporary disability, claimant's attorney is allowed 25 percent of any future compensation, not to exceed $200. In addition to the attorney fee awarded by the Referee, claimant is awarded a penalty of 25 percent of the eight days of the unpaid temporary disability in December 1984. The remainder of the Referee's order is affirmed.

CHARLES A. CLEMENS, Claimant
SAIF Corp Legal, Defense Attorney

WCB 85-08815
February 24, 1987
Order of Dismissal

Claimant has requested review of the Referee's order dated December 2, 1986. The request was mailed to the SAIF Corporation on December 31, 1986. SAIF received the request on January 2, 1987. SAIF forwarded the request to the Board on January 12, 1987. The Board received the request on January 13, 1987.

ORS 656.289(3) requires that a request for Board review be mailed to the Board and all parties no later than 30 days after the mailing date of the Referee's order. (Emphasis added). Strict compliance with ORS 656.289(3) is required to invoke our jurisdiction. Argonaut Insurance v. King, 63 Or App 847, 851-52 (1983).

Inasmuch as claimant's request was not timely filed with the Board, we are without jurisdiction to review the Referee's order. Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

BETTY G. DAVIS, Claimant
Dennis O'Malley, Claimant's Attorney
Dennis Ulsted, Defense Attorney

WCB 85-01372
February 24, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of that portion of Referee Seymour's order that set aside Determination Orders of January 23, 1985 and February 19, 1985 as premature and directed it to allow claimant to see another out-of-state physician. SAIF also seeks to have its October 7, 1985 denial of medical benefits and its February 25, 1986 denial of aggravation upheld. Claimant cross-requests review, seeking penalties and attorney fees for SAIF's refusal to authorize a new out-of-state treating physician. If we find that the claim was not prematurely closed, claimant also seeks to have her claim reopened due to an alleged

aggravation of her industrial injury. The issues are premature claim closure, compensability of medical treatment, penalties and attorney fees, aggravation and out-of-state medical treatment.

In July 1983, claimant suffered a compensable injury to her back after falling while lifting a mattress and box spring. Claimant initially treated with Dr. Forsgren, who took her off work and referred her to Dr. Sutherland, a neurosurgeon. Dr. Sutherland diagnosed lumbar disc syndrome and began conservative treatment. He treated her regularly and in November 1983 noted that in addition to her physical limitations she also had apparent psychological problems. In December 1983, claimant changed treating physicians to Dr. Albrecht, a chiropractor, who diagnosed severe, acute lumbosacral sprain/strain; moderate acute thoracic and cervical sprain/strain and vertebrogenic cephalgia. On December 12, 1983 Dr. Sutherland concurred in a referral of claimant to the Providence Pain Center and felt that, in view of her functional overlay, it would be better to avoid invasive procedures such as a myelogram.

In late January 1984, claimant notified SAIF that she was moving to California. On February 2, 1984, SAIF wrote claimant stating that it was their prerogative to choose her out-of-state physician and that they would choose a Board Certified Orthopedist in her area. Thereafter, apparently because claimant had missed some of the Pain Center treatments, claimant's benefits were suspended from February 6, 1984 to April 30, 1984.

On April 30, 1984 claimant began treating with Dr. Berrien, a California orthopedic surgeon, who had been selected by SAIF. Dr. Berrien noted claimant's chronic back discomfort and referred her to Dr. Porecha, a neurologist, in consultation. Dr. Porecha conducted an EMG and concluded on June 4, 1984 that claimant had no denervation, but did appear to have a lot of muscle spasms and was very anxious. Dr. Berrien felt claimant had evidence of sciatic irritation and on June 22, 1984 recommended an epidural block and physical therapy. On July 20, 1984, Dr. Berrien stated that claimant was not improving with either her treatment or physical therapy and stated that she could be released for regular duty as of July 23, 1984 for a trial of at least a month.

On August 9, 1984, claimant found new employment at a telephone answering service. She worked four hours but then went to the Scenic Hospital Emergency Room due to back pain. Dr. Berrien examined claimant on August 16, 1984 and noted that she was "crying and carrying on," having obtained no relief in her back distress. He felt he had nothing more orthopedically to offer and that she had a "tremendous" amount of emotional overlay. Claimant continued to be released for regular duty and was referred to the Central Valley Pain Center for evaluation and possible treatment.

She was evaluated at the Pain Center on August 17, 1984 and subsequently admitted on an in-house basis for portions of September and October of 1984. In a September 1984 letter, the Pain Center reported that in addition to low back pain, the industrial injury had triggered an adjustment disorder with mixed emotional and psychogenic pain disorder features. Claimant was well motivated and cooperative and Pain Center personnel recommended follow up psychotherapy for the next three months. On

November 12, 1984, Dr. Berrien opined that there was nothing to be offered for the relief of claimant's symptoms and that her subjective symptoms far outweighed any objective findings. He felt no more treatment was warranted and claimant could return to her normal line of work. He found her medically stationary.

On January 23, 1985 a Determination Order was issued that awarded claimant temporary disability from July 30, 1983 through July 22, 1984, but no permanent disability. At SAIF's request the Determination Order was reconsidered by the Evaluation Division. As a result, a second Determination Order was issued on February 19, 1985 which excluded temporary disability benefits from February 6, 1984 through April 30, 1984.

In April 1985, the Executive Director of the Pain Center wrote SAIF stating that claimant had made favorable progress under their treatment in September and October, but was in much need of aftercare treatment. They had last seen claimant on November 26, 1984 and at that time felt she was still disabled. In May 1985, Dr Berrien concluded that claimant had no objective impairment as a result of her industrial injury and that she should seek outside counseling for her noncompensable complaints. Dr. Berrien further noted that claimant had experienced many emotional setbacks related to her home life. On May 14, 1985 claimant was seen again in the Scenic Hospital Emergency Room for abdominal and low back pain.

Claimant's attorney wrote a letter to SAIF on July 11, 1985 requesting authorization for a new treating physician, as Dr. Berrien had refused to see her. SAIF formally denied the request on October 25, 1985.

In August 1985 Dr. Berrien sent a letter to SAIF indicating that the Emergency Room visits by claimant were not related to her industrial injury. He also stated that she had no psychological problems and that some new physical problems might be the etiology of her visits to the Emergency Room. On October 7, 1985 SAIF issued a denial of treatment for claimant's low back and abdominal pain as being unrelated to her original industrial injury.

In September 1985, claimant saw Dr. Roby, a chiropractor. Based on x-rays and positive orthopedic-neurological tests, Dr. Roby diagnosed numerous difficulties with claimant's back. Dr. Roby concluded that claimant was unable to return to her regular work and was in need of curative treatment. The Executive Director of the Central Valley Control Pain Center wrote a report on January 13, 1986 outlining claimant's treatment at the clinic. The report indicated that claimant obtained some relief from the physical therapy treatment, but was unable to master stress reduction techniques. The Director felt that claimant's home life continued to aggravate her back. Accordingly, the Director concluded claimant would have to live with this disability for the rest of her life and that she was permanently disabled from working in her regular capacity as a maid.

In February 1986 Dr. Roby again reported that claimant was neither medically stationary nor released for regular duty and was in need of additional treatment. SAIF issued a denial letter on February 25, 1986 denying claimant's aggravation claim. In addition, the denial stated:

"Furthermore, when an injured worker moves out of state, the workers' compensation insurance carrier has the right to prior approval of a change of treating physician. We informed your attorney by telephone and by letter that we did not authorize a change of treating physician. Therefore, the recent medical reports have no weight. If you believe your condition has worsened, we would suggest that you return to Dr. Berrien for further examination."

At hearing claimant testified that she sought SAIF's authorization for another doctor besides Dr. Berrien from November 1984 to May 1985. She stated she had to go to the Emergency Room on May 14, 1985 for both low back and abdominal pain. The bills for the Emergency Room along with Dr. Roby's bills were submitted to SAIF for payment. However, they remained unpaid.

A claimant is medically stationary if "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Further, the reasonableness of medical expectations at the time of claim closure is judged by the evidence available at the time, not by subsequent developments or a change in claimant's condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985).

Dr. Berrien, on November 12, 1984, concluded that claimant was medically stationary and that no additional treatment was warranted. By that time, claimant had completed her in-house program at the Central Valley Pain Center with no indication that she was in need of additional curative treatment. Thus, the medical evidence in November of 1984 indicated that claimant was medically stationary. Accordingly, the claim was not prematurely closed.

We do not disturb the Referee's finding that claimant was entitled to temporary disability benefits from February 6, 1984 through April 30, 1984. Consequently, the Determination Order of February 19, 1985 remains set aside. The January 23, 1985 Determination Order is reinstated in its entirety. SAIF is entitled to offset temporary disability benefits paid from July 23, 1984 to January 23, 1985, less the time claimant was undergoing in-house treatment at the Central Valley Pain Center.

We set aside SAIF's October 7, 1985 denial.

Claimant has the burden of proving by a preponderance of the evidence that her need for medical treatment is related to her compensable injury. Dr. Roby on September 12, 1985 stated that claimant was in need of medical treatment for continuing back problems related to her industrial injury. Moreover, the Pain Center had opined in April 1985 that claimant still had disability related to her original injury. The October 7, 1985 denial of SAIF is based upon Dr. Berrien's August 1985 report in which he concluded that any treatment claimant was receiving was unrelated to her original injury. However, Dr. Berrien had refused to

examine claimant and had not seen her since November 1984. Based on our review of the record, we find that claimant's Emergency Room treatment and treatment with Dr. Roby were related to her industrial injury.

We also find SAIF's refusal to authorize a new treating physician to have been unreasonable.

In the summer of 1985, claimant's attorney sought to obtain a new treating physician for claimant as Dr. Berrien had refused to continue to treat her. SAIF denied the request by letter on October 25, 1985 and in their denial of February 25, 1986. ORS 656.245(1) requires insurer's to provide reasonable medical services without regard to the injured worker's geographic location. Reynaga v. Northwest Farm Bureau, 300 Or 255, 261 (1985). An insurer's power to veto claimant's choice of an out-of-state physician under ORS 656.245(3) is not unlimited. Day v. S & S Pizza Co., 77 Or App 711, 716 (1986).

Dr. Berrien had refused to treat claimant since November of 1984. Claimant and her attorney repeatedly sought authorization to change treating physicians. This request was repeatedly turned down. The February 26, 1986 denial again instructed claimant to return to Dr. Berrien who had refused to see her. We find SAIF's refusal to authorize a new treating physician a denial of medical treatment as provided by ORS 656.245. We further conclude that this denial was unreasonable and that claimant is entitled to a 25 percent penalty assessed against unpaid medical treatment.

In order to establish an aggravation claim, claimant must establish by a preponderance of the evidence that her condition has worsened as a result of her original injury. ORS 656.273. In April 1985 the Executive Director of the Central Valley Pain Center stated that as of November 1984 claimant continued to be disabled. Dr. Roby indicated in November 1985 that, based on x-rays and positive neurological tests performed on September 12, 1985, claimant was in need of curative treatment and was not released to her regular work. In February 1986, Dr. Roby repeated that claimant was not medically stationary nor released for regular work. SAIF issued a denial of the aggravation claim on February 25, 1986, having given "no weight" to the opinion of Dr. Roby. We find that claimant has established an aggravation claim and set aside SAIF's February 25, 1986 denial. Consequently, the claim shall be reopened as of September 12, 1985 and shall be processed until closure under 656.268.

ORDER

The Referee's order dated April 1, 1986 is reversed, affirmed, and modified. That portion of the order that found claimant's claim prematurely closed is reversed. The January 23, 1985 Determination Order is affirmed in its entirety. The SAIF Corporation's October 27, 1985 denial of medical treatment is set aside. For SAIF's refusal to authorize a new treating physician, it is assessed a 25 percent penalty against Dr. Roby's and the Emergency Room's unpaid medical bills as of February 27, 1986. SAIF's February 25, 1986 denial of claimant's aggravation claim is set aside and shall be reopened as of September 12, 1985 and processed through closure under ORS 656.268. SAIF is permitted to off set temporary disability benefits paid between July 22, 1984

and September 12, 1985, less the period claimant was undergoing in-house treatment at the Central Valley Pain Center, against future permanent disability awards.

Claimant's attorney fees are modified. For his services at hearing, claimant's attorney is entitled to $600 for prevailing on the denial of medical treatment and $300 for prevailing on the award of a related penalty. Claimant's attorney is awarded $700 for prevailing on the aggravation claim. For services on Board review concerning the medical treatment and aggravation issues, claimant's attorney is awarded $500 as a reasonable attorney fee to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

JERRY F. FOSTER, Claimant
Malagon & Moore, Claimant's Attorneys
David Horne, Defense Attorney
Cummins, et al., Defense Attorneys

WCB 84-11283 & 84-12837
February 24, 1987
Second Order on Reconsideration

After the Board issued its Order on Reconsideration dated November 18, 1986, Wausau Insurance Companies submitted a request to reopen the record for the receipt of evidence it anticipated would be presented at another hearing in another case involving the same parties. Soon thereafter, claimant requested reconsideration of that portion of the Board's Order on Reconsideration that rejected his request for attorney fees in connection with the responsibility issue. We abated our Order on Reconsideration on December 11, 1986 to allow the parties time to respond to these requests. Subsequently, by letter dated December 23, 1986, claimant withdrew his request for reconsideration. Consequently, only Wausau's request is currently before the Board. The deadlines set by the Board for response to Wausau's request have expired.

We treat Wausau's request as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). We conclude that this case has not been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. See ORS 656.295. Remand, therefore, is denied. After reconsideration, the Board adheres to and republishes its Order on Review dated June 12, 1986 and Order on Reconsideration dated November 18, 1986, effective this date.

IT IS SO ORDERED.

A.G. McCULLOUGH, Claimant
Hayner, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 85-02415
February 24, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Holtan's order which awarded additional temporary total disability. On review, claimant contends that he is entitled to temporary disability benefits until the date his claim was closed by the Evaluation Division. The self-insured employer has moved for dismissal of this matter, contending that the Court of Appeals' subsequent finding that the claim was noncompensable renders the issue raised on this review moot.

In November 1982, while working as a millwright, claimant suffered a heart attack. A December 1983 hearing was held concerning the employer's denial of his claim. However, because of a continuance for additional evidence and argument, the record was not closed until November 1984. On December 7, 1984, a prior Referee found the employer responsible for claimant's heart attack and its sequelae.

On December 21, 1984, the employer asked Dr. Henke, claimant's treating physician, to provide copies of claimant's medical record. On January 24, 1985, the employer advised Dr. Henke that it had been "told [by your office] that [claimant] was considered medically stationary six months from the date of his heart attack." Calculating this "medically stationary" date to be May 23, 1983, the employer asked if the claim could be closed.

On February 5, 1985, Dr. Henke reported that, since the November 1982 heart attack, claimant had experienced several episodes of chest pain which were secondary to his post-myocardial infarction syndrome. Treatment had consisted of medications and periods of hospitalization in March 1983 and August 1983. The medication had eventually been discontinued in April 1984. Since that time, Dr. Henke noted that there had been no recurrence of the syndrome.

On February 20, 1985, the employer requested the issuance of a Determination Order. In its request, the employer noted that it had paid temporary total disability benefits from the November 1982 heart attack until May 23, 1983.

On February 26, 1985, claimant requested a hearing, contending that his temporary total disability benefits had been unlawfully terminated. Since his heart attack, claimant had neither returned to work nor been released to return to his regular work by his treating physician.

On March 1, 1985, the Evaluation Division reported that it was unable to issue a Determination Order based on the provided medical information. The employer was directed to obtain information concerning claimant's permanent impairment, residual physical capacity, and education.

On March 29, 1985, Dr. Henke responded to questions posed by claimant's attorney. After discussing the course of claimant's medical treatment, Dr. Henke concluded that claimant was medically stable on November 9, 1983. On April 3, 1985, in response to the employer's request for additional information, Dr. Henke further described the severity of claimant's condition. In Dr. Henke's opinion, claimant could return to work, but in a modified position that avoided strenuous physical activity.

The matter proceeded to hearing on April 18, 1985. At this time, no Determination Order had been issued. Relying on the Board's decision in Sharon Bracke, 36 Van Natta 1245 (1984), the Referee concluded that the employer was justified in terminating claimant's compensation prior to claim closure. In Bracke, the Board had held that under particular circumstances, within 14 days of a litigation order finding a claim compensable, an employer/insurer should pay time loss benefits until the date that

a claimant returned to work, was released to return to regular work, or was declared (as opposed to being determined under ORS 656.268) to be medically stationary. Finding Dr. Henke's opinion persuasive, the Referee determined that claimant's condition became medically stationary on November 9, 1983. Therefore, claimant was awarded additional temporary disability from May 24, 1983 through November 9, 1983.

Subsequent to the Referee's order, the Board's order in Bracke has been reversed by the Court of Appeals in an opinion which did not specifically address the Board's reasoning concerning this unilateral termination issue. Bracke v. Baza'r, 78 Or App 128 (1986). However, considering the court's subsequent opinion, the Board's decision in Bracke is of dubious precedential value. Richard M. Deskins, 38 Van Natta 494, 497 (1986). Furthermore, the Board's Bracke decision appears to run counter to the reasoning expressed in Volk v. SAIF, 73 Or App 643, 646 (1985). In Volk, SAIF terminated temporary disability benefits before the attending physician had approved a return to regular employment and before the issuance of a Determination Order. Citing ORS 656.268(2) and Scheidemantel v. SAIF, 68 Or App 822, 824-25, modified 70 Or App 552 (1984), the court concluded that SAIF was without authority to terminate claimant's benefits before the issuance of a Determination Order.

The presently relevant portion of ORS 656.268(2) provides that 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 of the medical reports submitted to the Evaluation Division. ORS 656.268(2). If the worker has not actually returned to work, nor been authorized by the worker's attending physician to return to regular employment, compensation shall be paid until a Determination Order has been issued pursuant to ORS 656.268. OAR 436-30-010(7); Volk, supra; Jackson v. SAIF, 7 Or App 109 (1971).

Following our review of this record, we conclude that, while processing this claim, the employer should have continued to pay temporary disability benefits. Once it was found responsible for the claim, the employer initiated procedures which eventually resulted in the claim's closure. Yet, when the employer terminated claimant's compensation, claimant had neither actually returned to work nor had he been released to return to his regular employment by Dr. Henke. Moreover, the employer had not received authorization from the Evaluation Division to discontinue claimant's disability benefits. Thus, under these circumstances, the employer was obligated to pay compensation until the issuance of a Determination Order.

Accordingly, we find that claimant is entitled to temporary disability benefits in addition to the benefits awarded by the Referee. These benefits should run from November 10, 1983 through May 1, 1985, the date of the first Determination Order. Inasmuch as the employer's actions were taken prior to the reversal of the Board's Bracke decision, we do not consider its conduct unreasonable. Consequently, penalties and accompanying attorney fees will not be assessed.

Subsequent to Referee Holtan's order, the Board affirmed

the prior Referee's order which had found the claim compensable. However, the Court of Appeals has reversed the Board's order, Weyerhaeuser Co. v. McCullough, 80 Or App 98 (1986), and claimant's petition for review has been denied by the Supreme Court. Weyerhaeuser Co. v. McCullough, 302 Or 158 (1986).

Based on the court's reversal of the Board's finding of compensability, the employer has requested the dismissal of this matter. The employer contends that the court's decision renders the issue presently before the Board moot. We decline to grant the employer's request.

The noncompensability of the claim has become final by operation of law. However, this determination does not extinguish the issue of whether the employer properly exercised its processing obligations during the period the claim was considered compensable. Were we to grant the employer's motion, our decision could be interpreted as a concurrence with the proposition that it is not always necessary for an insurer/employer to fulfill its statutory obligations. In addition, such a decision could encourage future insurers/employers to forsake their processing obligations, if they understood that their conduct would not be subject to review once the underlying claim was found noncompensable.

Anticipating today's decision, the employer has requested permission to offset the "overpayment" created by this order against claimant's permanent disability award as granted by a post-hearing Determination Order. The request is rejected because the court's ultimate finding of noncompensability has rendered the request meaningless. The court's decision ensures that there will be no future permanent disability payments concerning this claim. Thus, even if we granted the request, there is no longer a permanent disability award against which to offset this so-called "overpayment."

ORDER

The Referee's order dated April 25, 1985 is modified. In addition to the Referee's award of temporary disability, claimant is awarded temporary total disability compensation from November 10, 1983 through May 1, 1985. In lieu of the Referee's attorney fee award, claimant's attorney is awarded 25 percent of the increased compensation created by the Referee's order, as well as this order. However, claimant's total attorney fee award, for services at the hearing and on Board review, shall not exceed $3,000.

BERT E. MILTENBERGER, Claimant
Lindsay, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 86-0564M
February 24, 1987
Own Motion Determination on Reconsideration

On October 27, 1986 we issued an Own Motion Determination, closing claimant's claim for a January 29, 1979 injury. On November 26, 1986 we abated our previous order and requested the SAIF Corporation's response to claimant's contention that we lacked jurisdiction to enter a closure order. If we find we do have jurisdiction, claimant seeks an increased award for permanent partial disability. After reconsideration, we find that we have jurisdiction.

SAIF accepted claimant's injury claim as nondisabling. Claimant continued to work and apparently sought no medical treatment until November 1980. Thereafter, SAIF paid temporary disability compensation, noting that claimant's 1979 nondisabling claim had become disabling. Eventually, a November 17, 1981 Determination Order issued. In addition to temporary disability compensation, claimant received five percent unscheduled permanent disability. The Determination Order stated that claimant's five-year aggravation rights began November 17, 1981. This award was appealed and was subsequently increased to 15 percent by virtue of a February 1982 stipulation.

In August 1985 claimant's condition worsened, prompting the reopening of his claim. The claim was subsequently submitted to the Evaluation Division for closure. Noting the date of claimant's original injury, the Evaluation Division referred the claim to the Board for closure pursuant to ORS 656.278. Thereafter, the Board issued its Own Motion Determination, closing the claim.

Claimant objects to our order, contending that we lacked jurisdiction to consider the matter. He argues that the November 17, 1981 Determination Order granted him five years from the date of the order within which to submit an aggravation claim. Inasmuch as his claim has been reopened within that five year period, claimant contends that he is entitled to claim closure by the Evaluation Division under ORS 656.268.

At the time of claimant's 1979 injury, no statute required closure of a claim for a nondisabling injury. ORS 656.268(3), which requires carrier closure of a nondisabling claim, became effective on January 1, 1980. Or Laws 1979, ch 839 § 4(3) and 33; Webb v. SAIF, 83 Or App 386 (January 28, 1987). In addition, the 1979 version of ORS 656.262(11) (now ORS 656.262(12)) provided that if within one year after the injury, a worker claimed that a nondisabling injury had become disabling, the insurer or self-insured employer should immediately report the claim to the director. However, if the claim that a nondisabling injury had become disabling was made more than one year after the date of injury, the claim was to be treated as an aggravation claim pursuant to ORS 656.273. If the injury was nondisabling and no determination had been made, a claim for aggravation had to be filed within five years after the date of injury. ORS 656.273(4)(b).

The interplay of these statutes was discussed in Davison v. SAIF, 80 Or App 541, opinion modified on recon 82 Or App 546 (1986). In Davison, the claimant lost a small portion of his little finger. SAIF accepted the 1982 injury claim as nondisabling. The claimant did not seek reclassification of the injury from nondisabling to disabling within one year of the injury. See ORS 656.262(12). The claimant later sought reclassification from the Evaluation Division, contending that his claim had never been formally closed either administratively or by Determination Order as required by ORS 656.268(3). SAIF contended that claimant's request for reclassification was untimely because SAIF's previous "Notice of Acceptance" of the claim as nondisabling had simultaneously satisfied the closure requirements of ORS 656.268(3). The Davison court found that the claim had been misclassified from the outset. Thus, ORS 656.262(12) did not apply. The court further concluded that the notice did not comply

with ORS 656.268(3) because it had not informed the claimant that it was a notice of closure. Accordingly, since the claim had not been closed, the court reasoned that the claimant's right to seek a determination order had not yet expired.

Here, unlike Davison, there was no statutory requirement for the closure of a nondisabling injury claim. Moreover, no contention has been raised that claimant's 1979 injury was misclassified from the outset. Thus, unlike the facts present in Davison, the provisions of ORS 656.262(11) (now 656.262(12) and ORS 656.273(4)(b) are directly applicable to this situation.

Claimant's condition resulting from his January 1979 nondisabling injury worsened in November 1980. Concluding that the nondisabling injury had become disabling more than one year from the date of injury, SAIF correctly processed the claim as one for aggravation. Once claimant's condition stabilized, SAIF submitted the claim to the Evaluation Division for closure. Since claimant's injury had been nondisabling and no determination had been made, his aggravation rights were statutorily required to have commenced January 29, 1979, the date of his injury. ORS 656.273(4)(b).

Unfortunately, the November 21, 1981 Determination Order inaccurately stated that claimant's aggravation rights began as of the date of the order. This information was unquestionably misleading. However, a statement on an administrative form cannot modify the express language of controlling statutes. Thus, claimant's five-year aggravation rights, which began on January 29, 1979, had terminated by August 1985, when his condition worsened and SAIF voluntarily reopened his claim. Since claimant's aggravation rights had expired, we had jurisdiction to issue our own motion determination pursuant to ORS 656.278.

With respect to claimant's request for further permanent disability, the Board finds he has been adequately compensated by the prior awards and declines to grant any increase. Accordingly, we adhere to and republish our previous Own Motion Determination, effective this date.

IT IS SO ORDERED.

KARL E. MITCHELL, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Davis, Bostwick, et al., Defense Attorneys

WCB 85-12198 & 86-01597
February 24, 1987
Order Dismissing Cross-Request for Review

On February 10, 1987, claimant filed a cross-request for review of a Referee's December 19, 1986 order. Argonaut Insurance Company had filed its request for Board review on January 16, 1987. Thus, claimant's cross-request was filed more than 30 days after the date of mailing of the Referee's order and more than ten days after Argonaut's request for review. Accordingly, the cross-request is not timely filed. ORS 656.289(3).

ORDER

Claimant's cross-request for review is dismissed as being untimely filed.

ROBERT V. PUCKETT, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-08295
February 24, 1987
Order on Reconsideration

The Board issued its Order on Review in this matter on November 26, 1986. The order has not been appealed. On January 20, 1987, the Board received the self-insured employer's response to claimant's motion for reconsideration. Finding no such motion in the record, comments were requested concerning the question of whether the Board had jurisdiction to reconsider its order. Both parties have responded to this request.

Pursuant to ORS 656.295(8), a Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. The time within which to appeal an order continues to run, unless the order has been abated, stayed, or "republished." International Paper Co. v. Wright, 80 Or App 444 (1986).

Inasmuch as the Board's November 26, 1986 order has neither been appealed, abated, stayed, nor "republished" within the statutory 30-day period, it has become final by operation of law. Consequently, assuming for the sake of argument that claimant's motion was timely filed, the Board lacks jurisdiction to consider the request for reconsideration.

IT IS SO ORDERED.

VICTOR J. SHARROCK, Claimant
Robert Chapman, Claimant's Attorney
Davis, Bostwick, et al., Defense Attorneys
R. Ray Heysell, Defense Attorney
Rankin, VavRosky, et al., Defense Attorneys
Allen Owen, Defense Attorney

WCB 85-04343, 85-08908 & 85-10274
February 24, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Safeco Insurance Comapany requests review of that portion of Referee Brown's order that: (1) set aside its denial of claimant's occupational disease claim for his upper back condition; (2) upheld the SAIF Corporation's denial of his aggravation for the aforementioned condition; and (3) awarded claimant a $2,000 attorney fee. The issues are responsibility and attorney fees.

The Board affirms the Referee' order with the following comment.

Claimant suffered an injury to his left shoulder and arm in 1983 while working for SAIF's insured. The claim was accepted as a disabling injury and closed by a Determination Order that awarded no permanent disability. Claimant subsequently worked for a brief period for Falcon Manufacturing Company, who was insured by Argonaut Insurance Company.

Claimant next worked at Med-Ply (Lang Gangnes Corporation) in 1984. Prior to hearing, the parties stipulated to the periods each was at risk while insuring Med-Ply. Liberty Northwest Insurance Company was the insurer at risk prior to September 30, 1984. Argonaut was at risk after September 30, 1984 until January 1, 1985 and Safeco was the insurer at all times after January 1, 1985.

Claimant began having right shoulder and neck problems in September 1984 while working at Med-Ply. The neck, shoulder and arm conditions were ultimately diagnosed as nerve root compression at the C-7 on the right and surgery was performed in May 1985. Claimant filed a claim for aggravation with SAIF and occupational disease claims with Falcon Manufacturing Company and Med-Ply. Denials were issued by SAIF, Argonaut, in behalf of Falcon Manufacturing, and Safeco. Claimant timely appealed these denials. Immediately prior to hearing Argonaut, in behalf of Falcon Manufacturing, moved that it be dismissed as a party to the claim. Claimant did not object and the dismissal was granted.

At hearing, and on appeal, Argonaut contends that, as the insurer for Med-Ply, a claim was never filed with them nor were they joined as a party. Therefore, Argonaut asserts that they were not a party to the proceedings and the Referee and Board are without jurisdiction to find them responsible for claimant's occupational disease. The Referee concluded that claimant's filing with the employer, Med-Ply, was sufficient for the purposes of filing a claim and that, as a result of this filing, Argonaut was a party. On de novo review, we agree.

In order to file a claim, claimant is only required to provide notice to the employer. ORS 656.265. The employer is required to accept the notice of a claim and, within five days, report that claim to its insurer. OAR 436-60-010(1).

Claimant filed an occupational disease claim with Med-Ply on May 20, 1985. Safeco was the only Med-Ply carrier to issue a denial. We conclude that OAR 436-60-010(1) requires the employer to notify all insurers who are potentially at risk after the filing of a claim. Thus, all the insurers who were potentially at risk became parties after claimant's single filing with Med-Ply. This is consistent with the requirement under ORS 656.265 that a claimant need only notify the employer for purposes of filing a claim. Claimant is not required to determine who the insurers were for the period of his employment. That information is in the hands of the employer and, therefore, the employer must make that determination.

Accordingly, we agree that Argonaut was a party to the proceedings on this claim. However, we also agree that they were not the responsible insurer.

ORDER

The Referee's order dated March 6, 1986, as augmented, is affirmed.

EVERETT E. ROBINSON, Claimant WCB 82-08760
Emmons, et al., Claimant's Attorneys February 25, 1987
SAIF Corp Legal, Defense Attorney Order on Remand

This matter is before the Board on remand, pursuant to the Court of Appeals' February 13, 1987 Order of Dismissal and Remand. The court has remanded this matter to the Board for approval of the parties' disputed claim settlement.

Accordingly, the aforementioned disputed claim settlement is approved, and the request for Board review is dismissed.

IT IS SO ORDERED.

WILMA K. ANGLIN, Claimant
Malagon & Moore, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-00598
February 26, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Seifert's order that rejected claimant's request for penalties and attorney fees in connection with the self-insured employer's unreasonable delay in authorizing surgery and rejected claimant's request for temporary partial disability during the interim between the request for authorization and the performance of the surgery. The issues are aggravation, temporary disability compensation, interim compensation, penalties and attorney fees.

The Board affirms the order of the Referee on the issues of aggravation, temporary disability compensation, interim compensation and penalties with the following comments. Claimant injured her low back in June 1982 in the course of her employment as the produce manager of a grocery store when she slipped in some water on the floor and fell. Claimant initially received conservative treatment and was retrained as a real estate agent. In July 1984, claimant underwent chemonucleolysis at L4-5 and L5-S1. The claim was closed by Determination Order in February 1985 with an award of 35 percent unscheduled permanent partial disability.

During the remainder of 1985, claimant complained of increased back pain. Myelograms in March and June 1985 showed an extradural defect at L4-5. On October 18, 1985, a stipulation was approved whereby claimant received an additional 10 percent unscheduled permanent partial disability for her low back. A request for hearing which had been filed by claimant was dismissed with prejudice. It is unclear from the stipulation or from the record as a whole whether claimant's request for hearing related to a denied aggravation claim or simply to an appeal from the February 1985 Determination Order. In any event, the date upon which the stipulation was approved was the last award or arrangement of compensation within the meaning of ORS 656.273(1).

Two and a half weeks later, in early November 1985, claimant's treating orthopedic surgeon, Dr. Bert, requested authorization to perform a laminectomy at L4-5. Fourteen days after receiving the request for surgery authorization, the adjusting agency for the employer wrote Dr. Bert stating that it was in the process of scheduling an independent medical examination with the Orthopaedic Consultants.

On January 13, 1986, claimant filed a request for hearing alleging, among other issues, aggravation, temporary disability compensation and penalties and attorney fees for the employer's unreasonable refusal, resistance or delay in the payment of compensation and in failing to comply with the administrative rules regulating the processing of requests for surgery authorization. Claimant was examined by a panel of the Orthopaedic Consultants on January 23, 1986. The panel found that claimant was medically stationary and recommended against surgery, stating that home exercises and anti-inflammatory medications were sufficient to maintain claimant's condition adequately to allow her to perform her work as a real estate agent.

In mid-February 1986, Dr. Bert wrote claimant's attorney stating that he had received no reply from the insurer regarding the requested authorization for surgery. He then stated, "I do feel that [claimant] is partially disabled and unable to put in a full days work since November '85." The employer received a copy of this letter on February 25, 1986, when claimant submitted it to the Hearings Division as a proposed exhibit. Authorization for surgery was granted by the employer by telephone on April 9, 1986 and surgery was performed six days later, on April 15, 1986.

At the hearing, which was held in late May 1986, claimant indicated that beginning in November 1985, her field activities as a real estate agent (i.e. showing houses, canvassing for business, etc.) had decreased approximately one-third to one-half and that this had diminished her potential for income. She was paid strictly on a commission basis. Claimant's testimony regarding her allegedly decreased activities was tentative, vague and, at times, contradictory. She testified that well before November 1985 her back pain was hindering her ability to work and that Dr. Bert had suggested surgery several months prior to the last arrangement of compensation. She also testified that during the six months between November 1985 and April 1986 she earned a little over $3,000 in commissions. On cross-examination, claimant indicated that she earned about $6,000 in commissions for all of 1985.

In his Opinion and Order, the Referee ignored the aggravation issue and treated the temporary disability compensation issue as a request for interim compensation only. On the interim compensation issue, the Referee concluded that the employer had never received notice or knowledge of a medically verified inability to work within the meaning of ORS 656.273(6). The Referee concluded, therefore, that no interim compensation was due. On the penalty and attorney fee issues, the Referee found that the employer had unreasonably delayed in processing claimant's request for authorization for surgery, but also found that there was no compensation due during the relevant period and concluded, therefore, that no penalties or attorney fees could be assessed.

On Board review, claimant contends that she is entitled to temporary partial disability compensation regardless of whether she was entitled to interim compensation. Claimant's right to receive temporary disability compensation, of course, was terminated by the Determination Order issued in February 1985 and her continuing partial inability to work was recognized in the awards of permanent partial disability granted by that Determination Order and that the stipulation in October 1985. Claimant's argument, therefore, is that beginning in November 1985, her ability to work decreased beyond the level represented by the permanent partial disability awards, but not to the extent that she was totally disabled. This partial decrease in her ability to work, claimant contends, represented a compensable aggravation of her condition and entitled her to temporary partial disability compensation until the date of her surgery.

In examining claimant's contention that she sustained a compensable aggravation of her low back condition in November 1985, we note that there is no objective medical evidence which indicates that claimant's physical condition changed in the slightest after the last arrangement of compensation on October

18, 1985. The extradural defect at L4-5 upon which Dr. Bert intended to operate was diagnosed after a myelogram in March 1985 and was confirmed after a second myelogram in June 1985. There was no indication in the report by the Orthopaedic Consultants that this condition had worsened in the interim.

Claimant contends that a worsening of her condition is established by the letter from Dr. Bert to claimant's attorney dated February 19, 1986 and also by her own testimony. We disagree. Dr. Bert's letter stated that claimant was partially disabled since November 1985. This is not surprising in light of the fact that by November 1985 claimant had received a total of 45 percent unscheduled permanent partial disability and had been complaining of increased back pain since several months prior to the last arrangement of compensation in October 1985. Dr. Bert's letter did not state or otherwise indicate, however, that claimant was less able to work after the last arrangement of compensation than she was before that event. Dr. Bert's letter, therefore, does not establish a compensable aggravation of claimant's condition. Smith v. SAIF, 302 Or 396, 399 (1986).

As for claimant's testimony, we have already noted that it was tentative, vague and, at times, contradictory. In addition, claimant indicated that her income during the six months between November 1985 and April 1986 was the same as it was for comparable periods prior to the last arrangement of compensation. Although income does not always correlate with level of disability, especially in the case of a commission salesperson, claimant's testimony on this point certainly does not support her contention that she became less able to work after November 1985.

We conclude, therefore, that claimant has failed to prove a compensable aggravation of her low back condition after the last arrangement of compensation and that claimant is not entitled to temporary partial disability compensation between November 1985 and April 1986. In addition, although Dr. Bert's request for authorization for surgery in November 1985 satisfies the definition of a claim for aggravation within the meaning of ORS 656.273(3), neither that request, nor Dr. Bert's letter of February 19, 1986, constituted medical verification of a decreased ability to work after the last arrangement of compensation. Claimant, therefore, is not entitled to interim compensation on her aggravation claim. See ORS 656.273(6); see also ORS 656.212; Bono v. SAIF, 298 Or 405, 409-10 (1984).

This brings us to the issue of penalties. We agree with the Referee's conclusion that the employer acted unreasonably in processing claimant's request for authorization for surgery. We also agree with the Referee's conclusion that there was no compensation due during the relevant period upon which to assess a penalty. Claimant argues that even assuming there was no interim compensation or temporary partial disability compensation due during the relevant period, once she requested authorization for surgery, compensation in the form of medical services was due. She urges the Board to assess a penalty computed on the basis of the cost of her surgery. The Board has already concluded in a number of cases that the costs of medical services are not amounts "then due" within the meaning of ORS 656.262(10) until the services have actually been performed. See e.g., Lester R. Carman, 37 Van Natta 1686, 38 Van Natta 8, 38 Van Natta 44 (1986); Donald O. Otnes, 37 Van Natta 522, 524 (1985). We reaffirm that conclusion in this case.

On the issue of attorney fees, claimant contends that whether there was any compensation due during the relevant period, her attorney is entitled to a reasonable insurer-paid attorney fee under ORS 656.382(1) for causing the Referee to rule that the employer acted unreasonably in processing claimant's request for authorization for surgery. Two recent Court of Appeals decisions support claimant's argument: Spivey v. SAIF, 79 Or App 568, 572 (1986) and Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162, 164 (1986). A slightly older decision supports the opposite conclusion: Miller v. SAIF, 78 Or App 158, 161-62 (1986).

We conclude that we should follow the court's most recent pronouncements and thus hold that claimant's attorney is entitled to an attorney fee. Under the circumstances of this case and in light of the factors enumerated in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we conclude that an appropriate fee is $300.

ORDER

The Referee's order dated June 20, 1986 is affirmed in part and reversed in part. That portion of the order that refused to assess an insurer-paid attorney fee for services at the hearing in causing the Referee to rule that the employer was unreasonable in processing claimant's request for authorization for surgery is reversed. Claimant's attorney is awarded $300 as a reasonable attorney fee, to be paid by the self-insured employer. The remainder of the Referee's order is affirmed.

MICHAEL E. DAVISON, Claimant
W.D. Bates, Jr., Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-09422
February 26, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Davison v. SAIF, 80 Or App 541, opinion modified on recon 82 Or App 546 (1986). The court has remanded this case for closure of the claim.

Accordingly, this claim is remanded to the SAIF Corporation for claim closure under the provisions of ORS 656.268.

IT IS SO ORDERED.

TIMOTHY DUGAN, Claimant
Malagon & Moore, Claimant's Attorneys
Jeff Tyvol (SAIF), Defense Attorney

WCB 86-0662M
February 26, 1987
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his August 20, 1980 industrial injury. His aggravation rights have expired. The SAIF Corporation opposes reopening, contending that claimant's condition has not worsened since the last arrangement of compensation.

This claim was initially closed by a July 15, 1981 Determination Order. The most recent Determination Order issued September 25, 1986. In addition to temporary disability, claimant received 10 percent unscheduled permanent disability for a low back injury. This award gave him unscheduled permanent disability totalling 25 percent. Claimant requested a hearing.

On November 25, 1986, the parties orally agreed to settle the issues raised in claimant's hearing request. Claimant agreed to dismiss his request in return for an additional award of 10 percent unscheduled permanent disability.

On December 3, 1986, claimant's attorney requested own motion relief, contending that his claim should be reopened effective November 11, 1986. Claimant based his request on his treating physician's report that a November 25, 1986 MRI Scan had confirmed the presence of a large herniated disc. Concluding that claimant's compensable condition had worsened, the physician opined that temporary disability benefits should resume as of November 11, 1986.

Despite the reopening request, the parties proceeded with the settlement of claimant's hearing request. A copy of the stipulation present in this record does not indicate that it was signed by claimant. However, claimant's attorney signed the stipulation on December 8, 1986. The stipulation was eventually signed by a Referee on December 18, 1986.

Before addressing the question of whether claimant's condition has worsened, we must determine what date represents the last arrangement of compensation. Is it the date claimant formally agreed to settle his hearing request or is it the date the stipulation was actually entered? To resolve this question we look to a similar situation present when analyzing aggravation claims. We have previously concluded that as between the date of the Referee's order and the date of final opportunity to present evidence, the latter date was the appropriate date from which to establish a worsening. Steven M. Demarco, 38 Van Natta 886, 887 (1986); Joseph R. Klinsky, 35 Van Natta 332, 333-34, aff'd mem. 66 Or App 193 (1983).

Applying the aforementioned analysis to the present case, we conclude that the appropriate date from which to establish a worsening would be the date that claimant signed the stipulation. This date would represent claimant's final opportunity to present evidence concerning his condition. Yet, as noted above, the stipulation in the record does not indicate that it was signed by claimant. Thus, under these circumstances, we find that the appropriate date from which to establish a worsening would be December 8, 1986, the date claimant's attorney signed the stipulation.

Following our review of the record, we are persuaded that claimant's compensable condition has worsened since December 8, 1986, the last arrangement of compensation. The medical evidence suggests that the claim should be reopened effective November 11, 1986. However, inasmuch as claimant received additional permanent disability by virtue of the December 1986 stipulation, he implicitly conceded that his condition was medically stationary during this period. Claimant can not have it both ways. Either he was medically stationary on December 8, 1986, in which case he was not entitled to temporary disability benefits while he also received additional permanent disability; or he was not medically stationary on December 8, 1986, in which case he was entitled to temporary disability benefits, but should not have received additional permanent disability benefits.

Since the stipulation remains in full force and effect, the law of this claim establishes that claimant's condition was

medically stationary on December 8, 1986, the last opportunity for him to present evidence concerning his condition. Thus, because we find that claimant's compensable condition has worsened, the claim shall be reopened effective the following day, December 9, 1986.

Accordingly, we conclude that the claim should be reopened with temporary total disability compensation to commence December 9, 1986 and to continue until closure pursuant to ORS 656.278. As a reasonable attorney's fee, claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $600.

IT IS SO ORDERED.

JOANNE FELLNER, Claimant
Peter O. Hansen, Claimant's Attorney
Norman Cole (SAIF), Defense Attorney

WCB 84-07243, 84-06544, 85-01408 & 85-03160
February 26, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Pferdner's orders that: (1) upheld the insurer's denial of an aggravation claim for her right carpal tunnel condition; (2) upheld the denial of her occupational disease claims for left carpal tunnel and left/right ulnar nerve compression syndrome; (3) upheld the denial of her low back condition; (4) upheld the denial of her psychological condition; and (5) found that she had never filed an occupational disease claim for her bilateral foot condition. The issues are compensability, aggravation and claim filing.

The Board affirms the order of the Referee with the following comment.

Claimant worked for the Don Elton Restaurant from 1976 until December 1980 primarily as a hostess. She also worked at the Cottage Restaurant from April 1981 until October 1981 as a waitress. Both employers were insured by the SAIF Corporation. On May 8, 1984 claimant filed numerous claims against each employer for a variety of conditions. The Referee concluded that claimant had failed to file a claim for her bilateral foot condition, and therefore, concluded the claim was not before him.

Our review of the record reveals that claimant's physician sent a May 8, 1984 report alleging a claim against the Cottage Restaurant for a bilateral foot condition. We find this report sufficient to establish a claim for her foot condition. We note, however, that claimant first reported left foot problems beginning in 1980. Foot problems are again noted in May 1982 and finally diagnosed by Dr. Long as Mortons neuromas in July 1983. Dr. Long testified that his "best guess" was that claimant suffered from Morton neuromas which were related to walking and standing.

Based on our review of the medical and lay evidence, we find that claimant has failed to establish by a preponderance of the evidence that her employment at either restaurant was the major contributing cause of her bilateral foot condition or its worsening. Accordingly, SAIF's denial of that condition is upheld.

ORDER

The Referee's orders dated October 31, 1985, as supplemented, are affirmed.

HOLLISTER L. STARR, Claimant
Philip H. Garrow, Claimant's Attorney
Richard Barber (SAIF), Defense Attorney

WCB 86-00344 & 86-02134
February 26, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of those portions of Referee Podnar's order that upheld the SAIF Corporation's denials of two workers' compensation claims filed by claimant for his low back and rejected claimant's request for interim compensation, penalties and attorney fees for the second claim. The issues are good cause for claimant's failure to request a hearing on the first claim within 60 days, compensability of both claims and interim compensation, penalties and attorney fees on the second claim.

Claimant visited a family practitioner, Dr. Tuft, on September 5, 1985 complaining of pain in his low back which claimant attributed to working on the greenchain for the employer. Dr. Tuft diagnosed a low back strain, recommended that claimant take some time off work and prescribed conservative treatment. Claimant filed an 801 form for this injury on September 9, 1985. SAIF denied the claim two weeks later.

Claimant returned to light work on September 9, 1985 and resumed working on the greenchain the following week. Claimant worked on the greenchain through October 25, 1985, when he experienced a marked increase in back pain and transient neurological symptoms in his legs. Claimant was examined by a neurosurgeon, Dr. Newby, on October 29. Dr. Newby diagnosed a lumbosacral strain, took claimant off work and prescribed conservative treatment. SAIF received a copy of Dr. Newby's report on November 14, 1985.

After retaining legal counsel, claimant requested a hearing on SAIF's first denial on January 8, 1986, more than 60 days after the denial was issued. Two days later, claimant filed a second 801 form with the employer alleging an injury date of October 25, 1985. SAIF denied the second claim on January 29, 1986. Claimant requested a hearing on the denial two weeks later.

At the hearing, claimant testified that when he received SAIF's denial of his first claim, he read it, showed it to some of his family members and a coworker and then threw it away. Claimant stated that he did not consider the denial to be a "big deal" because he was back at work at that time and did not think the denial was worth contesting. Claimant also testified that after he returned to work subsequent to his first injury, he continued to experience low back pain which gradually increased in intensity until he left work near the end of October.

Regarding the second claim, claimant testified that he left work on Friday, October 25, 1985, without telling anyone at work about his increased back pain. His condition did not improve over the weekend and he testified that he called his employer on

Monday, October 28 and spoke to a woman who worked in the dispensary. He told the woman that he would not be coming to work because of his back pain and asked if he should file another 801 form. According to claimant, the woman told him that this was not necessary since he had already filed an 801 for his back the previous month. Claimant testified that he called the woman in the dispensary again after he was examined by Dr. Newby on October 29 and had the same basic conversation with her at that time. The following day, according to claimant, he called the woman a third time and again had the same basic conversation. Claimant stated that he did not work from October 1985 until May 1986.

The woman to whom claimant allegedly spoke on October 28, 29 and 30 also testified. She indicated that she was one of the persons that was normally notified when a worker was injured. She did not state the nature of her position in the dispensary, but did mention that she participated in the orientation of new employes. A later witness, claimant's former supervisor, referred to what appears to be the same woman as "the nurse." In any event, the woman testified that she did not remember any conversation with claimant on or about October 28, 1985 and further testified that she had never refused to provide an 801 form to any employe who requested one.

Claimant's former supervisor testified that he learned of both of claimant's back "injuries" from "the nurse." He was not asked, however, to state the date upon which he learned of claimant's second "injury" and the record indicates that he did not learn of it before October 18, 1985. This conclusion is based upon Exhibit 8, an exhibit included in the record but not admitted by the Referee, apparently on relevancy grounds. We find Exhibit 8 relevant, admit it and consider it in our review of this case. Exhibit 8 is a notice of termination of claimant's employment completed by claimant's former supervisor on November 18, 1985. The reason for the termination is stated as follows: "I assume he quit. He was suppose [sic] to be back to work two weeks ago, and he hasn't called or anything."

The Referee upheld SAIF's first denial on the ground that claimant had failed to request a hearing within 60 days and had not shown good cause for this failure as required by ORS 656.319(1). Claimant's only argument on Board review is that his actions were "not very bright." We affirm the Referee on this issue.

The Referee upheld the second denial on the ground that there was no evidence of a compensable industrial injury or occupational disease after claimant returned to work in September 1985 and also commented that he considered claimant's second claim an attempt to resurrect the denied and untimely appealed first claim. "This," the Referee concluded, "is not an acceptable procedure."

We affirm the Referee's action in upholding SAIF's second denial, but with the following comments. Claimant followed proper statutory procedure in filing his second claim. The issue is whether that claim is compensable. Because the denial of claimant's first back claim was upheld, claimant's first claim is noncompensable. The evidence indicates that when claimant

returned to work after his first injury his back was still symptomatic and that these symptoms gradually increased until claimant left work the second time. Under these circumstances, we conclude that claimant's second claim is one of occupational disease for the worsening of a preexisting noncompensable low back condition. As such, it was claimant's burden to establish a pathological worsening of his preexisting condition. Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979). On our de novo review of the evidence, we find that claimant has failed to carry this burden and hence conclude that claimant's second claim is noncompensable.

On the next issue, the Referee rejected claimant's request for interim compensation on the ground that the employer had received no medical verification that claimant was unable to work due to a compensable industrial injury or occupational disease sustained on or about October 25, 1985. The Referee considered Dr. Newby's October 29, 1985 report "as attaching to the first denied claim." Because of his finding that no interim compensation was due, the Referee also rejected claimant's request for penalties and attorney fees.

In order to be entitled to interim compensation, claimant must prove three elements: (1) a claim; (2) notice or knowledge of the claim by the employer; and (3) the expiration of the fourteen-day time limit of ORS 656.262(4) before SAIF issued its denial. See ORS 656.262(3) & (4). "Claim" is defined in ORS 656.005(7) as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." The pertinent portion of ORS 656.005(8)(a) defines "compensable injury" as "an accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death." This latter definition encompasses occupational diseases as well as accidental injuries. See ORS 656.804; 656.807(5).

On Board review, claimant presents three theories on the interim compensation issue. First, he contends that SAIF should have begun paying interim compensation 14 days after he informed the woman in the dispensary of his inability to work on October 28, 1985. In the alternative, claimant contends that SAIF should have begun paying interim compensation 14 days after it received a copy of Dr. Newby's October 29 report on November 14, 1985. If both of these theories fail, claimant contends that SAIF should have begun paying interim compensation 14 days after the employer received claimant's second 801 form on January 10, 1986. SAIF disputes claimant's first theory by attacking his credibility. It does not address claimant's second theory and concedes the correctness of claimant's third theory.

We reject claimant's first theory. Claimant's testimony that he repeatedly called his employer beginning on October 28, 1985, reported an industrial injury and requested to fill out a second 801 form is not supported by the rest of the record. We conclude that the evidence as a whole preponderates against this portion of claimant's testimony.

We accept claimant's second theory. SAIF received a copy of Dr. Newby's report dated October 29, 1985 on November 14,

1985, as evidenced by SAIF's date stamp. That report indicated that claimant was experiencing low back symptoms as a result of employment activity after he returned to work from his first alleged industrial injury and recommended that he remain off work for two weeks. This satisfies the definition of a "claim" in the second clause of ORS 656.005(7) as supplemented by the definition of a "compensable injury" in ORS 656.005(8)(a). In light of Dr. Newby's reference in the report to employment activity after claimant returned to work from his first alleged injury, the Referee was incorrect in considering the report as "attaching to the first denied claim." Consequently, SAIF should have issued a denial or begun payment of interim compensation within 14 days after it received Dr. Newby's report. SAIF, therefore, shall be required to pay claimant interim compensation for the period from November 14, 1985 through the date of its denial on January 29, 1986.

This leaves the issues of penalties and attorney fees. In light of the unique and confusing circumstances under which claimant's second claim arose, we do not find SAIF's action in failing to begin payment of interim compensation unreasonable until 14 days after claimant filed the second 801 form with the employer on January 10, 1986. We do find SAIF's action unreasonable, however, beginning January 24, 1986 and assess a penalty and attorney fee for unreasonable delay or resistance in the payment of compensation due between that date and January 29, 1986, the date of SAIF's second denial. See ORS 656.262(10); 656.382(1). We conclude that a penalty of 10 percent of this compensation and an attorney fee of $100 is appropriate under the circumstances of this case.

ORDER

The Referee's order dated June 19, 1986 is affirmed in part and reversed in part. Those portions of the order that upheld the SAIF Corporation's denials dated September 23, 1985 and January 29, 1986 are affirmed. Those portions of the order that rejected claimant's request for interim compensation, penalties and attorney fees are reversed. Claimant is awarded interim compensation for the period from November 14, 1985 through January 29, 1986. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $3,000, as a reasonable attorney fee. Claimant is awarded a penalty of 10 percent of the interim compensation due between Janaury 24 and January 29, 1986. Claimant's attorney is awarded an attorney fee of $100 on the penalty issue.

PETER G. VOORHIES, Claimant
Pozzi, et al., Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 82-04559
February 26, 1987
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Voorhies v. Wood, Tatum, Moser, 81 Or App 336 (1986). The court has mandated that claimant be granted a hearing concerning his denied claim. Therefore, this matter is remanded to the Hearings Division to schedule a hearing in accordance with the mandate of the court.

IT IS SO ORDERED.

DARREL P. TARTER, Claimant
Bennett, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 85-0345M
February 26, 1987
Own Motion Order on Reconsideration

Claimant has requested reconsideration of the Board's Own Motion Order dated May 8, 1986 which declined to reopen his claim for a December 9, 1978 industrial injury. In his request, claimant reiterates his contention that the SAIF Corporation initially misclassified his injury claim as nondisabling. Thus, he argues that he is entitled to an award of unscheduled permanent disability as a result of his compensable injury.

Pursuant to ORS 656.278(1), the Board has the continuing power and jurisdiction, upon its own motion, to modify, change, or terminate former findings, orders or awards if in its opinion such action is justified. After additional consideration of this matter, we do not find that the exercise of our own motion authority is justified.

Following our further review, we are not persuaded that the claim was misclassified from the outset. Furthermore, the evidence does not establish that, within one year of his compensable injury, claimant claimed that his nondisabling injury had become disabling. Thus, SAIF was not obligated to process the claim to closure through the Evaluation Division. ORS 656.262(12).

In addition, the record does not establish that claimant's condition attributable to his compensable injury has worsened since the last award or arrangement of compensation. ORS 656.273. Finally, we are not persuaded that the compensable injury has resulted in a permanent loss of claimant's earning capacity. ORS 656.214(5). Accordingly, on reconsideration, we adhere to our prior order, effective this date.

IT IS SO ORDERED.

CHARLES N. CAYWOOD, Claimant
SAIF Corp Legal, Defense Attorney

WCB 84-08583
March 2, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant, pro se, requests review of Referee Neal's amended order that upheld the SAIF Corporation's denial of his aggravation claim for his low back and increased his award of unscheduled permanent partial disability for his low back from 15 percent (48 degrees) to 25 percent (80 degrees). SAIF has moved the Board for orders striking claimant's appellant's and reply briefs for technical violations of the Board's administrative rules. In the alternative, SAIF objects to certain statements made by claimant in his briefs as containing evidence not previously introduced or admitted into the record. We treat claimant's presentation of evidence outside the record as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). The issues are SAIF's motions to strike claimant's briefs, remand, aggravation and extent of disability.

SAIF's motions to strike claimant's briefs are denied. An unrepresented worker is not strictly accountable for failing to follow the Board's administrative rules. OAR 438-05-035.

Claimant's request for remand is also denied. Claimant was represented by an attorney at the hearing. The additional evidence presented in claimant's briefs could have been presented at the hearing with the exercise of due diligence. See Delfina P. Lopez, 37 Van Natta 164, 170 (1985). This additional evidence has not been considered by the Board on review. On the merits, the Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated May 14, 1986, as amended by the order dated May 23, 1986, is affirmed.

GLEN L. EDENS, Claimant
Francesconi & Cash, Claimant's Attorneys
Richard Barber, Jr., Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 84-07667, 82-09893, 82-09894 & 84-10890
March 2, 1987
Order Denying Motion to Dismiss

Fremont Indemnity Company has moved the Board for an order dismissing the SAIF Corporation's request for Board review on the ground that neither it, its insured, nor its attorney were served with a copy of SAIF's request for Board review within the time provided by law. ORS 656.289(3); 656.295(2).

The Referee's order issued December 23, 1986. SAIF's request for Board review was mailed January 19, 1987 and received by the Board January 20, 1987. Neither Fremont nor its attorneys were served a copy of SAIF's request. However, on January 22, 1987 Fremont's attorneys received a computer generated letter acknowledging the request for review.

In Argonaut Insurance v. King, 63 Or App 847, 852 (1983), the court stated, "We hold that compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." (Emphasis added.) The "actual notice" referred to by the court in King was the Board's computer generated acknowledgement letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed.

Here, the Board's acknowledgement letter was received by Fremont's attorneys before the 30-day statutory period had expired. In the absence of prejudice to a party, timely service of a request for review on the attorney for a party, rather than the party, is sufficient compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra; Nollen v. SAIF, 23 Or App 420, 423 (1975) rev den (1976); Karen J. Bates, 38 Van Natta 964 (1986). Fremont does not contend that it was prejudiced by the manner in which it received notice of the request for Board review. Accordingly, the motion to dismiss is denied.

IT IS SO ORDERED.

THOMAS E. WOODWARD, Claimant
Malagon & Moore, Claimant's Attorneys
Pamela Schultz (SAIF), Defense Attorney

WCB 84-08962
March 2, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Woodward v. C & B Logging, 82 Or App 274 (1986). The court reversed that portion of the Board's order which had held that the parties' June 1979 stipulated determination order was the first award of compensation. Consequently, the court concluded that the claim was not properly closed until the issuance of a July 17, 1984 Determination Order. However, the court agreed with the Board that claimant's award of compensation was appropriate.

The court has remanded this matter to the Board for further proceedings not inconsistent with its opinion. Accordingly, consistent with the court's mandate, the parties are advised that the date commencing the running of the five-year period for aggravation claims is July 17, 1984.

IT IS SO ORDERED.

DALE A. HELVIE, Claimant
Olson Law Firm, Claimant's Attorneys
Roger L. Kromer, Attorney
Lester Huntsinger (SAIF), Defense Attorney
Carl M. Davis, Ass't. Attorney General

WCB 86-06428
March 4, 1987
Order of Dismissal

The insurer has requested review of the Referee's order dated January 26, 1987. The request for review was filed with the Board on February 27, 1987, more than 30 days after the date of the Referee's order. It is not timely filed.

ORDER

The insurer's request for review is hereby dismissed as being untimely filed.

JANET K. JACKSON, Claimant
Pozzi, et al., Claimant's Attorneys
Gretchen Wolfe (SAIF), Defense Attorney

WCB 85-03945
March 4, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee William Peterson's order that: (1) set aside its denial of claimant's aggravation claim for her low back condition; (2) assessed a 25 percent penalty and a $1,000 attorney fee for failing to comply with discovery rules; (3) assessed a 15 percent penalty not to exceed $500 of temporary total disability from March 25, 1985 to April 17, 1986 for SAIF's late denial of the aggravation claim and a related $200 attorney fee; and (4) awarded a $1,600 attorney fee for prevailing on the denial of the aggravation claim. The issues are aggravation, penalties and attorney fees.

The Board affirms that portion of the order that set aside the denial of claimant's aggravation claim and awarded a $1,600 attorney fee.

We reverse that portion of the Referee's order which assessed a penalty and accompanying attorney fee for a late denial.

SAIF received notice of the aggravation claim on November 26, 1984 and began the payment of interim compensation within 14 days as required by ORS 656.262(4). Subsequently, SAIF denied the aggravation claim on March 25, 1985 and stopped the payment of interim compensation. Despite the payment of interim compensation until the March 25, 1985 denial, the Referee concluded that SAIF was subject to a penalty for not denying the claim within 60 days as required by ORS 656.262(6). We disagree.

A penalty for a late denial can only be assessed "...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." ORS 656.262(10); EBI Companies v. Thomas, 66 Or App 105 (1983). Since claimant was paid interim compensation until the time of the denial of the aggravation claim, there were no amounts then due upon which to base the award of a penalty. See Kenneth L. Booras, 37 Van Natta 958 (1985). Consequently, SAIF did not unreasonably resist the payment of compensation and there is no basis for the award of an attorney fee. See Miller v. SAIF, 78 Or App 158 (1986). The Referee's award of a penalty and attorney fee for the late denial is reversed.

We next consider SAIF's failure to comply with discovery rules.

On May 7, 1985 claimant requested documentary evidence from SAIF pursuant to OAR 437-07-015(2). SAIF failed to respond to the request and in August of 1985 Referee Daughtry issued an order requiring SAIF to produce the documents within ten days. The order also provided that a penalty and attorney fee be assessed when the case was decided at the Hearings Division. SAIF did not comply with the order and on December 3, 1985 Referee Daughtry issued an Order to Show Cause requiring SAIF to explain why they had not complied with his prior order. SAIF again did not respond and on December 31, 1985 Referee Daughtry ordered that at a maximum penalty and $1,000 attorney fee be assessed at the time a final order was issued.

On de novo review of the record, we agree with the Referee that SAIF unreasonably failed to comply with Referee Daughtry's orders and discovery rules. Consequently, we affirm the Referee's award of a 25 percent penalty assessed against the temporary total disability due from March 25, 1985 to April 17, 1986, the date of the hearing, and the $1,000 attorney fee. See Morgan v. Stinson Lumber Co., 288 Or 595 (1980); Katie C. Holmes, 37 Van Natta 1134 (1985).

Further, we find the aggravation issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated June 5, 1986 is affirmed in part and reversed in part. That portion of the Referee's order that awarded a penalty and attorney fee for SAIF's untimely denial is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $500 for services on Board review concerning the aggravation issue, to be paid by the SAIF Corporation.

ARCHIE F. KEPHART, Claimant
Malagon & Moore, Claimant's Attorneys
Cheney & Kelley, Defense Attorneys

WCB 81-0173M
February 9, 1987
Order of Abatement

The Board has received claimant's motion to reconsider our Own Motion Order on Remand dated January 14, 1987. Claimant contends that he is entitled to an increased award of attorney fees, which should be paid by the self-insured employer and not out of claimant's compensation.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and the employer is requested to file a response to the motion within 20 days from the date hereof. OAR 438-12-005; Edward Hines Lumber Co. v. Kephart, 81 Or App 43 (1986).

IT IS SO ORDERED.

ARCHIE F. KEPHART, Claimant
Malagon & Moore, Claimant's Attorneys
Cheney & Kelley, Defense Attorneys

Own Motion 81-0173M
March 4, 1987
Own Motion Order on Remand on Reconsideration

On January 14, 1987, we issued an Own Motion Order on Remand, which adhered to our August 6, 1985 order. Pursuant to our order, claimant was granted permanent total disability and his attorney was awarded 25 percent of the additional compensation, not to exceed $1,000. Claimant requested reconsideration, contending that he was entitled to an increased award of attorney fees, which should be paid by the self-insured employer. On February 9, 1987, we abated our order and asked the employer to respond to claimant's motion.

Responding to our request, the employer notes that it has appealed our Order on Remand. The mailing date of its appeal was February 9, 1987. Inasmuch as our order had been abated when the employer initiated its appeal, jurisdiction over this matter remains with the Board. See International Paper Co. v. Wright, 80 Or App 444 (1986).

Following further consideration, we conclude that claimant is entitled to an increased award of attorney fees. The amount of a reasonable attorney fee is based on the efforts of the attorney and the results obtained. OAR 438-47-010(2). To assist us in determining the amount of the attorney fee, we generally consider the factors listed in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Considering the aforementioned rules and factors as each pertains to the circumstances of this case, we conclude that $2,000 is a reasonable award for claimant's attorney's services. This award shall be payable out of claimant's increased award of compensation. OAR 438-47-070.

Accordingly, our prior order is withdrawn. On reconsideration, we again adhere to and republish our August 6, 1985 order, except that claimant's reasonable attorney fee award is modified. In lieu of the prior maximum award of $1,000, claimant's attorney is awarded 25 percent of the increased compensation granted by this order, not to exceed $2,000.

IT IS SO ORDERED.

LAWRENCE N. SULLIVAN, Claimant
Malagon & Moore, Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 84-09511
March 4, 1987
Order on Review

Reviewed by Board Members en banc.

The insurer requests review of those portions of Referee Nichols' order that: (1) set aside its denial of claimant's psychological condition; (2) set aside its denial of treatment for claimant's alcohol abuse; (3) set aside the Determination Order of March 14, 1985 as premature; (4) refused to rate the extent of disability for claimant's right shoulder and low back conditions; (5) ordered further vocational assistance without any requirement that claimant first obtain treatment for his alcohol abuse; (6) refused to grant an offset in the amount requested by the insurer; (7) awarded a penalty and attorney fee for failure to pay an award of permanent partial disability granted in the Determination Order of March 14, 1985; and (8) awarded claimant's attorney a fee of $1,800 for prevailing on all of the above issues. The issues are res judicata, the compensability of claimant's psychological condition and treatment for alcohol abuse, premature closure, extent of disability, vocational assistance, offset, penalties and attorney fees.

Before sustaining his industrial injury in September 1980, claimant experienced a number of medical problems which have some relevance to the issues presented in this case. Claimant injured his left knee in a nonindustrial accident in May 1978. An immobilizing brace was prescribed. A short time later, blood clots developed in the leg and claimant underwent surgery for the removal of these clots. Claimant then underwent surgery to his left knee in June 1978 which included repair of a torn anterior cruciate ligament.

In early 1980, claimant underwent vascular surgery on his neck in an effort to alleviate headaches and other problems which he had been experiencing for a number of years. The surgery was relatively successful in relieving his headaches. Claimant also suffered from hypertension and began taking medication for this condition a few months prior to his industrial injury.

Claimant reinjured his left knee and also injured his right shoulder and low back in an industrial accident in September 1980 when he slipped and fell backwards onto the bed of a flatbed truck. After several weeks of conservative treatment by an internist, Dr. Ortiz, claimant began treating with an orthopedist, Dr. Corbett, for his left knee and with another internist, Dr. Brandt, for his right shoulder and low back.

After examining claimant's left knee, Dr. Corbett diagnosed a torn medial meniscus which was surgically removed in December 1980. Claimant recovered uneventfully after the surgery and Dr. Corbett declared the condition medically stationary in March 1981. He noted at that time that claimant's right shoulder and "neck" were still being treated by Dr. Brandt. The claim was closed by Determination Order dated April 28, 1981 with a 15 percent scheduled award for claimant's left knee.

Ten days before the issuance of the Determination Order, claimant's wife checked him into the alcohol treatment unit of a local hospital. She told the admitting nurse that claimant had been drinking heavily since having knee surgery one and a half

years earlier. This statement appears to be a reference to claimant's noncompensable knee surgery which had been performed nearly three years previously rather than the compensable knee surgery which had been performed less than five months previously. After admission to the facility, claimant told the examining physician that he had experienced periodic problems with alcohol for the previous 25 years and that these problems had intensified recently. Claimant stated that he drank to alleviate the pain in his left knee and low back and indicated that he was severely depressed. The alcohol treatment reports also mention unspecified family and financial problems. Claimant left the alcohol treatment unit against the advice of the medical staff after only six days in the facility.

During the next six months, claimant continued to complain periodically of left knee, low back and right shoulder and arm pain. In July 1981, the insurer issued a partial denial relating to claimant's low back condition. Claimant requested a hearing on this denial and also on the April 1981 Determination Order.

In October 1981, claimant checked himself back into the alcohol treatment unit of the hospital. He was intoxicated on admission and, after sobering up, left the facility after only three days. Depression was noted by the examining physician.

In April 1982, claimant's request for hearing concerning the April 1981 Determination Order and the partial denial of his low back condition was convened before Referee Danner. Claimant contended that the April 1981 Determination Order was premature, that the insurer's partial denial should be set aside, and that the Referee should proceed to rate the extent of claimant's disability. (Claimant orally contended at the beginning of the hearing that all of his compensable conditions had become medically stationary in the interim between the April 1981 Determination Order and the hearing.) Referee Danner found claimant's low back condition compensable and set aside the insurer's partial denial. The Referee also found that claimant's back condition had not been medically stationary at the time of the April 1981 Determination Order and set aside the Determination Order as premature. The Referee refused to address the issue of extent of disability, but indicated that the claim could be submitted immediately to the Evaluation Division for closure.

In June 1982, claimant began receiving vocational assistance through the Vocational Rehabilitation Division (VRD). Real estate sales, insurance adjusting and barbering were examined as possible vocational alternatives, but claimant did not think he was capable of performing these jobs.

In September 1982, claimant underwent surgery on his right shoulder at the acromioclavicular joint. The distal end of the clavicle showed signs of degeneration and a small portion of this degenerative tissue was removed. The operation alleviated most of claimant's right shoulder complaints. The surgery was performed by Dr. Samsell, an orthopedic surgeon, who also provided follow-up care for claimant's right shoulder through February 16, 1983. The insurer issued a partial denial relating to claimant's right shoulder condition on October 29, 1982.

In January 1983, claimant was examined by a psychiatrist, Dr. Colbach. At the time of the examination,

claimant's primary physical complaints related to his left knee and low back. In his report of this examination, Dr. Colbach noted that claimant overfocused on his physical problems and also noted signs of depression and a history of excessive alcohol consumption. His diagnoses were alcohol abuse, psychogenic pain disorder and dysthymic disorder. He thought that these conditions had been caused or materially worsened by claimant's September 1980 industrial accident and recommended treatment, especially for claimant's depression. The report was addressed to the insurer's attorney and copies of the report were sent to the insurer and to Dr. Samsell, claimant's treating orthopedist. From a date stamp which we conclude to be that of claimant's then current attorney, claimant's attorney received a copy of this report on March 2, 1983.

In April 1983, VRD closed claimant's vocational file. The reason for the closure was given as claimant's refusal of treatment for his alcohol problem which, according to the counselor assigned to claimant's case, made further vocational progress impossible. In later correspondence, VRD made it clear that this was not a final termination of vocational assistance and that claimant's file would be reopened once he had successfully completed alcohol treatment.

In August 1983, claimant was examined again by Dr. Samsell, the orthopedic surgeon who had performed his right shoulder surgery. Dr. Samsell concluded that claimant's left knee condition was medically stationary and rated his impairment at 15 percent. He also concluded that claimant's low back condition was medically stationary and rated the impairment for this condition at zero. In passing, Dr. Samsell noted claimant's right shoulder as a source of ongoing discomfort, but he made no comment on the medical status of the condition and gave no impairment rating. Claimant's knee and low back conditions were closed by Determination Order dated August 26, 1983 with an award of temporary total disability benefits from the date of the injury through the date of Dr. Samsell's report of August 5, 1983 and with a 15 percent scheduled award for claimant's left knee. No award was given for claimant's low back.

In September 1983, Referee Danner's April 1982 Opinion and Order was reviewed by the Board. In an order dated September 28, 1983, the Board upheld that portion of Referee Danner's order that set aside the insurer's partial denial of claimant's low back condition. The Board concluded, however, that claimant had failed to prove that his back condition was not medically stationary at the time of the April 1981 Determination Order and reversed that portion of the Referee's order that set aside the Determination Order as premature. The Board remanded the case to the Referee for a determination of the extent of permanent partial disability for claimant's left knee and low back conditions. The Board's order was later affirmed by the Court of Appeals. Sullivan v. Argonaut Insurance Co., 73 Or App 694 (1985).

On October 6, 1983, claimant drank heavily and then attempted suicide with medication. He was hospitalized from October 6 through October 13, 1983 and then began treatment with Dr. Johnson, a psychiatrist. The insurer issued a denial on November 23, 1983, which stated in pertinent part:

> "On November 4, 1983, your attorney made a claim of aggravation in connection with your

hospitalization October 6, 1983 for probable acute Amitriptyline overdose, complicated by ETOH ingestion. It is the opinion of [the insurer that] this condition and subsequent treatment of same is not attributable to the industrial injury you sustained on September 18, 1980."

In two letters dated in early 1984, Dr. Johnson indicated that claimant's depression and related suicide attempt were compensably related to his industrial injury and that claimant's condition was disabling. After the first of these letters, claimant was examined by another psychiatrist, Dr. Stolzberg, in January 1984. Dr. Stolzberg diagnosed claimant's condition as "adjustment disorder . . . with mixed emotional features and alcohol abuse." She indicated that claimant's October 1983 suicide attempt was a manifestation of preexisting personality and alcohol problems as aggravated by concern over financial and personal difficulties. She further indicated that claimant's 1980 industrial accident had played no material causative role in the development or deterioration of claimant's psychological condition.

In March 1984, the partial denials relating to claimant's right shoulder condition and his suicide attempt came to hearing before Referee Menashe. In an Opinion and Order issued on October 1, 1984, Referee Menashe set aside the right shoulder denial and upheld the denial of the suicide attempt and related treatment. At the end of his opinion, Referee Menashe stated:

"Psychiatric treatment by Dr. Johnson after the suicide attempt and hospital release may or may not be compensable. Upon review, I conclude the employer probably did not have that treatment in mind when it denied the suicide attempt. During the hearing, references concerning the psychiatric condition after the hospitalization came in tangentially to the suicide attempt issue. Rather than attempt to decide this complex medical question on less than a full record and under circumstances where the parties may not have understood it to be an issue, I conclude compensability of the post suicide attempt psychiatric condition remains unresolved. I make no finding whether a claim has been presented heretofore. In determining not to decide the compensability of the psychiatric condition because of the nature of this record, I am aware that additional issues are pending between the parties and in all likelihood another hearing will be necessary."

In June 1984, claimant's vocational rehabilitation file was reopened and claimant agreed to undergo alcohol evaluation. After conducting the evaluation, the alcohol counselor concluded that claimant was in "the late crucial to early chronic phase of chemical dependency" and recommended alcohol treatment. Claimant indicated that he would accept treatment at the alcohol unit of

the local hospital, but only if the insurer would pay for the treatment. The insurer issued an alcohol treatment denial on September 4, 1984. In an effort to ameliorate this situation, claimant's vocational counselor contacted a nearby Veteran's Administration Hospital and inquired whether he could be treated there. The counselor learned that claimant could receive treatment at no cost to him and informed claimant of this prospect. Claimant, however, refused to accept treatment at any facility other than the one that he had chosen. After this refusal by claimant, the vocational counselor closed his file until such time as claimant obtained alcohol treatment.

In December 1984, claimant's treating psychiatrist, Dr. Johnson, stated in a letter to claimant's attorney that claimant's depression was disabling. He also stated that claimant's abuse of alcohol was related to this depression and indicated that both claimant's depression and his abuse of alcohol were causally related to the industrial injury. Claimant's attorney sent a copy of this letter to the insurer. The insurer issued an aggravation denial on January 17, 1985. Claimant requested a hearing on this denial.

Late in January 1985, claimant was again examined by Dr. Samsell. Dr. Samsell concluded that claimant's shoulder condition was medically stationary and rated his impairment in the minimal range. When asked in later correspondence whether claimant's shoulder condition had been medically stationary on February 16, 1983, the date on which Dr. Samsell had discontinued follow-up care after claimant's shoulder surgery, Dr. Samsell replied in the affirmative. The claim was closed by Determination Order dated March 14, 1985. The Determination Order awarded no additional temporary disability compensation and 15 percent unscheduled permanent partial disability for claimant's right shoulder. Authorization to offset overpaid temporary disability compensation, if any, against the permanent disability award for the shoulder was granted. The insurer issued no payment to claimant in connection with the 15 percent unscheduled award. Claimant requested a hearing on this Determination Order and also requested penalties and attorney fees for the insurer's failure to issue payment of the 15 percent award granted by the Determination Order.

On April 2, 1985, claimant's treating psychiatrist, Dr. Johnson, wrote the insurer stating again that claimant's depression was causally related to his industrial injury, that the condition was not medically stationary and that the condition was totally disabling. This report was countered by another report from Dr. Klein (formerly Stolzberg), who indicated that claimant's psychological problems were related to financial problems and anxiety over the outcome of unresolved workers' compensation litigation.

By letter dated June 6, 1985, the insurer informed claimant that the permanent disability awarded for his right shoulder by the March 1985 Determination Order had been credited to a temporary disability compensation overpayment of more than $27,000, leaving a balance of more than $23,500 in overpaid temporary total disability.

The present case came to hearing before Referee Nichols on July 3, 1985. Claimant and his wife were the only witnesses at

the hearing. They testified that claimant's emotional state had deteriorated after his industrial injury and that his consumption of alcohol had increased. Claimant said he really "started hittin' [the bottle]" in 1981 or 1982. During the testimony of claimant's wife, it came out that she had filed for divorce some time between 1978 and the 1980 industrial accident and that abuse of alcohol was one reason for her action. The divorce proceedings were later dropped. The Referee made no express credibility findings, but stated that she had the impression that the witnesses were presenting their testimony in a light most favorable to themselves.

With regard to claimant's psychological condition, the insurer first argues that claimant's claim was barred by res judicata. It contends that the condition was ripe for adjudication at the time that claimant's suicide attempt was adjudicated before Referee Menashe in March 1984 and that claimant's present claim for the condition is barred because claimant failed to raise the issue at the time of the previous litigation.

Res judicata bars adjudication of any issue raised or raisable at the time of a previous adjudication if the issue is part of the same cause of action as the issues previously adjudicated. Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). To be raisable, an issue must have ripened to the extent that it could be adjudicated. In the case of claimant's psychological condition, this means that (1) the condition must have been diagnosed or otherwise recognized, (2) a claim for the condition must have been made against the insurer and (3) the insurer must have denied the claim or the 60 days for acceptance or denial must have passed. See Syphers v. K-W Logging, Inc., 51 Or App 769, 771, rev den 291 Or 151 (1981).

Claimant's psychological condition was recognized and diagnosed by Dr. Colbach in January 1983, 14 months prior to the hearing before Referee Menashe. The condition, apart from the suicide attempt and related treatment, was not formally denied until January 17, 1985, nearly a year after the hearing. The crucial questions, therefore, are (1) whether a claim for the psychological condition was made prior to the hearing before Referee Menashe and, if so, (2) whether more than 60 days passed between the date of the claim and the date of the hearing. If both of these questions are answered in the affirmative, claimant's psychological condition was ripe for adjudication at the time of the hearing before Referee Menashe.

We note initially that Referee Menashe expressly stated that he was not deciding any issue in connection with claimant's psychological condition beyond the suicide attempt and related treatment and further stated that he was not deciding whether claimant had made a claim for his psychological condition. Referee Menashe's statements show that he recognized the compensability of claimant's psychological condition as a potential issue. His statements, however, do not indicate that the parties had agreed to reserve claimant's psychological condition for later litigation and, by the same token, do not answer the question of whether claimant had presented a claim for this condition prior to that time.

"Claim" is defined in ORS 656.005(7) as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." Dr. Colbach's report of January 1983 diagnosed alcohol abuse, psychogenic pain disorder and dysthymic disorder (depression) and attributed all three conditions to claimant's industrial injury. We conclude that this report constituted a claim for claimant's psychological condition and also for the related alcohol abuse within the meaning of the above-quoted definition. See Marlene W. Ritchie, 37 Van Natta 1088, 1095-96 (1985); Billy Eubanks, 35 Van Natta 131, 131-32 (1983). This claim was made more than a year prior to the hearing before Referee Menashe and hence was effectively in denied status prior to that hearing. See ORS 656.262(6); Joyce A. Morgan, 36 Van Natta 114, 117-18, aff'd mem., 70 Or App 616 (1984). We conclude, therefore, that claimant's psychological and alcohol problems were ripe for adjudication at the time of the Menashe hearing.

The next question is whether claimant's claim for his psychological and alcohol problems was part of the same "cause of action" as the claim relating to his suicide attempt. A cause of action is an aggregate of operative facts which compose a single occasion for judicial relief. Carr v. Allied Plating Co., supra 81 Or App at 310. The number of operative facts that should be viewed as included within a single cause of action must be determined primarily on the basis of practical considerations of trial convenience and judicial economy. See Dean v. Exotic Veneers, Inc., 271 Or 188, 192-93 (1975); Carr v. Allied Plating Co., supra, 81 Or App at 310. To conserve the limited judicial resources of the Hearings Division and to encourage the speedy resolution of disputes, the Board has long expressed the policy that an unnecessary multiplicity of hearings should be avoided. See Elfreta Puckett, 8 Van Natta 158 (1972).

Good arguments can be presented on both sides of the question of whether claimant's psychological condition, alcohol problems and suicide attempt constitute a single cause of action. On the one hand, it can be argued that the suicide attempt involved a specific set of facts in a limited time frame and that the legal test for the compensability of a suicide attempt is somewhat different than that for the compensability of psychological or alcohol problems generally. See ORS 656.156(1); Jones v. Cascade Wood Products, 21 Or App 86, 88-89, rev den (1975). On the other hand, it can be argued that in order to have proven the compensability of his suicide attempt, it was necessary for claimant to present evidence indicating the compensability of the psychological condition and alcohol problems which precipitated the suicide attempt. See McGill v. SAIF, 81 Or App 210, 214-15, rev den 302 Or 461 (1986).

After our de novo review of the record, we conclude that claimant's suicide attempt and his alcohol problems were facets of his broader psychological condition and that all three constitute a single cause of action. The presentation of evidence bearing on the compensability of claimant's psychological condition and related abuse of alcohol was a natural part of his claim for the suicide attempt. Such evidence was in fact introduced before Referee Menashe. The same psychological condition (depression) diagnosed by Dr. Colbach prior to the Menashe hearing was

identified by Dr. Johnson as the source of claimant's suicide attempt. Claimant's abuse of alcohol, which also had been diagnosed by Dr. Colbach, was identified in Referee Menashe's opinion as a significant factor in claimant's suicide attempt. All three issues, therefore, were inextricably intertwined and presentation of evidence on one issue virtually necessitated presentation of evidence on the others.

In the hearing before Referee Nichols, the claims presented for claimant's psychological condition and abuse of alcohol were based upon events which occurred prior to the 1983 suicide attempt and the 1984 hearing before Referee Menashe. Claimant and his wife testified that claimant's psychological and alcohol problems developed in 1981 or 1982. No evidence was presented to indicate that the psychological or alcohol problems claimed after the 1984 hearing were in any way different from the problems identified by Dr. Colbach in 1983.

For all these reasons, we conclude that claimant's psychological condition, his alcohol problems and his suicide attempt constituted a single cause of action and that an opportunity for judicial relief was afforded for this cause of action in the hearing before Referee Menashe. Relitigation of this cause of action before Referee Nichols was precluded by res judicata. It follows that the insurer's denials of claimant's psychological and alcohol problems must be upheld. Further, even assuming that res judicata does not apply in this case, we conclude that the evidence recited earlier does not preponderate in favor of the conclusion that claimant's psychological and alcohol problems are compensably related to his industrial injuries.

Given the Referee's conclusion that claimant's psychological condition and the related alcohol abuse were compensably related to claimant's industrial injury and were not medically stationary at the time of the issuance of the March 1985 Determination Order, the Referee set aside the Determination Order as premature. Because the Board has reversed the Referee on the issues of claimant's psychological condition and related alcohol abuse and because there is no dispute that claimant's physical conditions were medically stationary at the time of the March 1985 Determination Order, we reverse the Referee on the premature closure issue and reinstate the March 1985 Determination Order.

Given this result, the Board next proceeds to rate the extent of disability for claimant's compensable low back and right shoulder conditions. The record is sufficiently developed for us to address these issues. The insurer requests that the Board affirm the April 1981 Determination Order that awarded no permanent partial disability for claimant's low back and that the Board reduce the unscheduled award of 15 percent (48 degrees) granted by the March 1985 Determination Order for claimant's right shoulder. The award granted by the April 1981 Determination Order for claimant's left knee was affirmed by Referee Nichols and the issue has not been appealed by either the insurer or the claimant.

With regard to claimant's low back, there is no objective medical evidence of any permanent impairment. Claimant testified briefly of some pain in his low back, but also testified that this pain did not restrict his ability to bend or lift in any significant fashion. Claimant's testimony does not convince us

that the injury to his back resulted in any permanent impairment. We conclude, therefore, that claimant is entitled to no award of permanent partial disability for his low back.

With regard to claimant's right shoulder, the evidence does reflect some level of permanent impairment. Claimant, therefore, is entitled to an unscheduled award for his shoulder. In rating the extent of claimant's unscheduled permanent partial disability for his right shoulder, we consider his physical impairment as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

Claimant is 48 years old, is of average intelligence and has a tenth grade education and a GED. He also received training as a barber. His work experience is in the areas of road and building construction and barbering.

Following our de novo review of the medical and lay evidence, we conclude that claimant's right shoulder impairment is in the minimal range. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of 48 degrees for 15 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the industrial injury to his right shoulder. We, therefore, affirm the award granted by the Determination Order of March 14, 1985.

Proceeding to the next issue, vocational assistance was discontinued until such time as claimant obtained alcohol treatment. The basis for the discontinuation of assistance was former OAR 436-61-121(1) & (2) (since amended and renumbered OAR 436-120-090(12)). Those subsections provided:

> "(1) Vocational assistance to a worker with physical, psychological, personal or family problems which would materially interfere with the worker's participation in services or return to work shall be appropriately limited. . . .
>
> "(2) Vocational assistance to a worker shall not be provided if it would not resolve the worker's lack of suitable employment."

The Referee concluded that the suspension of vocational assistance until claimant obtained alcohol treatment was "an abuse of discretion" given the evidence contained in the record. We disagree. Claimant's chronic alcohol problems have been thoroughly evaluated and documented and provide a reasonable basis for the conclusion that vocational rehabilitation efforts will not be effective until professional treatment is provided for these problems. We thus reverse the Referee on this issue.

The next issues concern an offset claimed by the insurer which included temporary disability compensation paid pursuant to Referee Danner's April 1982 Opinion and Order prior to the time

that the relevant portion of that order was reversed by the Board in September 1983. We agree with the Referee that the insurer is not entitled to offset this compensation against the permanent disability compensation later awarded by the March 1985 Determination Order. See ORS 656.313(2); Hutchinson v. Louisiana-Pacific Corp., 67 Or App 577, 581, rev den 297 Or 340 (1984). We also agree with the Referee's conclusion that the insurer's failure to pay the permanent partial disability awarded by the March 1985 Determination Order on account of this asserted offset was unreasonable and affirm the penalty and associated attorney fee assessed by the Referee.

The final issue, the amount of attorney fees awarded by Referee Nichols in connection with the insurer's denials of the psychological and alcohol problems and the premature closure and vocational assistance issues is moot in light of the Board's disposition of those issues. Claimant's attorney is entitled to a reasonable fee on Board review, however, in connection with the issue of the extent of claimant's right shoulder disability. The insurer requested a reduction in the right shoulder award and the Board affirmed the award. See ORS 656.382(2); Shoulders v. SAIF, 300 Or 606, 609-10 (1986). Claimant's attorney is not entitled to a fee either at the hearing or the Board levels, other than the one assessed pursuant to ORS 656.262(10), for prevailing on the offset issue. See ORS 656.382(1) & (2); Forney v. Western States Plywood, 297 Or 628, 633 (1984).

ORDER

The Referee's order dated September 27, 1985 is affirmed in part and reversed in part. Those portions of the order that affirmed the award of 15 percent (22.5 degrees) scheduled permanent partial disability for claimant's left leg (knee) as granted by the Determination Order of April 28, 1981 and that rejected the insurer's offset claim and assessed penalties and attorney fees for the insurer's failure to pay the permanent disability awarded by the March 14, 1985 Determination Order are affirmed. The remainder of the order is reversed. The insurer's denials of September 4, 1984 and January 17, 1985 relating to claimant's psychological condition and alcohol problems are reinstated and upheld. That portion of the Determination Order of April 28, 1981 which awarded claimant no unscheduled permanent partial disability for his low back is affirmed. The Determination Order of March 14, 1985 is reinstated and the award of 15 percent (48 degrees) unscheduled permanent partial disability for claimant's right shoulder is affirmed. The suspension of vocational assistance effective October 23, 1984 until claimant receives treatment for his abuse of alcohol is reinstated and upheld. Claimant's attorney is awarded $300 for services on Board review in connection with the issue of the extent of permanent partial disability for claimant's right shoulder, to be paid by the insurer.

Board Member Lewis, dissenting:

I respectfully dissent.

First, I disagree with the majority's conclusion that Referee Menashe did not preserve the issue of the compensability of claimant's psychiatric condition as it relates to his industrial injury. The Referee stated that the psychiatric treatment by Dr. Johnson, subsequent to claimant's suicide

attempt, was not contemplated in the insurer's November 23, 1983 denial. He went on to conclude that this issue presented a complex medical question which he was unwilling to resolve on the record before him. Noting that a future hearing was all but inevitable, Referee Menashe indicated the issue would be better litigated at that time. The Referee clearly intended to preserve this issue for a later date when the evidence could be more completely developed. Short of saying: "I preserve this issue for a future date," the Referee's intent could not have been plainer.

My review of the evidence indicates that the first reports made in claimant's behalf concerning a mental disorder were by Dr. Johnson, the treating psychiatrist, after the October 1983 suicide attempt. The suicide attempt and related treatment were denied by the insurer. Referee Menashe upheld the denial and treatment solely as it related to the suicide attempt. As stated above, he specifically preserved the issue of whether the psychiatric treatment might be related to claimant's industrial injury. Therefore, the compensability of the mental disorder was properly before the present Referee and there is no reason to reach subsequent issues. However, other issues were decided by the majority that compel me to comment further.

I disagree with the majority's conclusion that Dr. Colbach's January 1983 report constituted a claim for psychiatric treatment.

Dr. Colbach, a psychiatrist, was part of an Orthopaedic Consultants' panel examining claimant at the insurer's request for physical complaints related to his left knee, right shoulder and low back. At the time, claimant was not treating for any mental disorder. Dr. Colbach's presence suggests the insurer was investigating a possible psychological component to claimant's physical complaints and was not attempting to ascertain if claimant had a compensable mental disorder.

"'Claim' means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury which a subject employer has notice or knowledge." ORS 656.005(7). Dr. Colbach's report was made in behalf of the insurer, not claimant. Moreover, claimant had not sought treatment for any mental disorder nor did he for 10 months after Dr. Colbach's report. At most, Dr. Colbach's report put the insurer on notice of a potential claim for a related mental disorder and alcohol problem, but did not make a claim in behalf of claimant that he was obligated to litigate or waive.

Further, the majority does not treat claimant and the insurer equally regarding their obligations concerning the alleged claim. Despite the conclusion the report constitutes a claim, the insurer neither responded nor issued a denial. Following the majority's reasoning, it would be just as reasonable to apply Bauman v. SAIF, 295 Or 788 (1983) and conclude that because the insurer did not deny the "claim" within 60 days that, absent a showing of fraud, misrepresentation or illegality, it could not subsequently deny it. Such a result would be equally as unfair and incorrect as the majority's application of res judicata. No claim was made until after the October 1983 suicide attempt. The insurer properly responded to that claim and the parties litigated

the portion of the mental disorder that was sufficiently developed at the March 1984 hearing.

Most serious is the majority's application of res judicata to bar claimant's claim for alcohol and psychiatric treatment.

Res judicata, as used in Million v. SAIF, 45 Or App 1097 (1980), bars worker's compensation "claims which were or could have been litigated in a prior proceeding." However, res judicata must be modified to fit Workers' Compensation to prevent technical forfeitures of substantive rights. The concept must recognize that workers' compensation claims are not static and often involve a number of hearings on a variety of different issues which arise as a claim progresses. In addition, new aspects of a medical condition develop with time and the use of new and different diagnostic tests. As a result, the need may arise to litigate in light of new operative facts that subsequently develop. A strict construction of res judicata must be avoided. Larson, discusses this point as follows:

> "As to res judicata in compensation-related matters, the beginning point is recognition of the proposition that res judicata does apply to the decisions of compensation boards and commissions no less than to the decisions of a court. The idea of informality in compensation procedure does not extend so far as to undermine this fundamental principle, but the rule of liberality of construction in compensation matters can appropriately be invoked to avoid harsh and technical forfeitures." (emphasis added) 3, Larson, Workmen's Compensation Law, 15-426.226-426.229 Sec. 79.72(a) (1983 ed.).

The court has recognized the need for liberality in the use of res judicata by focusing its attention on aggregate operative facts. Events occurring subsequent to a hearing have been found to constitute new operative facts sufficient to prevent the operation of res judicata. Carr v. Allied Plating Co., 81 Or App 306 (1986). Kepford v. Weyerhaeuser, 77 Or App 363 (1986). The significance of Carr and Kepford is the court's recognition of the non-static nature of worker's compensation claims. In both cases the court rejected a mechanical application of res judicata that would have precluded hearings on the compensability of medical conditions.

Here, claimant's mental disorder and alcohol problem had never been litigated as they related to his industrial injury. The Referee in the March 1984 hearing concluded that the insurer's denial did not deny the condition as it related to the industrial injury. Even assuming the issue was not preserved by the Referee, the new evidence gathered concerning the relationship of the mental disorder and alcohol treatment to his industrial injury constituted new operative facts around which the claim was properly litigated at this hearing. This result is consistent with a liberal construction of res judicata and comports with substantial justice.

The purpose of res judicata is to promote judicial economy and finality in the litigation of claims. Therefore, it is important that what constitutes new operative facts sufficient to prevent the application of res judicata to claims that could have been raised earlier be carefully applied. As in Carr and Kepford, that will be done on a case by case basis based on the facts presented and not, as I feel was done here, in a technical manner.

Accordingly, I would affirm the Referee's well-reasoned opinion.

TED R. VICKERS, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-00045
March 4, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Neal's order that increased his unscheduled permanent disability award for a low back injury from 30 percent (96 degrees), as awarded by a November 21, 1985 Determination Order and prior awards, to 50 percent (160 degrees). On review, the issue is extent of permanent disability, including permanent total disability.

Following our de novo review of the medical and lay evidence, including claimant's testimony concerning his physical limitations and disabling pain, we are not persuaded that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). In addition, claimant has failed to establish that a combination of medical and nonmedical factors have effectively foreclosed him from gainful employment. See Livesay v. SAIF, 55 Or App 390 (1981).

We further conclude that the Referee's award of permanent disability adequately reflects claimant's permanent loss of earning capacity resulting from his compensable injury. See ORS 656.214(5). Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated June 13, 1986 is affirmed.

KAREN J. BATES, Claimant
William E. McCann, Claimant's Attorney
Brian L. Pocock, Defense Attorney
Dan Steelhammer (SAIF), Defense Attorney

WCB 85-15422 & 85-15423
March 6, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated February 5, 1987. Specifically, claimant requests that we reconsider those portions of our order that: (1) modified the Referee's award of attorney fees; and (2) declined to grant attorney fees for services on Board review.

For the reasons detailed in our prior order, we continue to conclude that the Referee's attorney fee award should be modified. In addition, we reiterate that claimant is not entitled to an attorney fee for her counsel's services on Board review.

Asserting that compensability was more than a potential issue on Board review, claimant contends that she is entitled to an attorney's fee. We disagree. Compensability was listed as an issue in Aetna Casualty Co.'s appellant's brief. However, its denial, as well as its argument on Board review, only questioned responsibility for claimant's aggravation claim. In addition to contesting responsibility in its respondent's brief, the SAIF Corporation alternatively questioned the compensability of claimant's "new injury" claim. Inasmuch as we agreed with the Referee's conclusions concerning Aetna's responsibility for claimant's condition, SAIF's "compensability" alternative did not materialize. Consequently, claimant responded to a potential compensability issue on Board review and, thus, is not entitled to an attorney fee. Wayne A. Hawke, 39 Van Natta 31 (January 23, 1987).

Accordingly, claimant's request for reconsideration is granted and our prior order is withdrawn. On reconsideration, we adhere to and republish our former order, as supplemented herein, effective this date.

IT IS SO ORDERED.

JAMES B. WELCH, Claimant
Burt, Swanson, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 85-05659
March 6, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Podnar's order that upheld the insurer's denial of claimant's request for authorization for surgery. The issue is medical services.

The Board affirms the order of the Referee with the following comment. In deciding the medical services issue in this case, the Referee emphasized that claimant's compensable condition had not worsened since a previous hearing. Claimant contends on Board review that the proposed surgery is reasonable and necessary regardless of whether claimant's condition has worsened.

We agree with claimant that it was not necessary for him to establish a worsening of his compensable condition to be entitled to medical services for that condition. See ORS 656.245. We disagree with claimant's assertion, however, that the proposed surgery is reasonable and necessary. The record as currently developed does not preponderate in favor of the conclusion that the proposed surgery would be of any curative or palliative benefit. We agree with the Referee, therefore, that the insurer's denial should be upheld.

ORDER

The Referee's order dated July 29, 1986 is affirmed.

BONNIE J. BAILEY, Claimant
Emmons, et al., Claimant's Attorneys
John Motley (SAIF), Defense Attorney

WCB 85-05598
March 10, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Michael V. Johnson's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim; (2) awarded claimant 15 percent (48 degrees) unscheduled permanent partial disability for her low back in lieu of a Determination Order which awarded no permanent disability; and (3) authorized SAIF to offset temporary disability compensation paid after September 7, 1984 against the permanent disability award. SAIF contends in its brief that claimant's permanent partial disability award should be reduced. The issues are aggravation, extent of disability and offset.

The Board affirms and adopts the order of the Referee. Claimant's attorney is not entitled to an insurer-paid attorney fee for services on Board review on the extent issue. See Teel v. Weyerhaeuser, 294 Or 588, 590 (1983); Saiville v. EBI Companies, 81 Or App 469, 472-73, rev den 302 Or 461 (1986). But see Travis v. Liberty Mutual Insurance, 79 Or App 126, 128, rev den 301 Or 445 (1986).

ORDER

The Referee's order dated July 8, 1986 is affirmed.

LESLIE COLVIN, Claimant
Malagon & Moore, Claimant's Attorneys
David C. Force, Attorney
Spears, Lubersky, et al., Defense Attorneys
Cliff, Snarskis, et al., Defense Attorneys

WCB 81-03061
March 10, 1987
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Colvin v. Industrial Indemnity, 83 Or App 73 (1986). The court has mandated that claimant's injury claim be accepted. In addition, we have been instructed to determine the amount of interim compensation owed claimant. The record suggests that claimant missed two work days immediately following the injury. However, the record is otherwise unclear whether she missed work prior to the denial of her claim.

We may remand for further evidence if we determine that a case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Following our review of this matter, we find that the issue of claimant's entitlement to interim compensation has been insufficiently developed. Consequently, we conclude that remand is appropriate.

Accordingly, the January 14, 1981 denial issued by Industrial Indemnity Company is set aside and this matter is remanded to Industrial Indemnity for acceptance and payment of compensation according to law.

Furthermore, the "interim compensation" issue is remanded to the Hearings Division for the taking of further evidence. A hearing shall be convened to determine the number of days claimant missed work as a result of her compensable injury prior to the denial of her claim. Thereafter, in accordance with the court's instructions, a Referee's order shall issue determining the amount of interim compensation owed.

IT IS SO ORDERED.

MYRON W. RENCEHAUSEN, SR., Claimant WCB 86-11026
Hayner, Stebbins, et al., Claimant's Attorneys March 10, 1987
Foss, Whitty & Roess, Defense Attorneys Order on Review
Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee Leahy's order that required it to pay an award of temporary total disability compensation granted by a previous Referee's order and assessed a penalty and attorney fee for unreasonable delay in the payment of compensation. The issues are compliance, penalties and attorney fees.

In a previous order, Referee Myers found that the employer had unilaterally terminated temporary total disability payments for claimant's compensable right shoulder condition after the condition had become medically stationary, but while the claim for that condition was still in open status. The Referee ordered the employer to pay temporary disability compensation through the date that the claim ultimately was closed by Determination Order, but authorized the employer "to offset this temporary disability payment, which is an overpayment, against any unpaid awards for permanent disability." The employer requested Board review of Referee Myers' order and refused to pay the additional temporary disability compensation pending appeal. Claimant requested a hearing in connection with this refusal which came before Referee Leahy in October 1986.

In documents submitted to Referee Leahy, the employer contended that an "overpayment" of temporary disability compensation is not payable "pursuant to" ORS 656.210 and thus is not "compensation" which must be paid pending appeal under the provisions of ORS 656.313. See ORS 656.313(1) & (4). Instead, the employer argued that an overpayment is a "necessary adjustment to compensation" payable under the provisions of ORS 656.268. See ORS 656.268(2) & (4). As authority for its position, the employer cited our recent decision in Terry L. Hunter, 38 Van Natta 134 (1986). In that case, we held that "interim compensation" awarded by a Referee pursuant to the Court of Appeals' decision in Bono v. SAIF, 66 Or App 138 (1983), rev'd, 298 Or 405 (1984) for periods during which the claimant was working full time at his regular salary was not "compensation" within the meaning of ORS 656.313 and thus was properly withheld pending appeal. 38 Van Natta at 135-36.

Referee Leahy refused to address the employer's argument, characterizing it as a "collateral attack" of Referee Myers' order. Referee Leahy then ordered the employer to pay "all of the compensation" awarded by Referee Myers and assessed a penalty and attorney fee for unreasonable delay in the payment of compensation.

Referee Leahy should have addressed the employer's argument. The employer's argument was not a "collateral attack" of the factual or legal basis of Referee Myers' decision to award compensation. The employer simply asserted that the kind of compensation awarded by Referee Myers' order did not have to be paid pending appeal and requested an administrative determination of the correctness and reasonableness of its interpretation of Referee Myers' order. See Irene M. Gonzalez, 38 Van Natta 954, 955-56 (1986).

Having said that, we turn to the merits of the employer's argument. A claimant must continue to satisfy the "leaves work" requirement of ORS 656.210 after he becomes medically stationary to be entitled to continued temporary total disability compensation pending issuance of a Determination Order under ORS 656.268. This is clear from Jackson v. SAIF, 7 Or App 109, 115 (1971), where the court ruled that a claimant is not entitled to continued temporary total disability compensation pending issuance of a Determination Order if he has returned to regular work or been released by his doctor to return to regular work. Therefore, ORS 656.210, substantively controls a claimant's entitlement to receive "overpaid" temporary disability compensation and such compensation is payable "pursuant to" that section. See Howard E. Hughes, 38 Van Natta 434, 435-36 (1986). ORS 656.210 is one of the sections enumerated in the definition of "compensation" in ORS 656.313(4) and thus, under ORS 656.313(1), "overpaid" temporary total disability compensation may not be withheld pending appeal. See Howard E. Hughes, supra, 38 Van Natta at 435-36 (distinguishing Terry L. Hunter, supra).

Although the substantive correctness of Referee Myers' decision to award additional temporary disability compensation for claimant's right shoulder condition was not disputed by the employer in this enforcement action, we add one further comment for the sake of clarity. Whether claimant returned to work or was released to return to work during the period for which Referee Myers awarded "overpaid" temporary total disability compensation was a factual question expressly answered in the negative by Referee Myers' Opinion and Order. This substantive factual determination was reviewable only on direct appeal of Referee Myers' order and thus cannot be addressed in this enforcement action.

Under the circumstances of this case, we conclude that the employer withheld the temporary disability compensation awarded by Referee Myers based upon an unreasonable interpretation of Referee Myers' order. We further conclude that the penalty assessed by Referee Leahy is appropriate in light of the employer's unreasonable action and that the attorney fee awarded by Referee Leahy is appropriate in light of the efforts of claimant's attorney through the hearings level. We thus affirm Referee Leahy's order, but for the reasons stated in this order.

ORDER

The Referee's order dated November 26, 1986 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the self-insured employer.

MARVIN C. WRIGHT, Claimant
THEODORE BERNARDS (dba Alderwood Homes) and NORMAN BERNARDS (dba Cascade Tractor), Employers
Vick, et al., Claimant's Attorneys
Johnstone & Peterson, Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Carl Davis, Ass't. Attorney General

WCB 85-00868, 85-05797, 85-05798 & 85-05799
March 10, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Foster's order that upheld the insurer's and noncomplying employer's denials of claimant's industrial injury claim. The issue is whether claimant was a subject employe.

In early August 1984, Theodore Bernards (hereafter T. Bernards) contacted claimant about assisting him in painting the private residence of his brother, Norman Bernards, (hereafter N. Bernards), and the building that housed N. Bernards' business, Cascade Tractor and Implement Company (hereafter Cascade Tractor). Claimant and T. Bernards had previously worked on other painting and remodeling projects. Claimant agreed to the offer of work. For these services, T. Bernards agreed to pay claimant $8.00 per hour and provide all the ladders, scaffolding, painting and surfacing materials necessary for performance of the job.

As part of the agreement, claimant drove his pick-up which contained carpentry tools necessary for the repair of a garage door. Claimant picked up T. Bernards at his home each morning and drove to the job site. However, T. Bernards did not return with claimant in the evening. The parties agree that claimant was to be compensated for travel time in one direction, either to or from the job site. Claimant testified that he was to be compensated for the time to the job site. T. Bernards testified that no agreement was reached on which direction claimant was to be compensated.

On August 24, 1984, claimant picked up T. Bernards at his home and proceeded to N. Bernards' private residence. In preparation for painting, they cleaned the outside of the residence with a rented power washer. After finishing the house, they proceeded to the Cascade Tractor building and cleaned one of the building's walls. The following day, T. Bernards was unable to work on the project. Consequently, claimant was instructed to finish the power washing of the Cascade Tractor building himself. After completing the cleaning, claimant returned the rented power washer. Rental for the machine was paid with a check provided by T. Bernards. During the balance of the week, claimant and T. Bernards prepared the surface of the residence for painting. T. Bernards exercised control over which job was performed. Yet, since they both had experience as painters, T. Bernards exercised no control over the details of the work, other than providing needed materials.

On the following Monday, while returning to complete the job on N. Bernards' residence, claimant and T. Bernards were involved in a motor vehicle collision. As a result, claimant suffered a broken right leg and other complications. While in the hospital, claimant was paid $232 by T. Bernards. The check was

drawn on an "Alderwood Homes, Incorporated" bank account and represented pay for 29 hours work on the residence and the Cascade Tractor building. T. Bernards testified that the use of the "Alderwood Homes" check was solely for convenience. N. Bernards testified that he was billed $12.50 per hour for T. Bernards and $8 per hour for claimant. The bill was paid to T. Bernards on a check issued by Cascade Tractor. Subsequently, N. Bernards reimbursed Cascade Tractor for the portion of work done on his residence. N. Bernards was aware claimant was working with his brother, but had no control over performance of the work.

Claimant filed claims with: (1) T. Bernards, individually; (2) Alderwood Homes, Incorporated, a company owned and operated by Theodore Bernards and Daniel Bernards; (3) Norman Bernards, individually; and (4) Cascade Tractor and Implement Company, a company solely owned by Norman Bernards. Cascade Tractor, by and through their insurer, Maryland Casualty Company, denied the claim on the basis that no employer/employe relationship existed between Cascade Tractor and claimant. The other alleged employers did not have workers' compensation coverage and were processed as claims against noncomplying employers. The claims were denied by the SAIF Corporation on the basis that claimant was not a subject employe.

The Referee concluded that no employer/employe relationship existed between claimant and any of the parties. He, therefore, upheld all the denials. After de novo review, we reverse.

Claimant must prove by a preponderance of the evidence that an employer/employe relationship existed between himself and one of the parties. Claimant can establish this relationship by proving that he is an employe under either the "right of control" test or the "nature of work" test. Woody v. Waibel, 276 Or 189 (1976). Bell v. Hartman, 44 Or App 21 (1980). We find that the "nature of work" test is not relevant to claimant's situation. The factors considered in applying the "right of control" test depend on the circumstances presented in each fact situation. See Woody v. Waibel, supra. at 192; Marlow v. Dexter Wood Products, 47 Or App 811 (1980); Bell v. Hartman, supra. Further, if claimant establishes that he was an employe of one of the parties, claimant must not be a nonsubject worker as defined by ORS 656.027.

The factors supporting the finding that claimant was an employe of T. Bernards are: (1) either party could terminate employment without liability; (2) T. Bernards had control over which buildings were to be worked on; (3) claimant was paid on an hourly basis by T. Bernards; and (4) except for the carpentry tools, T. Bernards provided all the equipment necessary for performance of the work. The factors supporting claimant's not being an employe of T. Bernards are: (1) none of claimant's pay was withheld for taxes or social security; and (2) T. Bernards did not exercise extensive control over the details of claimant's work performance.

We conclude that T. Bernards exercised sufficient control such that, at the time of the automobile accident, claimant was an employe of T. Bernards, individually. We are further persuaded that none of the exclusions under ORS 656.027 apply to make claimant a nonsubject employe. Finally, we find that claimant was not an employe for any of the other alleged employers.

Claimant also asserts that either N. Bernards, individually, or Cascade Tractor may be liable by operation of ORS 656.029(1). At the time of claimant's injury, ORS 656.029(1) stated:

> "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."

The purpose of ORS 656.029(1) was to protect employes of irresponsible and uninsured subcontractors. The statue was designed to place ultimate responsibility on a principal contractor who has the ability to: (1) choose the subcontractor; (2) insist upon appropriate compensation protection; and (3) pass on the responsibility of coverage. E.W. Eldridge Inc. v. Becker, 73 Or App 631 (1985). However, application of this statute has been limited to cases where the principal contractor actually "let a contract" within the meaning of ORS 656.029(1). See Todd A. Aucone, 37 Van Natta 552 (1985); Dennis P. Cummings, 36 Van Natta 260 (1984).

Following our review of this record, we conclude that neither N. Bernards, individually, or as a representative of Cascade Tractor, "let a contract" within the meaning of ORS 656.029(1). Consequently, we find that neither N. Bernards nor Cascade Tractor is responsible for the claim.

N. Bernard's business was selling farm machinery. He did not enter into the contract for the painting of his building in the regular course of his principal business. Further, he did not take bids as is inferred by the term "letting." Instead he merely entered into an oral arrangement with his brother concerning the painting of his business. Thus, N. Bernards, on behalf of Cascade Tractor did not "let a contract" such that the business would be a responsible party under ORS 656.029(1). Furthermore, N. Bernards, individually, only contracted for the painting of his personal residence and was not acting in the capacity of a business. Consequently, ORS 656.029(1) again has no application to this situation.

The parties also contend that claimant is excluded from coverage by operation of the "going and coming rule". We do not agree.

Generally, the "going and coming rule" states that, in the absence of special circumstances, an employe injured while going and coming from his place of work is excluded from workers' compensation coverage. An exception to this rule exists if an employe is being compensated for his travel at the time he incurs the injury. Fenn v. Parker Construction, 6 Or App 412 (1971).

T. Bernard testified that no agreement had been reached

on which direction claimant was to be compensated for. Claimant, however, stated that he was to be compensated for his time to the job site. We find claimant's version more convincing. The record establishes he drove T. Bernards to the job site each morning and did not drive him home in the evening. Consequently, we are persuaded that at the time of the automobile accident, claimant was receiving compensation according to his agreement with T. Bernards. Inasmuch as claimant was within the scope of his employment at the time of the automobile accident, the "going and coming rule" does not apply.

ORDER

The Referee's order dated April 30, 1986 is affirmed in part and reversed in part. That portion of the Referee's order that upheld the SAIF Corporation's denial on behalf of T. Bernard, individually, is set aside and the claim is remanded for processing according to ORS 656.268. Claimant's attorney is awarded $1200 for services at hearing and $700 for services on Board review, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

CARL L. BOHRER, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-13672
March 12, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee Nichols' order that: (1) found that his low back injury claim was not prematurely closed; (2) upheld the self-insured employer's denial of claimant's aggravation claim; and (3) increased claimant's award of permanent partial disability for his low back from the 20 percent (64 degrees) granted by Determination Order to 75 percent (240 degrees). Claimant contends that he is entitled to an award of permanent total disability. The employer cross-requests review of that portion of the order that awarded claimant's attorney an attorney fee for successfully defending against an issue raised orally by the employer at the beginning of the hearing, the issue of claimant's medically stationary date. The issues are premature closure, aggravation, extent of disability and attorney fees.

The Board affirms the order of the Referee on the issues of premature closure, aggravation and extent of disability with the following comment on the aggravation issue. Claimant returned to his regular work on a part-time basis on or about October 7, 1985. The claim was closed by Determination Order on October 24, 1985 with a 20 percent unscheduled award for his low back. On October 29, 1985, claimant left work and visited his family practitioner, Dr. Thompson, complaining of "continued and perhaps increasing low back pain." After our de novo review of the record, we conclude that when claimant left work on October 29, it was not because he was less able to work than he was on October 24, the date of the last arrangement of compensation. Instead, we conclude that claimant left work because the work he was performing was beyond his impaired physical abilities. Claimant's condition, therefore, did not worsen and he did not sustain a compensable aggravation. See Smith v. SAIF, 302 Or 396, 399-401 (1986); Gwynn v. SAIF, 84 Or App 67 (February 25, 1987).

On the issue of attorney fees, we reverse the order of the Referee. Claimant raised the issue of premature closure in his request for hearing. In raising this issue, claimant contended that he became medically stationary after the medically stationary date stated in the Determination Order. See ORS 656.268(1) & (2). At the beginning of the hearing, the employer orally contended that claimant was medically stationary prior to the date stated in the Determination Order.

The issue raised by the employer was the same as that raised by claimant: When was claimant medically stationary? The Referee affirmed that portion of the Determination Order relating to the medically stationary date. Under these circumstances, claimant's attorney was not entitled to an attorney fee concerning the medically stationary issue. See Teel v. Weyerhaeuser Co., 294 Or 588, 590 (1983); Saiville v. EBI Companies, 81 Or App 469, 472-73, rev den, 302 Or 461 (1986). But see Travis v. Liberty Mutual Insurance, 79 Or App 126, 128, rev den 301 Or 445 (1986).

ORDER

The Referee's order dated June 26, 1986 is reversed in part. That portion of the order that awarded claimant's attorney an attorney fee concerning the medically stationary issue is reversed. The remainder of the order is affirmed.

GERALD W. HANNAH, Claimant
Peter O. Hansen, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 85-12054
March 12, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of those portions of Referee Neal's order that: (1) set aside its denial of claimant's industrial injury claim for right carpal tunnel syndrome; (2) set aside its denial of further chiropractic treatment and exercise therapy for claimant's accepted neck, right shoulder and upper right arm conditions; and (3) assessed penalties and attorney fees in connection with the chiropractic treatment and exercise therapy denial. Claimant cross-requests review of that portion of the order that upheld the insurer's denial of claimant's industrial injury claim for headaches, pain in the middle and lower portions of his back and numbness, tingling and shooting pains in his right upper extremity. The issues are the compensability of claimant's various conditions, medical services, penalties and attorney fees.

Claimant compensably injured his neck, right shoulder and upper right arm on December 27, 1984 when he and a fellow employe were lifting a loaded pallet weighing about 250 pounds from the ground onto a loading dock. As claimant and the other employe moved the lead end of the pallet onto the loading dock, the load shifted, the other employe fell down and the pallet came down on the left side of claimant's head, forcing his head toward his right shoulder. Claimant then turned his body and held the pallet up with his right shoulder and right upper arm for a few seconds until several other employes came to his aid.

Claimant treated initially with a number of medical doctors for what was diagnosed as a cervical/dorsal strain and tendinitis of the right shoulder. Then, approximately one month after the industrial accident, claimant began treating with a chiropractor, Dr. Amodt. Dr. Amodt's initial diagnoses were thoracocervical strain or sprain and lumbar strain.

Despite Dr. Amodt's treatments, claimant continued to complain of severe pain throughout his spine, right shoulder and right arm, as well as headaches. He was examined by various consulting doctors, none of whom could find any objective basis for his complaints. A number of consulting doctors suspected a large functional or voluntary component to claimant's condition. One consulting physician, Dr. Higgins, an orthopedic surgeon, referred claimant for a course of physical therapy beginning in April 1985. The physical therapist's notes reflect some improvement in claimant's condition during the first few weeks of therapy, but little, if any, thereafter. The treatment was discontinued after about two months.

Claimant eventually underwent a cervical CT scan and two EMGs involving his right upper extremity. The CT scan and the first EMG were negative for cervical disc pathology. The first EMG, however, was indicative of bilateral carpal tunnel syndrome. The second EMG revealed what the examiner characterized as "minimal" evidence of cervical radiculopathy, but was less clearly indicative of carpal tunnel syndrome than the first EMG.

In July 1985, Dr. Amodt referred claimant to an exercise and physical fitness expert for exercise therapy. About a month after the referral, the fitness expert reported that claimant had experienced some improvement in his condition. After about two and a half months, the fitness expert indicated that claimant continued to make "some progress," but noted that claimant continued to complain of pain and stiffness throughout his neck and right shoulder.

In September 1985, after an inquiry by the insurer, Dr. Amodt gave his diagnoses of claimant's conditions as follows: cervical, thoracic and lumbar strains, right shoulder strain, myofascial pain syndrome, thoracic outlet syndrome, carpal tunnel syndrome and "greater occipital syndrome" with resultant headaches. Later the same month, the insurer issued a denial of all conditions other than the accepted injuries to claimant's neck, right shoulder and upper right arm. The insurer also denied further chiropractic and "physical reconditioning" treatments for claimant's compensable conditions. The claim was closed by Determination Order dated September 30, 1985, with an award of five percent unscheduled permanent partial disability.

In November 1985, claimant underwent a myelogram of his entire spine at the recommendation of Dr. Ordonez, a consulting neurosurgeon. The myelogram revealed no abnormality other than "a trace of impression upon the right [nerve] root sheath at C5-6." Later the same month, claimant came under the care of Dr. Long, a specialist in physical medicine and rehabilitation. After two more EMGs, Dr. Long diagnosed myofascial pain syndrome of the neck and right upper arm, bilateral carpal tunnel syndrome, worse on the right, ulnar nerve compression at the right elbow and possible mild cervical radiculopathy. In January 1986, Dr. Long recommended that claimant undergo a right carpal tunnel release. The insurer received a copy of Dr. Long's recommendation and reiterated its denial of claimant's carpal tunnel syndrome on January 23, 1986. Claimant nonetheless underwent a right carpal tunnel release in February 1986.

At the hearing, claimant testified on direct examination that prior to December 1984, he had filed only one or two workers'

compensation claims and that those claims involved his low or mid-back. He also stated that he was a party to the "Agent Orange" litigation and had claimed genetic damage, mental problems and frontal headaches in that cause of action. He testified that he had fully recovered from his previous industrial injuries and his Agent Orange symptoms prior to his most recent industrial accident and attributed a plethora of physical problems from his head to his legs to that accident.

With regard to Dr. Amodt's chiropractic treatment, claimant testified that it usually increased his pain, but occasionally provided transient relief from his symptoms. Claimant also testified that he was then receiving physical therapy at the direction of Dr. Long for his neck and shoulder and that the therapy had improved his mobility, but not his pain. Claimant was still off work at the time of the hearing.

After the insurer introduced a number of impeachment documents on cross-examination, claimant conceded that he had in fact filed workers' compensation claims for numerous conditions involving hemorrhoids, his low back, mid-back, upper back, left shoulder, right arm and elbow, left elbow, left hand and groin. Claimant stated that he had forgotten about most of these claims. The Referee stated in her opinion that she rejected claimant's testimony because she found it, "like many other of his actions evident throughout this claim, was calculated to keep him off work and on disability." After our de novo review of the record, we concur in the Referee's unfavorable credibility assessment.

Despite her finding that claimant was not credible, the Referee found claimant's carpal tunnel syndrome compensable based upon the reports of Dr. Long. The only statement by Dr. Long which indicates a causal connection between claimant's carpal tunnel syndrome and his industrial accident appears in a report dated November 22, 1985. In that report, Dr. Long stated:

> "I believe that the incident of 28 December 1984 contributed substantially to the development of the median wrist lesion and the ulnar lesion at the elbow. It is quite possible that these lesions pre-existed the incident of 28 December 1984, but there is no evidence that [claimant] had appreciable symptoms of median wrist lesions or ulnar compression at the elbows prior to December, 1984. The history of brief but very strenuous right upper extremity use may provide some basis for the work injury having caused or worsened the median and ulnar lesions in the right upper extremity."

We conclude that this opinion is insufficient to carry claimant's burden of proving that the industrial accident was a material contributing factor in the development of his carpal tunnel syndrome. We consider the opinion equivocal and speculative. Moreover, it is based upon history provided by a noncredible claimant. The only other opinion in the record which tends to support the compensability of claimant's carpal tunnel syndrome is a summary statement by Dr. Amodt which we do not find persuasive. There is one report in the record by Dr. Parrish, an internist who treated claimant briefly in late 1985, which

summarily states that the industrial injury did not contribute to claimant's carpal tunnel syndrome. We do not find this opinion particularly persuasive either. Nonetheless, it is claimant's burden to establish a material causal connection; not the insurer's burden to disprove such a connection. Ronald R. Theall, 38 Van Natta 1051, (1986). Accordingly, we conclude that claimant has failed to carry his burden. See Somers v. SAIF, 77 Or App 259, 263-66 (1986); Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

On the issue of the denial of further chiropractic and physical reconditioning treatment, the Referee concluded that the denial was an "overbroad" denial of "future medical care," set it aside and assessed a penalty and an attorney fee. We disagree with the Referee's conclusions and actions on this issue. The wording of the denial was as follows:

> "[I]nasmuch as you have been receiving chiropractic care and associated physio-therapy/reconditioning treatment anywhere from 3 to 5 times a week at least since July, 1985, approximately 3 months time, with no reported symptomatic relief, and we have received medical evidence to the effect that further chiropractic care/physical reconditioning is neither necessary or [sic] reasonable under the circumstances, we are hereby denying coverage for further chiropractic care/physical reconditioning care. This denial does not affect your rights [sic] to seek treatment with a medical doctor of your choice should you desire to pursue recovery from your condition; also provided the treatment for which you seek is related to the original accepted portion of the claim and is not treatment for any and all conditions unrelated to the compensable portion of your Workers' Compensation claim."

We do not read the insurer's denial to be an impermissibly overbroad denial of future medical treatment. The basis of the denial, as is clear from the language and context of the denial, was that claimant's ongoing course of chiropractic treatment and exercise therapy was not reasonable or necessary. The denial goes on to state that it was not the insurer's intention to deny any future medical services which were reasonable, necessary and causally related to claimant's compensable conditions. We find nothing improper in the wording of the denial.

The real issue was whether claimant's ongoing course of chiropractic treatment and exercise therapy was reasonable and necessary. On our de novo review of the record, we conclude that it was not. Claimant testified at the hearing that Dr. Amodt's chiropractic treatments usually increased his pain and only occasionally provided the most transient relief from his symptoms. This testimony is echoed in several medical reports throughout the record. Such treatment was providing no material curative or palliative benefit to claimant. It, therefore, was not reasonable or necessary. See Michael D. Barlow, 38 Van Natta 196, 197-99 (1986); Fernando Lopez, 38 Van Natta 95, 96-97 (1986).

As for the reasonableness and necessity of claimant's exercise therapy, the denial was issued after claimant had participated in the exercise program for two and a half months. At that point, claimant continued to complain of pain and stiffness in his neck and shoulder. From reviewing the reports of the physical fitness expert in charge of claimant's program, we conclude that no further material curative or palliative benefit was anticipated for claimant's compensable conditions. Further improvement in claimant's general physical condition may have been anticipated. The insurer, however, was required to provide only those medical services which were required by the nature of the injury or the process of recovery. ORS 656.245. The insurer was not required to increase claimant's general physical fitness.

Because we conclude that neither claimant's chiropractic treatment nor his exercise therapy was reasonable or necessary, we reinstate the insurer's denial. We hasten to add, however, that our decision in no way prohibits claimant from seeking or receiving chiropractic treatment, exercise therapy or any other form of medical treatment in the future if those medical services are reasonable, necessary and causally related to claimant's compensable conditions.

Because we find the insurer's denial of claimant's ongoing course of chiropractic treatment and exercise therapy proper, the denial was not unreasonable and penalties and attorney fees are not appropriate. See ORS 656.262(10); 656.382(1). Finally, concerning the issues raised in claimant's cross-request, we affirm the order of the Referee.

ORDER

The Referee's order dated May 1, 1986, as republished in the Order on Reconsideration dated June 5, 1986, is affirmed in part and reversed in part. Those portions of the order that set aside those portions of the insurer's denial dated September 27, 1985 relating to carpal tunnel syndrome, chiropractic treatment and physical reconditioning, that set aside the insurer's denial dated January 23, 1986, that assessed a penalty and associated attorney fee in connection with the insurer's denial of claimant's chiropractic care and physical reconditioning and that awarded claimant's attorney a fee for overturning the carpal tunnel syndrome denial are reversed. The remainder of the order is affirmed.

DELMER SEAL, Claimant
Pozzi, et al., Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney

WCB 84-06927
March 12, 1987
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Fink's order that awarded a $2,000 attorney fee. The issue is attorney fees.

The Board modifies the award of attorney fees.

In February 1974 claimant received permanent total disability due to a heart condition. In 1984 SAIF received information that claimant's condition had improved and submitted those reports to the Evaluation Division for a reevaluation of the claim. As a result, new Determination Orders were issued in May

and June 1984 reducing claimant's award to 40 percent unscheduled permanent disability. Claimant timely appealed the Determination Orders. Thereafter, the Referee reinstated the permanent total disability award. SAIF does not contest that portion of the Referee's order that reinstated his award of permanent total disability.

However, SAIF argues that claimant was not entitled to an insurer-paid attorney fee since it neither denied him compensation nor initiated the reduction of his award of permanent total disability. SAIF asserts that the Evaluation Division reduced the award upon its own reevaluation. After de novo review, we agree.

Claimant is entitled to an insurer-paid attorney fee if the insurer initiates review and it is subsequently determined that compensation awarded claimant should not be disallowed or reduced. ORS 656.382(2). However, ORS 656.206(5) states:

> "Each insurer shall reexamine periodically each permanent total disability claim for which the insurer has current payment responsibility to determine whether the worker is currently permanently incapacitated from regular performing work at a gainful and suitable occupation. Reexamination shall be conducted every two years or at such other more frequent interval as the director may prescribe. Reexamination shall include such medical examinations, reports and other records as the insurer considers necessary or the director may require. The insurer shall forward to the director the results of each reexamination.

Pursuant to this statute, SAIF is required to periodically reexamine claimant's permanent total disability award. Thus, by complying with this statute, SAIF did not initiate the reduction in claimant's permanent total disability award. Rather, the reduction of the permanent total disability award was at the discretion of the Evaluation Division. Therefore, claimant's award of an attorney fee should be paid out of compensation pursuant to ORS 656.386(2).

ORDER

The Referee's order dated June 18, 1986 is affirmed in part and modified in part. In lieu of the Referee's award of attorney fees, claimant's attorney is allowed 25 percent of the additional compensation granted by the Referee's order, not to exceed $2,000 as a reasonable attorney's fee. The remainder of the Referee's order is affirmed.

Board Member Lewis specially concurring:

I agree with the result that claimant's attorney fee should come from claimant's award of permanent total disability. SAIF's compliance with ORS 656.206(5) is not the same as initiating the reduction in claimant's permanent total diability.

However, this result assumes that the insurer is

reevaluating all permanent total disability cases on a regular basis. If evidence were presented that this statute was being applied selectively, such that the insurer was only sending particular cases to the Evaluation Division for reevaluation, I would conclude that the insurer is the initiating party. Under those circumstances, I would support the award of an insurer-paid attorney fee. Yet, without evidence of selective application I am unwilling to infer such a procedure from this record.

STEVEN J. SNELL, Claimant
Coons & Cole, Claimant's Attorneys
Garrett, Seideman, et al., Defense Attorneys

WCB 84-09529
March 12, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The self-insured employer requests review of that portion of Referee T. Lavere Johnson's order that awarded claimant's attorney an attorney fee for defending against the insurer's cross-request for hearing on the issue of extent of disability. The issue of extent of disability was raised by claimant in his request for hearing. The issue is attorney fees.

The attorney fee awarded by the Referee is deleted. Richard M. Deskins, 38 Van Natta 825, 38 Van Natta 908 (1986); see Allen Fanno, 38 Van Natta 1368 (1986)(OAR 438-47-075 applies to proceedings at the hearing level); see also Saiville v. EBI Companies, 81 Or App 469, 472-73, rev den 302 Or 461 (1986). But see Travis v. Liberty Mutual Insurance, 79 Or App 126, 128, rev den 301 Or 445 (1986).

ORDER

The Referee's order dated June 27, 1986, as supplemented and republished by the order dated August 5, 1986, is reversed in part. That portion of the order that awarded claimant's attorney an attorney fee for prevailing on the self-insured employer's cross-request for hearing is reversed. The remainder of the order is affirmed.

GENE S. BAKER, Claimant
David Jensen, Claimant's Attorney
Lester Huntsinger (SAIF), Defense Attorney

WCB 86-02052
March 13, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of Referee Seifert's order which: (1) affirmed a January 29, 1986 Determination Order that did not award permanent disability for a back injury; and (2) declined to assess a penalty and accompanying attorney fees for the SAIF Corporation's alleged unreasonable failure to timely provide a medical report. On review, the issues are extent of permanent disability, penalties, and attorney fees.

We affirm the order of the Referee with the following comments.

Following our de novo review of the medical and lay evidence, we are not persuaded that claimant's compensable injury has resulted in a permanent loss of earning capacity. See ORS 656.214(5). Consequently, we agree with the Referee that claimant is not entitled to an award of unscheduled permanent disability.

Furthermore, we do not consider SAIF's conduct unreasonable. The record suggests that SAIF could not have received Dr. Baker's report until April 15, 1986, at the earliest. Claimant received a copy of the report at the April 21, 1986 hearing. Documents acquired after the initial disclosures must be provided to the other parties within ten (10) days after the disclosing party's receipt of the documents. OAR 438-07-015(4). Inasmuch as SAIF provided claimant with a copy of Dr. Baker's report within ten days of its receipt of the report, we conclude that its actions were not unreasonable.

ORDER

The Referee's order dated May 6, 1986 is affirmed.

DONNA J. HALSEY, Claimant
David Force, Claimant's Attorney
Gleaves, et al., Defense Attorneys

WCB 85-04608
March 13, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of those portions of Referee Holtan's order that awarded claimant "interim compensation" for the period from March 6 to April 5, 1985 and penalties and attorney fees based upon that compensation for failure to comply with the administrative rules relating to disclosure of documents. The issues are interim compensation, penalties and attorney fees.

Claimant began working for a motor home manufacturer in February 1983. Her job exposed her to a number of chemical fumes. In early 1985, claimant began to experience nausea in the mornings with exposure to certain odors at home and at work, including the chemical fumes.

On February 26, 1985, claimant visited Dr. Jeffrey, a family practitioner, and they discussed her recurring nausea. Dr. Jeffrey suspected that claimant was experiencing morning sickness due to pregnancy. Claimant expressed concern that the chemical fumes at work might be harmful to her unborn child. She later provided Dr. Jeffrey with a list of the chemicals around which she worked, some of which Dr. Jeffrey recognized as potential hazards to claimant's unborn child.

The day following her visit with Dr. Jeffrey, claimant went to work at 6:00 a.m. and worked half of her eight-hour shift. Claimant's supervisor then sent her home because claimant was complaining of nausea. Claimant returned to work the next morning and after less than a half hour was again sent home by her supervisor because of nausea.

After confirming that claimant was pregnant, Dr. Jeffrey wrote a note dated March 1, 1985 to claimant's employer. The note read:

> "To whom it may concern: [Claimant] has been followed here for pregnancy. We advised her that she should not work about adhesives and bonding products unless she is in a well-ventilated space. If there is a question about this matter, please feel free to call and discuss it with us."

After receiving this note, a representative of the employer contacted Dr. Jeffrey, discussed the situation with him and told him that the employer was attempting to find a position for claimant in a well-ventilated area. Claimant returned to work in her regular position while the employer attempted to find her another position. As it turned out, the employer was unable to find another position for claimant, who was unwilling to continue working in her regular position. The employer, therefore, terminated claimant's employment, effective March 6, 1985.

Claimant filed an 801 form on March 25, 1985. In that form, claimant stated that she had been laid off due to her inability to work in the employer's plant because she was pregnant and was being exposed to "toxic fumes." The insurer denied the claim less than two weeks later on April 5, 1985.

At the hearing, claimant and her husband testified that she had experienced an uneventful pregnancy and had given birth to a healthy baby boy. The focus of the hearing, therefore, was whether the morning sickness which claimant experienced at work was a compensable occupational disease. The Referee found the claim noncompensable, but ordered the insurer to pay interim compensation from March 6, 1985, the date upon which claimant's employment was terminated, through April 5, 1985, the date of the insurer's denial. In deciding that interim compensation was due from the insurer, the Referee concluded that Dr. Jeffrey's note, when viewed in the context of the events surrounding claimant's termination from employment, constituted a "claim" which triggered the insurer's duty to begin paying interim compensation 14 days after claimant left work. See ORS 656.262(4); Marlene W. Ritchie, 37 Van Natta 1088, 1094-96 (1985). In another portion of his order, the Referee assessed a penalty of 25 percent of the interim compensation awarded and an attorney fee of $250 for a disclosure of documents violation.

Although the Referee did not expressly state in his order that claimant left work because of her morning sickness, he appeared to assume that this was the case. After our de novo review of the record, we conclude that claimant's morning sickness played no material role in her absence from work after March 6, 1985. Instead, we conclude that claimant left work because of concern that her unborn child might be harmed at some point in the future through claimant's exposure to chemical fumes. With this factual clarification in mind, we turn to a discussion of applicable law.

A "claim" as defined in ORS 656.005(7) may be either express: "a written request for compensation from a subject worker or someone on the worker's behalf;" or implied: "any compensable injury of which a subject employer has notice or knowledge." "Compensation" is defined in ORS 656.005(9) as "all benefits, including medical services, provided for a compensable injury to a subject worker . . . by an insurer or self-insured employer pursuant to [chapter 656]." "Compensable injury" is defined in ORS 656.005(8)(a) as "an accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death." An occupational disease is considered an "injury" for purposes of these definitions. See ORS 656.804; 656.807(5); Brown v. SAIF, 79 Or App 205, 208 n.2, rev den 301 Or 666 (1986). "Occupational disease" is defined in ORS 656.802(1)(a) as "[a]ny 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."

From the above definitions, it is evident that before a "claim" can exist, a worker must have asserted a right to workers' compensation benefits or an existing and potentially work-related injury or disease must have come to the attention of the employer. At the time that claimant left work on March 6, 1985, the employer had no reason to suppose that claimant had sustained any injury or disease as a result of her employment. Claimant left work because of her concern that continued exposure to chemical fumes could be harmful at some point in the future to her unborn child, not because of morning sickness or any other existing and potentially work-related injury or disease. Mere exposure to potentially harmful substances at work without any evidence of existing physical or mental harm does not constitute an "injury" within the context of the above-quoted definitions. Brown v. SAIF, supra, 79 Or App at 208-09. Claimant asserted no entitlement to workers' compensation benefits until March 25, 1985, when she filed her 801 form. Under these circumstances, we conclude that a "claim" did not exist prior to March 25, 1985. No interim compensation was due on this claim because the insurer denied the claim within 14 days. See ORS 656.262(4) & (6); Jones v. Emanuel Hospital, 280 Or 147, 151 (1977).

In light of the above discussion, those portions of the Referee's order that awarded interim compensation, an associated attorney fee and a penalty for the disclosure violation computed from the award of interim compensation shall be reversed. The attorney fee awarded in connection with the disclosure violation shall be affirmed. See Spivey v. SAIF, 79 Or App 568, 572 (1986); Wilma K. Anglin, 39 Van Natta 73 (February 26, 1987).

ORDER

The Referee's order dated June 14, 1986 is affirmed in part and reversed in part. Those portions of the order that awarded interim compensation for the period from March 6 through April 5, 1985, an associated attorney fee and assessed a penalty of 25 percent of the interim compensation awarded are reversed. The remainder of the Referee's order, including that portion of the order that awarded claimant's attorney an attorney fee of $250 in connection with the disclosure violation issue, is affirmed.

ELMER R. MASSENGILL, Claimant
Ackerman, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 85-00783
March 13, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee Holtan's order that awarded claimant temporary total disability compensation from May 16, 1984 through the date of claim closure and assessed penalties and attorney fees for unreasonable resistance to the payment of compensation. The issues are temporary disability compensation, penalties and attorney fees.

On the issue of temporary disability compensation, the Board affirms and adopts the order of the Referee. On the issues of penalties and attorney fees, we reverse. The

overlapping claims in this case were sufficiently confusing and claimant's failure to maintain contact with the employer was sufficiently egregious that we conclude that no penalty or attorney fee was appropriate for unreasonable resistance to the payment of compensation. See ORS 656.262(10); 656.382(1); Hollister L. Starr, 39 Van Natta 79 (February 26, 1987).

ORDER

The Referee's order dated July 3, 1986 is affirmed in part and reversed in part. That portion of the order concerning penalties and accompanying attorney fees is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the self-insured employer.

GENE M. CLARKE, Claimant
Malagon & Moore, Claimant's Attorneys
Gleaves, et al., Defense Attorneys
Alan Ludwick (SAIF), Defense Attorney

WCB 85-14249 & 85-07940
March 16, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Nichols' order that: (1) found that his "new injury" claim with Liberty Northwest Insurance Corporation for a low back condition was barred as untimely filed; and (2) upheld the SAIF Corporation's denial of his aggravation claim for the aforementioned condition. On review, claimant contends that SAIF is the responsible party, but in any event, that his claim against Liberty should not be barred. Should we conclude that the claim with Liberty is not barred, Liberty argues that SAIF is responsible for claimant's condition.

Following our de novo review of the medical and lay evidence, we are persuaded that the incident that occurred while claimant was working for Liberty's insured independently contributed to the causation of his disabling condition, i.e., to a worsening of the underlying condition. See Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). Thus, we agree with the Referee's finding that claimant suffered a "new injury." In addition, we concur with the Referee's conclusion that claimant's "new injury" claim with Liberty is barred due to its untimeliness. Accordingly, we affirm the order of the Referee.

ORDER

The Referee's order dated June 25, 1986 is affirmed.

ROBERT S. FARR, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-03587
March 16, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of those portions of Referee Galton's order that: (1) awarded claimant temporary total disability compensation for the period of November 23, 1983 through January 8, 1984; (2) calculated claimant's temporary total disability compensation based on a wage of $12.17 per hour and a work week of 35 hours; and (3) awarded claimant 30 degrees for 20

percent scheduled permanent partial disability for the right leg, in addition to the 15 degrees for 10 percent awarded by the March 8, 1985 Determination Order. Claimant cross-requests review, contending that the Referee failed to award attorney fees for claimant's prevailing on the issues involving temporary total disability compensation. The issues are entitlement to temporary total disability compensation, the rate thereof, scheduled permanent partial disability and attorney fees.

We affirm the Referee's order, with the following addition. Claimant's cross-request for review is well-taken. The Referee's order did not provide for an award of attorney fees despite claimant's obtaining increased temporary total disability compensation at hearing. Claimant was entitled to attorney fees, and they shall be awarded by way of this order.

ORDER

The Referee's order dated June 2, 1986 is affirmed as herein modified. In addition to the provisions set forth in the Referee's order, claimant's attorney is allowed attorney fees in an amount equal to 25 percent of the increased temporary total disability compensation awarded at hearing, not to exceed $750. Fees shall be payable out of claimant's increased compensation. For services on Board review, claimant's attorney is awarded $650, to be paid by the insurer.

ALBERT HUNTLEY, Claimant
Peter O. Hansen, Claimant's Attorney
Spears, Lubersky, et al., Defense Attorneys

WCB 85-02476, 86-00293 & 86-00294
March 16, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Mulder's Order on Reconsideration that: (1) declined to award additional temporary disability or a related penalty and attorney fee; (2) refused to assess a penalty and attorney fees for improper claims processing; and (3) declined to assess penalties and attorney fees for the self-insured employer's failure to promptly reimburse claimant the cost of his van. The employer cross-requests review of that portion of the order that: (1) awarded claimant additional reimbursement for the purchase of a van; and (2) awarded claimant part time attendant care. The issues are temporary disability, claims processing, medical services, penalties and attorney fees.

The Board affirms the order of the Referee with the following modification.

The insurer argues that the issue of attendant care was not properly before the Referee as claimant had never submitted bills for payment regarding these services. We disagree.

Prior to hearing, claimant requested reimbursement for attendant care provided by his wife. The request contained both the rate and the number of hours for which claimant sought the reimbursement. In response to that request, the employer issued a denial on February 20, 1985. We conclude that claimant's request for reimbursement constituted a bill for services rendered. Consequently, the issue was properly before the Referee.

The Referee concluded that claimant was not entitled to reimbursement for attendant care on an eight hour, seven-day-per-week basis. However, he concluded that claimant should obtain reimbursement for attendant care four hours per day, four days per week, commencing January 1, 1985. Our review of the medical and lay evidence supports that portion of the Referee's order that permitted the payment of half-day attendant care.

However, the Referee further stated that claimant was not required to submit bills for future attendant care. We modify that portion of the order.

Claimant is entitled to medical services reasonably and necessarily incurred as a result of an industrial injury. ORS 656.245(1); Wetzel v. Goodwin Brothers, 50 Or App 101 (1981). The insurer must pay for these medical services within 60 days of receipt of the bills. ORS 656.262(6); See Billy J. Eubanks, 35 Van Natta 131 (1983). Further, the insurer need not pay for services that are unrelated to the injury, unnecessary or inappropriate according to accepted professional standards. OAR 436-10-040(1)(a).

The need for medical care is an on-going process which the insurer properly monitors. In order to determine whether billing is reasonably related to the injury and within the guidelines of OAR 436-10-040, it is incumbent upon the claimant to see that bills are submitted to the insurer. Should the insurer question the medical services, it has 60 days to investigate the propriety of the bills before it must respond. These procedures provide a check on the payment of medical services and can only operate if bills are submitted that the insurer can examine. The submission of these bills is a prerequisite to reimbursement.

Here, the medical evidence clearly supports claimant's request for attendant medical care. However, Dr. Ward, upon whom the Referee relies, stated that such care would be on a periodic and unpredictable basis. Based on this statement, it is reasonable to assume that the amount of care required will vary depending on claimant's condition. Therefore, claimant is required to provide the employer bills for the attendant care he actually uses at regular intervals.

ORDER

The Referee's Order on Reconsideration dated May 2, 1986, as modified, is affirmed.

ROBERT T. TRAVER, Claimant
Parker, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 85-04025 & 85-05292
March 16, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

EBI Companies requests review of Referee Leahy's order that set aside its denial of responsibility relating to claimant's low back condition and its denial of compensability and responsibility relating to claimant's upper back and bilateral shoulder conditions. The issues are compensability of claimant's upper back and bilateral shoulder conditions and responsibility for all three of claimant's conditions.

The Board affirms that portion of the Referee's order that found claimant's upper back and bilateral shoulder conditions compensable and assigned responsibility for those conditions to EBI.

We reverse that portion of the Referee's order that also found EBI responsible for claimant's low back condition. Claimant's low back condition is separable from his upper back and shoulder conditions and the evidence, at best, is in equipoise on the question of whether claimant's underlying low back condition was worsened by his employment for the second employer. We accept claimant's statement that he continued to experience low back pain after he was released to return to work from his first injury. Under these circumstances, responsibility for claimant's low back condition remains with the first employer and its insurer, United Employers Insurance Company. See Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986); Eva L. (Doner) Staley, 38 Van Natta 1280, 1281 (1986).

ORDER

The Referee's order dated May 30, 1986, as supplemented and republished by the order dated June 17, 1986, and by the order dated July 1, 1986, is reversed in part. That portion of the order that assigned responsibility for claimant's low back condition to EBI Companies is reversed. United Employers Insurance Company shall be responsible for this condition. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $600 for services on Board review on the compensability issue, to be paid by EBI Companies.

FREDRICK J. CRANE, Claimant
Noreen K. Saltveit, Claimant's Attorney
Mark Bronstein (SAIF), Defense Attorney
Rankin, VavRosky, et al., Defense Attorneys

WCB 85-05988, 85-11942, 85-10513 & 85-11941
March 17, 1987

Reviewed by Board Members Lewis and McMurdo.

Argonaut Insurance Company requests review of that portion of Referee Tenenbaum's order that set aside its denial of responsibility for claimant's low back condition and upheld the SAIF Corporation's denial of responsibility for the aforementioned condition. In the alternative, Argonaut seeks remand for the taking of additional evidence. On cross-appeal, claimant requests review of that portion of the order that declined to award an attorney fee.

Hearing was held on April 28, 1986. Following the hearing, Argonaut was found responsible for claimant's low back condition. At the time of hearing, claimant was not medically stationary and was undergoing conservative treatment for his low back condition. A CT scan had been performed prior to hearing revealing a large disc bulge at the L5-S1. Dr. Hoppert, the treating physician, diagnosed lumbar syndrome secondary to disc bulging at the L5-S1 level.

Subsequent to hearing, claimant had increased pain in his low back radiating down both legs. As a result, he had underwent a myelogram that demonstrated an anterior compression defect upon the centrum of the thecal sac at the L5-S1 level. The discovery of the nerve root compression resulted in Dr. Hoppert altering his prior opinions and recommending surgery.

In light of this additional information and request for surgery, Argonaut requests remand for the taking of additional evidence regarding responsibility. After de novo review, we agree that remand is warranted.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand it must be clearly shown that material evidence was not obtainable with due diligence before the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164 (1985). Further, newly discovered evidence which explains or clarifies a diagnosis is sufficient to support remand of the case where that evidence was unavailable at the first hearing. Thomas C. West, 38 Van Natta 855 (1986).

Here, claimant had not received a full explanation of his back condition and radicular leg pain prior to the hearing. The additional June 1986 tests provided a more complete explanation of claimant's condition, revealing nerve root compression. The importance of those tests and the new information provided is reflected in Dr. Hoppert's request for surgery. The new diagnostic information was not available until after the myleogram and, therefore, could not have been obtained with due diligence prior to hearing. Accordingly, this matter is remanded for the taking of additional evidence in light of the newly discovered information regarding claimant's low back condition.

ORDER

The Referee's order dated May 21, 1986 is vacated and this matter is remanded to Referee Tenenbaum for further proceedings consistent with this order.

EMMETT P. CURTIS, Claimant
Olson Law Firm, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-03321
March 17, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of that portion of Referee Seymour's order that awarded claimant a $500 attorney fee for his defense against the employer's cross-request for hearing. The issue is attorney fees. We reverse.

Claimant sustained a compensable shoulder injury in May 1985. The claim was ultimately closed by a February 10, 1986 Determination Order that awarded, inter alia, 20 percent unscheduled permanent partial disability for the left shoulder. Claimant requested a hearing, asserting entitlement to a greater award of permanent disability. The employer filed a cross-request for hearing, seeking a reduction in both the permanent partial and temporary total disability awards made by the Determination Order. The Referee reduced claimant's temporary total disability award, but affirmed the award of permanent partial disability. The Referee then awarded claimant a $500 attorney fee for defending against the employer's cross-request on the issue of permanent partial disability. The Referee cited Travis v.Liberty Mutual Insurance, 79 Or App 126 (1986), as authority for the attorney fee.

The employer asserts that Travis is distinguishable from the present case, in that while Travis involved a cross-appeal to the Board, this case involves a cross-appeal to the Hearings Division. We do not find the distinction meaningful, for OAR 438-47-075, the administrative rule governing cross-appeal attorney fees, applies to all cross appeals. See Steven J. Snell 39 Van Natta 115 (March 12, 1987); Allen Fanno, 38 Van Natta 1368 (1986).

The employer next asserts that Travis is distinguishable in that in Travis, the employer did not prevail in reducing the benefits awarded by the Determination Order. In the present case, the employer succeeded in its efforts to reduce claimant's temporary total disability award. Again, however, we do not find the distinction meaningful. The issue here is whether an attorney fee was awardable on the issue of permanent partial disability. The employer did not succeed in reducing that award; it succeeded in obtaining a reduction of a collateral award.

Finally, the employer argues that OAR 438-47-075 controls, despite the court's Travis holding. The administrative rule provides:

> "In the event of a cross-appeal by either party, 47-000 to 47-095 shall be applied as if no cross appeal was taken, unless the party initiating the appeal withdraws his appeal and the cross appellant proceeds; in which case the cross appellant shall be considered the initiating party."

Because claimant did not withdraw his appeal of the permanent partial disability issue, the employer argues that the aforementioned administrative rule precludes the attorney fee awarded by the Referee. The employer relies, in part, on Richard M. Deskins, 38 Van Natta 494, on reconsideration, 38 Van Natta 825 (1986). Claimant responds that Deskins is contrary to the "clear mandate" of Travis, supra, and that the Board is not bound to follow its own administrative rules.

We agree with the employer. The court in Travis concluded that an insurer's cross appeal on the issue of extent of permanent disability constituted a request "initiated by an employer or insurer." It held, therefore, that a successful defense against such a request entitled the claimant to an attorney fee pursuant to ORS 656.382(2). As we subsequently noted in Deskins, supra, however, the Travis court did not discuss OAR 438-47-075 in reaching its decision. Finding in Deskins that we are bound to follow the dictates of our own rule, see Wattenbarger v. Boise Cascade Corp., 301 Or 12 (1986), we denied the claimant's request for an attorney fee. Deskins, 38 Van Natta at 826. Deskins is similar to the present case.

We remain of the belief that we are bound by our own administrative rules. Until we are instructed otherwise by superior authority, we will follow them. The Referee's attorney fee award shall be reversed.

ORDER

The Referee's order dated June 26, 1986 is reversed in

part and affirmed in part. That portion of the Referee's order that awarded claimant a $500 attorney fee for defending against the self-insured employer's cross-request for hearing is reversed. The remainder of the Referee's order is affirmed.

JERRY L. JARVIS, Claimant
Vick & Associates, Claimant's Attorneys
Judy L. Johnson (SAIF), Defense Attorney
Davis, Bostwick, et al., Defense Attorneys

WCB 85-14849 & 85-12492
March 17, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of those portions of Referee Mulder's order that upheld the SAIF Corporation's denial of claimant's right shoulder condition on behalf of one employer and upheld another denial of the same condition by the SAIF Corporation on behalf of a subsequent employer. In addition, claimant has submitted a motion for relief from default in that his initial brief on Board review was not timely filed. The issues are whether the Board will consider claimant's brief in reviewing this case, compensability and responsibility.

The Board concludes that waiver of the briefing deadlines in this case is necessary to avoid undue hardship and prevent manifest injustice. OAR 438-11-025. Consequently, the Board has considered claimant's brief on Board review. On the merits, the Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated July 9, 1986 is affirmed.

CLAY B. SHEPPERD, Claimant
Quintin B. Estell, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-09838
March 17, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim relating to the thoracic and lumbar regions of his spine, (2) upheld SAIF's denial of medical services; and (3) rejected claimant's request for penalties and attorney fees for a disclosure violation. The issues are aggravation, medical services, penalties and attorney fees.

The Board affirms the Referee on the issues of aggravation, medical services and penalties. On the issue of attorney fees, we reverse. Although there was no compensation due from which to calculate a penalty, claimant's attorney is nonetheless entitled to an attorney fee for establishing the disclosure violation. See Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162, 164 (1986); Spivey v. SAIF, 79 Or App 568, 572 (1986); Wilma K. Anglin, 39 Van Natta 73 (WCB Case No. 86-00598; February 26, 1987). But see Miller v. SAIF, 78 Or App 158, 161-62 (1986). We conclude that an attorney fee of $100 is appropriate under the circumstances of this case.

ORDER

The Referee's Order on Reconsideration dated May 23, 1986 is reversed in part. That portion of the order that rejected

claimant's request for attorney fees for the disclosure violation is reversed. Claimant's attorney is awarded an attorney fee of $100, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

BETTY J. WILSON, Claimant
Nick Chaivoe, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 83-09241
March 17, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Leahy's order that affirmed a Determination Order which increased claimant's award of unscheduled permanent partial disability for his low back to 30 percent (96 degrees). In its brief on review, the employer argues that claimant's award should be reduced. The issue is extent of disability.

Claimant compensably strained her low back in May 1983 when she pushed a large roll of paper off a trailer. She was treated primarily by Dr. Apple, a chiropractor, and the claim was closed by Determination Order in September 1983 with a five percent unscheduled award.

Within two months of claim closure, claimant returned to Dr. Apple complaining of increased pain. The claim was reopened. Claimant underwent a number of diagnostic procedures including an EMG and bone scan which were negative. She also received treatment at a pain center and vocational assistance. Vocational assistance was terminated in March 1984 for failure to cooperate. Claimant was declared medically stationary by Dr. Apple and he and a number of consulting doctors indicated that she should avoid heavy lifting. The claim was reclosed in September 1984 with a 25 percent unscheduled award in addition to the five percent previously awarded. Claimant returned to modified work for the employer in October 1984 and in February 1985, returned full time to the work she was performing at the time of her original injury.

In rating the extent of claimant's unscheduled permanent partial disability for her low back, we consider her physical impairment as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

Claimant was 40 years old at the time of the hearing. According to one psychological report in the file, claimant has an I.Q. of 74, which would place her in the borderline retarded category. Elsewhere in the file, a vocational report states that claimant graduated from high school with a 2.0 G.P.A. Claimant has also received training as a keypunch operator. After our de novo review of the record, including claimant's testimony, we find that her level of intelligence is at least in the dull normal range and is probably in the normal range. Claimant's work history includes an unspecified job in a hospital and various jobs in the employer's paper mill.

Following our de novo review of the medical and lay evidence, we conclude that claimant's low back impairment is in the minimal range. Exercising our independent judgment in light

of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of 48 degrees for 15 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to her industrial injury.

ORDER

The Referee's order dated April 3, 1986 is reversed in part. That portion of the order that affirmed the award by Determination Order dated September 6, 1984 of 25 percent (80 degrees) unscheduled permanent partial disability in addition to the five percent (16 degrees) previously awarded by the Determination Order dated September 19, 1983 is reversed. Claimant is awarded 10 percent (32 degrees), in lieu of the 25 percent granted by the 1984 Determination Order, for a total award to date of 15 percent (48 degrees). The remainder of the Referee's order is affirmed.

MARNELL F. BINKLEY, Claimant
David Force, Claimant's Attorney
Spears, Lubersky, et al., Defense Attorneys

WCB 86-04429
March 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of that portion of Referee Brown's order that set aside its denial of claimant's occupational disease claim for his low back. The issues are compensability and responsibility.

Claimant originally injured his low back in August 1977 in the course of his employment with Pacific Motor Trucking Company (PMT) when he helped unload a truck containing heavy rolls of carpeting. Claimant was treated primarily by Dr. Serbu, a neurosurgeon, and complained of low back and left leg pain. All treatment was conservative. Dr. Serbu released claimant to his regular work at PMT in March 1978. The claim was eventually closed by Determination Order in October 1978 with no award of permanent partial disability. Except during periodic lay-offs when he worked briefly for several other trucking companies, claimant continued to work for PMT until September 1981, when he was again laid off. In October 1981, claimant began working for another trucking company, T.J. Transport.

In February 1982, claimant visited his family practitioner, Dr. Fletchall, with complaints of acute low back pain and numbness in his right leg. Dr. Fletchall took x-rays of claimant's low back and compared them to x-rays taken at the time of claimant's 1977 injury. He interpreted the x-rays as showing marked narrowing of the L5-S1 disc space since 1977 and thought that the disc at that level was degenerating. He attributed this degeneration to "the jar and chatter" of truck driving. After receiving a copy of Dr. Fletchall's report, PMT issued denials of compensability and responsibility. Claimant requested hearings on the denials, but filed no claims against any of his other employers. Claimant continued working for T.J. Transport until August 1982.

PMT's denials came to hearing before Referee Nichols on January 7, 1983. In an Opinion and Order issued later the same month, Referee Nichols upheld PMT's responsibility denial on the ground that claimant had sustained a "new injury" after leaving PMT in September 1981. Referee Nichols' decision was affirmed by the Board and the Court of Appeals and the Supreme Court denied review.

Soon after Referee Nichols issued her order, claimant filed a claim against T.J. Transport. T.J. Transport did not respond to the claim within 60 days and claimant requested a hearing. In March 1984, claimant and T.J. Transport entered into an stipulation whereby T.J. Transport agreed to pay overdue interim compensation, penalties and attorney fees. According to a statement in the stipulation, which we accept as factual, claimant returned to work as a truck driver on August 30, 1983 and continued to work periodically through the date of the stipulation for one or more unnamed employers.

On May 7, 1984, claimant returned to work for PMT and worked until October 18, 1985. In November 1985, claimant visited Dr. Davis, an orthopedic surgeon, on referral from Dr. Fletchall. Claimant complained of ongoing low back and left leg pain and occasional right leg pain. Dr. Davis ordered a CT scan to rule out the possibility of a ruptured disc. The CT scan showed no evidence of a disc protrusion or spinal stenosis. In December 1985, after reviewing the CT scan, Dr. Davis diagnosed claimant's condition as "irritable low back syndrome" and stated:

> "It is my opinion that [claimant] has had a significant injury to his back in 1977, that his continuing work as a long-haul truck driver has added stress to his back, and caused him to recurrently have pain and disability. He presents himself with one of his painful episodes at this time."

Dr. Davis went on to recommend that claimant participate in a "back rehabilitation program" and suggested the Injured Workers' Program at Sacred Heart Hospital in Eugene.

Claimant was examined by another orthopedic surgeon, Dr. Baker, on February 4, 1986. In a report of the same date, Dr. Baker stated:

> "I am in complete agreement with Dr. Davis' evaluation on this gentleman. In my opinion, his original injury in 1977 was a significant injury to his back. Continued wear and tear has progressed and is aggravated by his continuing work as a long-haul truck driver. Presently he is having one of his painful episodes which necessitates his being off work."

Dr. Baker concurred in Dr. Davis' recommendation of a "back rehabilitation program." At the end of his report, Dr. Baker summarized his previous remarks by stating: "In my opinion, [claimant's] present condition is a continuation of the previous problem beginning in August 1977."

In March 1986, counsel for T.J. Transport wrote a letter to Dr. Davis which stated in pertinent part:

> "As you recall, we discussed your evaluation of [claimant] on January 31, 1986 [sic]. Based on our conversation, it is my understanding that [claimant's] most recent

employment activities at Pacific Motor Trucking Company contributed in major part to a worsening in his preexisting lower back condition.

"If the above is consistent with your understanding, please sign and date this letter in the space provided below. . . ."

Dr. Davis signed the letter and dated it March 21, 1986.

Claimant filed an 801 form with PMT on February 13, 1986 and PMT issued a denial later the same month. Claimant requested a hearing on this denial which was consolidated with the request on the T.J. Transport denial. The denials came to hearing before Referee Brown on June 4, 1986. At the beginning of the hearing, claimant's attorney announced that the claim against T.J. Transport had been settled and that claimant was withdrawing the request for hearing relating to that employer.

Claimant was the only witness at the hearing. He testified that after returning to work for PMT in May 1984, his low back and leg pain gradually increased until October 1985, when he could no longer tolerate it. Claimant attributed his increased pain to the continual "bouncing" associated with his work as a truck driver. He did not think that he could ever return to truck driving. Claimant denied working during the year prior to returning to PMT in May 1984, a statement contradicted by the March 1984 stipulation between claimant and T.J. Trucking.

In his opinion, the Referee correctly indicated that in order to establish a compensable claim against PMT, claimant had the burden of proving that his work activity for PMT after May 7, 1984 was the major contributing cause of a pathological worsening of his preexisting low back condition. See Weller v. Union Carbide Corp., 288 Or 27, 35 (1979); Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983). The Referee then acknowledged that the issue presented was primarily a medical question and that the medical evidence in the record did not preponderate in favor of compensability. He nonetheless concluded that the "collateral evidence" tipped the scale in claimant's favor and thus set aside PMT's denial.

We disagree with the Referee's conclusion. The reports of Dr. Davis and Dr. Baker provide little or no basis for the conclusion that claimant's condition pathologically worsened after May 7, 1984. Although Dr. Davis signed a letter composed by counsel for T.J. Transport stating that claimant's preexisting back condition had been "worsened" by claimant's most recent work activities with PMT, the document does not define what kind of a worsening was contemplated and Dr. Davis' earlier report indicates that only a symptomatic worsening had occurred. As for claimant's testimony, we conclude that it is more consistent with a symptomatic worsening than a pathological one. We conclude, therefore, that claimant has failed to establish a compensable occupational disease.

ORDER

The Referee's order dated July 29, 1986 is reversed in part. Those portions of the order that set aside the self-insured

employer's denial dated February 21, 1986 and that awarded claimant's attorney an associated attorney fee of $1,400 are reversed. The remainder of the order is affirmed.

CYNTHIA J. CLARK, Claimant
Cash Perrine, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 86-00753
March 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee Quillinan's order that upheld the insurer's denial of claimant's aggravation claim for her low back and declined to award additional temporary disability compensation. In her brief on review, claimant also raises the issues of penalties and attorney fees for failure to accept or deny her aggravation claim in a timely fashion. By separate motion, claimant has requested that the Board remand the case for further development on the aggravation issue. The issues are remand, aggravation, res judicata, rate of temporary disability compensation, penalties and attorney fees.

Claimant requests that the Board remand this case for receipt of reports of a CT scan and myelogram, performed after the date of the hearing, as well as a post-hearing opinion by claimant's treating neurosurgeon, Dr. Kendrick. Less than a month before the hearing, claimant was examined by a panel of the Orthopaedic Consultants. The panel recommended the additional diagnostic tests which ultimately were performed after the date of the hearing. In view of the recommendation by Orthopaedic Consultants for additional diagnostic tests, the insurer suggested that the hearing be postponed. Claimant objected to a postponement and insisted on proceeding to hearing on the record as it stood at that time. Claimant did not request that the record be held open for the receipt of evidence of the results of the proposed diagnostic tests or of any other evidence based upon those tests.

Under these circumstances, we conclude that the case has not been improperly, incompletely or otherwise insufficiently developed or heard by the Referee and that remand would be inappropriate. See ORS 656.295(5). Consequently, claimant's request for remand is denied.

On the aggravation, res judicata and temporary disability issues, the Board affirms the order of the Referee.

On the penalty and attorney fee issues, the Referee entered no ruling. Claimant had raised the issues of penalties and attorney fees for the insurer's allegedly late denial of her aggravation claim in her request for hearing, but these issues were not included by the Referee in her statement of the issues at the beginning of the hearing. Both claimant and the insurer expressly acknowledged and approved the Referee's statement of the issues and the record on the penalty and attorney fee issues was not developed. Under these circumstances, we conclude that it would not be in the interests of substantial justice to address the issues of penalties and attorney fees raised by claimant on Board review. See ORS 656.012(2)(b); 656.283(7); 656.295(5) & (6); Peter R. Rios, 38 Van Natta 868 (1986).

ORDER

The Referee's order dated August 11, 1986 is affirmed.

DARRELL D. COWGILL, Claimant
Cash Perrine, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 85-08197
March 19, 1987
Order on Review

Reviewed by Board Members en banc.

The insurer requests review of that portion of Referee Nichols' order that set aside its denial of claimant's occupational disease claim for his right shoulder. The issue is compensability.

Claimant visited Dr. Johnson on May 2, 1985 complaining of pain in his right shoulder. According to Dr. Johnson's chart notes, claimant stated that his shoulder had bothered him for many years, ever since a football injury. Claimant also stated that he had experienced an acute increase in shoulder discomfort and weakness beginning a couple of days earlier at a golf course when he lifted his golf bag. Dr. Johnson prescribed conservative treatment.

Claimant's shoulder did not respond to conservative treatment and in late May 1985, Dr. Johnson referred claimant to Dr. Carroll, an orthopedic surgeon. On May 28, 1985, claimant underwent an arthrogram and a rotator cuff tear was diagnosed. Dr. Carroll recommended surgery.

Two or three days after his condition had been diagnosed, claimant contacted his employer's office and spoke to the personnel coordinator. Claimant told the personnel coordinator that he was having problems with his shoulder and asked for a comparison of health insurance and workers' compensation benefits. After the personnel coordinator finished comparing the benefits provided under the two systems, claimant remarked that workers' compensation benefits "were a lot more." Claimant filed a workers' compensation claim a few days later stating that his shoulder had become sore "over the last couple of years."

Claimant underwent surgical repair of his rotator cuff on June 6, 1985. The insurer denied the compensability of claimant's condition the following month. In September 1985, Dr. Carroll stated in a letter to claimant's attorney, "I would be in favor of supporting [claimant's] position that his work has had an important effect on the deterioration and eventual rupture of his right shoulder tendons."

At the time that claimant filed his claim, he was 55 years old and had worked for the employer as a saw fitter for nearly seven years. At the hearing, claimant testified that his job involved the sharpening of large, heavy band saw blades twice per day. Claimant described the process as consisting of the following steps: removing the blade from the saw, loading it onto a dolly, rolling the dolly to a grinding machine, loading the blade onto the grinding machine, sharpening the blade, removing the blade from the grinding machine onto a dolly, rolling the dolly back to the saw and putting the blade back onto the saw. Claimant indicated that he was required to lift his arms above his head on a few occasions during this process, but he did not detail

the nature, frequency and duration of this overhead activity. On cross-examination, claimant conceded that he was assisted during most, if not all, of the blade sharpening process either by cranes or other power operated machinery or by other employes.

With regard to the golf bag incident, claimant indicated that it was a relatively minor event and characterized the pain associated with it as "kind of like snapping you on the shoulder with a rubber band." Claimant admitted having broken his collarbone in football in high school, but denied that he told Dr. Johnson that his shoulder had bothered him ever since that time.

The record was left open for a deposition of Dr. Carroll and for a report by a consulting orthopedic surgeon, Dr. Wade. At the beginning of his deposition, Dr. Carroll stated that he considered claimant's work activity as a saw fitter "a major contributing factor" to the rupture of his rotator cuff. Later, Dr. Carroll related that when he performed surgery on claimant's shoulder the rotator cuff tear was not a fresh, sharply defined tear, but the culmination of a longstanding degenerative process. He described the golf bag incident as the "last gasp" that resulted in the rupture of the degenerated tendon.

On cross-examination, Dr. Carroll stated that claimant had never told him how much of his work activity was above shoulder level, but that it was his assumption that it was between four and six hours per day. Dr. Carroll stated that his opinion regarding the contribution of claimant's work activity to his shoulder condition could be different if this assumption was not substantially accurate. Dr. Carroll also stated that he was unaware of the football injury that claimant had sustained and, assuming that claimant had experienced pain in his shoulder since that injury, he stated that the rotator cuff degeneration he observed was consistent with the football injury.

Dr. Wade stated in his report that claimant's rotator cuff tear was due to a combination of the golf bag incident and the natural degeneration of the cuff with daily activities which had no particular correlation with claimant's work activity. He concluded that claimant's shoulder condition was "not substantially related to his employment."

In order to prove the compensability of an occupational disease claim for his shoulder condition, claimant has the burden of establishing by a preponderance of the evidence that his work activity was the major contributing cause of the degeneration of his rotator cuff. Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983). On our de novo review of the record, we conclude that claimant has failed to carry this burden. The crucial medical evidence supporting the claim is of questionable validity at best. As was clear from the deposition, Dr. Carroll did not have a full or accurate description of claimant's medical history or of his work activity. When informed more accurately of these matters, Dr. Carroll indicated that his opinion might not be valid. Under these circumstances, we conclude that the opinion of Dr. Wade, which was based upon complete and accurate information, is more persuasive than that of Dr. Carroll. See Somers v. SAIF, 77 Or App 259, 263 (1986).

ORDER

The Referee's order dated May 12, 1986 is reversed in part. Those portions of the order that set aside the insurer's denial of claimant's right shoulder condition and awarded an associated attorney fee are reversed. The denial dated July 2, 1985 is reinstated and affirmed. The remainder of the order is affirmed.

Board Member Lewis dissenting:

I respectfully dissent. From my review of the file, claimant has carried his burden of proving that his work as a saw fitter was the major contributing cause of the degeneration and eventual rupture of his rotator cuff. Like the Referee, I conclude that Dr. Carroll had a sufficient understanding of claimant's work activities and history regarding his shoulder problem, to make a valid and persuasive opinion. Also like the Referee, I find Dr. Carroll's opinion, as the treating physician, more persuasive than that of Dr. Wade.

Consequently, I would affirm the well reasoned opinion of the Referee.

Beneficiaries of LAWRENCE DIGBY, Claimant WCB 85-01620
Welch, Bruun & Green, Claimant's Attorneys March 19, 1987
Richard Barber, Jr. (SAIF), Defense Attorney Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Thye's order that found that Judy Digby was entitled to benefits pursuant to ORS 656.226. The issue is whether Judy Digby is a beneficiary.

This claim originally came before us on the question of compensability of the myocardial infarction of Lawrence Digby, deceased. On review, we reversed the Referee's finding of compensability and reinstated SAIF's denial. Lawrence W. Digby, 37 Van Natta 992 (1985). Prior to our order, denied Judy Digy's claim for benefits. SAIF contended that Judy Digby was not the proper beneficiary. On May 17, 1985, Referee Thye issued an order upholding this denial. Subsequent to that hearing, we reversed the Referee's finding of compensability. Thereafter, claimant requested review by the Court of Appeals.

Pending review by the Court of Appeals, Judy Digby provided new evidence regarding her marital status and asked the Board to remand the case for the taking of additional evidence concerning her status as beneficiary. Concluding that the new evidence warranted remand, we granted the request. However, we acknowledged that the issue would be moot should our order finding the underlying claim noncompensable be upheld. Lawrence W. Digby, 38 Van Natta 92 (1986). Thus, the order on remand was predicated on a subsequent finding of compensability by the Court of Appeals.

Since our remand order, the Court of Appeals has affirmed the Board's finding that the underlying myocardial infarction claim was not compensable and review has been denied by the Supreme Court. Digby v. SAIF, 79 Or App 810 rev den, 302 Or 35 (1986). Therefore, as SAIF correctly points out, the present case is moot and without effect.

Judy Digby concedes that the claim is no longer compensable. However, she asserts that but for the second denial, she would have received benefits until our subsequent finding of noncompensability.

We disagree. SAIF processed this claim according to law. Its' denial of Ms. Digby's claim as a beneficiary was reasonable, and all pending benefits were paid correctly.

ORDER

The Referee's order dated July 29, 1986 is vacated and this matter is dismissed.

CURTIS G. RUSSELL, Claimant
Ackerman, et al., Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 85-07734
March 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of that portion of Referee Foster's order that set aside its denial of claimant's aggravation claim. Claimant cross-appeals that portion of the order that refused to award temporary total disability after June 11, 1985. Should we reverse the Referee's finding of an aggravation, claimant seeks additional unscheduled permanent disability. The issues are aggravation, temporary disability and extent of unscheduled permanent disability.

The Board affirms the order of the Referee.

Claimant's brief was submitted one day late. The brief's lateness has been waived pursuant to OAR 438-11-025 as claimant has established that the waiver is necessary "to avoid undue hardship and prevent manifest injustice." Consequently, the brief has been considered on appeal.

Further, we find the aggravation issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated May 12, 1986 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

CHARLES E. LECKINGTON, Applicant
Ann Kelley, Ass't. Attorney General

WCB CV-86009
January 22, 1987
Findings of Fact, Conclusions and Proposed Order (Crime Victim Act)

Applicant has requested review by the Workers' Compensation Board of the Department of Justice's (Department) Findings of Fact, Conclusions and Order on Reconsideration dated June 2, 1986. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.365. The Department based its denial on its finding that claimant's compensable loss did not meet the minimum $250 requirement as set forth in ORS 147.015(1).

FINDINGS OF FACT

The parties have submitted this case to the Board on the following stipulated facts: Applicant was the victim of an assault and robbery that occurred on November 23, 1985. The applicant and the assailant were neither related nor did they share the same household. Applicant committed no wrongful act nor did he substantially provoke the assailant. He timely reported the crime to law enforcement officials. His claim for benefits with the Crime Victim's Compensation Program was timely filed. As a result of the assault, applicant incurred medical expenses totalling $220. This total includes $32 for an eyeglass lens and $188 for hospital expenses.

CONCLUSIONS

Pursuant to ORS 147.015, applicant is entitled to an award under the Compensation of Crime Victims Act (Act), if, among other requirements:

> "(1) [He] is a victim, or is a dependent of a deceased victim of a compensable crime that resulted in a compensable loss of more than $250."

It is undisputed that applicant was the victim of a compensable crime and that he has timely filed his application for benefits. However, there is also no dispute that applicant sustained a compensable loss in an amount less than the statutory minimum requirement of $250. That being the case, applicant is not entitled to an award of compensation under the Act. See Robert E. Stam, Jr., 37 Van Natta 1097 (1985). Accordingly, I conclude that the Department's Findings of Fact, Conclusions and Order on Reconsideration dated June 2, 1986 should be affirmed.

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated June 2, 1986 be affirmed.

A.G. McCULLOUGH, Claimant
Hayner, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 85-02415
March 20, 1987
Order on Reconsideration

The self-insured employer has requested reconsideration of the Board's Order on Review dated February 24, 1987. Specifically, the employer asks that we authorize an offset of the "overpaid" temporary disability benefits awarded by our order against previously paid permanent disability benefits. The request for authorization is denied.

In our prior order, we concluded that the employer was obligated to pay temporary disability benefits until claimant was released to regular work, returned to regular work, or a Determination Order issued. Since claimant had neither actually returned, nor been released to return, to his regular work before

the issuance of a Determination Order, we held that temporary disability compensation should not have been terminated.

Subsequent to the issuance of the Determination Order, the appellate courts found the claim not compensable. By this time, claimant had apparently received his entire permanent disability award as granted by the Determination Order. Anticipating our decision directing it to pay temporary disability benefits, the employer requested permission to offset the "overpayment" created by our order against the permanent disability award. We rejected the employer's request. We reasoned that the appellate courts' decision of noncompensability ensured that there would be no future permanent disability payments against which to offset the so-called "overpayment."

An employer/insurer may not recoup overpayments without prior authorization from the Board, a Referee, or the Workers' Compensation Department. Forney v. Western States Plywood, 66 Or App 155, 159-60 (1983), aff'd 297 Or 628 (1984). In Forney, the court implicitly decided that an employer/insurer may still recover an overpayment by offsetting it against future compensation after obtaining the approval of a Referee or the Board. Travis v. Liberty Mutual Insurance, 79 Or App 126 (1986). This future compensation is limited to awards of permanent disability. Harold D. Bates, 38 Van Natta 992 (1986). If the "overpayment" exceeds the unpaid permanent disability award, the authorization continues after the initial offset. Dennis E. Berliner, 38 Van Natta 1284 (1986).

The employer argues that the prior Determination Order authorized an offset by stating that "DEDUCTION OF OVERPAID TEMPORARY TOTAL DISABILITY, IF ANY, FROM UNPAID PERMANENT DISABILITY IS APPROVED." We do not find this argument persuasive. At the time of the Determination Order, no overpaid temporary disability existed. We fail to see how the Determination Order could have authorized an offset for a so-called "overpayment" created some 21 months later. Furthermore, when the "overpayment" was created, no permanent disability award remained unpaid. Thus, there was no award against which to offset the "overpayment."

In support of its request, the employer cites Arnold C. Blondell, 36 Van Natta 818, 36 Van Natta 1062 (1984). In Blondell, we found that the employer was not prohibited from claiming an overpayment which had been caused by procedural dictates of the law. However, we concluded that any recovery of the overpayment must be accomplished in accordance with the Forney decision and would be offset against compensation to which claimant may become entitled in the future. Blondell, 36 Van Natta at 819.

Our decision is consistent with the aforementioned reasoning. An "overpayment" may have been created by our order. Yet, we need not address that question. The appellate courts' ultimate finding of noncompensability has insured that no future compensation will be forthcoming concerning this claim. Thus, there will be no further amounts against which the employer can offset this "overpayment." Moreover, the permanent disability benefits were appropriately paid pursuant to a standing Determination Order while the claim was considered compensable.

The fact that the claim has ultimately been found noncompensable does not entitle the employer to recover this compensation which was properly paid pending review of the compensability question. ORS 656.313; Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581 (1984).

Accordingly, the employer's request for reconsideration is granted and our prior order is withdrawn. On reconsideration, we adhere to and republish our former order, as supplemented herein, effective this date.

IT IS SO ORDERED.

JOHN E. CAIN, Claimant
Malagon & Moore, Claimant's Attorneys
Wiswall & Hendricks, Defense Attorneys
Phillip Nyburg (SAIF), Defense Attorney

WCB 82-10108
March 23, 1987
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Cain v. Woolley Enterprises, 83 Or App 213 (1986). The court has mandated that this matter be remanded to the Referee for the taking of additional evidence and for reconsideration.

Accordingly, this matter is remanded to Referee McCullough for consideration of the new evidence and for further action consistent with the court's opinion.

IT IS SO ORDERED.

LARRY L. MOE, Claimant
Vick & Associates, Claimant's Attorneys
Davis, et al., Defense Attorneys

WCB 85-10486
March 23, 1987
Order of Dismissal

Claimant's attorney requested Board review March 3, 1987. On March 5, 1987 attorneys for defendant/respondent filed a motion to dismiss the request based on claimant's failure to serve all parties to this proceeding, specifically the claimant and the employer. Copies of the motion are shown as having been served on all parties.

We have received no response to defendant/respondent's motion. Therefore, this matter is dismissed.

KAREN M. PARTRIDGE (WELCK), Claimant
Peter O. Hansen, Claimant's Attorney
Steven T. Maher (SAIF), Defense Attorney

WCB 85-07711
March 23, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Mulder's order that: (1) upheld the SAIF Corporation's denial dated March 24, 1983 of an unspecified condition causing claimant to experience recurrent episodes of nausea and vomiting; (2) upheld SAIF's de facto denials of medical treatment for recurrent episodes of nausea and vomiting; (3) upheld SAIF's de facto denial of an alleged aggravation claim; (4) rejected claimant's request for interim compensation; and (5) rejected claimant's request for penalties and attorney fees for failure to accept or deny the various claims in timely fashion and for failure to pay interim compensation. The issues are res judicata, compensability,

medical services, aggravation, interim compensation, penalties and attorney fees.

Claimant compensably injured her low back on January 18, 1982 when she was pressed against the interior wall of the trailer of a freight truck by a pallet of groceries on a pallet jack. Two days after the accident, claimant sought treatment at a hospital for low back and leg pain. A CT scan revealed a mild to moderate bulging disc at L4-5 which contacted the L4 nerve root. While in the hospital, claimant was attended by Dr. Mack, her family practitioner. Besides low back and leg pain, Dr. Mack noted neck tightness and a headache and recorded a history of migraine headaches accompanied by photophobia, nausea and vomiting. His diagnoses were acute low back strain and probable migraine headache associated with tension.

Later the same day, claimant was examined by Dr. Crumpacker, a neurologist. Besides low back and leg pain, Dr. Crumpacker noted neck pain, tingling in the left upper extremity and a severe headache accompanied by nausea and vomiting. Claimant told Dr. Crumpacker that she had experienced migraine headaches all of her adult life and that during the previous three years the headaches had gradually increased in frequency from about once per year to about once every two or three weeks. The headaches usually lasted from 8 to 24 hours and were treated with medications and, occasionally, with injections at the emergency room.

After claimant had been in the hospital for nearly two weeks, she was examined by a neurological surgeon, Dr. Franks. Claimant told Dr. Franks that her low back and leg pain had not improved significantly during her hospital stay. Dr. Franks found claimant "a bit histrionic" in her movements during physical examination and suspected a functional component to her complaints, but reluctantly decided to proceed with a myelogram and bone scan to rule out the possibility of a herniated disc or other organic cause of claimant's pain. He noted claimant's history of migraine headaches and commented that this condition had "apparently [been] made worse recently because of the stresses of her trauma." The myelogram yielded no evidence of a herniated disc. The bone scan was indicative of very mild sacroiliitis on the right. Claimant was discharged from the hospital by Dr. Mack on February 5, 1982 with a final diagnosis of acute low back strain syndrome and mild sacroiliitis with apparent tension, anxiety and migraine headaches.

During the next seven months, claimant sought emergency room treatment for back and neck pain, headaches, nausea and vomiting on at least six occasions and was hospitalized on three occasions. During this period, Dr. Manley, an orthopedic surgeon, became claimant's primary treating physician. In May 1982, Dr. Manley opined that claimant's headaches were not migraines, but instead were tension headaches related to chronic back and neck pain due to the industrial injury. In July 1982, Dr. Brown, a consulting neurologist, reviewed claimant's records and opined that claimant's headaches were not causally related to her industrial injury. On August 11, 1982, SAIF issued a denial of what it termed claimant's "headache symptoms and any treatment directed to this problem." Claimant requested a hearing on this denial. Claimant's back and neck condition was closed by Determination Order in December 1982 with an award of 10 percent

unscheduled permanent partial disability. Claimant requested a hearing on this Determination Order.

Claimant was again hospitalized for back and neck pain, headaches, nausea and vomiting in January 1983. In a letter dated January 8, 1983, Dr. Manley informed SAIF that claimant had experienced an acute exacerbation of her symptoms and requested that her claim be reopened. During the next three months, claimant sought emergency room treatment for back and neck pain, headaches, nausea and vomiting on at least three occasions and was hospitalized again in March 1983. On March 24, 1983, SAIF issued an aggravation denial relating to claimant's neck and back condition on the ground that the condition had not worsened. The denial went on to state:

> "Also we are denying your condition which has caused nausea and vomiting. However, we will continue to pay for medical treatment per ORS 656.245 as long as the medical bills and treatment are related to your neck and back condition."

Claimant requested a hearing on this denial. During the next six months, claimant sought emergency room treatment for back and neck pain, headaches, nausea and vomiting on at least five occasions and was hospitalized twice.

A hearing was held in June 1983 before Referee Menashe. In his Opinion and Order which was issued in September 1983, the Referee designated the issues as extent of disability for claimant's back and neck condition and the compensability of claimant's headaches. The Referee then stated, "The denial issued on March 24, 1983 was not litigated." This was a reference to the denial of claimant's aggravation claim and her "condition which has caused nausea and vomiting." The Referee set aside the headache denial and increased claimant's unscheduled award for her back and neck to 25 percent.

Between the date of Referee Menashe's order and the hearing before Referee Mulder in March 1986, claimant sought emergency room treatment at least a dozen times for back and neck pain, headaches, nausea and vomiting. On one of these occasions, claimant was hospitalized for four days in April 1985. SAIF refused to pay for much of the treatment associated with claimant's frequent emergency room visits on the ground that the March 24, 1983 denial was still in effect. Claimant requested a hearing on the March 1983 denial and the individual refusals of payment for medical services and also raised aggravation, interim compensation, penalties and attorney fees as issues in connection with her April 1985 hospitalization.

At the hearing before Referee Mulder, SAIF argued that res judicata barred litigation of the March 24, 1983 denial because claimant had failed to litigate the denial at the time of the previous hearing before Referee Menashe. Referee Mulder accepted this argument and, in light of this conclusion, ruled that claimant's claim for medical services, her aggravation claim, her claim for interim compensation and her request for penalties and attorney fees were without merit.

Res judicata bars litigation of any issue raised or raisable at the time of a previous adjudication if the issue was

part of the cause of action previously adjudicated. Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). The party asserting the affirmative defense of res judicata has the burden of establishing that the issue allegedly barred falls within the scope of the previously adjudicated cause of action. See Norman E. Thurston, 37 Van Natta 1663, 1666 (1985); Lewis Twist, 34 Van Natta 290, 293 (1982), aff'd, Tektronix Corp. v. Twist, 62 Or App 602, rev den 295 Or 259 (1983).

We conclude that SAIF has failed to establish that the March 24, 1983 denial fell within the scope of the cause of action adjudicated by Referee Menashe in his September 1983 order. Claimant had requested a hearing on the denial. Referee Menashe then stated in his opinion: "The denial issued on March 24, 1983 was not litigated." Only two interpretations of Referee Menashe's statement appear plausible under these circumstances: (1) the parties had agreed to reserve the denial for later adjudication; or (2) claimant had failed to raise the denial as an issue at the hearing or put on evidence to contest the denial. If the latter of these interpretations is correct, claimant had failed to carry her burden of proof on the denial and the denial would have been upheld by Referee Menashe later in his order. The order, however, made no disposition of the denial. This leaves the former interpretation as the most plausible and causes us to conclude that the denial was reserved for the litigation which eventually occurred before Referee Mulder. The Referee erred, therefore, in ruling that the denial could not be litigated by virtue of the doctrine of res judicata.

Turning then to the substance of claimant's nausea and vomiting claim, a number of medical professionals gave their opinions on the issue of causation. As indicated earlier, Dr. Manley, claimant's treating orthopedist, thought that claimant's headaches and related nausea and vomiting were caused by muscle tension associated with back and neck pain due to the industrial injury. He later added that the medication which claimant was taking for her back and neck pain might also play a role. Dr. Reardon, a family practitioner, appears to agree with this analysis and also suggests a functional component. Dr. Colistro, a psychologist, thought that the headaches and related nausea and vomiting were caused by psychological conditions which had been caused or materially worsened by the chronic pain associated with claimant's industrial injury. Dr. Girod, an internist, thought that claimant's nausea and vomiting could be related to medications which she might be taking, but otherwise did not see a causal relation to the industrial injury. Orthopaedic Consultants were uncertain of the cause of claimant's nausea and vomiting, but suspected that they were of functional origin. Only Dr. Brown, the consulting neurologist, found no plausible link between claimant's nausea and vomiting and her industrial injury.

In view of all of the evidence, we conclude that claimant has established a material causal connection between her recurrent episodes of nausea and vomiting and her industrial injury whether the connection is back pain, medication or psychological factors. That portion of SAIF's denial of March 24, 1983 that denied the condition causing claimant's nausea and vomiting shall be set aside. We also set aside SAIF's de facto denials of medical treatment relating to claimant's recurrent episodes of nausea and vomiting.

Moving to the aggravation issue, claimant was hospitalized in April 1985 for four days due to persistent nausea and vomiting secondary to back pain. Claimant, of course, had visited the emergency room and had been hospitalized on numerous prior occasions. Under these circumstances, we conclude that claimant's April 1985 hospitalization is better characterized as a fluctuation in symptoms rather than a worsening of her condition. SAIF's de facto denial of claimant's alleged aggravation claim, therefore, shall be upheld.

With regard to the interim compensation, penalties and attorney fees issues, claimant's condition was already in denied status at the time of the alleged aggravation in April 1985. Under these circumstances, interim compensation was not due and penalties and attorney fees for improper claims processing are not appropriate.

ORDER

The Referee's order dated April 17, 1986 is affirmed in part and reversed in part. That portion of the order that upheld the denial of March 24, 1983 is reversed and that portion of the denial that denied the condition causing claimant's nausea and vomiting is set aside. That portion of the order that upheld SAIF's de facto denials of medical treatment are set aside. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,400 for services at the hearing on the compensability and medical services issues and $600 for services on Board review, to be paid by the SAIF Corporation.

LISA V. PROTHO, Claimant
Steven C. Yates, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-01561
March 23, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of Referee Thye's order that: (1) set aside its denial of claimant's aggravation claim for the low back; (2) assessed a 25 percent penalty and an associated attorney fee for the insurer's alleged unreasonable denial; and (3) awarded claimant a $200 attorney fee for the insurer's alleged unreasonable failure to timely provide certain medical reports. The issues are aggravation, penalties and attorney fees.

We affirm that portion of the Referee's order that awarded claimant an attorney fee for the insurer's failure to timely provide discovery. On the remaining issues, we reverse.

Claimant is a former cannery worker who suffered a low back strain/sprain on October 13, 1979. The claim was accepted as disabling and claimant sought chiropractic treatment from Dr. DeShaw. Dr. DeShaw released claimant to return to regular work on October 26, 1979, finding her medically stationary with no permanent residuals. The insurer closed the claim in June 1980 with an allowance of temporary total disability only. Claimant did not appeal.

After being released to return to work, claimant worked for approximately one week before being laid off for reasons

unrelated to her compensable injury. She then did not seek medical treatment for more than three years. On March 30, 1983, she returned to Dr. DeShaw, complaining of recurrent low back symptoms. DeShaw reported that claimant's pain had returned "for no apparent reason," although he noted that the symptoms were similar to those claimant experienced following the 1979 strain. Dr. DeShaw requested authority to resume chiropractic treatments, but specifically indicated that he was not seeking a reopening of the claim.

Claimant was seen briefly by Drs. Robinson and Poulson before beginning treatment with chiropractors McMahon and Buttler in November 1984. Dr. McMahon found claimant not medically stationary and began a series of chiropractic treatments. A subsequent CT scan revealed bilateral spondylosis at L5. On March 26, 1985, Drs. McMahon and Buttler reported that claimant was in a "worsened condition" due to "many positive findings."

Claimant returned to Dr. Poulson in April 1985. Poulson opined that claimant exhibited a spondylolisthesis of L5 on S1. Although he did not discuss the cause of claimant's returned symptoms, Poulson recommended surgery "only if the patient feels her pain is severe enough that she wants to go through with surgery." Surgery was never performed. The insurer issued a denial of claimant's aggravation claim on April 30, 1985, asserting that claimant's condition was no longer related to the 1979 injury and that there had been no worsening.

In September 1985, the insurer sent claimant to Drs. Berman and Abrams for an independent chiropractic examination. The examination revealed few objective findings. Drs. Berman and Abrams opined that claimant's 1979 sprain/strain had completely resolved without permanent residuals, and that claimant could return to work consistent with her small physical stature. In an addendum to their report, the physicians stated that claimant's bilateral spondylosis was not caused by her industrial injury and that there had been no material worsening of the underlying condition.

In April 1986, claimant was examined by Dr. Gripekoven, an orthopedic surgeon. Claimant reported that the chiropractic treatment she had been receiving had been of little benefit and that she felt "about the same." Dr. Gripekoven agreed with Dr. Poulson that claimant exhibited a grade I spondylolisthesis and a pars interarticularis defect at L5. He found no evidence of permanent impairment and no need for further treatment.

In April 1986, Dr. DeShaw, the original treating physician, was asked his opinion regarding claimant's current condition. He reported that when he had last seen claimant in March 1983, her 1979 strain had completely resolved and that any ongoing symptoms would be unrelated to the original injury.

Dr. Buttler was deposed. He testified that while claimant did exhibit preexisting spondylosis, the 1979 injury likely caused that condition to develop into a spondylolisthesis (a forward slipping of the L5 vertebra), resulting in claimant's symptoms. He admitted, however, that he could not be certain whether there had been a spondylolisthesis present prior to claimant's injury.

Dr. Gripekoven was also deposed. He stated that while the 1979 work incident did make claimant symptomatic for the first

time, the later development of her condition was the result of an unrelated, natural progression of the underlying disease. Dr. Gripekoven also opined that there had been no objective worsening of the underlying condition.

Dr. Abrams testified that there was no evidence that the 1979 injury caused or worsened claimant's underlying spondylolisthesis. He felt that claimant's current condition was unrelated to the original injury, and that there was a potential relationship between claimant's symptoms and a motor vehicle accident in which she was involved after being laid off in late 1979.

Claimant testified that she was asymptomatic before the 1979 injury. She further stated that although she did not seek medical treatment for three years after her initial treatments with Dr. DeShaw, her low back symptoms never fully resolved after the injury.

The Referee found that claimant's underlying condition had not worsened. He concluded, however, that claimant had been at least temporarily less able to work in March 1985, when Dr. Buttler reported that she was not "presently" released for work. Relying on the then-current aggravation standard set forth in Smith v. SAIF, 78 Or App 443 (1986), the Referee found that claimant had established the compensability of her aggravation claim.

After the Referee's order, the Supreme Court expressed its agreement with the Court of Appeals that in order for a claimant to establish a compensable aggravation, she must prove a worsening of her condition by demonstrating that she is "more disabled," i.e., less able to work. Smith v. SAIF, 302 Or 396 (1986). According to the court, if a claimant files a claim for a worsening, seeking increased benefits for permanent partial disability, she must demonstrate a worsening that makes her less able to work to the extent that she is less able to obtain and hold employment in the broad field of general occupations than she was prior to the worsening. On the other hand, if she files a claim to obtain additional temporary total disability benefits, she must prove a worsening that makes her less able to work to the extent that she is temporarily incapacitated from regularly performing work at a gainful and suitable occupation. See Cutright v. Weyerhaeuser, 299 Or 290 (1985).

To prove an aggravation, claimant must show that her condition is worse than it was at the time of the last award of compensation. Gwynn v. SAIF, 84 Or App 67 (February 25, 1987); Consolidated Freightways v. Foushee, 78 Or App 509, rev den 301 Or 338 (1986). She must also prove that the worsening is related to the original compensable injury. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984). Increased symptoms in and of themselves are not compensable; they are not sufficient to require payment of additional compensation, unless the worker suffers pain or additional disability that results in loss of the worker's ability to work and the worker thereby suffers a loss of earning capacity. Smith, supra, 302 Or at 401.

We agree with the Referee that claimant's underlying condition has not worsened. Therefore, if claimant is to prove a compensable aggravation, she must not only demonstrate that her increased symptoms are related to her 1979 injury, she must also

prove that they have rendered her more disabled (less able to work) than she was at the time of her 1980 claim closure. After reviewing the record, we find that claimant has failed to prove either element of her claim. First, we are not persuaded that claimant's industrial injury remains a material contributing cause of her current symptoms. While it appears that the injury made claimant's underlying condition symptomatic for the first time, the lengthy hiatus between the injury and claimant's return for treatment in 1983 strongly suggests that the effects of the injury resolved during the interim. According to Drs. Gripekoven, Abrams and Berman, claimant's 1983 return for treatment was necessitated by the natural and unrelated development, if any, of her congenital disease.

We are mindful that Dr. Buttler attributed claimant's current condition to a spondylolisthesis resulting from the 1979 injury. We find, however, that Buttler failed to adequately explain why claimant did not require medical treatment for more than three years after briefly visiting Dr. DeShaw in late 1979, or why, at the end of DeShaw's treatment, he found claimant to have completely resolved. We are more persuaded by the opinions of the consulting physicians.

Second, even if claimant's current condition is related to her 1979 injury, we find that her symptoms have not rendered her less able to work than she was at the time of the 1980 closure. Claimant's 1979 layoff was unrelated to her injury, and at the time of closure she appeared to have resolved. Years later, Drs. Berman, Abrams and Gripekoven found claimant still to be without impairment and capable of returning to work. While Dr. Buttler opined that claimant had "worsened" because of "many positive findings," he did not discuss how worsened symptoms would reduce claimant's ability to work. Without more evidence of decreased capacity for employment, claimant's aggravation claim must fail. It follows that the penalty and attorney fee assessed by the Referee for the insurer's alleged unreasonable denial shall also be set aside.

ORDER

The Referee's order dated August 28, 1986 is reversed in part and affirmed in part. Those portions of the order that set aside the insurer's denial of claimant's aggravation claim and assessed a 25 percent penalty and attorney fee for the insurer's alleged unreasonable denial are reversed. The remainder of the Referee's order is affirmed.

MYRON E. BLAKE, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Lester Huntsinger (SAIF), Defense Attorney

WCB 85-05348 & 85-08114
March 25, 1987
Order on Review (Remanding)

By the Board en banc.

EBI Companies seeks review of those portion of Referee Neal's order that: (1) set aside its denial of claimant's industrial injury claim for his low back condition; (2) upheld the SAIF Corporation's denial of responsibility for the aforementioned conditions; and (3) enforced an interim order denying EBI an independent medical examination. Specifically, EBI seeks reversal

of the interim order and remand for the independent medical examination. The issues are remand and the propriety of the interim order.

Claimant suffered a compensable injury to his upper and lower back in 1977. This claim was accepted by SAIF and ultimately closed by a 1979 Determination Order. In July 1983, claimant suffered a second compensable injury after striking his head. This claim was accepted by EBI and closed by an October 1983 Determination Order. Thereafter, claimant returned to work as an electrician for EBI's insured.

In January 1985, claimant experienced disabling pain in his neck and low back. As a result, claimant filed a claim for new injury with EBI. In April 1985, EBI denied responsibility for claimant's condition, concluding that it was due to a preexisting condition. In May 1985, claimant requested that SAIF voluntarily reopen his claim for aggravation. SAIF denied the request and opposed the issuance of an own motion order reopening the claim, stating that claimant's condition had not materially worsened since the last arrangement of compensation. In July 1985, the Board issued an order consolidating the two matters for hearing.

In November 1985, EBI scheduled an independent medical examination. In response, claimant filed a Motion to Quash the notice of examination. After considering the arguments of the parties, the Acting Presiding Referee granted the motion.

Hearing was held in March 1986. The Referee found the main issue to be responsibility. Based on the evidence in the record, the Referee concluded that claimant had suffered a new injury. Consequently, EBI's denial was set aside. Despite EBI's objections, the Referee felt constrained to enforce the Acting Presiding Referee's interim order denying the independent medical examination. However, the Referee noted that EBI's ability to put on a defense to its denial had been significantly impaired by the interim order.

EBI requests that we set aside the interim order and remand the case for completion of the incompletely and improperly developed record. After de novo review, we agree.

Claimant's argument centers on ORS 656.325(1) which states:

> "Any worker entitled to receive compensation under ORS 656.001 - ORS 656.794 is required, if requested by the director, the insurer or the self-insured employer, to submit to a medical examination at a time and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director. However, no more than three examinations, except by consulting physicians, may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the

examination has taken place, and no compensation shall be payable during or for on account of such period." (emphasis added).

Claimant contends that EBI's denial precluded him from compensation, and therefore, the insurer is not entitled to an independent medical examination pursuant to ORS 656.325(1).

This argument was rejected in Victoria Napier, 34 Van Natta 1042 (1982), which continues to be good law. Consequently, we hold that a denial does not preclude the insurer from obtaining independent medical examinations in the manner prescribed by ORS 656.325.

Permitting independent medical examinations after a denial of compensation is consistent with the Workers' Compensation Act's policy, "[T]o provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings to the greatest extent practicable." ORS 656.012(2)(b). We do not consider preventing an insurer from obtaining meaningful and relevant evidence concerning a contested denial to be either fair or just.

ORS 656.325(1) must be read in light of the Workers' Compensation Act's explicit and implicit statutory policy of providing a forum for the just and fair administration of claims. When viewed in this manner, the first six words of the statute are ambiguous and are subject to statutory construction within the context of the entire Act. See Newell v. Taylor, 212 Or 522 (1958). Considering ORS 656.325(1) within this context, we conclude that it applies to claimant's seeking compensation as well as those receiving its benefits. In pursuing a claim, the claimant proceeds on the premise that he is entitled to compensation. This contention is sufficient to require the claimant to submit to an examination within the limits of the statutes and rules.

Thus, for the above reasons we adhere to our previous decision in Napier, supra. Consistent with this opinion, we reverse the Acting Presiding Referee's Interim Order and conclude that EBI was entitled to an independent medical examination. Accordingly, this record has been incompletely and insufficiently developed and we remand for the taking of additional evidence. ORS 656.295(5).

ORDER

The Referee's order dated April 10, 1986 is vacated and this matter is remanded to the Hearings Division for further proceedings consistent with this order.

ROBERT E. BUTSON, Claimant
Steven C. Yates, Claimant's Attorney
Nelson, et al., Defense Attorneys

Own Motion 86-0654M
March 25, 1987
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his August 24, 1979 industrial injury. Claimant's aggravation rights have expired. The insurer continues to pay claimant's medical expenses, but opposes reopening for the payment of temporary total disability compensation.

After thorough review of the medical evidence, the Board finds no persuasive evidence of an objective worsening of claimant's compensable condition. Claimant has received permanent disability awards totalling 65 percent and it is apparent that his symptoms are consistent with this award. We also find that claimant has not been gainfully employed since 1982 and is not entitled to compensation for temporary total disability in any event. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985). The request for own motion relief is hereby denied.

IT IS SO ORDERED.

MICHAEL E. DAVISON, Claimant
W.D. Bates, Jr., Claimant's Attorney
William Blitz (SAIF), Defense Attorney

WCB 83-09422
March 25, 1987
Second Order on Remand

Claimant has requested reconsideration of the Board's Order on Remand dated February 26, 1987 that remanded his claim to the SAIF Corporation for closure pursuant to ORS 656.268. Claimant asks that we award an attorney fee in the amount of 25 percent of any permanent disability award granted at the time of claim closure, not to exceed $2,000.

Claimant's request is granted. For efforts expended and results obtained in this matter, claimant's attorney is awarded 25 percent of any permanent disability award granted when his claim is closed. ORS 656.386(2); OAR 438-47-010 et seq. This attorney fee award shall not exceed $2,000.

Accordingly, our Order on Remand is withdrawn. On reconsideration, we adhere to and republish our prior order, as supplemented herein, effective this date.

IT IS SO ORDERED.

LONA L. EMERY, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-03674
March 25, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Emery v. Adjustco, 82 Or App 101 (1986). The court affirmed the Board's order in Lona L. Emery, 37 Van Natta 947 (1985), which had found that the claim had not been prematurely closed. However, inasmuch as the Board made no finding concerning the extent of claimant's permanent disability, the court remanded for a determination of this issue.

After conducting our de novo review of the record, we conclude that the compensable injury has resulted in a permanent loss of earning capacity. ORS 656.214(5). In rating the extent of claimant's permanent disability, we consider her physical impairment attributable to her compensable cervical condition, which includes the credible testimony concerning her pain and physical limitations, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Following our review of the medical and lay evidence, and considering the aforementioned guidelines, we conclude that a

10 percent unscheduled permanent disability award adequately compensates claimant for her compensable injury.

ORDER

Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for her compensable injury. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,000. This award shall be paid from claimant's permanent disability award.

TIMOTHY H. FITZPATRICK, Claimant
Coons & Cole, Claimant's Attorneys
Cummins, Cummins, et al., Defense Attorneys

WCB 85-02237
March 25, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Quillinan's order, as adhered to on reconsideration, that set aside its "back up" denial of claimant's bilateral carpal tunnel syndrome claim. On review, the insurer contends that: (1) its denial was permissible under Bauman v. SAIF, 295 Or 788 (1983); and (2) claimant's condition is not compensable.

Following our de novo review of the record, we are not persuaded that the insurer's acceptance of the claim was prompted by fraud, misrepresentation, or other illegal activity. Accordingly, we agree with the Referee that the insurer's denial is prohibited under Bauman v. SAIF, 295 Or 788 (1983). Our agreement with the Referee's conclusion concerning the Bauman issue, should not also be interpreted as an affirmance of the Referee's alternative finding of compensability.

ORDER

The Referee's order dated May 30, 1986, as reconsidered June 24, 1986, is affirmed. Claimant's attorney is awarded $550 for services on Board review, to be paid by the insurer.

CHARMAINE A. FRAZIER, Claimant
Gary Jensen, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 85-07844
March 25, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Brown's order that set aside its denial of claimant's injury claim for her head and neck condition. The issue is compensability.

Claimant was working for the employer as a shim operator. On April 26, 1985, she alleges that she pulled a wire causing a pipe to fall striking her on the head. Claimant stated that she became dizzy and nauseated. After the incident she remained at work until the lunch break and then went home. She called her supervisor to tell her that she would not be returning that day. On April 30, 1985 she saw Dr. Byerly who, based on claimant's statements regarding dizziness, nausea and headaches, diagnosed contusion of the head and cervical vertebrae. Subsequently, he referred her to Dr. Serbu, a neurosurgeon, for additional tests. Dr. Serbu found her head and neck to be normal. Neither physician could document objective evidence demonstrating claimant had suffered the injury she described. The insurer denied the claim on June 18, 1985.

Immediately prior to the start of hearing, the Referee viewed the machine on which claimant had worked. Afterwards, the plant manager testified that, based upon his measurements of the machine and surrounding area, claimant could not have been struck in the manner she described. Further, he had attempted to duplicate the injury three days after the incident using the same machine set up in a similar fashion. He could not get the pipe to strike him in the manner stated by claimant. Ms. Cessna, claimant's supervisor, also was unable to understand how the pipe could have hit claimant.

Claimant's co-worker, Ms. Davis, testified that at the time of this incident she was working in front of claimant's machine. Ms. Davis did not actually see the pipe fall or strike claimant. However, she heard the pipe fall and claimant say "ouch". She turned and saw claimant with her hand on her head. Claimant initially told her that the pipe had struck her in the arm and hand, but soon thereafter told her that it struck her in the head. At the time, they laughed about the incident, believing that claimant was not seriously hurt.

Ms. Cessna, claimant's supervisor, testified that after she heard about the incident she attempted to determine if claimant was injured. She observed claimant standing in front of her press and rubbing her head. She asked claimant if she was all right. Stating that the pipe had struck her head, claimant responded that she felt nauseated and dizzy. Ms. Cessna asked if she could look at her head, but claimant refused stating that it would be all right. Claimant declined an offer to lie down, waited until the lunch break, and then went home. Her mother testified that when claimant arrived home she appeared pale and drawn. Later that day, claimant called Ms. Cessna to tell her that she would not return to work as a result of her headaches, dizziness and nausea.

The insurer contends that claimant failed to carry her burden of proof. After de novo review, we agree.

After observing the machine and listening to the testimony, the Referee concluded that claimant had unreliably described the location of the pipe when it fell. Further, claimant testified that she never spoke to Ms. Cessna after the incident until her phone call later that day. The Referee could not reconcile the testimony of claimant and Ms. Cessna and could find no reason to disbelieve Ms. Cessna's testimony. Similarly, we are unable to reconcile the testimony of claimant and Ms. Cessna.

Claimant's strongest evidence comes from her coworker Ms. Davis. However, Ms Davis stated that claimant initially told her she was struck in the arm and hand. It was not until later that claimant told her she was struck in the head. No evidence was offered why claimant may have altered the location where she was struck. Ms. Davis further stated that they both laughed about the situation and that she did not believe claimant was really hurt. She did not observe any physical injury to claimant.

The medical evidence also does not support claimant. Claimant testified that as a result of this incident she received a bump on the head. She treated four days after the alleged

incident, but Dr. Byerly could find no objective evidence of claimant having sustained an injury. Dr. Serbu, a neurosurgeon, also could find no objective evidence of an injury to claimant's head or neck. Other than an unrelated carpal tunnel problem, the medical evidence offers no objective evidence of impairment. Further, assuming claimant does have a condition related to her symptoms of dizziness, nausea and headaches, the medical evidence does not support that condition being related to an injury at work.

After a full review of the medical and lay evidence we conclude that claimant failed to prove by a preponderance of the evidence that she sustained a compensable injury for which she required treatment. Therefore, the order of the Referee is reversed.

ORDER

The Referee's order dated July 29, 1986 is reversed.

DAVID NIEMANN, Claimant

Own Motion 87-0095M
March 25, 1987
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his January 24, 1980 industrial injury. His aggravation rights have expired. The self-insured employer opposes claimant's request, contending that claimant is foreclosed from receiving further compensation by virtue of a March 10, 1982 disputed claim settlement.

We disagree with the employer's interpretation of the March 1982 settlement. By its terms, the agreement specifically settled claimant's request for hearing concerning the denial of an aggravation claim. We do not interpret the agreement as an attempt to foreclose claimant from all future compensation attributable to his original compensable injury. Such an agreement would be contrary to law. See ORS 656.236; 656.245; 656.273.

The record submitted for our review suggests that claimant is experiencing symptoms exclusively attributable to his "original industrial injury and subsequent surgeries." Thus, it would appear that claimant's current need for medical treatment is related to his compensable injury. Yet, the right to payment of medical services continues for the life of the claimant and is a matter concerning a claim. ORS 656.245(2); 656.283(1); Loretta Sanders, 38 Van Natta 175 (1986). Accordingly, since claimant is entitled to request a hearing concerning the medical services issue, it is an inappropriate issue for own motion relief. ORS 656.245(2); 656.283(1); Loretta Sanders, supra.

We turn to claimant's reopening request. Following our review of the record, we find that claimant's compensable condition has worsened. Accordingly, his request for claim reopening is granted. Temporary total disability compensation shall commence effective November 10, 1986 and shall continue until closure pursuant to ORS 656.278.

IT IS SO ORDERED.

BENJAMIN E. PRYOR, Claimant
Michael Jeske, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-15060
March 25, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Brown's order that set aside its denial of claimant's bilateral carpal tunnel syndrome claim. On review, the insurer contends that the claim is not compensable. We agree and reverse.

Claimant was 49 years of age at the time of hearing. He has a prior history of hand and wrist complaints dating from March 1970. These complaints of stiffness and tingling arose after he began working on a green chain. At that time, his condition was diagnosed as thoracic outlet syndrome. In October 1970 Dr. Campagna, neurosurgeon, performed decompression surgery of the right brachial plexus. During the following 15 years, claimant operated his own trucking business, worked as a postal carrier, and started a public transportation service. During this period, his condition was relatively asymptomatic.

In September 1985 claimant began working for a furniture manufacturer. Initially, he was employed as a truck driver. However, in November 1985, he was assigned to gluing veneer. As a gluer, claimant used a paint roller, mostly with his right hand, to apply glue to some 150 skateboards per day. Within two days of performing these activities, he sought medical treatment for hand and arm complaints from Dr. Kho, neurologist.

Claimant advised Dr. Kho that his symptoms had initially improved following the 1970 surgery. However, within three months his complaints returned, particularly whenever he used his hands extensively. Dr. Kho diagnosed acute myofascial pain syndrome, tendo-synovitis, bilateral carpal tunnel syndrome, and right lateral epicondylitis. Claimant was restricted from heavy, repetitive, manual labor, administered trigger-point injections, and prescribed medication. Within approximately two weeks, only claimant's complaints of tendo-synovitis and bilateral carpal tunnel syndrome remained.

The insurer denied responsibility for claimant's hand and arm complaints. Noting his prior history, the insurer contended that claimant's present problems were symptoms of his underlying and preexisting condition.

In December 1985 Dr. Kho referred claimant to Dr. Strukel, orthopedist. Concurring with the diagnosis of bilateral carpal tunnel syndrome, Dr. Strukel recommended surgery. In January 1986 Dr. Strukel performed a right carpal tunnel release. This surgery has relieved claimant's pain and diminished his numbness.

Dr. Kho reported that the etiology of carpal tunnel syndrome was tendo-synovitis and can "very well" occur following repeated wrist movements. Dr. Kho stated that this syndrome is an entirely different medical syndrome than the thoracic outlet syndrome for which claimant was previously treated. There is no indication that Dr. Kho reviewed Dr. Campagna's 1970 reports. In conclusion, Dr. Kho opined that claimant's present symptoms were the result of heavy manual labor with repetitive hand movements.

Dr. Strukel identified claimant's truck driving as the "inciting factor" in the onset of his bilateral carpal tunnel disease. Although claimant's two days as an assembler would not result in severe carpal tunnel syndrome, Dr. Strukel concluded that the disease was worsened by the assembly activities. Dr. Strukel conceded that claimant's problem would not be associated with his recent employment if Dr. Campagna's records indicated that claimant had carpal tunnel disease in 1970.

Dr. Tennyson reviewed the medical record, was present during claimant's testimony, and testified at the hearing. Dr. Tennyson described carpal tunnel syndrome as a condition in which there is a progressive compression of the median nerve as it courses through the carpal tunnel. The etiology of the syndrome is generally idiopathic. Dr. Campagna's 1970 reports, Dr. Kho's electrical studies, and Dr. Strukel's surgery reports, persuaded Dr. Tennyson that claimant's condition was of relatively long standing. In Dr. Tennyson's opinion, claimant's work activities as an assembler and a truck driver were not a material contributing factor in the genesis of his carpal tunnel syndrome. Dr. Tennyson concluded that the work activities had increased claimant's symptoms, but had not worsened the condition's underlying pathology.

Persuaded by Dr. Tennyson's opinion, the Referee concluded that claimant's work activities had not worsened his carpal tunnel syndrome. However, since the onset of claimant's symptoms was sudden and unexpected, the Referee analyzed the claim under an accidental injury theory. Using this analysis, the Referee found the insurer responsible for claimant's symptomatic worsening.

Following our de novo review of the record, we are not persuaded that claimant's work activities were either the major or a material contributing cause of his bilateral carpal tunnel syndrome, or its worsening. Consequently, we conclude that his claim is not compensable under either an occupational disease or accidental injury theory.

Although claimant's testimony concerning causation is probative, it may not be persuasive when the issue involves a complex medical question. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Considering claimant's prior similar complaints and the complexity of his condition, we have determined that the resolution of the causal relationship between his work activities and his bilateral carpal tunnel syndrome can best be achieved through an appraisal of the medical opinions. The lay testimony is not rejected. However, the medical opinions have been accorded significant probative weight.

Both Drs. Kho and Strukel attributed claimant's current problem to his work activities. These opinions were based on the physicians' examinations, findings, and claimant's medical history. However, neither physician apparently had the opportunity to review Dr. Campagna's 1970 reports. Furthermore, neither physician differentiated between an increase in claimant's symptoms and a worsening of the underlying pathology of his bilateral carpal tunnel syndrome. Dr. Tennyson persuasively explained this distinction in describing the long standing nature of claimant's condition and concluding that claimant's work activities had increased his symptoms, but had not worsened the

underlying pathology. Moreover, unlike the aforementioned examining physicians, Dr. Tennyson had reviewed Dr. Campagna's 1970 reports.

When medical experts disagree, more emphasis is generally placed on opinions that are well-reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259 (1986). Inasmuch as Dr. Tennyson had reviewed the entire medical record and considering the persuasiveness of his explanation concerning the relationship between claimant's preexisting condition and his work activities, we place more emphasis on his opinion. Accordingly, we find that the evidence fails to establish that claimant's work activities were either the major or a material contributing cause of his bilateral carpal tunnel syndrome, or its worsening.

ORDER

The Referee's order dated June 2, 1986 is reversed. The insurer's denial issued December 3, 1985 is reinstated and upheld.

SHARON SALZER, Claimant
Francesconi & Cash, Claimant's Attorneys
Rankin, VavRosky, et al., Defense Attorneys

WCB 85-12483
March 25, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

The self-insured employer requests review of that portion of Referee Podnar's order that set aside its denial of claimant's medical services claim for low back surgery. The issue is the compensability of that medical procedure.

Claimant is a former meat wrapper who suffered a compensable lumbosacral strain in May 1978. After approximately four months of conservative chiropractic treatment, claimant returned to her regular work. No impairment was foreseen by the treating chiropractor. Claimant's symptoms continued, however, and she sought additional treatment from Dr. Butler. Xrays were normal and Dr. Butler suggested "poor body mechanics" as the cause of claimant's ongoing pain. Subsequent neurological tests were also normal, and in October 1978, Dr. Reimer, a neurologist, stated that claimant was capable of regular, full-time employment.

A July 1979 Determination Order closed the claim with an award of temporary disability only. Claimant continued to work without additional treatment for more than three years. She briefly saw Dr. Voy in April 1983, but no additional objective findings were noted. Finally, in February 1985, claimant came under the care of Dr. Berselli, a neurologist. Dr. Berselli suspected a bulging lumbosacral disc and scheduled a series of diagnostic tests. A CT scan revealed a posterior bulge of the L5-S1 annulus fibrosis. A myelogram was normal. A discogram was considered unreliable, and magnetic imagery testing revealed a central herniation of the L5-S1 disc.

Dr. Berselli placed claimant in a flexion jacket for a period of two months, apparently without significant benefit. Dr. Berselli then suggested an injection of chymopapain into the L5-S1 disc space. His authorization request for that procedure prompted the employer to obtain consulting opinions from Drs. Misko, Reimer, Parsons and Rosenbaum. Dr. Misko was of the

opinion that claimant would benefit from an L5-S1 laminectomy and fusion. Dr. Reimer, finding no objective evidence of nerve root compression or significant disc herniation, disagreed. Dr. Parsons agreed with Dr. Misko that claimant was a good surgical candidate. Dr. Rosenbaum disagreed, finding a dearth of objective findings and a marked functional component to claimant's claim. Dr. Berselli, the treating physician, continued to recommend the chymopapain injection, and he specifically stated his disagreement with the physicians recommending surgery.

It is claimant's burden to prove the reasonableness and necessity of her proposed surgery. ORS 656.245(1); McGarry v. SAIF, 24 Or App 883 (1976). The Referee noted that the medical opinions in that regard were diametrically opposed. He found claimant's claim for surgery compensable, however, relying on the opinions of Drs. Misko, Parsons and Berselli. The Referee apparently concluded that all of the aforementioned physicians supported surgical intervention. Although the Referee was correct with regard to Drs. Parsons and Misko, his assessment of Dr. Berselli's opinion was incorrect. As noted supra, Dr. Berselli specifically voiced his disagreement with Dr. Parsons' recommendation for surgery.

We find Dr. Berselli's opinion to be persuasive. He is the treating physician who, more than any other doctor, has had the opportunity to determine claimant's treatment, progress and needs. He has had first hand access to all diagnostic and clinical data, and we find that he is in the best position to determine whether surgery is warranted. He has indicated that it is not. We also find Dr. Reimer's opinion to be of significant value, for he saw claimant soon after her 1978 injury and has followed her claim throughout the treatment period. It is also Dr. Reimer's opinion that surgery is not reasonable and necessary. The consulting physicians, including those who have recommended surgery, have had limited contact with claimant. To the extent that that is significant, the consultants are in a position inferior to that of Drs. Berselli and Reimer.

After de novo review of this record, we find that claimant has failed to prove the necessity of her proposed surgery. The Referee's finding to the contrary shall be reversed.

ORDER

The Referee's order dated October 29, 1986 is reversed in part and affirmed in part. That portion of the order that directed the self-insured employer to authorize and cause to be provided claimant's proposed surgery is reversed. The remainder of the order is affirmed.

JOHN R. WINFREY, Claimant
Roll, et al., Claimant's Attorneys
Rankin, VavRosky, et al., Defense Attorneys

WCB 86-02703
March 25, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Lipton's order that upheld the insurer's denial of claimant's request for authorization for surgery involving his neck. The self-insured employer cross-requests review of that portion of the order that set aside its denial of claimant's aggravation claim of

his neck condition. The issues are aggravation and medical services.

The Board affirms the order of the Referee on the medical services issue. As presently developed, the medical record does not support the conclusion that the proposed surgery is reasonable and necessary.

On the aggravation issue, we reverse. Even assuming that claimant's compensable condition has worsened, an issue hotly debated in the medical record, it is apparent from history recorded by Drs. Nash, Berkeley, Wilson and Gripekoven in late 1985 and early 1986 that the worsening occurred prior to the last arrangement of compensation on October 4, 1985. We find this history more reliable than claimant's testimony to the contrary at the hearing. Consequently, we conclude that claimant has failed to establish a compensable aggravation. See ORS 656.273(1).

ORDER

The Referee's order dated July 29, 1986 is reversed in part. Those portions of the order that set aside the self-insured employer's denial dated February 11, 1986 and awarded an associated attorney fee of $1,400 are reversed. The remainder of the order is affirmed.

HARRY E. BAKER, Claimant
Roll, et al., Claimant's Attorneys
Jeff Gerner (SAIF), Defense Attorney

WCB 85-10969
March 31, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Quillinan's order that awarded claimant 160 degrees for 50 percent unscheduled permanent partial disability for a psychological condition, whereas the August 14, 1985 Determination Order awarded temporary total disability only. The issue is extent of unscheduled psychological disability. We modify the Referee's award.

Claimant is a former State agency service coordinator whose claim for mental stress was found compensable by way of a July 1983 Opinion and Order. The order was subsequently affirmed by the Board. Claimant also has a prior compensable low back injury for which he has received an award of 30 percent unscheduled disability.

Prior to the hearing on his stress claim, claimant came under the care of Drs. Ackerman and Holland for his psychological condition. It was noted that claimant was suffering from severe alcoholism as well as stress and anxiety. A job change was recommended and vocational assistance was initiated. Claimant's alcoholism frustrated the initial vocational efforts, however, and he was assigned to a detoxification unit where he underwent treatment in early 1984.

Following his treatment, claimant was vocationally reevaluated. He was found to possess transferable skills in several areas including personnel, negotiation, administration, sales and office procedures. He indicated a strong desire to continue working with the public and he made application to other State agencies offering people-oriented positions.

In June 1984 claimant began treating with Dr. Christensen, a psychologist. He complained of diminishing confidence and ambition, as well as fears of failing. The administration of an MMPI, however, failed to reveal evidence of depression. While it demonstrated that claimant was angry and frustrated, it also revealed his willingness to engage in therapy. Dr. Christensen expressed reservations about claimant's ability to return to work for his prior employer or other bureaucracies. Although claimant made progress throughout the remainder of 1984, he suffered a psychological relapse in April 1985, largely as a result of personal problems. When seen by Dr. Holland on April 16, 1985, claimant exhibited increased emotional distress. Despite that observation, Dr. Holland found claimant psychologically stationary with no evidence of permanent impairment resulting from this compensable claim. Dr. Christensen reviewed Dr. Holland's report and concurred.

An August 14, 1985 Determination Order found claimant entitled to periods of temporary disability compensation, but no award of permanent disability. Shortly thereafter, claimant expressed an interest in moving to California for the purpose of locating employment. At the time of the hearing, he had found a heavy equipment operator position and he was working full time. Although riding in heavy equipment bothers his back, claimant can do the job. He continues to look for less rigorous employment, however.

Claimant credibly testified that he sees his primary problem as an inability to deal with unstructured employment. He feels that if he were placed in an environment characterized by clear directives and instructions, he would succeed. He was not receiving psychological therapy at the time of the hearing, but complained that his anxiety appeared to be returning. Claimant is 43 years of age and has a GED. Before his State agency employment, claimant worked primarily as a laborer.

The Referee found claimant entitled to an award of 50 percent unscheduled disability for his psychological condition. This award, combined with claimant's prior low back award, brought the total amount of unscheduled disability he had received to 80 percent. In making the 50 percent award, the Referee concluded that claimant was now precluded from "any administrative or quasi-administrative position." She also found that he was effectively precluded from the prior heavy work he had done, although she noted that claimant was apparently succeeding as a heavy equipment operator.

We agree with the Referee that claimant is entitled to an unscheduled award for his psychological condition. We find, however, that an award of 50 percent was excessive. First, we disagree with the Referee that claimant is precluded from "any administrative or quasi-administrative" position. While he may not be capable of work involving loose administrative structure, he appears to be capable of performing paperwork, detail-oriented tasks, or any employment in a structured setting. He is relatively young and appears to have at least average aptitudes. He has a demonstrated ability to be persuasive, and he appears highly motivated for success.

After considering claimant's age, education, vocational aptitudes and interests, his work background, psychological

impairment and other pertinent social and vocational factors, we conclude that claimant would be adequately and appropriately compensated by an unscheduled award of 20 percent for his psychological disability. The Referee's award shall, therefore, be modified.

ORDER

The Referee's order dated May 30, 1986 is modified in part and affirmed in part. That portion of the Referee's order that awarded claimant 160 degrees for 50 percent unscheduled permanent partial disability for his psychological condition is modified. In lieu of the Referee's award, claimant is awarded 64 degrees for 20 percent unscheduled permanent partial disability for his psychological condition. Claimant's prior 30 percent award for the low back is unaffected by this order and shall remain in full force and effect. Claimant's attorney's fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed.

CLIFFORD A. BETTIN, Claimant
Pozzi, et al., Claimant's Attorneys
Foss, Whitty & Roess, Defense Attorneys

Own Motion 86-0257M
March 31, 1987
Own Motion Order

Claimant has requested that we exercise our Own Motion authority pursuant to ORS 656.278(1) and reopen his low back injury claim for additional compensation. Claimant's aggravation rights have expired. The self-insured employer opposes claimant's request. After reviewing the record, we find that claimant's claim should be reopened.

Claimant sustained a compensable low back injury in June 1976. A June 14, 1979 Determination Order awarded temporary disability and 10 percent unscheduled permanent partial disability for the low back. The claim was later reopened for surgeries and was closed again by way of a March 2, 1984 Determination Order, with an additional award of 55 percent unscheduled disability. Claimant appealed from the Determination Order and was granted permanent total disability by way of an August 20, 1984 Opinion and Order. That award was reversed by the Board on July 26, 1985. However, our order awarded claimant an additional 15 percent unscheduled low back disability, bringing his total award to 80 percent.

On September 19, 1985, claimant returned to his treating physician, Dr. Berselli, complaining of increased low back pain. Suspecting a possible problem at another level of claimant's spine, Dr. Berselli placed him in a flexion jacket and authorized additional temporary total disability compensation. The employer issued a denial of claimant's request for reopening. Subsequently, Dr. Berselli issued a report, stating:

> "In my opinion, I think this patient's condition has deteriorated from an objective viewpoint. I think he is in need of active medical care and he is not at this time able to engage in any type of work."

In its response to claimant's request that we reopen his claim, the employer does not specifically deny that claimant has worsened. Instead, it argues that claimant has retired from the workforce and is, therefore, not entitled to additional

compensation. See Cutright v. Weyerhaueser, 299 Or 290 (1985). The employer cites Karr v. SAIF, 79 Or App 250 (1986), for the proposition that a claimant is not entitled to further compensation once he has voluntarily retired, even if he has been rendered incapable of working due to his compensable injury.

We need not consider the employer's interpretation of Karr, supra, since we find that claimant has not retired from the work force. The evidence is that while claimant is receiving Social Security disability benefits, he is not receiving retirement-related compensation. He is also continuing to seek work within his rather substantial physical limitations.

We find that claimant's condition has worsened as a result of his compensable injury, and that the worsening has occurred since the last arrangement of compensation. We hereby order, therefore, that claimant's claim be reopened and that the self-insured employer commence temporary total disability payments as of September 19, 1985. The employer shall continue those payments through the date of the next proper closure. As a reasonable attorney fee, claimant's attorney is awarded 25 percent of the increased compensation made payable by this order, not to exceed $600. The fee shall be paid out of claimant's compensation.

IT IS SO ORDERED.

LESLIE COLVIN, Claimant
Malagon & Moore, Claimant's Attorneys
David C. Force, Attorney
Peter Hansen, Attorney
Cliff, Snarskis, et al., Defense Attorneys

WCB 81-03061
March 31, 1987
Second Order on Remand

An Order on Remand issued in this matter on March 10, 1987. Subsequent to our order, the parties have forwarded for our approval a "Stipulated Order on Remand." Pursuant to the stipulation, the parties have agreed that "the appropriate disposition of the case on remand to the Workers' Compensation Board would simply be to order claim acceptance without further additional temporary disability." We find that this stipulation is in keeping with the Court of Appeals' mandate and also dispenses with the necessity of taking further evidence concerning the issue of claimant's entitlement to interim compensation.

Accordingly, our prior Order on Remand is withdrawn. The Stipulated Order on Remand is approved. Pursuant to the stipulated order, the Industrial Indemnity Company's January 14, 1981 denial is set aside and this matter is remanded to Industrial Indemnity for acceptance and processing according to law.

IT IS SO ORDERED.

JUDY J. GORNICK, Claimant
Pozzi, et al., Claimant's Attorneys
Thomas Sheridan (SAIF), Defense Attorney

WCB 86-00831
March 31, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of that portion of Referee Fink's order that granted claimant an award of permanent total disability in lieu of an award by Determination Order of 40 percent (128 degrees) unscheduled permanent partial disability for her low back. The issue is extent of disability, including permanent total disability.

Claimant compensably injured her low back in a lifting incident in March 1980. In May 1980, claimant came under the care of Dr. Ordonez, a neurosurgeon, and a herniated disc was diagnosed. Later the same month, Dr. Ordonez performed a discectomy at L5-S1. Claimant improved after surgery, but then worsened in early 1982. On May 14, 1982, Dr. Ordonez performed a further discectomy at L5-S1 and Dr. Brenneke, an orthopedic surgeon, performed a lumbosacral fusion.

Dr. Ordonez declared claimant medically stationary in December 1982 and rated her impairment at 15 to 20 percent. Dr. Brenneke agreed that claimant was medically stationary, but rated her impairment at 30 to 40 percent. The claim was closed by Determination Order in February 1983 with a 40 percent unscheduled award.

After claim closure, claimant returned to Dr. Brenneke complaining of continuing low back pain and numbness and tingling in her legs. Dr. Brenneke referred claimant for pain center treatment which was minimally helpful. While at the pain center, claimant was examined by a psychologist, Dr. Yospe, who found her somatically preoccupied and questioned her motivation for resolving her pain problem or returning to work. Dr. Yospe continued to treat claimant after her discharge from the pain center.

Claimant again returned to Dr. Brenneke in May 1984 complaining of increased pain. Dr. Brenneke prescribed physical therapy. In October 1984, claimant began treating with Dr. Close, a chiropractor. After several months with no improvement in claimant's complaints, chiropractic treatment was discontinued. In December 1984, Dr. Brenneke wrote SAIF stating that claimant was unable to work and that her claim should be reopened. SAIF issued an aggravation denial in March 1985. This denial was set aside by Referee Neal in August 1985.

In November 1985, claimant was examined by a panel of the Orthopaedic Consultants. The panel found claimant medically stationary and rated her impairment as mildly moderate. Claimant was then examined by a consulting psychiatrist, Dr. Klein. She found claimant psychologically stationary and rated her as without permanent psychological impairment. She then commented:

> "I am noticing some increased pain and disability behavior in [claimant] and feel that she is entrenching in a disabled role. I do not feel that further psychiatric treatment would be of any help and would simply suggest at this time that her case be

> closed and she be allowed to get on with her life. She certainly was presenting herself as highly disabled, far out of proportion to the objective findings, and I have a lot of question about her motivation for returning to work. . . . I feel [claimant] would benefit by a return to active employment but do not see her as well motivated despite her protests to the contrary."

Dr. Yospe, claimant's treating psychologist, later concurred in these reports.

In December 1985, Dr. Brenneke referred claimant to Dr. Ordonez for his reevaluation of her pain complaints. Dr. Ordonez decided to order a number of tests to rule out any physical basis for the complaints. Claimant underwent a CT scan, a bone scan and an EMG. The tests were essentially negative, although the CT scan did suggest some mild bulging of the L4-5 disc. As the tests ordered by Dr. Ordonez were being completed, SAIF wrote Dr. Brenneke and asked whether he concurred in the reports of the Orthopaedic Consultants and Dr. Klein. He replied that he did, assuming that the tests ordered by Dr. Ordonez were negative. The claim was closed by Determination Order in January 1986 with no award of permanent partial disability in excess of that granted by the previous Determination Order. After claim closure, Dr. Ordonez reported that there was little objective evidence of permanent impairment resulting from claimant's industrial injury and stated that he would rate claimant's impairment as minimal, "mainly because of her pain."

In a letter to claimant's vocational consultant in February 1986, Dr. Brenneke stated that claimant was released to return to work in the sedentary category. Less than three months later, however, in a letter to claimant's attorney, Dr. Brenneke stated:

> "After receiving this patient's records, this patient has significantly deteriorated from December 1984 through the present. The patient has continuing and unremitting pain accentuated by every-day [sic] activities.
>
> "She has been evaluated for further surgery and this is not feasible. She has been treated by the Pain Clinic without lasting success. She has been seeing Dr. Yospe who has been unable to help her overcome the mental aspects of chronic pain.
>
> "I feel that this patient is unable to perform any significant work and is totally disabled."

At the hearing, when asked to describe her physical condition, claimant stated: "Like there is [sic] a thousand needles in my lower back and my right leg is tingling." She went on to testify that just about any activity resulted in a dramatic increase in her low back pain and caused her to spend most of the day lying on a heating pad. Claimant also testified at length concerning a number of places at which she had applied for work.

She indicated, however, that she did not feel capable of performing any of the jobs for which she had applied.

A vocational consultant who had begun working with claimant shortly before the hearing testified that claimant was employable in a number of occupations.

The Referee concluded that claimant was entitled to an award of permanent total disability. He emphasized claimant's pain behavior during the hearing and dismissed Dr. Klein's report questioning claimant's motivation with the statement: "This type of report is rather typical of the reports received from this psychiatrist. I have seen her reports in many cases and have never seen one favorable to the injured worker."

We disagree with the Referee's conclusion that claimant is permanently and totally disabled for a number of reasons. First, it was improper for the Referee to reject Dr. Klein's opinion regarding claimant's motivation to return to work based upon reports authored by Dr. Klein in other cases. Neither of the parties introduced evidence of these other reports. The Referee, in effect, supplemented the record in this case with his informal impression that Dr. Klein was biased and employed that impression to reject Dr. Klein's evaluation of claimant.

Supplementation of the record by a Referee is inconsistent with the achievement of substantial justice and denies the parties their right to an impartial forum. See ORS 656.283(7); 656.708(3). It denies the parties the opportunity to dispute or otherwise comment on the matters surreptitiously added to the record by the Referee. See Groshong v. Montgomery Ward Co., 73 Or App 403, 407-09 (1985). We, therefore, must reject the Referee's statement to the effect that Dr. Klein is biased against injured workers. We find Dr. Klein's evaluation of claimant's motivation to return to work persuasive in light of the rest of the record in this case.

Second, Dr. Yospe, claimant's treating psychologist, concurred in Dr. Klein's evaluation of claimant. This fact was not noted by the Referee.

Third, we do not find Dr. Brenneke's most recent opinion persuasive. In December 1985, Dr. Brenneke expressed his agreement with the Orthopaedic Consultants and Dr. Klein that claimant's physical impairment was in the mildly moderate category and that she was without psychological impairment. A few months later, without significant explanation, he stated that claimant was permanently and totally disabled. We see nothing in the medical record to support Dr. Brenneke's unexplained change of opinion.

Fourth, the medical evidence as a whole preponderates against the conclusion that claimant has sustained sufficient physical or psychological impairment as a result of her industrial injury which, when combined with the social and vocational factors in this case, renders her permanently and totally disabled. See ORS 656.206(1)(a). Claimant was 43 years old at the time of the hearing. She has 10 years of formal education and a GED. Her work experience is varied. The record supports the conclusion that claimant has the present ability to perform work in the light and sedentary categories. Claimant, therefore, is not entitled to the award granted by the Referee.

As for the extent of claimant's permanent partial disability, we conclude that it does not exceed the 40 percent (128 degrees) previously awarded. We, therefore, reverse that portion of the Referee's order that granted claimant an award of permanent total disability and reinstate the Determination Order.

ORDER

The Referee's order dated June 12, 1986 is reversed in part. Those portions of the order that awarded claimant permanent total disability and his attorney an associated attorney fee are reversed. The Determination Order dated January 6, 1986 is reinstated and affirmed. The remainder of the Referee's order is affirmed.

GREGORY P. JACKSON, Claimant
SAIF Corp Legal, Defense Attorney

Own Motion 87-0149M
March 31, 1987
Own Motion Order

This matter has been referred to the Board for closure pursuant to its own motion authority under ORS 656.278. We conclude that we lack jurisdiction.

Claimant suffered an August 8, 1973 injury that resulted in the amputation of his right forearm. The SAIF Corporation denied his claim for benefits, contending that he was not an Oregon subject worker at the time of the incident. In October 1974, the parties entered into a disputed claim settlement. By virtue of the settlement, claimant received a sum of money and, in return, SAIF's denial remained in "full force and effect forever." SAIF further agreed to pay for future medical care and treatment that was necessarily attributable to claimant's right forearm injury or prosthesis.

The record establishes that claimant has recently received additional medical treatment for his right forearm and prosthesis. SAIF has apparently paid for these treatments, as well as provided benefits for time missed from work. However, by the terms of the 1974 settlement, claimant's condition is not considered to be the result of a compensable injury. Consequently, he is not entitled to benefits under the Workers' Compensation Law. ORS 656.245; 656.289(4); 656.278. Rather, SAIF is apparently contractually obligated to pay for certain medical care and medical treatment. Yet, the enforceability of such an agreement does not lie with the workers' compensation system since the parties have previously conceded that SAIF's denial of the claim would forever remain in full force and effect.

Accordingly, the request for own motion relief is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

ROBERT S. KNAPP, Claimant
Harper, Leo & Hollander, Claimant's Attorneys
Cliff, Snarskis & Yager, Defense Attorneys

WCB 85-13478 & 85-14456
March 31, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Knapp's order that: (1) affirmed the Determination Order dated March 19, 1985 that awarded 7.5 degrees for five percent scheduled permanent

disability for claimant's left knee condition; (2) declined to award unscheduled permanent disability for his low back condition; (3) declined to assess penalties and attorney fees for the insurer's alleged de facto denial of his low back condition; (4) determined that his upper back injury claim had not been prematurely closed; (5) awarded 48 degrees for 15 percent unscheduled permanent disability for his upper back condition; and (6) upheld the insurer's denial of claimant's upper back aggravation claim. The insurer cross-requests review of the Referee's permanent disability award. The issues on review are extent of permanent disability, de facto denial, premature closure, aggravation, penalties and attorney fees.

Following our de novo review of the medical and lay evidence, we affirm the order of the Referee with the following comment.

The Referee concluded that the insurer's payment of compensation on claimant's low back claim constituted acceptance. Mere payment of compensation does not constitute acceptance of a claim. ORS 656.262(9); Gregg v. SAIF, 81 Or App 395 (1986). After conducting our review of this record, we are not persuaded that the insurer's conduct in processing the claim was unreasonable. However, had we considered the insurer's conduct unreasonable, there would be no "amounts then due" upon which to base a penalty.

ORDER

The Referee's order dated June 13, 1986 is affirmed.

OLIVIO MEDRANO, Claimant
Bottini & Bottini, Claimant's Attorneys
Richard Barber (SAIF), Defense Attorneys

WCB 85-03889
March 31, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of that portion of Referee McCullough's order that increased claimant's unscheduled permanent disability award for a low back injury from 50 percent (160 degrees), as awarded by a Determination Order, to 75 percent (240 degrees). The issue on review is extent of unscheduled disability.

We find that claimant's award of permanent disability should be reduced. Consequently, we modify that portion of the Referee's order.

Claimant, 36 years of age at the time of hearing, compensably injured his low back in February 1984 while working as a rock picker. A CT scan in June 1984 showed some disc bulging at the L5-S1 level. In November 1985 x-rays revealed mild lower lumbar discogenic degeneration. Claimant's condition has been diagnosed as low back strain. All treatment has been conservative.

Claimant was extensively evaluated at Callahan Center in late 1984. Their evaluation established that he was an undocumented farm laborer with a fourth grade Mexican education. He could not read or write in English and could understand only simple instructions in English. He is physically limited to light-medium work involving no lifting over 25-40 pounds, no repetitive bending, no prolonged sitting, and no prolonged working in a stooped or cramped position. His work history involves primarily jobs as a physical laborer.

A March 1985 Determination Order awarded 50 percent (160 degrees) unscheduled permanent partial disability. Following closure, claimant's back symptoms continued. He sporadically worked in a variety of farm labor jobs until November 1985. Except for one day of farm work in May 1986 claimant has not returned to work.

In rating the extent of unscheduled permanent disability for claimant's low back, we consider his physical impairment as reflected in the medical record and the testimony at hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984). Following our de novo review of the medical and lay evidence, and considering the aforementioned guidelines, we conclude that a 50 percent unscheduled disability award adequately compensates claimant for his compensable low back condition.

ORDER

The Referee's order dated July 31, 1986 is affirmed in part and reversed in part. The Referee's unscheduled permanent disability award is reversed and the Determination Order's award of 50 percent (160 degrees) unscheduled permanent disability is affirmed. The remainder of the Referee's order is affirmed.

LAWRENCE N. SULLIVAN, Claimant
Malagon & Moore, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 85-14645
March 31, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

The insurer requests review of that portion of Referee Shebley's order that set aside the Determination Order dated February 16, 1986 as premature. The issue is premature closure.

The premature closure issue in this case concerns a psychological condition which Referee Nichols found compensable in a previous Opinion and Order. A majority of the Board recently reversed that portion of Referee Nichols' order that found claimant's psychological condition compensable. Lawrence N. Sullivan, 39 Van Natta 88 (March 4, 1987). In the same order, a majority of the Board found all of claimant's compensable conditions medically stationary and reinstated a Determination Order dated March 14, 1985 which had closed the claim. We find no persuasive evidence in the present record which indicates that any of claimant's compensable conditions have worsened since March 14, 1985. The claim, therefore, remains closed under the Determination Order of that date.

ORDER

The Referee's order dated May 7, 1986 is reversed. The claim remains closed under the Determination Order dated March 14, 1985.

EDWARD R. WEIGEL, Claimant
Quintin B. Estell, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney
Davis, Bostwick, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 85-15945, 86-05016 & 86-04249
March 31, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Myers' order that did not award an attorney fee in a case involving responsibility for claimant's low back condition. Argonaut Insurance Company has submitted a motion to expand the scope of the Board's review to include the merits of the responsibility issue. The parties also disagree as to who should be responsible for paying for a transcription of closing arguments recorded at hearing. The issues are attorney fees, whether the Board has jurisdiction to consider the merits of the responsibility issue, if so, which of the insurers is responsible, and payment for the transcription of closing arguments.

We draw from the Referee's statement of the facts. Claimant compensably injured his low back on February 6, 1985, while working for Argonaut's insured. A lumbar strain was diagnosed and a CT scan revealed a minimally bulging disk at L5-S1. Claimant was referred for vocational rehabilitation and a Determination Order of September 20, 1985 awarded 20 percent unscheduled disability for the low back. By the time of the Determination Order, claimant's condition had improved.

On October 2, 1985, claimant entered into a wage subsidy agreement with SAIF's insured, and he began working as a school janitor for the employer several days later. His low back pain immediately increased and, by early December 1985, claimant sought additional treatment. On December 13, 1985, Dr. Nickila reported that claimant was not medically stationary. On January 10, 1986, Dr. Nickila opined that claimant's compensable condition had materially worsened. Consulting physician, Dr. Buza, essentially concurred. Claimant was eventually released to return to regular work on February 3, 1986.

Claimant submitted claims to both Argonaut and SAIF. Argonaut issued a denial based on responsibility only. SAIF denied that claimant was a subject employe of its insured at the time of his second period of disability. Liberty Northwest Insurance Corporation, which was peripherally involved, also issued a denial of compensability.

Relying on Wood v. SAIF, 30 Or App 1103 (1978) and John P. Keeble, 37 Van Natta 480 (1985), the Referee found Argonaut to be the responsible employer. He further held that because claimant took no position with regard to which insurer should be held responsible, no attorney fee would be awarded for services at hearing. Claimant requested review solely on the issue of attorney fees.

We first discuss Argonaut's motion that we expand the scope of our review to include the merits of the responsibility issue. From the outset, the insurer's motion was largely unnecessary; the scope of our de novo review encompasses all issues considered by the Referee. We are not limited to a review of those issues specifically raised by claimant on review. See e.g. Destael v Nicolai Co., 80 Or App 596 (1986).

On de novo review we find that the Referee's allocation of responsibility to Argonaut should be reversed. Subsequent to the Referee's order, we decided Nancy A. Fowler, 38 Van Natta 1291 (1986), in which the claimant received vocational assistance as a result of a compensable injury and was ultimately placed in wage subsidy employment. The claimant then suffered a second period of disability while employed by the wage subsidy employer. The claimant filed an aggravation claim with the original employer and a new injury claim with the wage subsidy employer. Relying on Wood, supra, Keeble, supra, and Firkus v. Alder Creek Lumber Co., 48 Or App 251 (1978), the Referee held the first employer responsible, reasoning that the second period of disability logically flowed from the first injury in that it occurred during a period of vocational assistance arranged as a result of the original injury.

We reversed, noting that the claimants in Wood and Firkus, supra, were injured while enrolled in programs directly operated by the Vocational Rehabilitation Division. We found that while the Vocational Rehabilitation Division is not an "employer" within the meaning of ORS 656.005(14), a wage subsidy employer is, and is therefore required to provide workers' compensation coverage to its employees. We found no reason to distinguish wage subsidy employment from regular employment in responsibility cases, and we disavowed any language in Keeble, supra, to the contrary.

The present claimant's second period of disability occurred during wage subsidy employment. The medical evidence is that the wage subsidy employment was a material cause of his worsened condition. On these facts, and pursuant to Fowler, supra, the wage subsidy employer insured by SAIF is responsible. That portion of the Referee's order pertaining to responsibility will be reversed.

We next turn to claimant's request for attorney fees for services at hearing. We have found SAIF to be responsible for claimant's current condition. Prior to hearing, SAIF issued a denial of the compensability of claimant's claim. Claimant is entitled to a reasonable attorney fee for services at hearing for ultimately prevailing against that denial. ORS 656.386(1).

Last we address payment for the transcription of closing arguments. At the conclusion of the hearing, SAIF requested that closing arguments be recorded. It did not ask that the recorded arguments be transcribed. Claimant did ultimately make the request for transcription. He argues, however, that because SAIF requested that arguments be recorded, it should pay for the later transcription. We disagree and hold that claimant, as the party who requested transcription, should bear the expense associated therewith.

Claimant also asserts that the Board should pay for the transcription pursuant to ORS 656.295(3). That statute provides:

> "When review has been requested, the record of such oral proceedings at the hearing before the referee as may be necessary for purposes of review shall be transcribed at the expense of the Board."

In this case, we find that the closing arguments heard

by the Referee are not necessary for the purposes of our review. Claimant shall pay for the transcription.

ORDER

The Referee's order dated June 25, 1986 is reversed in part and affirmed in part. Those portions of the order that set aside Argonaut Insurance Company's denial of claimant's aggravation claim and failed to award claimant's attorney a fee for services at hearing are reversed. Argonaut's denial is reinstated. The SAIF Corporation's denial of claimant's new injury claim is set aside and SAIF is ordered to process claimant's claim according to law. SAIF is ordered to reimburse Argonaut Insurance Company for all relevant claims costs incurred by Argonaut. Claimant's attorney is awarded a reasonable attorney fee of $1,500 for services at hearing, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

FRED B. ZAHLER, Claimant
Aspell, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 85-08530
March 31, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The self-insured employer requests review of that portion of Referee McCullough's order which awarded claimant 60 percent (192 degrees) unscheduled permanent disability for an upper back injury, in lieu of a previous award of 10 percent (32 degrees) by a June 21, 1985, Determination Order. On review, the sole issue is extent of unscheduled permanent disability. We find that the award should be reduced. Consequently, we modify the Referee's order.

Claimant, 39 years of age at the time of the hearing, compensably injured his upper back in October 1983, while moving a stack of doors. His treating physician, Dr. Glidden, M.D., diagnosed "thoracic spine and concurrent myofascitis." Treatment was conservative, consisting of anti-inflammatory medication, pain pills, and physical therapy.

Claimant returned to light duty work on December 1, 1983, and soon thereafter resumed regular work. A Determination Order issued on May 29, 1984, awarding time loss only. Since this closure, the claim has been reopened and closed on two occasions. The claim was most recently reopened in March 1985. In May 1985, Dr. Glidden considered claimant medically stationary and released him to moderate work. Dr. Glidden recommended that claimant avoid heavy or moderate work with the upper body. Dr. Glidden further stated, that he was unable to explain the lack of improvement in claimant's condition from a physical or objective standpoint.

In June 1985, Dr. Warren, orthopedist, performed an independent medical examination. Dr. Warren reported that claimant's prognosis was good and that his problems would resolve if he avoided excessive bending, twisting, stooping or lifting. Thereafter, a June 1985 Determination Order awarded 10 percent unscheduled permanent disability. Vocational services were undertaken, but were terminated in September 1985, due to claimant's alleged noncooperation.

Claimant's work experience primarily includes heavy labor, with some clerical/supervisory experience as well. He has worked as a farmhand, choker setter, lumber mill laborer, and door assembler. Claimant has also worked for a scrap metal company, where his tasks included completing shipping orders and supervising other workers.

Claimant testified that he experiences constant "sharp pain" between the shoulder blades, that he cannot drive a vehicle for more than 45 minutes because it hurts to sit that long, and that it hurts to lay down or to walk. He felt that his pain had not changed since he last saw Dr. Glidden in May 1985, and that he cannot return to heavy work.

The Referee stated that claimant's "physical limitations are substantial." Reasoning that these limitations prevent claimant from returning to his former work activities, the Referee concluded that a 60 percent unscheduled permanent disability award was appropriate. We agree that claimant's injury and physical limitations have resulted in a permanent loss of earning capacity in excess of the Determination Order's 10 percent permanent disability award. However, we consider the Referee's award to be excessive.

To prevail on the issue of entitlement to an award for unscheduled permanent partial disability, a worker must prove by a preponderance of the evidence that as a result of the industrial injury there has been a permanent loss of earning capacity. "Earning capacity" is defined as a worker's "ability to obtain and hold gainful employment in the broad field of general occupations." Surratt v. Gunderson Bros., 259 Or 65 (1971). In rating the extent of a worker's permanent disability we consider his physical impairment, which includes lay testimony concerning his disabling pain and physical limitations, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Following our de novo review of the medical and lay evidence, and considering the aforementioned guidelines, we conclude that a total award of 20 percent unscheduled permanent partial disability adequately compensates claimant for his compensable upper back injury.

ORDER

The Referee's order dated June 30, 1986, is modified in part. In lieu of the Referee's award, claimant is awarded 10 percent disability. This gives him a total award to date of 20 percent (64 degrees) unscheduled permanent disability for his upper back injury. Claimant's attorney's fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed.

SET FORM
No. 625a (Rev.)
Sept. 1, 1983

AMENDED CERTIFICATE AND ORDER for FILING ADMINISTRATIVE RULES WITH THE SECRETARY OF STATE

FILED
MAR 19 1987
BARBARA ROBERTS
SECRETARY OF STATE

I HEREBY CERTIFY that the attached copy is a true, full and correct copy of rule(s) adopted by the WORKERS' COMPENSATION BOARD (Agency) on March 4, 1987 (Date) to become effective April 15, 1987 (Date)

The within matter having come before the WORKERS' COMPENSATION BOARD (Agency) and all procedures having been in the required form and conducted in accordance with applicable statutes and rules and being fully advised in the premises:

Notice of Intended Action published in OAR Bulletin: NO ☐ YES ☒ Date Published: January 15, 1987

NOW THEREFORE, IT IS HEREBY ORDERED THAT the following action be taken:
(List Rule Number(s) or Rule Title(s) on Appropriate Lines Below)

PERM. ☒ or TEMP. ☐

Adopted: (New Rules) 438-11-015 and 438-11-035. Rules of Procedure Relating to Briefs and Other Documents and Filing and Service of Documer in Contested Workers' Compensation Cases on Board Review

Amended: (Existing Rules) 438-07-005, May 1, 1984, Rules Relating to Medical, Vocatio and Other Documentary Evidence at Hearing in Contested Workers' Compensation Cases

Suspended: (Temporary Only) 438-11-015 (temp.), WCB Admin 5-1986, December 31, 1986

438-11-035 (temp.), WCB Admin 5-1986, December 31, 1986

Repealed: (Existing Rules)

RECEIVED
MAR 19 1987
LEGISLATIVE COUNSEL'S OFFICE

as Administrative Rules of the WORKERS' COMPENSATION BOARD (Agency)

DATED this 19th day of March, 19 87

By: [signature] (Authorized Signer)

Title: Board Member

Statutory Authority: ORS 656.726(4); 183.310 to 183.410

Subject Matter: Rules of Practice and Procedure for Hearings and Board Review of Contested Cases under the Workers' Compensation Law

Statement of Need Attached: ☐ Previously filed Fiscal Impact Attached: ☐ Previously filed

For Further Information Contact: Roger C. Pearson, Senior Staff Attorney Phone: 378-3308

BEFORE THE WORKERS' COMPENSATION BOARD OF

THE STATE OF OREGON

In the Matter of the Adoption of Permanent Rules of Procedure for Workers' Compensation Board Review of Contested Cases under the Workers' Compensation Law and the Permanent Amendment of the Rule of Practice and Procedure regarding Medical, Vocational and other Documentary Evidence in Hearings under the Workers' Compensation Law	)	ORDER OF ADOPTION

1. The Workers' Compensation Board, pursuant to its rulemaking authority under ORS 656.726(4) and in accordance with the Administrative Procedures Act, ORS 183.310 to 183.410, duly filed a notice of its intent to amend its rules of practice and procedure pertaining to Board review of contested cases under the Workers' Compensation Law and medical, vocational and other documentary evidence in hearings under the Workers' Compensation Law. This notice was published in the Secretary of State Administrative Rules Bulletin on January 15, 1987.

2. Notice of intent to amend the aforesaid rules was also mailed to a representative sample of attorneys active in practice before the Board. Comments regarding the proposed rules were also solicited from members of the Board's staff and from the Referees in the Hearings Division.

3. No request for a public hearing was received from any person or organization.

4. No comments have been received from members of the public. One change in the proposed rules has been made in response to staff review of the rules. The words "personally or" have been added to OAR 438-11-035(2)(a). This addition was proposed to make the aforementioned subsection consistent with OAR 438-11-035(2)(b). With this addition, OAR 438-11-035(2)(a) provides as follows:

> "(a) A true copy of any thing delivered for filing under these rules shall be simultaneously served <u>personally or</u> by mailing by first class mail, postage prepaid, through the United States Postal Service, to each other party to the review, or to their attorneys." (Emphasis added).

5. Under its authority granted by ORS 656.726(4), the Board finds:

a. That the applicable rulemaking procedures have been followed, and

b. That the rules being adopted are reasonable and proper.

In accordance with its notice of intended action, it is hereby ORDERED

That Rule 438-07-005 as set forth on Exhibit "A" and Rules 438-11-001 through 438-11-035 as set forth on Exhibit "B," both certified to be true copies of the originals and both hereby made a part of this order, are hereby adopted, to be effective March 9, 1987.

Dated this 4 day of March, 1987.

WORKERS' COMPENSATION BOARD

Evelyn S. Ferris, Chairman

George Lewis, Board Member

C. Gregory McMurdo, Board Member

0025F5

EXHIBIT A

Deleted material in brackets; added material underscored.

438-07-005 MEDICAL, VOCATIONAL AND OTHER DOCUMENTARY EVIDENCE

(1) Statutory references: Medical reports as evidence, ORS 656.310(2); Vocational reports, ORS 656.287.

(2) To avoid unnecessary delay and expense medical evidence should be presented in the form of written reports and should include:

(a) History of the injury or disease;

(b) Pertinent medical history;

(c) Present complaints;

(d) All sources of history and complaints;

(e) Date of examination;

(f) Findings on examination;

(g) Impairment of physical or mental function including loss of reserve capacity;

(h) Cause of [disability] impairment and opinion whether [it] the impairment is all or in part work related;

(i) Medical treatment indicated;

(j) Liklihood of permanent [disability] impairment and opinion whether the condition is likely to change; and

(k) The reason for the opinion.

(3) This rule distinguishes full disclosure of information [,] between the parties, as required by OAR 438-07-015, from

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submission of evidence for consideration in disposition of a case.

(a) Not less than twenty (20) days before the hearing date, or within seven (7) days after mailing of notice of hearing, if the notice of hearing is mailed less than twenty (20) days before the hearing, the insurer shall file with the assigned referee originals or legible copies of all documents upon which the insurer intends to rely, together with an index. The documents shall be arranged in chronolgical order and numbered [,] in Arabic numerals[,] in the lower right corner of each page, beginning with the document of earliest date. The number shall be preceded by the designation "Ex, and pagination of multiple-page exhibits shall be designated by a dash followed by the page number. For example, page two of exhibit two would be designated "Ex 2-2." The index shall include the exhibit number, description of the exhibit, author, number of pages, and date of the document. The insurer at the time of filing shall [provide to] serve all other parties with copies of the index and copies of [any] all exhibits [not in their possession].

(b) Not less than ten (10) days before the scheduled date of hearing, or within seven (7) days of mailing of a copy of the insurer's exhibit index, whichever [comes] occurs later, the claimant shall file with the assigned referee any additional exhibits which the claimant wishes to offer in evidence. The additional exhibits shall be accompanied by a supplemental exhibit index, prepared in the same fashion as the insurer exhibit index

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and numbered so as to coincide, in chronological order, with the insurer submission. These exhibits should be marked in the same fashion as the insurer's submission, and should include letter sub-designations so as to ensure a chronological order. For example, a claimant wishing to submit an exhibit which falls chronologically between Exhibits 6 and 7 of the insurer's submission should designate [his] the exhibit as "Ex 6A." The claimant shall [provide] serve all other parties with a copy of the supplemental index [as well as] and [copies of any] exhibits [not in their possession].

[Further supplemental exhibits may be submitted, provided they are accompanied by supplemental indexes meeting the above requirements. Further supplemental exhibits must be filed and provided to the other parties within seven (7) days of the submitting party's receipt of the exhibits.]

(c) Application: These exhibit submission rules apply to all written evidence except evidence offered solely for impeachment purposes.

(4) At the hearing the referee may in his or her discretion allow admission of additional medical reports or other documentary evidence not filed as required by (3) above. In exercising this discretion, the referee shall determine if good cause has been shown for failure to file within the prescribed time limits [as well as factors of surprise or prejudice to the other parties].

(5) The insurer may subpoena the claimant's [doctor]

attending or consulting physician(s) or vocational expert for cross-examination. Medical, surgical, hospital [or] and vocational reports offered by the insurer will also be accepted as prima facie evidence provided the insurer agrees to produce the doctor or vocational expert for cross-examination upon request of the claimant. The reports of any doctor, medical or vocational expert who has refused to make himself or herself available for cross-examination shall be excluded from the record unless good cause is shown [to receive] why such evidence should be received. The cost of the cross-examination of any doctor or vocational expert under this section shall be paid by the insurer.

(6) To avoid unnecessary cost and delay, the Board encourages the use of written interrogatories or depositions, or other discovery devices, to secure evidence.

(7) The referee may appoint a medical or vocational expert to examine the claimant and to file a report with the referee. The parties may also agree in advance to be bound by such expert's findings. The cost of examinations and reports under this rule shall be paid by the insurer.

(8) The referee may decline to receive in evidence either at or subsequent to the hearing, any medical or vocational report offered by a party who has refused to make the report available to the referee or other parties, or to permit examination thereof as required by the rule of the referee.

(9) With approval of the referee, interrogatories may be

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directed through the referee to any medical or vocational expert whose reports are tendered as evidence. The reasonable cost, if any, of obtaining answers to the interrogatories in this manner will be paid from the Administrative Fund.

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Exhibit "B"

OREGON ADMINISTRATIVE RULES

CHAPTER 438. WORKERS' COMPENSATION BOARD

DIVISION 11. RULES OF PRACTICE AND PROCEDURE FOR BOARD REVIEW OF CONTESTED CASES UNDER THE WORKERS' COMPENSATION LAW

TABLE OF CONTENTS

BOARD REVIEW

438-11-001 STATUTORY AUTHORITY; ADOPTION PROCEDURES.

(1) The statutory authority for the adoption of these rules is ORS 656.726(4).

(2) These rules are adopted in accordance with ORS Chapter 183 and the Attorney General's Model Rules of Procedure applicable to rulemaking functions.

438-11-003 APPLICABILITY; EFFECTIVE DATE; REPEAL OF PRIOR RULES

(1) These rules apply to all cases in which a party or parties request Board review of an order of a Referee pursuant to ORS 656.289 and 656.295. These rules do not apply to proceedings before the Board on its own motion pursuant to ORS 656.278, proceedings before the Board under the third-party law pursuant to ORS 656.576 to 656.595 and proceedings before the Board after remand from an appellate court.

(2) These rules are effective November 1, 1986 and apply to all cases on Board review pending on and after that date.

(3) OAR 438-11-005, effective May 1, 1984, and OAR 438-11-011 (Temporary), effective May 6, 1986, are repealed as of the effective date of these rules.

438-11-005 REQUEST FOR BOARD REVIEW.

(1) The time for and manner of filing a request for Board review of a Referee's order are set forth in ORS 656.289 and 656.295.

(2) "Filing" of a request for Board review of a Referee's order has the meaning set forth in OAR 438-05-040(4).

(3) Copies of a request for Board review of a Referee's order shall be simultaneously mailed to all parties who appeared at the hearing and to their attorneys, if represented by an attorney.

(4) The request should recite the name of the claimant, the WCB case number, the identity of the party requesting review and should contain a brief statement of the reason review is requested.

438-11-010 SCOPE OF BOARD REVIEW.

(1) Review by the Board is do novo upon the entire record. The Board may remand a matter to the Hearings Division to take additional evidence, report findings to the Board or to enter an Opinion and Order on remand.

(2) The Board will not ordinarily entertain oral argument. All issues and arguments should be reduced to writing and filed pursuant to 438-11-015. The case will be reviewed in the ordinary course of business without prior notice to the parties of the date or time of review.

438-11-015 BRIEFS AND OTHER DOCUMENTS.

(1) Filing of briefs is not jurisdictional; however, the Board views briefs as a significant aid to the review process. Briefs submitted for consideration by the Board shall comply with this section.

(2) The party requesting Board review shall file its appellant's brief to the Board within 21 days after the date of mailing of the transcript of record to the parties. Respondent(s) shall file its (their) brief(s) within 21 days after the date of mailing of the appellant's brief. Any party who has filed a cross-request for review shall include its cross-appellant's opening brief as a part of its respondent's brief. An appellant may file a reply and/or cross-respondent's brief within 14 days after the date of mailing of the respondent's and/or cross-appellant's brief. A cross-appellant may file a cross-reply brief within 14 days of the mailing date of a cross-respondent's brief.

(3) Extensions of time for filing of briefs will be allowed only on written request filed no later than the date the brief is due. A statement whether opposing counsel (or a party if the party is not represented by counsel) objects to, concurs in or has no comment regarding the extension of time requested shall be furnished for any request other than a first request for an extension of 14 days or less. First requests for extension of more than 14 days and all requests beyond the first request will be allowed for good cause only. Mere press of business without other circumstances will not be considered good cause.

438-11-020 MOTIONS THAT TOLL TIME.

Unless otherwise ordered by the Board, the filing of a motion to dismiss a request or cross-request for review, to remand a case to the Hearings Division or to strike a brief tolls the time for the next event in the review process.

438-11-025 MOTION FOR WAIVER OF RULES.

Except as otherwise prohibited by law, the Board may waive any provision of OAR 438-11 upon motion of a party to avoid undue hardship or prevent manifest injustice. A motion for waiver of rules shall include a statement of the facts and circumstances relied upon and shall be simultaneously served upon all other parties or their attorneys.

438-11-030 BOARD ORDER; RECONSIDERATION.

(1) The Board order on review shall set forth the parties, the issues, the Board's decision and shall advise all parties of appeal rights.

(2) A request for reconsideration of a Board order shall include a concise statement of the reason(s) reconsideration is requested. An order on reconsideration shall state whether or not the original order is withdrawn for reconsideration.

438-11-035 FILING AND SERVICE OF BRIEFS AND OTHER DOCUMENTS.

(1) Filing.

(a) Any thing to be filed with the Workers' Compensation Board pertaining to review by the Board of a Referee's order shall be delivered to the Workers' Compensation Board, 480 Church Street, S.E., Salem, Oregon 97310.

(b) Filing of briefs, motions for extensions of time and all other things required to be filed within a prescribed time may be accomplished by mail and shall be complete upon deposit in the mail if mailed on or before the due date by first-class mail, postage prepaid, through the United States Postal Service.

(c) If filing is not done as prescribed in subsection (b) of this section, then filing shall not be timely unless the thing is actually received by the Board within the time fixed for filing.

(2) Service.

(a) A true copy of any thing delivered for filing under these rules shall be simultaneously served personally or by mailing by first-class mail, postage prepaid, through the United States Postal Service, to each other party to the review, or to their attorneys.

(b) Any thing delivered for filing under these rules shall include or have attached thereto either an acknowledgement of service by the person served or proof of service in the form of a certificate executed by the person who made service showing personal delivery or deposit in the mails together with the names and addresses of the persons served.

0021FE

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

In the Matter of the Compensation of
Patrick M. Hannum, Claimant.

HANNUM,
Petitioner,

v.

EBI COMPANIES et al,
Respondents.

(84-07520; CA A36184)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 12, 1986.

Howard R. Nielsen and Vick & Associates, Salem, filed the brief for petitioner.

Jerald P. Keene, Portland, argued the cause for respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

In this workers' compensation case, claimant seeks review of an order of the Board affirming the referee's order that upheld EBI's denial of his aggravation claim. We affirm.

Claimant sustained a compensable injury to his left knee in 1976. In October, 1978, he received an award of permanent partial disability. He continued to receive medical treatment and in 1982 consulted a physician and then filed a claim for aggravation. EBI reopened the claim, which was later closed by determination order with an award on the aggravation claim. Claimant sought a hearing of the award. The only issue posed by either party was the extent of disability. The referee increased the award to 75 degrees, and EBI filed a request for Board review.

At the same time, EBI issued a "backup" denial of the aggravation claim "on the basis of fraud and misrepresentation," and claimant requested a hearing on that denial. Essentially, EBI asserted that claimant had misled his treating physician and the examining physician regarding the cause of his present knee pain. It developed at the hearing that he had fallen and twisted his knee while shovelling snow at his residence. He had not disclosed that to the doctors and had told them that his knee had collapsed without any cause.

Before the hearing on the "backup" denial, EBI requested that the Board stay the appeal of the aggravation award pending final determination of EBI's denial of compensability. Claimant objected and requested that EBI be ordered

to pay the aggravation compensation awarded. The Board, in a written opinion, granted the motion to stay and also held that EBI did not have to pay the compensation pending review of that order.

In the hearing on EBI's "backup" denial the referee found that EBI could properly issue a "backup" denial under *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), because claimant had misrepresented the cause of his present knee condition. He also found that the present condition was not an aggravation of the compensable injury and upheld the denial. The Board affirmed without opinion.

Claimant sought review only of the Board's order affirming the denial. He does not challenge the finding that he

had misled the doctors and EBI or that there was fraud involved in making the aggravation claim. He argues instead that the award of compensation in the aggravation hearing is *res judicata* and forecloses an adjudication of compensability.

Bauman appears to authorize a "backup" denial when acceptance of the claim is induced by fraud, misrepresentation or other illegal activity. Consequently, a determination of a claim is not *res judicata* if fraud, misrepresentation or illegal activity supports a subsequent denial. *Bauman* suggests no time limit on a "backup" denial, and we discern no basis for holding that the denial in this case was unreasonable in terms of the length of time between the original acceptance and the denial. EBI only learned of the fraud when claimant testified at the aggravation hearing and issued the denial right after that hearing. We conclude that EBI was not foreclosed by *res judicata* from issuing the denial.

Claimant also asserts that he should have been awarded penalties and attorney fees because of EBI's unreasonable denial. The referee found that the denial was proper and not unreasonable and denied penalties and attorney fees. We concur.

In the final assignment, claimant contends that EBI was required to continue payment of the aggravation award pending review of that order under ORS 656.313(1). The problem is that the Board's order which stayed the appeal and suspended payment by EBI of the compensation award is not before us. EBI stopped paying benefits in response to an order of the Board, which is not in issue on this review. We express no opinion as to the propriety of the Board's opinion and order suspending payments.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

KNAPP,
Respondent,
v.
CITY OF NORTH BEND,
Appellant.
(85-919; CA A38486)

Appeal from Circuit Court, Coos County.

Richard L. Barron, Judge.

Argued and submitted December 5, 1986

Daniel M. Spencer, Coos Bay, argued the cause for appellant. With him on the briefs was Foss, Whitty & Roess, Coos Bay.

Michael R. Stebbins, North Bend, argued the cause for respondent. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Larry K. Amburgey and Craig A. Crispin, Portland, filed a brief *amici curiae* for Food Employers, Inc.; Gourmet Brands, Inc.; Lynden Farms/Belozer's Hatchery; McCracken Motor Freight, Inc.; Mid-Columbia Medical Center; Nike, Inc.; Northwest Packers Industrial Associations, Inc.; Oregon Self-Insurers Association; Oregon Trucking Association, Inc.; PayLess Drug Stores Northwest, Inc.; Portland Chamber of Commerce; The Port of Portland; Rogue Valley Medical Center; Silver Eagle Industries; Stayton Canning Company; Timber Operators Council; Truitt Brothers, Inc.; and Trus Joist Corporation.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Plaintiff was employed as a police sergeant by defendant city and suffered an on-the-job injury in January, 1983, for which he received workers' compensation benefits. His physician released him for regular work in November, 1984. Between those dates, defendant promoted another officer to fill his former position. When plaintiff requested reinstatement to the position, defendant refused on the ground that the position was not available. Defendant later rehired him as a patrolman. The principal issue is whether defendant's failure to reinstate plaintiff to his former position violated ORS

659.415(1),[1] which provides:

> "A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, provided that the position is available and the worker is not disabled from performing the duties of such position. If the former position is not available, the worker shall be reinstated in any other position which is available and suitable. A certificate by a duly licensed physician that the physician approves the worker's return to the worker's regular employment shall be prima facie evidence that the worker is able to perform such duties."

In *Shaw v. Doyle Milling Co.*, 297 Or 251, 683 P2d 82 (1984), the Supreme Court answered essentially the same question under the statute as it read before it was amended by Oregon Laws 1981, chapter 874, section 14. The statute construed by the Supreme Court provided:

> "A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment or employment which is available and suitable upon demand for such reinstatement, provided that the worker is not disabled from performing the duties of such position. A certificate by a duly licensed physician that the physician approves the worker's return to the worker's regular employment shall be prima facie evidence that the worker is able to perform such duties."

The court concluded:

> "The main purpose of ORS 659.415 is to guarantee that an

> employer shall not discriminate against a disabled worker for exercising the worker's rights under the Workers' Compensation Law. This statute is but one of a set of statutes reflecting the legislature's concern to prohibit employment discrimination on the basis of handicap. * * * Where the position still exists, although filled by another employee, the returning employee is entitled by the statutory text to reinstatement. To hold otherwise would permit an employer unilaterally to vitiate the mandate of ORS 659.415 and to thwart the broader legislative scheme to afford employment opportunity and security to the handicapped." 297 Or at 255.

Defendant and *amici* argue that the present statute cannot be interpreted as its predecessor was in *Doyle*, because the 1981 amendment added the proviso to the reinstatement requirement that the former position be "available." They maintain that "available" means existing and vacant; plaintiff contends that a worker's former position is "available" if it exists, whether or not it has been filled by another employe between the time when the worker was injured and the time when he qualifies for and demands reinstatement.

The parties' most persuasive arguments turn on their views of the policy and purpose of the statute. However, defendant and *amici* make a number of other arguments which we will address first. They rely on the legislative history of the statute as originally enacted by Oregon Laws, 1973, chapter 660, section 5, the history of the 1981 amending act, the

[1] A violation of that provision is an unlawful employment practice under ORS 659.415(3) and is actionable under ORS 659.121.

legislature's decisions not to amend the statute in 1979[2] and 1983 and interpretations of the statute by the Bureau of Labor and Industries (Bureau). The thrust of the arguments is that, when it was originally enacted in 1973, the statute was intended to require reinstatement only if the employe's former position was vacant; that the Bureau has always so interpreted the statute, before and after the 1981 amendment; that that amendment was designed to clarify and restate the original intent and was not meant as a substantive change; and that the legislature's inaction in 1979 and 1983, like its action in 1981, reflected its awareness and acceptance of the Bureau's administrative interpretation. Those arguments defeat themselves, because they presuppose that before the

1981 amendment the statute meant the opposite of what the Supreme Court construed it to mean in *Shaw v. Doyle Milling Co., supra.*

Amici state:

> "Plaintiff argued below that (1) the Legislature's 1981 amendment was not intended to change prior law, (2) *Shaw v. Doyle Milling Co., supra,* defined the plain language of the prior law, and (3) therefore, the Legislature intended its 1981 amendment to fall within the terms of the *Shaw* interpretation.
>
> "This logic is a classic non sequitur. The erroneous logic fails because the Legislature intended to preserve what *it believed to be prior law,* not what the court some three years later read into the words of the prior statute. Far from intending no change from a *Shaw* interpretation, the 1981 amendments intended no change from requiring reinstatement--but only to an open or next available position." (Emphasis *amici's.*)

We think that the *non sequitur* is to be found in *amici's* argument rather than plaintiff's. The court in *Shaw* declared what the prior law meant; it is circular to argue that the prior law had a different meaning, or that the legislature so believed, before the court said what it meant. Stated otherwise, the law meant at the beginning of 1981 what the court in 1984 interpreted it to have meant at the beginning of 1981.[3]

Defendant and *amici* contend that *Shaw* is not dispositive, because it construed ORS 659.415(1) before it was

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[2] ORS 659.415 was amended by Oregon Laws 1979, chapter 813, section 3, but not in any respect which bears on the issue here.

[3] In 1983, the Bureau promulgated OAR 839-06-140, which, as pertinent, defines "available" as "vacant." That rule is of little assistance to us, because it simply perpetuated the Bureau's incorrect understanding of what the unamended statute meant and, therefore, what the Bureau regarded the clarifying 1981 amendment as continuing to mean. (The Bureau offered a statement to the House Committee on Labor that the proposed 1981 amendment was intended to clarify "the intent of the statute, but does not alter any rights presently enjoyed by workers subject to this provision.") *Shaw* was decided the year after the promulgation of the rule.

Defendant also relies on our decision in *Carney v. Guard Publishing Co.,* 48 Or App 147, 616 P2d 548, *modified* 48 Or App 927, 630 P2d 867; *rev den* 290 Or 171 (1980), as support for its interpretation of "available." The language it points to in *Carney* is, in its context, of no assistance to defendant. The statute we interpreted in *Carney* was ORS 659.420, which pertains to reemployment of injured workers in *other* "available and suitable" positions if they are *unable* to resume their former positions. Different considerations arise when the issue is the displacement of workers to provide a position for an injured worker who never held that position rather than restoring a worker to a former position which the employer filled during the worker's disability.

amended to add the language on which they rely. We agree that *Shaw* is not directly controlling regarding the meaning of that language.[4] However, *Shaw* is fatal to defendant's and *amici's* arguments based on legislative history and the Bureau's interpretations of the statute, because those arguments rest on the premise that, before the amendment, the statute meant what the court in *Shaw* held that it did not. We turn to whether the amendment changed that meaning.

The phrase "provided that the position is available" is ambiguous; "available" *can* reasonably be defined in two different ways, as the parties arguments demonstrate. The legislative history of the 1981 amendment is not helpful, much less decisive, in ascertaining which definition the legislature intended. As best we can discern, the principal purpose of the relevant portion of the amendment had little to do with the addition of the "available" proviso to the reinstatement requirement. The purpose was to make clear that reinstatement to a former position and placement in a different available and suitable position were sequential requirements rather than options between which employers could freely choose.

The question becomes which of the possible interpretations of "available" is more consistent with the statutory purposes and policies. *See State ex rel Cox v. Wilson*, 277 Or 747, 562 P2d 172 (1977). Both parties offer persuasive arguments. Defendant contends:

> "The purpose of the statute is to maintain the employment relationship. The employer must reinstate a worker to his former position if it is vacant. If it is not vacant, then the worker is to be reinstated to the next suitable vacancy. The statute does not require the employer to preserve a worker's former position, and reinstate the worker to that position regardless of how long the worker has been off, and regardless of whether the position has been filled by another worker.
>
> "The proviso in ORS 659.415 '* * * provided the position is available * * *,' limits the employer's obligation under the statute. It protects the employer by limiting the nature of the affirmative act required under the statute.

> "To interpret the proviso '* * * provided that the position is available' to mean '* * * provided that the position is in existence * * *,' would require the employer to reinstate the worker to his former position regardless of how long he has been away from his job, and regardless of whether the position has been filled by another worker. Such an interpretation would provide the employer with little or no protection, and render the limiting clause meaningless.
>
> "A common scenario in the work place is that after a worker is injured, his position is filled by another worker so that the business at hand continues. To interpret 'available' to mean 'vacant,' as opposed to 'in existence' is more reasonable. The worker's 'employee' status is maintained, while at the same time the employer's responsibility under the statute, as intended by the legislature, is limited in such a way to provide for an orderly workplace."

[4] The court in *Shaw* did not construe the word "available," which did appear in the unamended statute in connection with positions other than the employe's former one.

Plaintiff responds:

"To hold that an employer does not have a duty to reinstate the injured worker would leave that worker and his or her family without a job and without income. Such a result would virtually render ORS 659.415 meaningless. No worker with a family to support will dare to make a claim for workers' compensation benefits where it might result in him or her being off of work for any length of time. There would be no job for them when they returned to work. They would no longer be entitled to temporary total disability benefits under the Workers' Compensation System, and they would be reduced to seeking income through the welfare system. This clearly undermines the employee's ability to resort to the Workers' Compensation System which is contrary to the public policy of the State of Oregon.

"* * * * *

"To interpret the statute as urged by the defendant, would result in the injured worker not being returned to a position of self-support and maintenance until such time as the employer deemed it appropriate. Additionally, the statutory interpretation urged would result in the handicapped worker's right to engage in remunerative employment not being protected, but being subject to the whim of the employer."

The trial court explained its ruling:

"There are two competing values in the case which are important and deserve recognition. Both values have merit and it is unfortunate the court cannot equally balance them.

As the court stated, the interpretation set forth by plaintiff as to the meaning of ORS 659.415 is more reasonable and fair. The Oregon legislature could not have intended for an injured workman to be jobless because his employer must fill the workman's position during his period of disability. This would put a high premium on seeking benefits, especially in cases where a workman has no choice because his injury is of such a severity that he could not work even if he wanted to do so. The workman could do nothing to protect himself. On the other hand, the employer can protect itself by making it clear that any replacement may very well be temporary. This may not be the best solution, but at least it is available to the employer."

We agree with plaintiff and the trial court. It is significant that, at the time when it added the new proviso to the reinstatement requirement, the legislature did not amend ORS 659.405, which declares the policy of the statutes, including ORS 659.415, relating to civil rights of the handicapped. Under the current statute, as under the earlier version construed by the court in *Shaw*, the interpretation defendant advocates "would permit an employer unilaterally to vitiate the mandate of ORS 659.415 and to thwart the broader legislative scheme to afford employment opportunity and security to the handicapped." 297 Or at 255. Stated summarily, defendant's interpretation would enable employers to free themselves from the statutory reinstatement requirement simply by deciding to fill an injured employe's position with a permanent replacement. We hold that, because plaintiff's former position was in existence at the time when he sought and was qualified for reinstatement, defendant violated the statute by not reinstating him.

Defendant also assigns error to the court's award of back wages to plaintiff. It argues that, "because the employer in this case fulfilled its statutory duty pursuant to the terms of [ORS 659.415], plaintiff is not entitled to back wages from the time of his request for reinstatement." We have held that defendant did not comply with ORS 659.415(1), and plaintiff was therefore entitled to the damages awarded. ORS 659.121(1).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John P. Kleger, Claimant.

KLEGER,
Petitioner - Cross-Respondent,

v.

UNIVERSAL UNDERWRITERS INSURANCE et al
Respondents - Cross-Petitioners.

(WCB 84-07458, 83-10245; CA A37255)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 23, 1986.

Howard R. Nielsen, Salem, argued the cause and filed the brief for petitioner - cross-respondent.

Richard C. Pearce, Portland, argued the cause and filed the brief for respondents - cross-petitioners.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed on petition and cross-petition.

WARREN, J.

Claimant seeks review of an order of the Workers' Compensation Board which held that the medical treatment he sought was necessitated by a compensable injury but that the compensable condition had not worsened since the last arrangement of compensation so as to require a reopening of the claim. On *de novo* review, we affirm on the petition and write only to consider, in the light of *Compton v. Weyerhaeuser,* 301 Or 641, 724 P2d 814 (1986), insurer's argument on cross-petition that the Board should have remanded the case to the referee for the taking of additional evidence which allegedly shows that the condition for which claimant seeks medical benefits is not related to his compensable injury. The evidence consists of surveillance films taken after the hearing showing claimant performing activities which he suggested at the hearing he was unable to perform, the testimony of the investigator who made the films, reports

of claimant's treating doctor, who, after viewing the films, changed his opinion concerning the cause of claimant's condition, and the report of a second doctor who examined claimant after the hearing.

As the Board stated, the surveillance films are offered, in part, to impeach claimant's testimony. The record shows that insurer was aware, before the hearing, of claimant's tendency to exaggerate his disability. It could have had the films made before the hearing. The medical reports deal with the cause of claimant's present condition requiring medical treatment and support the conclusion that the condition is not related to the compensable injury. The reports could have been obtained before the hearing, if the doctors had been aware of the true nature of claimant's disability. The fact that claimant misstated his disability at the hearing should not open the door for evidence which insurer, by investigation, could have obtained before hearing. Under the test set out in *Compton v. Weyerhaeuser, supra,* we agree with the Board that the evidence should not be considered.

Affirmed on the petition and on the cross-petition.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Adelie M. Webb, Claimant.

WEBB,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 83-00463; CA A37873)

Judicial Review from Worker's Compensation Board.

Argued and submitted October 20, 1986.

Stephen Behrends, Eugene, argued the cause and filed the brief for petitioner.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With her on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Soliciter General, Salem.

No appearance for respondent Douglas County Lumber Co.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded for payment of medical benefits from December 2, 1982, to April 26, 1984, and for award of penalties and attorney fees; otherwise affirmed.

WARREN, J.

Claimant seeks review of a Workers' Compensation Board order denying him medical benefits and penalties and attorney fees for SAIF's alleged wrongful denial of compensation.

Claimant, a log truck driver, suffered a compensable back injury on July 9, 1979, when he fell while throwing a wrapper over a load of logs. The injury was diagnosed as a pulled muscle or strain, and SAIF accepted the claim as nondisabling on August 6, 1979. Claimant's back pain continued intermittently. In April, 1980, a doctor reported that he was suffering from pain due to degenerative changes in his back which were not related to the injury. In May, 1980, SAIF denied claimant's request to reopen the claim. SAIF also denied an aggravation claim on August 27, 1981, stating that the symptoms were related to his noncompensable preexisting osteoarthritis. Claimant requested a hearing.

Dr. Allcott began treating claimant in June, 1981. In a report of September 2, 1981, he described two distinct conditions: 1. recurrent low back syndrome secondary to industrial muscle strain; 2. underlying osteoarthritis. Allcott concluded that the symptoms were caused by both conditions.

On October 22, 1981, the referee approved a disputed claim settlement. The agreement is confusing and vague. Claimant agreed to withdraw his hearing request. SAIF expressly withdrew its August 27, 1981, denial of the aggravation claim and reissued it as a partial denial relating only to the underlying osteoarthritic condition. SAIF expressly accepted conditions described by Allcott as "low back syndrome" and strained muscles and agreed to pay medical bills related to them. SAIF also agreed to pay claimant $6,500 in settlement of the disputed claim but not as an acceptance of the osteoarthritis or a hernia claim which was then also pending nor as time loss associated with the aggravation claim. We view SAIF's acceptance of the aggravation claim with regard to the low back syndrome as a reopening of the claim.

On December 3, 1982, SAIF issued a letter denying an "aggravation claim" and further medical treatment, because the treatment was related to osteoarthritis and not to the

compensable back condition.[1] Claimant requested a hearing. On April 16, 1984, the referee convened the hearing but then postponed it, because the 1979 claim had never been closed; the referee believed that it was unnecessary for claimant to seek benefits by way of an aggravation claim while the claim was still open.

On April 26, 1984, SAIF issued a notice of closure which stated that medical treatment had been completed and that there were "no temporary total disability benefits due as a result of" the 1979 injury. At the reconvened hearing on December 13, 1984, claimant asked that the back claim be reopened, because he had permanent disability as a result of the 1979 injury. He also asked for medical benefits and

benefits for temporary total disability from the date of the denial of December 3, 1982. He sought penalties and attorney fees for SAIF's refusal to pay medical benefits after that date and for its alleged improper closure of the claim on April 26, 1984.

The referee concluded that there was evidence of permanent disability and agreed that the claim had been improperly closed. He determined that claimant was not entitled to temporary total disability from the date of the denial, however, because he had retired before that time. He also denied medical benefits, because the evidence did not persuade him that claimant's medical treatment was related to the compensable injury. He awarded no penalties, but did award attorney fees for prevailing on the claim closure issue.

The Board reversed the referee in part, holding that claimant could not challenge claim closure initially at a hearing, but had first to seek a determination order from the Evaluation Division as required by ORS 656.268(3).[2] The

Board also reversed the award of attorney fees related to that issue. The Board agreed with the referee that the medical evidence did not support the conclusion that claimant's treatment and disability were related to the 1979 injury. Claimant now seeks reversal of the Board's order with regard to his

[1] There is no document separately identifiable as an aggravation claim.

[2] ORS 656.268 provides, in part:

"(2) When the injured worker's condition resulting from a disabling injury has become medically stationary, unless the injured worker is enrolled and actively engaged in training, the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and the employer, if any, and request the claim be examined and further compensation, if any, be determined. A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the Evaluation Division and to the worker and to the employer, if requested by the worker or employer. 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 of the medical reports submitted to the Evaluation Division under this section. If the attending physician has approved the worker's return to the worker's regular employment and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of any vocational assistance provided by this chapter.

"(3) When the medical reports indicate to the insurer or self-insured employer that the worker's condition has become medically stationary and the insurer or self-insured employer decides that the claim is disabling but without permanent disability, the claim may be closed, without the issuance of a determination order by the Evaluation Division. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker and to the Workers' Compensation Department. The notice must inform the worker of the decision that no permanent disability results from the injury; of the amount and duration of temporary total disability compensation; of the right of the worker to request a determination order from the Evaluation Division within one year of the date of the notice of claim closure; of the aggravation rights; and of such other information as the director may require. Within one year of the date of the notice of such a claim closure, a determination order subsequently shall be issued on the claim at the request of the claimant or may be issued by the Evaluation Division upon review of the claim if the division finds that the claim was closed improperly. If an insurer or self-insured employer has closed a claim pursuant to this subsection and thereafter decides that the claim has permanency, the insurer or self-insured employer shall request a determination order as provided in subsection (2) of this section. If an insurer or self-insured employer has closed a claim pursuant to this subsection, if the reasonableness of that closure decision is at issue in a hearing on the claim and if a finding is made at the hearing that the closure decision was not supported by substantial evidence, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be owing between the date of original closure and the date upon which the claim is closed by determination order. The penalty shall not be less than $500."

entitlement to medical benefits from December 3, 1982, the date of the denial, to April 26, 1984, the date when the claim was closed, and the related award of penalties and attorney fees. We conclude that he is entitled to the relief he seeks.

The first referee incorrectly concluded that the 1979 back claim had to be formally closed. SAIF had accepted it as nondisabling, and at the time of the injury no statute required closure of a claim for a nondisabling injury. (ORS 656.268(3), which requires carrier closure of a nondisabling claim, became effective on January 1, 1980. Or Laws 1979, ch 839, §§ 4(3) and 33.) In their settlement, however, the parties agreed that

claimant's *aggravation claim* for the low back syndrome was compensable. Whether that condition was disabling or not, the claim was subject to provisions for claim closure. ORS 656.268(2) or (3). *See Woodward v. C & B Logging,* 82 Or App 274, 728 P2d 51 (1986). SAIF's December 3, 1982, denial circumvented the closure process by attempting to terminate SAIF's future responsibility for the claim before the extent of the accepted condition had been determined. *Roller v. Weyerhaeuser Co.,* 67 Or App 583, 679 P2d 341, *amplified* 68 Or App 743, 683 P2d 654, *rev den* 297 Or 601 (1984).

We conclude that SAIF could not terminate its responsibility in that fashion and that its obligation to pay medical benefits continued until the date of closure. We also conclude that the denial was unreasonable in the light of the medical evidence in existence at the time, which indicated that claimant's medical treatment was related to the accepted low back condition. Claimant is entitled to penalties and attorney fees for the unreasonable denial. In all other respects, we affirm the Board's opinion.

Reversed and remanded for payment of medical benefits from December 2, 1982, to April 26, 1984, and for the award of penalties and attorney fees. In all other respects the Board is affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Richard L. Manley, Claimant.
ESCO CORPORATION et al
Petitioners,
v.
MANLEY,
Respondent.
(WCB 83-11309; CA A37730)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 20, 1986.

Allan M. Muir, Portland, argued the cause for petitioners. With him on the brief were William H. Replogle and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Nelson R. Hall and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed.

WARREN, J.

In this workers' compensation case, employer seeks reversal of the Board's finding that the condition for which claimant underwent surgery in 1983 was related to a compensable back injury.

Claimant suffered a compensable herniation of his back in 1980, when he fell into a box at work. Dr. Borman performed surgery which he described as a left side lumbar diskectomy at L4-L5 in 1981, which employer agreed was necessitated by the fall. Claimant returned to work, but in March, 1982, he experienced sharp pain in his back after engaging in nonwork-related activities. Borman performed surgery which he described as a right side lumbar diskectomy at L4-L5 in 1982, which employer also agreed was compensable. Claimant had considerable relief from the surgery and appeared to be fully recovered when, in January, 1983, he experienced pain after driving his truck. Borman ultimately performed a third surgery, which he described postoperatively as a lumbosacral diskectomy at L5-S1. Employer denied claimant's request for a reopening and in November, 1983, formally denied a claim for compensation for the surgery.

At employer's request, Dr. Howell reviewed claimant's medical records. In his opinion, the condition for which claimant underwent the third surgery was unrelated to the 1980 injury. He explained that the 1983 surgery was performed in an area entirely different from the first two surgeries and that the objective abnormalities which substantiated the 1983 diagnosis were not present following the 1980 injury.

Although Borman never disputed that the surgery was at a different level from the first two, he did "dispute Howell's conclusion." Because he did not explain that statement, we assume, as the Board did, that Borman disputes Howell's conclusion regarding the causal relationship of the 1983 surgery to the 1980 injury. Dr. Rosenbaum also examined claimant and reviewed his medical records. In his deposition of August, 1984, he testified that, in his opinion, the 1983 surgery was not related to the injury or to the two previous surgeries.

The Board reviewed the notes of the doctors who analyzed the x-ray and myelograms and concluded that the third surgery was conducted at the same level as the first two.

We have reviewed those reports and conclude that, although they create some uncertainty as to the exact location of claimant's back problem, they do not persuade us, in the face of the statements of the operating surgeon, that the three surgeries were at the same level. Borman reported before the hearing:

> "In retrospect, this patient underwent three surgical procedures. An L4-L5 diskectomy for alleviation of left lower extremity pain January 5, 1981, and an L4-L5 diskectomy on April 8, 1982, for alleviation of right lower extremity pain and more recently a lumbosacral diskectomy on July 6, 1983 to relieve recurrent right lower extremity pain."

Unfortunately, the most that can be gleaned from his opinion concerning the relationship between the 1980 injury and the 1983 surgery is that Borman disputes Howell's conclusion that there was no relationship between the injury and the third surgery. Borman's reports lack an affirmative statement concerning his own opinion of the relationship between the surgeries and the injury and, more importantly, do not explain the basis for his disagreement with Howell. On *de novo* review we conclude that the 1983 surgery was performed at L5-S1, and we are persuaded by the better reasoned opinions of Howell and Rosenbaum that the need for the third surgery was not caused by the 1980 work incident. We conclude that claimant has not met his burden of proving by a preponderance of the evidence that the 1983 surgery was compensably related to the 1980 fall.

Reversed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

JANZEN,
Appellant,
v.
SUNRIVER LANDS, INC.,
Respondent.
(36791; CA A38634)

Appeal from Circuit Court, Deschutes County.

Walter I. Edmonds, Judge.

Argued and submitted December 5, 1986.

Michael R. Stebbins, North Bend, argued the cause for appellant. With him on the briefs was Hayner, Stebbins & Coffey, North Bend.

William M. Holmes, Bend, argued the cause for respondent. With him on the brief was Gray, Fancher, Holmes, Hurley & Bischof, Bend.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Reversed and remanded on Count I for further proceedings not inconsistent with this opinion; otherwise affirmed.

PER CURIAM

Plaintiff alleges that defendant, his former employer, violated ORS 659.415 by failing to reinstate him to his former position when he was released to return to work after suffering a compensable injury. In a separate "count," he contends that defendant violated its employe handbook and wrongfully terminated him. The trial court granted summary judgment for defendant, and plaintiff appeals.

His first assignment is that the trial court erred by ruling that ORS 659.415(1) does not require an employer to reinstate an employe to his existing former position if the employer had filled that position during the time when the employe was away from work because of a compensable injury. We agree with plaintiff for the reasons stated in *Knapp v. City of North Bend,* 83 Or App 350, ___ P2d ___ (decided this date). Plaintiff makes three further assignments. However, we understand him to waive those assignments if his first assignment is decided in his favor.[1]

Reversed and remanded on Count I for further proceedings not inconsistent with this opinion; otherwise affirmed.

[1] Plaintiff states in the conclusion of his opening brief:

"The plaintiff requests that the ruling of the trial court be reversed as to Assignment of Error No. 1 and judgment be entered for the Plaintiff for his back wages from August 1, 1983 until such time as he has been reinstated in his former

position of employment and for his costs, disbursements and attorney's fees incurred in the prosecution of his claim.

"And, in the alternative, if the court does not reverse the trial court as outlined in the [preceding] paragraph, then Plaintiff requests this matter be remanded to the trial court to allow the Plaintiff to go to trial as to both counts of his Complaint as outlined in Assignments of Error Nos. 2, 3 and 4."

We understand plaintiff to mean that the other assignments are intended only as alternatives to plaintiff's first one, although the fourth assignment relates to his wrongful termination claim rather than the claim with which the first assignment is concerned.

Given the posture of the case, we cannot now accord the precise and detailed relief plaintiff describes in connection with his first assignment. He does not argue or assign as error that he as well as defendant moved for summary judgment and that the case could have been decided by the trial court on cross-motions for summary judgment. Our reversal of the summary judgment for defendant requires further proceedings in the trial court, and we cannot instruct the court regarding the particulars of the judgment before the trial court proceedings are completed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Susan D. Chapman, Claimant.

CHAPMAN,
Petitioner,

v.

EBI COMPANIES et al,
Respondents.

(WCB 85-02929; CA A38597)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 14, 1986.

Judith H. Uherbelau, Ashland, argued the cause for petitioner. With her on the brief was Cottle, Howser & Munsell, Ashland.

Jerald P. Keene, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch & Klor, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

PER CURIAM

Order modified to award 40 percent unscheduled permanent partial disability; affirmed as modified.

PER CURIAM

This is a workers' compensation claim in which claimant seeks review of the Workers' Compensation Board's reduction of the referee's award for injury to her back. We review *de novo* and modify the Board's order to award claimant 40 percent unscheduled permanent partial disability. *See Hoag v. Duraflake,* 37 Or App 103, 585 P2d 1149, *rev den* 284 Or 521 (1978).

Order modified to award 40 percent unscheduled permanent partial disability; affirmed as modified.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Frank H. Hostler, Claimant.

HOSTLER,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-06328; CA A38271)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 14, 1986.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

John A. Reuling, Jr., 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 Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

PER CURIAM

Order modified to award 55 percent permanent partial disability for loss of use of a hand; affirmed as modified.

PER CURIAM

This is a workers' compensation claim for injury to claimant's right hand. Claimant contends that the Worker's Compensation Board's reduction of the referee's award was improper.

By a determination order, claimant was awarded 20 percent loss of use of his hand. The referee increased the award to 70 percent loss of use, and the Board reduced the referee's award to 45 percent. On *de novo* review, we find no fault with the Board's assessment of the factors considered in determining claimant's loss of use of his right hand or with the percentages of loss assigned to those factors. Due to an arithmetical error in the calculation, however, the Board reduced the referee's award to 45 percent rather than 55 percent loss of use, and we accordingly modify the award to 55 percent loss of use.

Order modified to award 55 percent permanent partial disability for loss of use of a hand; affirmed as modified.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Aaron L. Brandner, Claimant.

PINKERTON, INC. et al,
Petitioners,

v.

BRANDNER et al,
Respondents.

(WCB 84-07614, 84-07615; CA A37411)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 18, 1986.

Kenneth L. Kleinsmith, Portland, argued the cause for petitioners. On the brief were Meyers & Terrall, and Scott H. Terrall, Portland.

James L. Edmunson, Eugene, argued the cause for respondent Aaron L. Brandner. With him on the brief was Malagon & Moore, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents Valley Iron & Steel Co., and SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, James E. Mountain, Jr., Solicitor General, and Victoria Rudometkin, Certified Law Student, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Petitioners Pinkerton, Inc., and its insurer, Crawford & Company, seek review of an order of the Workers' Compensation Board which affirmed the referee's holding that claimant had sustained compensable injuries to his knee and his back while working for Pinkerton. We affirm.

Claimant sustained a compensable back injury in 1979 while working at Valley Iron & Steel. He continued to have difficulty with his low back, which resulted in three determination orders granting additional disability and time loss, the latest in August, 1983. To date, he has been awarded 57.5 percent unscheduled permanent partial disability.

Claimant began work for Pinkerton as a security guard on June 4, 1984. He testified that on June 13, while making rounds as a security guard at a mill, he heard a noise in the mill. He stated that he started down the stairs outside the mill, stepped on a cat and fell down the stairs. At the time, only his left knee hurt. However, the next morning his back

hurt. Pinkerton accepted the knee claim and denied the back claim on June 26, 1984. Then, on October 4, 1984, Pinkerton issued a "back-up denial" of the knee claim.

Petitioners argue that the Board erred in holding that they could not deny the claim for the left knee. Under *Bauman v. SAIF*, 295 Or 788, 679 P2d 1027 (1983), an employer cannot deny the compensability of an accepted claim more than 60 days after receiving notice of the claim, without a showing of fraud, misrepresentation or other illegal activity. Petitioners contend that claimant misrepresented the facts because "all of the circumstances" show that claimant fabricated the claim for the fall. Petitioners point to claimant's background of claims made for back problems shortly after each return to work, the substantial disability benefits that he has received and his failure in vocational assistance programs as evidence that he misrepresented the facts. Petitioners also argue that his credibility is questionable because of inconsistencies between his testimony and that of other witnesses.

Petitioners have the burden of proving that a misrepresentation occurred. They have not met that burden. The medical reports support a finding that a fall occurred, and petitioners produced no evidence to discredit the doctor's

findings. Further, the referee found that the inconsistencies in the testimony were not significant and, by accepting claimant's version of the facts, impliedly found claimant credible. We give substantial weight to a referee's findings regarding credibility. *Condon v. City of Portland*, 52 Or App 1043, 629 P2d 1324, *rev den* 291 Or 662 (1981). Petitioners did not prove that a misrepresentation occurred and, therefore, its denial was not justified.

Petitioners also argue that claimant's back condition was either an aggravation or a continuation of his previous condition. In either instance, Pinkerton would not be responsible. However, the evidence shows that claimant had recovered from his previous injury sufficiently to assume a job with Pinkerton. Dr. Redfield, the treating physician, concluded that the fall "materially and independently" contributed to claimant's low back disability. Pinkerton is responsible for the back injury which occurred during its employment and which contributed independently to claimant's disability. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 675 P2d 1044 (1984); *Home Ins. Co. v. EBI Companies*, 76 Or App 112, 708 P2d 1157 (1985).[1]

Affirmed.

[1] We find no error in the award of attorney fees to claimant.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Kenneth W. Emerson, Claimant.

EMERSON,
Petitioner,

v.

DEPARTMENT OF FISH AND WILDLIFE et al,
Respondents.

(WCB 84-05601; CA A38480)

Judicial Review from Workers' Compensation Board.

Submitted on record and briefs January 9, 1987.

Craig B. Cordon, Portland, and Wade P. Bettis, Jr., LaGrande, filed the brief for petitioner.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Darrell E. Bewley, Assistant Attorney General, Salem, filed the brief for respondents.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Reversed; referee's order reinstated.

PER CURIAM

Claimant seeks review of the Workers' Compensation Board's order awarding him unscheduled permanent partial disability compensation. Because we agree with the referee, we reverse the Board and reinstate the referee's order.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Harry J. Marshall, Claimant.
MARSHALL,
Petitioner,
v.
SAIF CORPORATION et al,
Respondents.
(WCB 84-09863; CA A38620)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 9, 1987.

Nelson R. Hall, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Reversed in part; referee's order with respect to scheduled disability reinstated; otherwise affirmed.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board reducing the amount of a scheduled award for loss of use of the left and right legs and increasing an award of unscheduled disability. It appears that the Board misinterpreted the medical evidence in erroneously concluding that claimant's disability was limited to his feet. In fact, as SAIF concedes, the disability extends to his legs. On *de novo* review, we conclude that the referee's award of 50 percent scheduled disability for loss of use of each leg is more appropriate.

Reversed in part; referee's order with respect to scheduled disability reinstated; otherwise affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
William R. Gwynn, Claimant.

GWYNN,
Petitioner,

v.

STATE ACCIDENT
INSURANCE FUND CORPORATION et al,
Respondents.

(WCB No. 84-11354; CA A38534)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 20, 1986.

Ronald L. Bohy, Salem, argued the cause and filed the the brief for petitioner.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. On the brief were Dave Frohnmayer, Attorney General, James E. Mountain, Jr., Solicitor General, and Keith L. Kutler, Assistant Attorney General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

Claimant seeks review of the Workers' Compensation Board's affirmance of SAIF's denial of an aggravation claim. On *de novo* review, we find that claimant has not suffered a worsening of his condition that would qualify as an aggravation under ORS 656.273. Claimant's symptoms resulting in time loss were anticipated at the time of the last arrangement of compensation. Because it is clear, however, that the time loss is related to his original injury, we write to consider whether a claimant can recover temporary total disability benefits for work missed after the last arrangement of compensation as a result of a compensable condition without showing an aggravation.[1]

Temporary total disability is awarded for disability of a nonpermanent nature. ORS 656.210.[2] Its purpose is to

[1] We note that our discussion is limited to temporary total disability and does not pertain to interim compensation, which is payable pending acceptance or denial of an aggravation claim. ORS 656.262; *Jones v. Emanuel Hospital,* 280 Or 147, 570 P2d 70 (1977); *Silsby v. SAIF,* 39 Or App 555, 592 P2d 1074 (1979).

[2] ORS 656.210(1) provides, in part:

"When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser."

compensate a claimant for loss of income. *Taylor v. SAIF*, 40 Or App 437, 595 P2d 515, *rev den* 287 Or 477 (1979). An insurer's responsibility to pay temporary total disability on an accepted claim continues until the worker is medically stationary and is not enrolled in an authorized vocational program. ORS 656.228.

ORS 656.273 provides, in part:

> "(1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury.
>
> "(2) To obtain additional medical services or disability compensation, the injured worker must file a claim for aggravation with the insurer or self-insured employer. In the event the insurer or self-insured employer cannot be located, is unknown, or has ceased to exist, the claim shall be filed with the director."

After claim closure, an employer's duty to pay additional compensation commences only on proof of a worsening of the compensated condition (an aggravation) or on the reopening of the claim. Medical services required by the original injury are payable for the life of the claimant and do not require reopening. ORS 656.245.[3]

In *Smith v. SAIF*, 302 Or 396, 400, 730 P2d 30 (1986), the Supreme Court stated:

> "If the claim is filed under ORS 656.210 to obtain additional temporary total compensation [for time loss], the claimant must prove a *worsening* that makes the claimant less able to work to the extent that the worker is temporarily incapacitated from 'regularly performing work at a gainful and suitable occupation.' *See Cutwright v. Weyerhaeuser*, 299 Or 290, 294, 702 P2d 403 (1985)." (Emphasis supplied.)

The court's opinion leaves us somewhat perplexed, however, as to its conclusion concerning the relevant dates to be examined in determining whether a claimant has experienced a worsening. The court agreed with our analysis in *Smith v. SAIF*, 78 Or App 443, 448, 717 P2d 218 (1986), where we stated:

> "'Worsened' conditions means a change in condition which makes a claimant more disabled, either temporarily or permanently, than he was *when the original claim was closed.*" (Emphasis supplied.)

Then, in its description of what a claimant must prove to show entitlement to increased benefits for permanent partial disability, the court states that

> "the claimant must demonstrate a worsening that makes the

[3] ORS 656.245(1) provides:

> "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability. Such medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. The duty to provide such medical services continues for the life of the worker."

> claimant less able to work to the extent that he is less able to obtain and hold employment in the broad field of general occupations than he was *prior to the worsening.*" 302 Or at 400. (Emphasis supplied.)

The last emphasized portion was not necessary to the decision. We consider it *dictum* and not a deliberate pronouncement that the date for comparison with a claimant's present condition is the date just before the worsening, rather than the date of the last award of compensation. That conclusion would completely undermine a system which by necessity involves the closing of claims, even though it is knowable that the claimant will experience a waxing and waning of symptoms or that certain activities will activate symptoms. As we have stated repeatedly, to prove an aggravation, a claimant must show that the condition is worse than it was at the time of the last award of compensation. *See Consolidated Freightways v. Foushee,* 78 Or App 509, 717 P2d 633, *rev den* 301 Or 338 (1986).

Claimant's time loss is due to a disability which existed at the time of the last arrangement of compensation. There is no aggravation, and no additional compensation is due, temporary *or* permanent.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Edward O. Miller, Claimant.

MILLER,
Petitioner,

v.

COAST PACKING COMPANY,
Respondent.

(WCB No. 79-03231; CA A36292 (Control))

In the Matter of the Compensation of Edward O. Miller, Claimant.

BRANDER MEAT COMPANY et al,
Petitioners,

v.

MILLER et al,
Respondents.

(WCB No. 83-02511; CA A36331, A36318)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 8, 1986.

Ronald W. Atwood, Portland, argued the cause for petitioners Brander Meat Company and Glen Falls Insurance Co. With him on the briefs were Patric J. Doherty and Rankin, McMurry, VavRosky & Doherty, Portland.

William Hensley, Portland, argued the cause for respondent and petitioner Edward O. Miller. With him on the brief was Francesconi & Cash, P.C., Portland.

Jerald P. Keene, Portland, argued the cause for respondents Coast Packing Company and Eldorado Insurance Co. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded in A36318 and A36331 for an award of compensation consistent with this opinion; affirmed in A36292.

ROSSMAN, J.

In these consolidated cases, Brander Meat Company (Brander), claimant's employer at the time of a 1970 head injury, seeks review of an order in which the Workers' Compensation Board, on its own motion, held that it was responsible for claimant's current condition, which includes complex partial seizure disorder, psychosis and arm, neck and shoulder syndrome. Claimant also petitions for review, asserting that, in the event that we grant the relief sought by Brander, we should find that Coast Packing Company (Coast) is responsible for the complex partial seizure disorder and the arm, neck and shoulder syndrome. We have considered and rejected Brander's various procedural arguments. We write only to address the questions of compensability and responsibility raised by Brander's fourth and fifth assignments of error and claimant's petition.

Claimant worked for Brander as a butcher. On March 11, 1970, he was struck in the head by a beef shackle weighing approximately 25 pounds and suffered a laceration and concussion. His claim was accepted and closed in April, 1970, with no award of permanent partial disability.

In 1974, while working for Brander's successor, Coast, claimant lacerated his right hand with a rumping knife. Coast accepted the claim, and after surgery and medical treatment it was closed with a determination order, issued July 24, 1974, and an award of 10 percent permanent partial disability. The award was increased in 1975 by another determination order and was reopened by stipulation for further surgery, treatment and time loss. Doctors reported in January and February, 1976, that the hand injury was medically stationary, and claimant entered a vocational program.

In 1976, claimant began consulting with psychol-

ogists and psychiatrists in connection with the vocational program. Drs. Sloat and Duncan each diagnosed paranoid psychosis, for which Duncan prescribed Mellaril, a phenothiazine preparation.

In May, 1977, Coast and claimant entered a disputed claim settlement with regard to the 1974 hand injury, which purported to absolve Coast of any responsibility for claimant's

emotional, psychological and psychiatric problems. He continued to seek medical treatment, this time for what he complained of as upper arm, shoulder and neck pain. In April, 1978, he began seeing Dr. Olmsheid, a neurologist, for symptoms of headaches, dizzy spells, intermittent shakiness, lightheadedness, nausea, sweatiness and blurring of vision. Ultimately, the condition was diagnosed as complex partial seizure disorder.

Claimant sought compensation for complex partial seizure disorder (CPSD), paranoid psychosis and arm, neck and shoulder syndrome (ANS). Both Brander and Coast denied the compensability of each condition.[1] Despite the procedural maze, the present posture of this case may be summarized by stating that, eventually, all three claims were consolidated by the Board for consideration on its own motion.

The Board concluded that the symptoms and the treatment of the psychosis could not be separated from the symptoms and the treatment of CPSD. It also found that all three conditions are related to the 1970 head injury and held Brander responsible. We agree with the Board that the CPSD is related to the 1970 injury, but we disagree with the Board's opinion with respect to the psychosis and ANS.

The complexity of claimant's conditions and their apparent interrelatedness makes it tempting to do as the Board here did: assign full responsibility for all conditions to Brander, because objective medical evidence shows that the 1970 head injury contributed to claimant's dominant condition, the CPSD. We conclude, after reviewing the record, that the Board's bunching of responsibility is too simple a resolution and is not justified by the medical evidence.

The overwhelming medical evidence is that CPSD was brought on by the 1970 blow to the head. Olmsheid explained in his deposition that a head injury can cause the formation of scar tissue which can interfere with the transmission of electrical signals in the brain. The result is a seizure disorder, in this case described as CPSD.

It is undisputed that the administration of phenothiazine for claimant's psychosis temporarily lowered his seizure threshold. Brander asserts, therefore, that treatment of the psychosis accelerated CPSD and that, under the last injurious exposure rule, responsibility for the CPSD shifted to Coast, claimant's employer at the time of the hand injury.

[1] Claimant never actually sought compensation for ANS from Brander. Brander was joined on the Board's own motion in the proceeding to determine the compensability of the condition.

Brander's argument assumes that claimant's psychosis is related to the hand injury. The reports consistently state that claimant had symptoms of CPSD immediately after the head injury, long before his hand injury. What doctors perceived to be symptoms of the paranoid psychosis might actually have been symptoms of CPSD, and the treatment claimant received for the psychosis only made the symptoms of CPSD more noticeable to the point that the condition could be diagnosed. The treatment for the psychosis did not cause or worsen CPSD. It merely made the symptoms more perceptible. We conclude that a preponderance of the evidence indicates that CPSD was neither caused nor worsened by the treatment which claimant received for the psychosis. Brander remains responsible for the condition and its medical treatment.

All the doctors agree that claimant's predisposition to paranoid psychosis preexisted the 1974 injury at Coast, and we are also persuaded that it preexisted the 1970 injury at Brander. The question relating to compensability is whether either injury caused the condition to become more symptomatic to the point of causing disability or a need for medical treatment. *See Barrett v. D & H Drywall,* 300 Or 325, 709 P2d 1083 (1985), *on reconsideration* 300 Or 553, 715 P2d 90 (1986). Although the medical reports are not entirely consistent, the common thread is that claimant's psychosis became more symptomatic after the hand injury, when he experienced frustration in not being able to return to work. There is no medical evidence linking the psychosis to the head injury.

Contrary to the Board's finding, we find, on the basis particularly of the testimony of Olmsheid, that the symptoms of the psychosis and CPSD are sufficiently distinguishable that they can be analyzed and treated separately. If either employer would have been responsible for claimant's psychosis, it is Coast and not Brander. The record shows that the disputed claim settlement between claimant and Coast

expressly absolved Coast of responsibility for the psychosis. Claimant is bound by that settlement.

The medical evidence indicates that there is no organic explanation for ANS. Both the referee and the Board found insufficient evidence to link the condition directly to either employment and, indeed, according to Dr. Nathan, there is a question whether claimant suffers from any condition fairly described as arm, neck and shoulder syndrome, objectively or subjectively. There is no medical evidence linking the alleged condition to the 1970 injury at Brander, to the 1974 injury at Coast, to CPSD or, even, to the paranoid psychosis. The Board found, however, that there were reasons "other than organicity" to explain the alleged condition and held Brander responsible, without explanation. The pertinent medical evidence is insufficient to show that ANS is related to either the 1970 or 1974 injury. Claimant therefore has not sustained his burden of proof with respect to ANS, and the claim is not compensable.

In summary, claimant's condition known as CPSD is the responsibility of Brander, as are the medical expenses for

its treatment. The paranoid psychosis is not the responsibility of Brander, because the medical evidence does not indicate a relationship between the condition and claimant's 1970 injury. Neither is it the responsibility of Coast, because of the disputed claim settlement. The purported ANS condition is not compensable.

Reversed and remanded in A36318 and A36331 for an award of compensation consistent with this opinion; affirmed in A36292.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Steve Krajacic, Claimant.

KRAJACIC,
Petitioner,

v.

BLAZING ORCHARDS et al,
Respondents.

(WCB 84-02476; CA A37693)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 11, 1986.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Malagon & Moore, and Robert J. Guarrasi, Eugene.

John A. Reuling, Jr., 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 Newman and Deits, Judges.

DEITS J.

Affirmed on aggravation claim; reversed on payment for out-of-state chiropractic care and referee's order on that claim reinstated.

DEITS, J.

Claimant petitions for judicial review of a Workers' Compensation Board order which found that he did not perfect an aggravation claim pursuant to ORS 656.273 and denied payment for out-of-state chiropractic treatment. We affirm on the aggravation claim and reverse on the payment for out-of-state treatment.

Claimant sustained a low back injury in September, 1977. The claim was accepted and classified as nondisabling. Claimant has had ongoing treatment and consultations since 1977. The medical reports indicate that he had a chronic lumbosacral strain.

Claimant relies primarily on two letters from his treating chiropractor, Dr. Rethwill, to establish his aggravation claim. In the first letter of July, 1982, Rethwill stated that he had treated claimant since April and that spinal manipulation relieved his symptoms. Although Rethwill requested authorization for more monthly treatments for claimant, the letter as a whole indicates that the more frequent treatments are to treat continuing symptoms.

In a letter to SAIF on September 14, 1982, ten days before the five-year anniversary of claimant's injury, Rethwill stated:

> "Mr. Krajacek [*sic*] has come to this office displaying a very apprehensive attitude as to the future of his case. This man has undoubtedly has [*sic*] sustained a permanent injury. He works quite hard but states that with what he has to do he still tries to take it easy. He does seem to have improved over former conditions but then inevitably after a week or so here he comes again feeling nauseated and with his lower back aching and out of alignment. Sometimes when the pain is worse in the lower back he complains of a headache also.
>
> "* * * * *
>
> "My next step in this case is that he needs to go to a neurosurgeon who is one of the best in the field and if it is alright [*sic*] with him I am going to recommend that he go to Dr. Campagna in Medford. He needs more help than I can give him to resolve the chronic problem."

Claimant argues that, under *Haret v. SAIF,* 72 Or App 668, 697 P2d 201, *rev den* 299 Or 313 (1985), these reports

were sufficient to state a claim for an aggravation. In *Haret,* the claimant severely wrenched her neck, resulting in problems in her neck and some trouble with her right arm. The referee found no loss of function in the right arm and awarded her permanent partial disability based on loss of function of the cervical spine alone. The claimant had not seen a physician for a year when she went to a neurosurgeon. He reported to SAIF and emphasized the difficulties that the claimant was having with her right arm. We held that the neurosurgeon's report was an aggravation claim putting SAIF on notice to determine if there had been a worsening of the condition.

The requirements for an aggravation claim are not rigorous. However, an indication of a changed condition must be made. *Haret v. SAIF, supra,* 72 Or App at 672. ORS 656.273 provides, in part:

> "(1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, *for worsened conditions resulting from the original injury.*
>
> "* * * * *
>
> "(3) A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." (Emphasis supplied.)

As we noted in *Haret,* the purpose of subsection (3) is to allow an aggravation claim to be made by a physician's report which requests additional services. However, "additional services" must be read together with ORS 656.273(1).

JOSEPH, C. J.

This workers' compensation case involves the responsibility of two insurance companies that provided workers' compensation coverage for employer. Claimant experienced an industrial injury on March 31, 1983. She filed a claim on April 14, stating that she was suffering right arm strain with numbness in her hand and last two fingers. Employer, then insured by Industrial Indemnity (Industrial), accepted the claim on May 2, 1983. In June of that year, employer moved its workers' compensation coverage to American Fire & Casualty (American), which agreed to provide coverage as of March 28, 1983, which was before claimant's injury.

The Workers' Compensation Department wrote to Industrial on August 2, 1983, advising it that its period of responsibility had ended on March 27, 1983. Industrial, however, continued paying benefits to claimant until January, 1984, when its claims representatives noticed that its coverage had supposedly ended four days before the injury. On January 12, Industrial sent claimant a denial notice and forwarded her file to American, along with a demand for reimbursement of claim expenses. Industrial stopped paying benefits as of that date.

On February 6, 1984, claimant requested the designation of a paying agent pursuant to ORS 656.307(1)(b). Industrial responded that it did not provide coverage and that, therefore, a paying agent was not warranted. American denied responsibility, asserting that Industrial could not issue a denial of responsibility for an accepted claim. Then Industrial reversed its position and agreed to a paying agent designation. American responded that it would not concede compensability until it had completed its investigation. A paying agent order never issued.

The referee determined that, under the rule in *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), Industrial could not deny its responsibility for the accepted claim. The referee awarded claimant attorney fees for prevailing against Industrial on the denied claim and a 25 percent penalty on all temporary disability compensation due from January 4, 1984, to the date of the order and additional attorney fees for securing penalties. The referee awarded a 25 percent penalty

against American for its unreasonable delay and refusal to provide "interim compensation" from January 12 through February 17, 1984, and attorney fees for securing that penalty and for American's "unreasonable denial of compensability" in refusing to agree to a paying agent order.

The Board reversed on the issue of responsibility on the authority of *Retchless v. Laurelhurst Thriftway*, 72 Or App 729, 696 P2d 1181, *rev den* 299 Or 251 (1985), and concluded that, because American was liable in fact, given the effective date in its contract, Industrial was relieved of responsibility for claimant's compensation. The Board affirmed penalties and attorney fees against both insurers but increased the total attorney fee award against American to $1450 from the referee's total award of $800.

Only American seeks review of the Board's order.[1] In its first assignment of error, it argues that it cannot be responsible for claimant's compensation, because (1) Industrial could not issue a back-up denial, (2) Industrial had waived its right to "avoid responsibility" or (3) American's contract only extended retroactive coverage to claims not yet accepted when the contract was signed.

The general rule of *Bauman v. SAIF, supra,* is that an insurer, after accepting a claim, cannot deny it. That bar applies equally to denials of responsibility and to denials of compensability. *Jeld-Wen, Inc. v. McGehee,* 72 Or App 12, 15, 695 P2d 92, *rev den* 299 Or 203 (1985). In *Retchless v. Laurelhurst Thriftway, supra,* 72 Or App at 731, we interpreted those cases to mean that the first employer or insurer must continue to pay compensation *unless and until* someone else is determined to be responsible.[2]

Claimant gave notice of her injury to employer as required by ORS 656.265. Employer then had the burden to notify the insurance carrier of the claim. ORS 656.262(3).

Industrial was the carrier at the time and was properly notified. It duly accepted the claim and commenced payment of compensation. At that point, compensability and responsibility were resolved to the extent of the acceptance, and the *Bauman* and *Retchless* principles attached to protect claimant from vacillation by her employer or its insurance carrier.

The question is whether responsibility shifted when employer contracted with American to provide retroactive coverage. American argues that it did not intend to pick up existing claims that had already been filed in the retroactive period; rather it intended simply to process new claims based on occurrences in that period but not filed before the execution of its contract. American's unexpressed intent, however, does not govern the extent of its coverage. The contract does, and it provides that American would bear all of employer's compensation liability arising during the contract period. Furthermore, ORS 656.419(1) provides:

> "A guaranty contract issued by an insurer *shall* provide that the insurer agrees to *assume,* without monetary limit, the *liability* of the employer, *arising during the period the guaranty contract is in effect* * * *." (Emphasis supplied.)

Both by the terms of its contract and under the statute, American has responsibility for all workers' compensation liability that arose after the effective date of its insurance, whenever asserted.

American also argues that Industrial waived any right it had to avoid responsibility, because it did not file its notice of termination with the Department until July, 1983,

[1] Industrial acknowledges that claimant should not have been left without compensation; it has not contested penalties and attorney fees awarded against it. *See Fred Shearer & Sons v. Stern,* 77 Or App 607, 713 P2d 1078 (1986).

[2] American submits that the rule in *Retchless v. Laurelhurst Thriftway, supra,* is an aberration which should be overruled in order to remove confusion. The confusion suffered by American more likely stems from its entry into a retroactive agreement than from the rule in *Retchless,* which others have found capable of application. *Fred Shearer & Sons v. Stern, supra,* n 1.

and in that notice it stated that it had cancelled coverage as of April 15, 1983. Industrial's responsibility ended, because American and employer entered into an agreement which terminated Industrial's liability. ORS 656.423(3) provides that an employer may cancel coverage by providing other coverage and that cancellation is "effective immediately upon the effective date of the other coverage." Industrial could not "waive" employer's cancellation of its coverage.[3] Under Amer-

ican's contract, it accepted responsibility for all liability which arose after March 27, 1983.

In another assignment of error, American argues that, because claimant did not assert entitlement to penalties and attorney fees at the outset of the hearing, the referee and Board did not have authority to award them. To support that assertion, it cites *EBI Companies v. Thomas,* 66 Or App 105, 672 P2d 1241 (1983), in which we held that an issue designated as "failure to meet requirements of ORS 656.307" did not raise the issue of whether penalties or attorney fees should be allowed for a late denial under ORS 656.262(9).[4] In her request for hearing, claimant here raised, *inter alia,* the issues of compensability, responsibility under ORS 656.307 and penalties and attorney fees. Unlike the request for hearing in *Thomas,* the request in this case specifically raised penalty and attorney fees issues. The Board's awards, therefore, were within the bounds of its authority.

American also assigns error to the Board's ruling that it "should have paid temporary total disability benefits as interim compensation." It argues that no interim compensation was due, either because it supposedly issued a denial within 14 days of notice of the claim to it or because an award of interim compensation would constitute a double recovery for claimant. It also argues that, because no compensation was due, no penalties could be awarded. ORS 656.262(10).

Under ORS 656.262(2) and (4), interim compensation is due within 14 days after an *employer* has notice or knowledge of the claim, unless the right to compensation is denied within that period. *See Bono v. SAIF,* 298 Or 405, 692 P2d 606 (1984). The interim period between notice to employer and acceptance of the claim began when claimant notified employer of her injury in April, 1983, and lasted until Industrial accepted her claim. Once Industrial had accepted her claim, further time loss was a matter of her temporary disability. When American agreed to assume all of employer's workers' compensation liabilities, it also assumed claimant's accepted claim. American, therefore, could not have owed *interim* compensation from January 12, 1984, to February 17,

1984. Therefore, the Board's award of a 25 percent penalty could not be based on failure to pay interim compensation.

What American did owe was prompt payment of

[3] American claims that it was prejudiced by Industrial's actions. Any prejudice was self-inflicted. It has to accept the compensability of the claim because of its choice to provide retroactive coverage.

[4] That provision is now ORS 656.262(10).

temporary total disability benefits. Its refusal to begin payment when Industrial notified it of its obligation on January 12 and its effort to deny responsibility constituted a refusal to pay compensation. Assessing a penalty and attorney fees for that was technically appropriate, ORS 656.262(10), even if the Board mischaracterized the basis for its action. However, Industrial has been assessed a 25 percent penalty based on exactly the same unpaid benefits. To uphold the penalty against American would result in claimant's receiving a 50 percent penalty. That part of the award must be stricken, given that Industrial has not sought review.

American also contests the two attorney fee awards granted by the referee, under ORS 656.382(1), for claimant's attorney's efforts in securing a penalty for failure to pay compensation and for the efforts to obtain a paying agent order. The Board affirmed the awards but increased the total award to $1450.[5]

American first argues that the fees based on the penalty award were erroneous, because no compensation was due. However, we have already concluded that it owed claimant TTD.[6] It further argues that, because there is no specific statutory authority for awarding attorney fees for resisting the issuance of a paying agent order, that award was erroneous. *EBI Companies v. Thomas, supra.* The award granted by the Board, however, was based on ORS 656.382(1), which states in pertinent part:

> "If an insurer * * * unreasonably resists the payment of compensation, the * * * insurer shall pay to the claimant * * * a reasonable attorney fee * * *."

American's refusal to accede to the issuance of an order resulted in claimant's not receiving compensation for an already accepted claim. Once American had assumed all workers' compensation liabilities of her employer, it had no right to question her entitlement to compensation. American's resistance to paying compensation and to the appointment of a paying agent in the circumstances of this case falls within ORS 656.382(1) as unreasonable resistance to payment of compensation.

The Board was also correct in awarding one total fee, rather than two separate fees, as the referee did. Fees are awarded on the basis of the efforts of the attorney, *Saiville v. EBI Companies*, 81 Or App 469, 472, 726 P2d 394, *rev den* 302 Or 461 (1986), and all the fees generated by claimant's attorney in this case were for efforts to overcome American's resistance. Therefore, attorney fees assessed against American for claimant's attorney's efforts throughout the hearing process and for the attempt to get a paying agent order were proper. The Board's award of $1450 was reasonable.

Order modified by striking penalty based on "interim compensation"; affirmed as modified.

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[5] The Board discussed the referee's award for resistance to a paying agent order as a penalty. It did not, however, award a penalty but affirmed and increased the attorney fees award.

[6] Attorney fees for resisting payment can be awarded, whether or not there is a penalty or compensation due under ORS 656.262(10). *See, e.g., Miller v. SAIF*, 78 Or App 158, 162, 714 P2d 1105 (1986). In this instance we have stricken the penalty, but that has no necessary effect on the attorney fees issue.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Harold Turner, Claimant.
INTERNATIONAL PAPER COMPANY,
Petitioner,
v.
TURNER et al,
Respondents.
(WCB 83-09731; 84-02465; CA A39913)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 9, 1987.

Paul L. Roess, Coos Bay, argued the cause for petitioner. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Michael R. Stebbins, North Bend, argued the cause for respondent Harold Turner. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Linda DeVries Grimms, Assistant Attorney General, Salem, argued the cause for respondents Bohemia, Inc. and SAIF Corporation. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed.

WARREN, J.

International Paper seeks review of an order of the Workers' Compensation Board affirming the referee, who held that claimant had suffered an aggravation of a previously compensated condition. On *de novo* review, we find that claimant has not suffered an aggravation and reverse the Board.

Claimant sustained an injury to his left knee on September 12, 1978, while working as a sander for International Paper. On February 14, 1982, a determination order awarded ten percent loss of use of the left leg, and that award was ultimately affirmed by a referee after a hearing on March 30, 1983. The referee's order is the last arrangement of compensation.

In July, 1983, claimant was hired by Bohemia as a dryer/feeder and cleanup laborer, both of which entailed standing continuously. After two weeks on the job he quit because of pain, swelling and cramps in his left leg. His request for a reopening of the original claim was denied by International Paper, as was his claim for benefits against Bohemia. We agree with the Board's conclusion that claimant has not suffered a new injury so as to support a claim against Bohemia.

In order to establish an aggravation of his scheduled leg disability so as to warrant a reopening of the claim against International Paper, claimant must prove that his condition is worse. ORS 656.273. A worsened condition means a *change* which makes a claimant more disabled, either temporarily or permanently, than he was at the time of the last award of compensation. *See Smith v. SAIF,* 302 Or 396, 730 P2d 30 (1986).[1] On *de novo* review, we find that there has been no change in claimant's condition and that he has experienced only a recurrence of symptoms which were anticipated at the time of the last arrangement of compensation.

In June, 1982, following the removal of a step staple, Dr. Holbert reported that "when [claimant] is active on the

knee, it swells up." At the hearing of March 30, 1983, which was held before the last award of compensation, claimant testified that, if he were to return to a job which required him to be on his feet for eight hours, he would experience swelling and pain in his knee. When claimant went to work for Bohemia, that is what he experienced. In Dr. Hayhurst's opinion, claimant's work at Bohemia did not result in a "significant change in his symptomatology [*sic*]," or, in fact, in any "significant symptomatology [*sic*]." The conditions that occurred at Bohemia were anticipated when claimant received his last award. We conclude that claimant has not shown that his condition has changed since the last arrangement of compensation and, therefore, we reverse the Board's decision awarding benefits for an aggravation.

Reversed.

[1] Because compensation for a scheduled disability is for loss of use of a scheduled body part, ORS 656.214, "more disabled" in this case means increased loss of use of that body part.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Delmer J. Hultberg, Claimant.
COASTAL FARM SUPPLY,
Petitioner,
v.
HULTBERG,
Respondent.
(84-12594; CA A38687)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 1, 1986.

E. Jay Perry, Eugene, argued the cause for petitioner. With him on the brief was Cleaves, Swearingen, Larsen & Potter, Eugene.

Edward J. Harri, Albany, argued the cause for respondent. With him on the brief was Emmons, Kyle, Kropp, Kryger & Alexander, Albany.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

Employer seeks review of an order of the Workers' Compensation Board which reversed the referee and held claimant's knee injury compensable. We find that the evidence preponderates in favor of compensability and affirm.

Employer hired claimant in September, 1984, to help set up a new store. Claimant testified that he twisted his left knee twice on October 3, 1984, while unloading freight at the store. His parents also testified that, on October 3, 1984, he reported to them that he had twisted his knee at work. Although the injury caused swelling, pain and limping, he continued to work, and did not then file a claim.

Three of claimant's supervisors testified that, at different times, they each asked him why he was limping and whether the injury occurred at work. They testified that claimant said that he did not believe that it had happened at work. One supervisor testified that he said that he hurt his knee playing softball, although another supervisor present during that conversation testified that he did not remember him mentioning any cause for the injury.

Claimant denied that his supervisors had asked whether the injury occurred at work. He testified that he did mention to one superivsor that the injury happened at the new store. He also testified that he had not played softball for months and that he had not indicated that the injury had occurred while he was playing softball.

On October 8, 1984, he went to an emergency room, where a physician treated his knee and referred him to a specialist. The knee required surgery, which was performed later that month. Claimant had not then filed a claim. He testified that he had waited, because he was afraid that if he did file a claim he might lose his job. After the surgery his employer informed him that he had been replaced. Claimant filed a claim on October 31, 1984, after he had been fired.

On this record, the credibility of the witnesses is crucial. The referee concluded that, although "claimant appeared * * * to be trying to be candid in his response to questions, his specific testimony * * * is entirely inconsistent with the documentary record prepared much closer in time to the alleged injury date." Furthermore, the referee stated, "I

have relied more on the written record as I conclude that the passage of time and the obvious concern by the witnesses for the respective party which presented them has tinged the testimony of those witnesses."

The Board rejected the referee's conclusion:

> "While we agree with the referee that the facts of this case are a bit puzzling, we find that the evidence preponderates in favor of compensability. Although we did not observe claimant's demeanor at hearing and, therefore, we are unable to make a credibility finding in that regard, our reading of the transcript satisfies us that claimant answered the questions presented to him in an honest and straightforward manner. We are also satisfied that claimant's witnesses testified truthfully, even though they were obviously concerned for claimant's welfare."

In exercising *de novo* review we generally defer to the referee's determination of credibility, when it is based on the referee's opportunity to observe the witnesses. *Humphrey v. SAIF*, 58 Or App 360, 363, 648 P2d 367 (1982). However, when the referee's conclusion is based not on demeanor, but on an objective evaluation of the *substance* of a witness's testimony, the referee has no greater advantage in determining credibility than we do. *Davies v. Hanel Lumber Company*, 67 Or App 35, 38, 676 P2d 946 (1984).

The referee found claimant's demeanor candid. We defer to that evaluation. The referee rejected claimant's specific testimony, because he perceived a conflict between that testimony and the documentary evidence. That rejection, therefore, is grounded in the referee's objective evaluation of the *substance* of claimant's testimony. We do not defer to that determination. Rather, we find that the documentary evidence does not directly conflict with that testimony.

The documentary evidence includes the physicians' records of claimant's visits. The emergency room record indicates that, although claimant had been moving freight that week, he remembered no specific trauma. The records of the specialist state:

> "Patient * * * notes that on approximately 10-3-84 while

at work moving a heavy shipment but not noting any specific episode of trauma, he probably injured his left knee." [1]

The documentary evidence does not wholly support claimant's testimony that there were two specific twisting incidents on October 3, 1984. However, we agree with the Board's conclusion:

"The notation appearing in the emergency room record implies that claimant at least suggested to his physician that he injured himself on the job. * * * [T]his notation, coupled with the testimony of claimant and his witnesses, makes it more likely than not that claimant suffered a compensable injury * * *."

Claimant has established compensability by a preponderance of the evidence.

Affirmed.

[1] The referee rejected the evidentiary value of the specialist's notation. The referee believed that the passage of time since the injury had tainted claimant's statement of the cause of his injury. However, we find that his concern about losing his job adequately explains the delay in filing. *See Westmoreland v. Iowa Beef Processors*, 70 Or App 642, 645, 690 P2d 1105 (1984), *rev den* 298 Or 597 (1985). Furthermore, we find that the earlier emergency room record is consistent with this later notation.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kathy K. Calkins, Claimant.

CALKINS,
Petitioner,

v.

WESTCRAFT CHAIR, INC. et al,
Respondents.

(WCB 84-02419; CA A36874)

Judicial review from Workers' Compensation Board.

Argued and submitted March 12, 1986.

L. Leslie Bush, Portland, argued the cause for petitioner. With him on the brief was Tamblyn & Bush, Portland.

Edward C. Olson, Portland, argued the cause and filed the brief for respondents.

Before Richardson, Presiding Judge, and Warren and Deits, Judges.

DEITS, J.

Reversed and remanded.

DEITS, J.

Claimant seeks review of an order of the Workers' Compensation Board, upholding the referee's order which granted employer's motion to dismiss her claim for compensa-

tion for a hip injury. The motion was granted on the ground that the hip claim is barred by *res judicata*. Because we hold that the claim was not barred, we reverse and remand.

Claimant was employed as a sewing machine operator. In September, 1980, she was injured at work when a furniture frame fell on her. Her claim for compensation was accepted and processed to closure on February 12, 1981. For several months before that injury, she had been experiencing pain in her right hip. She attributed the pain to difficulties in operating a defective sewing machine at work and reported the pain to her employer. She did not, however, file a formal claim for compensation for the hip condition at that time.

The difficulty in this case arises because the nature and extent of the injury claimed by claimant and accepted by the carrier is unclear. Generally, the injury is described in the medical reports as a low back and neck injury, but claimant was treated for her hip problems when she was treated for the September injury and employer's carrier paid for those treatments.

The question of whether the hip injury relates to the 1980 accident first arose in August, 1982. At that time, the carrier had claimant examined by an independent physician. He concluded:

> "In listening to the patient's recountation [*sic*] of the mechanism of injury, I can certainly understand the spinal complaints but it is difficult for me to correlate the mechanism of injury with a right hip involvement. Again, addressing the issue of continuing palliative care, it is my opinion that such is not warranted with the spinal complaints, but such may be warranted relative to the right hip; however, as I have said, I do not understand the alleged mechanism of injury on a correlative basis with the right hip problem. Thus, I feel that it might be equitable for the patient to receive palliative treatment over the next 2-4 weeks, at which time I feel that she should be terminated."

On the basis of that physician's report, on November

1, 1982, the carrier sent a letter to claimant's treating physician purporting to deny all further palliative care. Claimant requested a hearing to contest the termination. The request stated in part:

> "The issues are as follows:
>
> "1. De facto denial of low back/hip problem and attorney's fees allowable on a denied claim."

Evidence concerning the origin and extent of the hip injury was presented in a hearing on May 26, 1983. In his opinion and order, the referee said:

> "Even if a hip claim can be justified from the arguably vague reference by Dr. Hughey [claimant's treating physician] to 'pelvic hypotonicity,' he made no clear reference to hip treatment. In fact, no one mentioned the right hip until Dr. Kelley's IME two years later, and there he discounts any logical connection to the September 24, 1980 incident.
>
> "* * * * *
>
> "I find no duty to deny a nonexistent hip claim.

"*ORDER*

"The right hip claim is dismissed. Claimant is not entitled to a denial thereof."

The Board affirmed that order without opinion. Claimant then filed a specific claim for the hip injury. The carrier's *de facto* denial of that claim was contested in a hearing before another referee, who said:

"Notwithstanding some confusion at the prior hearing as to what the issues really were, and the fact that if reviewing this *de novo* I would probably come to a different conclusion, I agree with Mr. Olson that this claim is now barred by the doctrine of *res judicata*

"* * * * *

"Clearly the hearing before Referee Leahy involved the same issue which was litigated before me.

"*ORDER*

"It is therefore ordered that claimant's right hip claim is dismissed, and she shall take nothing by or through this proceeding."

On review, the Board again affirmed without opinion.

The principles of *res judicata* apply to workers' compensation cases. *See Million v. SAIF*, 45 Or App 1097, 610 P2d 285 (1980). As this court noted in *Conner v. Delon Oldsmobile Co.*, 66 Or App 394, 398, 674 P2d 1180 (1984), *res judicata* requires that, in a second litigation on the same cause of action, "[a]ny matters which plaintiffs did or could have litigated in the first action are barred if the cases are based on the same aggregate of operative facts which compose a single occasion for judicial relief."

We conclude that *res judicata* does not bar claimant's hip claim, because it was a separate claim which did not involve the same operative facts. The fact that claimant was treated at the same time for the hip injury and the injuries resulting from the furniture frame incident has caused confusion. However, the evidence demonstrates that there were separate injuries, that claimant did not file a claim for the hip injury before the first hearing and that the first referee properly treated the hip injury as a separate injury, requiring a separate claim.

The Board's affirmance of the second referee's dismissal of the hip claim on the ground of *res judicata* was improper.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Patrick J. Duty, Claimant.
LES SCHWAB TIRE CENTER OF PORTLAND,
Petitioner,
v.
ELMER'S PANCAKE HOUSE et al,
Respondents.
(WCB 84-09090, 84-13541; CA A39373)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 17, 1986.

D. Kevin Carlson, Portland, argued the cause and filed the brief for petitioner.

Cynthia S.C. Shanahan, Portland, argued the cause for respondents Elmer's Pancake House and Safeco Insurance Company. With her on the brief were Schwabe, Williamson, Wyatt, Moore & Roberts, and Roger A. Luedtke, Portland.

William H. Schultz, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, appeared for respondent Patrick J. Duty.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Award of attorney fees for services on Board review reversed; otherwise affirmed.

PER CURIAM

Petitioner challenges an order of the Workers' Compensation Board affirming the referee's holding that petitioner is responsible for claimant's compensable back injury. Claimant sustained a low back strain and hamstring rupture in 1979 while working for Elmer's Pancake House. He was relatively free of symptoms until June 28, 1984, when he was lifting tires at petitioner's. He felt a pressure sensation in his lower back, which left him sore by the end of his shift. He exacerbated the condition a few days later while shoveling dirt in a non-employment situation. On *de novo* review we conclude that the referee was correct in the determination that claimant suffered a new injury on June 28 and that petitioner is responsible.

Petitioner also challenges the award of $100 to claimant's attorney for "services on review" by the Board. Claimant concedes that, having filed no brief at the board level, no attorney fees should have been awarded.

Award of attorney fees for services on Board review is reversed; otherwise affirmed.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Lynn O. Nelson, Claimant.

NELSON,
Petitioner on Review,

v.

SAIF CORPORATION,
Respondent on Review.

(WCB 84-02707; CA A34757; SC S32745)

On review from the Court of Appeals.*

Argued and submitted June 4, 1986.

Michael M. Bruce, Eugene, argued the cause and filed a brief for petitioner on review.

Margaret E. Rabin, Assistant Attorney General, Salem, argued the cause for respondent on review.

Samuel J. Imperati, Portland, filed a brief *amicus curiae* for Oregon Public Employes Union Local 503, SEIU, AFL-CIO, CLC. With him on the brief were James S. Coon and Aitchison, Imperati, Barnett & Sherwood, P.C., Portland.

Allan M. Muir, Portland, filed a brief *amicus curiae* for Association of Workers' Compensation Defense Attorneys. With him on the brief was Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Before Peterson, Chief Justice, and Lent, Linde, Campbell, Carson and Jones, Justices.

LENT, J.

The decisions of the Court of Appeals and the Workers' Compensation Board are affirmed.

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*Judicial review of order of Workers' Compensation Board. 78 Or App 75, 714 P2d 631 (1986).

LENT, J.

The issue is whether money paid by the employer, pursuant to a collective bargaining agreement, into the employees' pension fund and for medical and dental insurance for the employees is a part of "the daily wage the worker was receiving" for the purpose of calculating the amount of compensation for temporary total disability to which the worker was entitled under ORS 656.210. We hold that it is not.

Under *Sahnow v. Fireman's Fund Ins. Co.*, 260 Or 564, 568-69, 491 P2d 997 (1971), we take the facts as found by the Court of Appeals:

> "Claimant suffered a compensable injury on October 11, 1983. At the time of the injury, he was a member of the Oregon Public Employees Union. Under the union's negotiated labor

contract with the state, he was entitled to employer-paid fringe benefits, including pension benefits and medical and dental insurance. The benefits were provided in lieu of a salary increase."

Nelson v. SAIF, 78 Or App 75, 77, 714 P2d 631 (1986).

The controversy between these parties arises from the fact that claimant, by reason of an injury on the job, became entitled to workers' compensation for temporary total disability to be paid by the State Accident Insurance Fund Corporation (SAIF). The amount of compensation payable for temporary total disability under ORS 656.210 is tied to a percentage of wages claimant was receiving at the time of his injury. In determining what were those wages, SAIF did not include the amounts paid by claimant's employer into the pension fund established under the Public Employes' Retirement System and did not include the amounts paid by the employer as premiums for medical and dental insurance for claimant and his fellow employees.[1]

Claimant requested a hearing, contending that these fringe benefits paid by his employer fell within the words "or

similar advantage" contained in *former* ORS 656.005(27).[2] This statute provided:

> " 'Wages' means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer. * * *"

The referee agreed with claimant and issued an appropriate order.

On review sought by SAIF, the Workers' Compensation Board (Board) reversed the referee. The Board utilized what it termed a principle of statutory construction that "where general words follow an enumeration of specific items or classes, the general words will be construed as restricted by the specific designation so that they include only items of the same kind or class as those specifically enumerated." The Board concluded that these fringe benefits could not readily be converted into a cash equivalent as could board, rent, housing and lodging and, therefore, were not of "similar advantage." For this line of reasoning, the Board relied on the decision in *Morrison-Knudsen Constr. Co. v. Director, OWCP,* 461 US 624, 103 S Ct 2045, 76 L Ed 2d 194 (1983), construing similar language in the Longshoremen's and Harbor Workers' Compensation Act. A second basis for the Board's decision was that *former* ORS 656.005(27) provided that the enumer-

[1] We shall refer to the amount paid into the pension fund and for medical and dental insurance as "fringe benefits."

[2] At the time of this worker's accidental injury, the definition of "wages" was found in ORS 656.005(27). The definition is now found at ORS 656.005(26), which provides:

> " 'Wages' means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes the amount of tips required to be reported by the employer pursuant to section 6053 of the Internal Revenue Code of 1954, as amended, and the regulations promulgated pursuant thereto, or the amount of actual tips reported, whichever amount is greater. * * *"

ated items and those of similar advantage had to be received from the employer. The Board reasoned that board, rent, housing and lodging are "received from the employer" because the employee has the immediate right to use and control them, but that the fringe benefits are not received from the employer because the employee has not that immediate right. The Board concluded that this difference took the fringe benefits out of the statutory definition of wages.

On judicial review, the Court of Appeals adopted the Board's reasoning and affirmed the Board.

We allowed claimant's petition for review to consider his contentions, which have never been made in, or addressed by, this court in the years since 1917 when the amount of compensation for temporary total disability was first tied to the worker's wages. Or Laws 1917, ch 288, § 10. In his petition for review, he has continued to focus on whether the money paid by his employer to others is of "similar advantage" to the items enumerated in the statute.

Amicus union urges that claimant's argument that the fringe benefits are of similar advantage is well taken but advances the further proposition that the fringe benefits are wages as defined in *former* ORS 656.005(27) for an additional reason.

Amicus union argues that employer-paid benefits of this kind are a mandatory subject of collective bargaining under ORS 243.650 to 243.782, which require both a public employer and its employees' representatives to bargain in good faith with respect to employment relations, which is defined in ORS 243.650(7) as follows:

> " 'Employment relations' includes, but is not limited to, matters concerning direct or indirect monetary benefits, hours, vacations, sick leave, grievance procedures and other conditions of employment."

The union argues that it agreed to trade higher salaries for these employer-paid fringe benefits, and had it not done so, the employee "could well have afforded to buy" the benefits on his own. We shall assume, arguendo, this is true. That being so, argues the union, the employer's payments are a part of the "money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident," the very words of the definition of "wages." Because these benefits are within that definition of wages, it is not necessary, says the union, to address at all the language following the word "accident" in the definition.

SAIF, the Board, the Court of Appeals and amicus Association of Workers' Compensation Defense Attorneys focus on the words following the word "accident" in the statute. They contend that there is no similarity between

board, rent, housing and lodging on the one hand and these fringe benefits on the other. That being so, they say, the fringe benefits are not of similar advantage.

We believe that the analyses of all concerned has mistaken the true point of departure for determining the

amount of compensation for temporary total disability to which this claimant is entitled. It is ORS 656.210 that creates the duty to pay compensation for temporary total disability and prescribes the formula for calculation of the amount to be paid. ORS 656.210(1) provides:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser. * * *"[3]

Calculation of the amount of compensation payable for temporary total disability requires ascertainment of the weekly wage of the injured worker. ORS 656.210(2) mandates that this be done by multiplying "the daily wage the worker was *receiving*" (emphasis added) at the time of his injury by a figure that depends on how many days per week the worker was regularly employed.[4]

Neither the Board nor the Court of Appeals addressed the text of ORS 656.210, which is the statute that fixes the amount of compensation. That amount derives from the daily wage the worker was "receiving." Both the Board and the Court of Appeals addressed the concept of the receiving of wages only in the context of *former* ORS 656.005(27). Implicit in the decision of each is the idea that the item of similar advantage must be "received." We believe that that is so, but we believe that it is ORS 656.210 that primarily makes it so. *Former* ORS 656.005(27) identified the source of what is received. The source must have been the employer under the former statute. Our conclusion that this was the function of the words "received from the employer" in *former* ORS 656.005(27) is borne out by the subsequent amendment, which now includes in "wages" the amount of "tips" an employee receives in addition to the amounts received from the employer. See the amended statute, ORS 656.005(26), in footnote 2, *supra.*

The key question becomes whether claimant was "receiving" the fringe benefits as a part of his daily wage. Certainly, claimant was not receiving the funds in a literal sense. They never came into his physical possession. The

[3] ORS 656.211 provides:

"As used in ORS 656.210(1), 'average weekly wage' means the average weekly wage of workers in covered employment in Oregon, as determined by the Employment Division of the Department of Human Resources, for the last quarter of the calendar year preceding the fiscal year in which compensation is paid."

[4] ORS 656.210(2) provides:

"For the purpose of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving at the time of his injury:

"(a) By 3, if the worker was regularly employed not more than three days a week.

"(b) By 4, if the worker was regularly employed four days a week.

"(c) By 5, if the worker was regularly employed five days a week.

"(d) By 6, if the worker was regularly employed six days a week.

"(e) By 7, if the worker was regularly employed seven days a week.

"As used in this subsection, 'regularly employed' means actual employment or availability for such employment."

money paid for medical and dental insurance was nothing more or less than premiums. The individual members of the class insured, *i.e.*, the employees, had no right *ever to receive* any part of the funds created by payment of those premiums. Until an employee might need medical or dental care, he would not even be entitled to any benefit of the insurance created by payment of the premiums, let alone any part of the money. Until an employee became eligible, through retirement or termination, he would have no right to receive any money in the pension fund.

We conclude that, within the meaning of ORS 656.210, claimant was not "receiving" the money paid by his employer into the pension fund and into premiums for medical and dental insurance.

This conclusion makes it unnecessary to decide whether these fringe benefits are "wages" for the purpose of CF12former ORS 656.005(27) and present ORS 656.005(26).[5]

The decisions of the Court of Appeals and the Board are affirmed.

[5] We cannot help being aware that the relationship between rates of workers' compensation and the premiums paid by employers for workers' compensation insurance is a subject of controversy between organized labor and organized management at each session of the legislature. If fringe benefits of this kind are to become a part of the base for calculating payment of compensation, the legislature can easily so provide by amending the present statutes.

IN THE SUPREME COURT OF THE STATE OF OREGON

SACHER,
Petitioner on Review,
v.
BOHEMIA, INC.,
Respondent on Review.

(TC No. 16-80-01732; CA A31373; SC S32129)

In Banc*

On review from the Court of Appeals.**

Argued and submitted January 28, 1986.

William H. Wiswall, Springfield, argued the cause for petitioner on review. With him on the petition were Karen Hendricks, and Wiswall and Hendricks, P.C., Springfield, and Jacob Tanzer, and Ball, Janik & Novack, Portland.

Richard A. Roseta of Flinn, Brown & Roseta, Eugene, argued the cause for respondent on review.

CARSON, J.

The Court of Appeals is affirmed. The trial court is reversed.

*Roberts, J., retired February 7, 1986.

**On Appeal from Circuit Court, Lane County, Laurie K. Smith, Judge Pro Tempore. 74 Or App 685, 704 P2d 528 (1985).

CARSON, J.

This is a negligence action brought by plaintiff under Oregon's Employer Liability Act (ELA), ORS 654.305 to 654.335. Plaintiff was injured by a mill table saw owned by his employer, Cascade Handle Company, Inc. (Cascade), located on the premises of the Culp Creek sawmill owned by Bohemia, Inc. (Bohemia). Plaintiff sought to recover damages for severe injury to his hand from Bohemia under ORS 654.305 and 654.310. The jury returned a verdict in plaintiff's favor. After reduction for plaintiff's comparative negligence, the trial court entered a judgment for $420,000. Bohemia appealed, arguing that the trial court erred by denying its motion for directed verdict. The Court of Appeals reversed. *Sacher v. Bohemia, Inc.*, 74 Or App 685, 704 P2d 528 (1985). We affirm the Court of Appeals.

THE STATUTES

ORS 654.305 provides:

> "Generally, all owners, contractors or subcontractors and other persons having charge of, or responsible for, any work involving a risk or danger to the employes or the public, shall use every device, care and precaution which it is practicable to use for the protection and safety of life and limb, limited only by the necessity for preserving the efficiency of the structure, machine or other apparatus or device, and without regard to the additional cost of suitable material or safety appliance and devices."

ORS 654.310 provides:

> "All owners, contractors, subcontractors, or persons whosoever, engaged in the construction, repairing, alteration, removal or painting of any building, bridge, viaduct or other structure, or in the erection or operation of any machinery, or in the manufacture, transmission and use of electricity, or in the manufacture or use of any dangerous appliance or substance, shall see that all places of employment are in compliance with every applicable order, decision, direction, standard, rule or regulation made or prescribed by the Workers' Compensation Department pursuant to ORS 654.001 to 654.295."

FACTS

Plaintiff's employer, Cascade, manufactures broom handles at its home plant in Eugene. In order to obtain the

wooden stock or blanks from which to make the handles, Cascade contracted with lumber producers, such as Bohemia, whose waste from sawmill operations produced suitable raw materials. In 1973, Cascade built and installed a permanent facility at Bohemia's Culp Creek sawmill to scavenge suitable pieces of waste wood and prepare them for handle manufacture.

Cascade's operation at the Culp Creek sawmill consisted of a combination saw[1] mounted upon a 30 by 15 foot

[1] The saw unit was constructed by Cascade, using a vertical saw from Cascade's Springfield warehouse. The saw unit originally had two circular vertical saw blades mounted parallel to each other. The Cascade millwright and machinist added a third horizontal saw blade to the unit so as to make the most efficient use of space. The saw unit produced squared blanks.

platform located adjacent to Bohemia's waste wood conveyor and approximately 50 feet from Bohemia's trim saw. Cascade's saw unit, containing both horizontal and vertical saw blades, was approximately six or seven feet long and partially enclosed in a plywood shell. The wood scavenged from the Bohemia waste wood conveyor was fed into one end of the saw unit by one Cascade employee. The wood then would be run through feed rollers to position it for a cut by the vertical saw blades. The material then passed through another set of feed rollers that positioned the wood for the horizontal saw blade. The ends then were trimmed by the trim saws. The handle blanks and waste from the blank operation then were expelled from the saw unit where the other Cascade employee, the offbearer or outfeed operator, removed the blanks and stacked them to be bundled. When the area provided for stacking became full, the Cascade employees would bundle the blanks into units and deposit the unit bundles into large bins on the level below the platform. When a bin was full, a Bohemia forklift operator would remove it to an area of the mill yard to await loading upon a Cascade truck. Bohemia's forklift operator also would load the bundled blanks onto Cascade's truck to be transported to Cascade's home plant. The waste from the Cascade saw unit was replaced onto the Bohemia conveyor to continue its journey to the chipper or the "hog." The sawdust generated was added to the waste on Bohemia's "hog" conveyor. The record indicates that Bohemia was paid by the piece or board foot of the finished blanks, and received

approximately $2,000 a month from Cascade for the waste wood scavenged for the handle operation.

The platform and shelter housing the Cascade saw unit were designed and constructed by Cascade employees with materials purchased from Bohemia. Bohemia's saw filer occasionally sharpened the blades of the Cascade saws. Bohemia's millwright repaired Cascade's storage table and taught plaintiff to do the same. The millwright also instructed plaintiff how to repair the conveyor systems and plaintiff undertook the repair responsibility for both the Cascade and Bohemia operations.

Bohemia employees worked in close proximity and, upon occasion, side-by-side with Cascade employees, including plaintiff. The employees of both companies took breaks and meals at the same time and shared common facilities for such respite.

Plaintiff was injured when he attempted to remove a "sticker" — a piece of wood jammed in the feed rollers between the two vertical saw blades and the single horizontal saw blade — while the saws were running. The vertical blades, which rotated away from plaintiff, caught the piece of wood being used by plaintiff to dislodge the "sticker" and drew his hand into the blades, causing severe injury.

THE OREGON EMPLOYERS' LIABILITY ACT

Oregon's Employers' Liability Act originally was proposed by initiative in 1910 and adopted as Oregon Laws 1911, chapter 3. Its purpose was to impose higher standards of care than did the common law upon employers engaged in lines of work "involving risk or danger." Or Laws 1911, ch 3, § 1. The

ELA gives rise to actions in negligence, but it does not create a cause of action in addition to that of the common law. *See Howard v. Foster & Kleiser*, 217 Or 516, 533, 332 P2d 621, 629 (1958); *Shelton v. Paris*, 199 Or 365, 368, 261 P2d 856, 860 (1953).

Until 1913, when Oregon's first Worker's Compensation Act was enacted (Or Laws 1913, ch 112), employees injured on the job could proceed against their employers under common-law negligence, negligence *per se* or, after 1911, the ELA, for injuries resulting from inherently dangerous or risky work. The ELA applied only to employers "having charge of,

or responsible for, any work involving risk or danger to the employees or the public." *See* Or Laws 1911, ch 3, § 1.[2]

From 1913 to 1965, employers that would otherwise be subject to the ELA for injuries to their employees (*i.e.*, those in charge of, or responsible for work involving risk or danger to their employees) could opt into the Worker's Compensation Act which would immunize them from liability under the ELA, or opt not to participate in the Worker's Compensation Act and to remain subject to the ELA. *See former* ORS 656.022(1); 656.024 *repealed by* Or Laws 1965, ch 285, § 95.[3]

Initially, the ELA was held to allow both members of the general public and employees of employers engaged in "work involving risk or danger" to recover for injuries sustained from inherently dangerous instrumentalities under the control of the employer. *See Clayton v. Enterprise Electric Co.*, 82 Or 149, 161 P 411 (1916). Two years after *Clayton*, in *Turnidge v. Thompson*, 89 Or 637, 175 P 281 (1918), the court limited *Clayton* and held that members of the general public, as such, could not recover under the ELA. In construing provisions of the original Act regarding "work on or about [electrical] wire," the court stated: "Turnidge was neither a person engaged in work on or about the wire [that caused his death] nor [was he] an employee of the owner of the wire." 89 Or at 653.

This court held in *Byers v. Hardy*, 216 Or 42, 48, 337 P2d 806 (1959), that an action against a third-party employer could only be maintained because of the reference in ORS 654.305 to a risk or danger to "the public." "This court has consistently held that it is not every member of the public that is thus protected." 216 Or at 48. The court held that those members of the "public" who are protected are:

> "* * * only those whose employment or duties require them to be about machinery of an employer other than his own or

> whose duties may require such person to expose himself in or about hazardous conditions or structures of such other employer which are prohibited or circumscribed by the Act. * * *" 216 Or at 48.

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[2] ORS 654.305 is taken verbatim from that part of Oregon Laws 1911, chapter 3, section 1, referred to as the "and generally" clause.

[3] In 1965, the legislature decided that virtually all employers should be subject to the Workers' Compensation Laws. ORS 656.022. ORS 656.020 allows injured workers to bring an action for damages against their employer, if that employer has failed to comply with the requirements of the Workers' Compensation Law. If the work involves risk or danger, the ELA may apply.

Because Bohemia was not plaintiff's employer, we examine the basis upon which Bohemia otherwise could be held responsible for plaintiff's injury. As we held in *Miller v. Georgia-Pacific Corp.*, 294 Or 750, 754, 662 P2d 718 (1983):

> "Before the ELA can be made the basis of a claim for relief by an injured worker suing a defendant other than an employer of the worker, however, the defendant must be in charge of or have responsibility for work involving risk or danger in either (a) a situation where defendant and plaintiff's employer are simultaneously engaged in carrying out work on a common enterprise, or (b) a situation in which the defendant retains a right to control or actually exercises control as to the manner or method in which the risk-producing activity is performed. *Wilson v. P.G.E. Company*, 252 Or 385, 391-92, 448 P2d 562 (1969); *Thomas v. Foglio*, 225 Or 540, 545-57, 358 P2d 1066 (1961). * * *"

The present dispute involves the application of the first branch of statutory liability, "common enterprise."

COMMON ENTERPRISE

The "common enterprise" rationale had its genesis in the "intermingled employees" rule first announced in *Rorvik v. North Pac. Lumber Co.*, 99 Or 58, 190 P 331 (1920), 99 Or 82, 195 P 163 (1921). In *Rorvik*, the plaintiff's decedent was killed while supervising the loading of the steamship of which he was captain. At the time of the incident that caused his death, the decedent was standing on the dock adjacent to a pile of lumber stacked by the defendant's employee to be loaded upon the decedent's vessel. He was fatally injured when two carloads of lumber, being propelled by a horse, struck and toppled a pile of lumber which was stacked too close to the tracks upon which the cars ran. This court stated:

> "* * * [W]e deduce the rule that the Employers' Liability Act does not extend to the protection of the general public as such, but that it does extend its protection to employees of the particular person owning or operating dangerous machinery or engaged in hazardous employments, and to other persons or employees of other corporations whose lawful duties require

> them to be or work about such machinery, or expose themselves to the hazards of the machinery or appliances in use by the owner thereof." 99 Or at 70.[4]

In *Meyers v. Staub*, 201 Or 663, 272 P2d 203 (1954), this court held it sufficient to invoke the ELA if the defendant third-party employer's "interlocking interests with the employer amount to 'an intermingling of duties and respon-

[4] In *Rorvik v. North Pac. Lumber Co.*, 99 Or 58, 78, 190 P 331 (1920), 99 Or 82, 195 P 163 (1921), the court noted that:

> "* * * the deceased was necessarily in the position he occupied and engaged with defendants' employees in loading the vessel. It is true that the duties of the deceased and the employees of the steamship company began where the actual physical labor of defendants' employees left off, but no link in the chain was broken; the loading was a continuous work, and could not be otherwise; the lumber was put upon the slings extending from the vessel by defendants' employees, and from that position moved aboard by machinery operated by the employees of the steamship company. The vessel could not be loaded in any other manner, and while deceased was in one sense a 'member of the public,' in another he was an employee engaged in working about or in the vicinity of machinery, found by the jury to be dangerous, which brings the case squarely within the rule announced in *Clayton v. Enterprise Electric Co.*, 82 Or 149 (161 Pac 411)."

sibilities' so as to bring relationship of the defendant to the workman within the spirit of the [ELA]." 201 Or at 668, citing *Drefs v. Holman Transfer Co.*, 130 Or 452, 456, 280 P 505 (1929) and *Clayton v. Enterprise Electric Co., supra.*

In *Warner v. Synnes*, 114 Or 451, 230 P 362 (1924), 114 Or 459, 235 P 459 (1925), this court stated that where a contractor supplies employees to do work for another, and that other employer retains control over a risk-creating or dangerous activity, an employee injured by that activity would have an action under the ELA against the third-party employer. The court found that the third-party employer in *Warner* had no control over the risk-creating activity or the individual employee; thus the employee had no action under the ELA.

In *Thomas v. Foglio*, 225 Or 540, 545, 358 P2d 1066 (1961), the court noted that the defendant must be the plaintiff's employer in some sense of the word to be liable under ELA.

> "At the juncture where we held that a plaintiff could recover under the Employers' Liability Law against one who did not directly employ him, the word 'employer' took on a special and broader meaning embracing situations in which

> the defendant would not be considered an employer of the plaintiff workman as that term is ordinarily understood. The treatment of the defendant as the employer of one whom he has not *directly* [emphasis in original] employed to do the work out of which the injury arises can be justified on the ground that *the plaintiff becomes the defendant's employee in the sense that the plaintiff is performing work on a project of which defendant's operations are an integral part. The plaintiff becomes, in effect, an adopted employee to carry out the work project in which plaintiff's actual employer and his adoptive employer are participating. To draw the defendant into the employer-employee relationship in this sense, it must be shown that the defendant was one 'having charge of, or responsible for the work.'* ORS 654.305." (Emphasis added.)

It was to bring employers other than the injured worker's direct employer within the Act's provision that the "common enterprise" rationale was developed.

In *Wilson v. P.G.E. Company*, 252 Or 385, 448 P2d 562 (1969), a case decided under the "contractor-right of control" branch of the ELA, the court concluded that for a case to fall under the "common enterprise" theory, the defendant employer must do more than have its own employees working with plaintiff toward the furtherance of a common enterprise. The defendant's control must create the risk of danger which resulted in the plaintiff's injury.

> "We do not construe the ELA to impose a duty upon each employer, engaged in a common enterprise with another, to make safe the equipment and method of work of the other, even though both have a measure of control over the activity in which they are jointly engaged. The injury must result by virtue of the commingling of the activities of the two employers and not be solely attributable to the activities or failures of the injured workman's employer." 252 Or at 391. (Citation omitted.)

This same rationale was recently applied in the decision of the

Court of Appeals in *Miller v. Georgia-Pacific Corp.*, 55 Or App 358, 362-63, 637 P2d 1354 (1981), with which this court agreed. *See Miller v. Georgia-Pacific Corp., supra,* 294 Or at 756.

The "common enterprise" test set forth in *Wilson* was drawn from *Thomas,* where this court held that the ELA could be invoked against a third-party employer when the

third-party employer defendant and the plaintiff's employer participated in a common enterprise involving an "intermingling of duties and responsibility" of the employees of both employers. 225 Or at 547. This participation must be more than a common interest in an economic benefit which might accrue from the accomplishment of the enterprise. *See Wilson v. P.G.E. Company, supra; Warner v. Synnes, supra.* However, "[a]n employer may be in 'charge of' work within the meaning of ORS 654.305 even though he is in charge of an activity which forms only a component part of a common enterprise." *Thomas v. Foglio, supra,* 225 Or at 549. In *Thomas,* this court held that an employer can be regarded as "having charge of" work where the component part of the general undertaking for which he is responsible involves any risk-creating activity on the part of his employees or calls for the use of equipment over which he has control and which, if not maintained with proper safeguards, necessarily exposes the employees of the other employer to an unreasonable risk in the course of carrying on the common enterprise. 225 Or at 549-50. "[T]he word 'work' in ORS 654.305 means more than actual physical movement of employees hired to perform a job; it means the entire enterprise with all of the component parts necessary to the completion of the enterprise in which both employers have joined to accomplish." 225 Or at 549-50.

Under the "common enterprise" test, control or charge over the particular employee injured is not required to invoke the ELA, but control or charge[5] over the activity or instrumentality that causes the injury is. *See Thomas v. Foglio, supra; Metcalf v. Roessel,* 255 Or 186, 190-91, 465 P2d 699 (1970). Thus, third-party employers may be held liable if their negligence, as measured by the ELA, results in injury to: 1) an "adopted" employee (*see Thomas v. Foglio, supra*); or 2) an "intermingled employee" (*see Rorvik v. North Pac. Lumber Co., supra*); or 3) an employee of an independent contractor hired by the defendant where the defendant retains or exercises a right to control the risk-creating activity or instrumentality (*see Warner v. Synnes, supra*).

Thus, the "common enterprise" test requires, first, that two employers (the plaintiff's actual employer and a

third-party defendant employer) participate in a project of which the defendant employer's operations are an "integral" or "component" part,[6] *Thomas*; second, the work must involve a risk or danger to the "employes or the public," ORS 654.305; third, the plaintiff must be an "employee" of the defendant employer, as enumerated above; and fourth, the defendant must have charge of or responsibility for the activity or instrumentality that causes the plaintiff's injury, *Thomas.*

[5] This control or "charge" may be exercised directly or through intermediaries. *See* ORS 654.320.

APPLICATION TO THIS CASE

In this case, Bohemia employees assisted in the handle-blank operation by forklifting completed bins of blanks to the yard, later loading those blanks onto Cascade trucks for transport to Cascade's home plant, by occasionally sharpening Cascade's saws and by producing the wood waste that the Cascade employees scavenged for blank production. Bohemia also supplied the conveyors used to bring Bohemia waste wood to the Cascade operation and to transport Bohemia and Cascade waste to the chipper or "hog." Cascade employees, including plaintiff, undertook at least some responsibility for the maintenance and repair of Bohemia's waste conveyor system, including removing pieces of metal detected by a metal detector, thawing frozen rollers and replacing worn out pins and rollers. Bohemia had the right, by contract, to approve all hiring of employees to work in Casade's handle blank operation. These facts do not meet the requirements to make this joint project a "common enterprise."

The dispositive factor in this case is that there is no evidence that Bohemia was in charge of or responsible for that part of the handle blank production operation that caused plaintiff's injury. Cascade alone designed, built, installed and operated the saw unit. They provided their own labor, maintenance, supplies and paid for their own utilities. Plaintiff was not injured because of a failure on Bohemia's part to take proper precautions regarding its own equipment (the conveyors, forklift or other nearby mill machinery)[7] or employees.

Bohemia was not shown to be in charge of or responsible for the design, maintenance or operation of the Cascade saw unit nor the activity of plaintiff while operating the saw unit. Plaintiff did not establish that a "common enterprise" existed between Bohemia and Cascade, therefore, Bohemia may not be held liable under the ELA for plaintiff's injuries.

The Court of Appeals is affirmed. The trial court is reversed.

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[6] In *Thomas v. Foglio*, 225 Or 540, 358 P2d 1066 (1961), the words "integral" (at p 545) and "component" (at p 549) part were used, perhaps, as synonyms.

[7] As the Court of Appeals pointed out, "[t]he case could be different, for example, if plaintiff had been injured while operating or repairing the conveyer, which appears to have been under Bohemias's direct control." *Sacher v. Bohemia, Inc.*, 74 Or App 685, 691, 704 P2d 528 (1985). We need not decide that question today.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Charlotte J. Johnson, Claimant.

JOHNSON,
Respondent on Review,

v.

SPECTRA PHYSICS et al,
Respondents on Review,
EBI COMPANIES et al,
Petitioner on Review.

(WCB Nos. 83-02119, 83-02685, 83-10719;
CA A33862; SC S32604)

On review from the Court of Appeals.*

Argued and submitted July 2, 1986.

Jerald P. Keene, Portland, argued the cause for petitioner on review, Junction City Residential Center/EBI Companies. With him on the petition for review was Roberts, Reinisch & Klor, P.C., Portland.

David C. Force, Eugene, argued the cause for respondent on review, Charlotte J. Johnson.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent on review, SAIF Corporation.

Before Peterson, Chief Justice, and Lent, Linde, Campbell, Carson and Jones, Justices.

CARSON, J.

The Court of Appeals is affirmed in its conclusion that claimant's disease arose out of and in the scope of her employment at Marloc. The Court of Appeals is reversed in its conclusion that the subsequent denial of responsibility of the carpal tunnel syndrome was unlawful. Remanded to the Court of Appeals for further determination.

*On judicial review from an Order on Review of the Workers' Compensation Board, 77 Or App 1, 712 P2d 125 (1985).

CARSON, J.

In this workers' compensation case, claimant seeks compensation from two previous employers for her carpal tunnel syndrome.[1] One employer, Marloc Corporation (Marloc), denied compensability. The other employer, Junction City Residential Center (Junction City Center), accepted

[1] Dr. Jewell, a hand surgeon who testified at claimant's hearing of November 17, 1983, described the carpal tunnel syndrome as

> "* * * the manifestation of compression of the median nerve at the wrist. The most common cause for carpal tunnel is what's known as a nonspecific tenosenovitus [sic]. By that, I mean that the enveloping membranes which cover the nine tendons which pass through the carpal tunnel get inflammed [sic] and produce swelling which causes compression and subsequent lack of function within the median nerve."

claimant's back injury claim but denied responsibility for her carpal tunnel syndrome.[2] The issue on review is whether Junction City Center's denial is barred by ORS 656.262(6),[3] as construed in *Bauman v. SAIF*, 295 Or 788, 790, 670 P2d 1027 (1983), which forbids insurers from denying previously accepted claims.

The referee upheld the denials of both employers and the Workers' Compensation Board (Board) affirmed. The Court of Appeals reversed, holding that claimant had proven that her carpal tunnel syndrome arose out of and in the scope

of her employment at Marloc, that Junction City Center's denial was invalid, and remanded to the Board.[4] We affirm in part and reverse in part.

Claimant worked for Marloc from 1969 until January 14, 1981. Claimant's work included hand sanding, shearing plastic, screen printing, riveting and sawing, work that required strenuous, repetitive labor with her wrists and hands. From June 2, 1982, until February 17, 1983, she worked as a waitress for Junction City Center, a care home for the elderly. Her work at Junction City Center included carrying trays of dishes and food, washing dishes and busing dishes in containers weighing up to 40 pounds.

On September 5, 1982, claimant injured her back and right arm while carrying dishes. She filed a claim against Junction City Center on November 4, 1982. On her claim form, the space for "NATURE OF INJURY OR DISEASE" stated "BACK INJURY"; the space for "PART OF BODY AFFECTED" stated "MIDDLE BACK & ARM." A space adjacent to the latter space provided blocks to indicate "LEFT" or "RIGHT." Claimant placed an "X" in the "RIGHT" block. The claim form did not refer to the carpal tunnel syndrome. No one had diagnosed the condition when claimant filed the claim form.

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[2] Spectra Physics employed claimant from October 19 until December 24, 1981. Although its name appears in this case's title, Spectra Physics is not a party to this dispute.

[3] ORS 656.262(6) provides:

"(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 or 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. The notice of acceptance shall:

"(a) Advise the claimant whether the claim is considered disabling or nondisabling.

"(b) Inform the claimant of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury of the claimant is nondisabling by requesting a determination thereon pursuant to ORS 656.268.

"(c) Inform the claimant of employment reinstatement rights under ORS chapter 659.

"(d) Inform the claimant of assistance available to employers for job site modification under ORS 656.622."

[4] We note that SAIF moved the Court of Appeals for reconsideration to clarify the court's instructions on remand to the Board. The motion was denied. Once it had been determined that Junction City Center's insurer, Employee Benefits Insurance Company (EBI), had accepted the carpal tunnel syndrome claim, a determination of responsibility was unnecessary. As the result of the application of the rule in *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), EBI became the responsible party by virtue of its alleged original allowance of the claim.

Claimant sought initial treatment from a chiropractor, Dr. Hill, on October 14, 1982. Dr. Hill's first medical report was sent to Employee Benefits Insurance Company (EBI), Junction City Center's insurer, on October 21, 1982. Dr. Hill described claimant's condition as "[a]cute traumatic subluxation strain of the cervical spine with a paravertebral myofascitis and right extension brachial neuralgia" (strain of the upper back with pain radiating down the right arm).

On November 16, 1982, claimant consulted a neurosurgeon, Dr. Tsai, about her back and arm injuries. Dr. Tsai diagnosed an upper thoracic strain and the bilateral carpal

tunnel syndrome and decided that both were related to claimant's work. On November 22, 1982, EBI received Dr. Tsai's medical report, which, after noting the above-mentioned diagnosis, stated that "[n]o neurosurgical, diagnostic or therapeutic procedure is indicated at this time." On December 1, 1982, EBI accepted claimant's claim for the back injury on the same form that she had submitted.

On February 1, 1983, claimant saw another neurosurgeon, Dr. Campagna. Dr. Campagna, more concerned with claimant's back injury than with her carpal tunnel syndrome, cursorily asked her whether she had done repetitive work such as needlepoint. She replied that she occasionally crocheted. Dr. Campagna concluded that claimant's crocheting caused the carpal tunnel syndrome; he did not ask her about her work at Marloc or Junction City Center.

On February 10, 1983, 80 days after EBI received Dr. Tsai's medical report, EBI notified claimant that it "must respectfully deny your claim for medical, surgical and time loss benefits as it relates to your condition of bilateral carpal tunnel syndrome not being related to your industrial claim and injury of September 5, 1982." EBI's letter added that "we are still processing your claim under ORS 656.245 (Medical Services) as it relates to your thoracic sprain as a result of your industrial injury of September 5, 1982."

On February 18, 1983, Dr. Campagna performed carpal tunnel release surgery on claimant's wrists. On February 24, 1983, claimant filed an occupational disease claim against Marloc for the carpal tunnel syndrome. Marloc's insurer, SAIF, denied the claim on March 16, 1983.

Dr. Jewell, a hand surgeon, examined claimant on October 28, 1983. He concluded that claimant's work at Marloc, not her occasional crocheting, had caused the carpal tunnel syndrome. In January 1984, Dr. Campagna first learned of claimant's work at Marloc. He then agreed with Dr. Jewell that claimant's work at Marloc had caused her carpal tunnel syndrome.

The referee found that claimant's condition was not a compensable occupational disease chargeable to Marloc. The Board affirmed the referee.

ORS 656.802(1)(a) provides:

"As used in ORS 656.802 to 656.824, 'occupational disease' means:

> "Any disease or infection which arises out of and in the scope of employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

The Court of Appeals reversed the Board, concluding that "claimant proved by a preponderance of the evidence that her carpal tunnel syndrome arose out of and in the scope of her employment at Marloc." *Johnson v. Spectra Physics,* 77 Or App 1, 5, 712 P2d 125 (1985). In workers' compensation cases, we do not disturb findings of fact by the Court of Appeals if the findings are supported by evidence. *Sahnow v. Fireman's Fund Ins. Co.,* 260 Or 564, 569, 491 P2d 997 (1971). There is evidence to support the finding that claimant's occupational disease is compensable as to Marloc.

The referee also found that EBI properly denied responsibility for claimant's carpal tunnel syndrome. The Court of Appeals reversed, concluding that the denial violated the rule of *Bauman v. SAIF, supra.*

Bauman holds that "once an insurer has accepted a claim under ORS 656.262(6), which requires acceptance or denial of a workers' compensation claim within 60 days after the employer has notice or knowledge of the claim, the insurer may not subsequently deny the compensability of the underlying claim." 295 Or at 790. In *Bauman,* the insurer had accepted the claimant's original claim for bursitis. Two and one-half years later, the claimant's condition worsened and his physician asked the insurer to reopen the claim. The insurer then reversed its original acceptance. This court held that an insurer could not deny a condition that it already had accepted because such vacillation "would encourage degrees of instability in the workers' compensation system that we do not believe the statute contemplates." *Id.* at 793. We continued: "If, as in this case, the insurer *officially notifies* claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity." *Id.* at 794. (Emphasis added.) As the Court of Appeals noted in *Jeld-Wen, Inc. v. McGehee,* 72 Or App 12, 14-15, 695 P2d 92 (1985), *Bauman* recognizes that

retrospective denials cause instability, create evidentiary problems and frustrate the timely resolution of claims.

In this case, the Court of Appeals concluded that EBI had retrospectively denied this claim, thereby violating the rule of *Bauman:*

> "At the time that EBI accepted the claim for Junction City Center, it had knowledge of the carpal tunnel syndrome and was on notice that claimant claimed that it related to her back injury. It does not assert any of the exceptions to the *Bauman* rule of fraud, misrepresentation or other illegal activity. *See Liberty Northwest Ins. Corp. v. Powers,* 76 Or App 377, 380, 708 P2d 1202 (1985). It could not, therefore, deny the compensability of the claim." 77 Or App at 5.

The Court of Appeals recently summarized its holding: "The scope of the acceptance is governed by the notice or knowledge that the employer has of the nature of claimant's condition at

the time of its acceptance." *Destael v. Nicolai Co.*, 80 Or App 596, 601, 723 P2d 348 (1986). The reasoning of the Court of Appeals seems to be that once an insurer accepts a claim, it must accept any allegedly related conditions if the insurer knows or has notice of the other conditions when it accepts the original claim. Even though the insurer does not mention the other condition in its acceptance, it may not then deny the other condition without running afoul of the *Bauman* rule.

However, *Bauman* applies only to a claim "specifically" or "officially" accepted by the insurer. 295 Or at 793-94. ORS 656.262(6) requires that the insurer or self-insured employer furnish the claimant with "[w]ritten notice of acceptance or denial of the claim * * * within 60 days after the employer has notice or knowledge of the claim." An insurer must accept a particular claim in writing, and subsequently deny that particular claim after the 60 days prescribed by ORS 656.262(6) have elapsed, before *Bauman* applies.

The insurer's knowledge or notice of a condition is not a substitute for a specific written acceptance as defined by *Bauman*. By the same token, an insurer's silence regarding one aspect of a claim is neither acceptance nor denial of that aspect of the claim. Silence is neutral. One could argue that if an insurer's silence regarding a condition implies anything, it would imply denial, not acceptance.

ORS 656.262(6) requires only that the insurer respond in writing to a claim within 60 days of its notice or knowledge of the claim; it does not convert the insurer's failure to respond specifically to a condition into acceptance of that condition. If an insurer specifically accepts in writing only one of several conditions or injuries encompassed by a single claim, the insurer has not "specifically" or "officially" accepted the other conditions allegedly related to the accepted part of the claim.

Here, EBI never specifically accepted claimant's carpal tunnel syndrome. As stated above, the claim form on which EBI accepted claimant's back and arm injury claim mentioned only the back and right arm injury. Although EBI received Dr. Tsai's report eight days before it accepted claimant's back and arm injury, we conclude that EBI's silence regarding claimant's carpal tunnel syndrome was not an acceptance of that disease.

However, our conclusion about the effect of EBI's failure to respond to claimant's carpal tunnel syndrome does not resolve this case. We agree with claimant and the Court of Appeals that the back and arm injury and the carpal tunnel syndrome are aspects of a single claim. EBI assigned one claim number to the back and arm injury and the carpal tunnel syndrome and treated the injury and the disease as aspects of a single claim in its denial letter to claimant. However, claimant's back and arm injury and her carpal tunnel syndrome, although aspects of one claim, are separate. While the Court of Appeals did not specifically conclude that claimant's back and arm injury was in fact related to the carpal tunnel syndrome in this case, in *Destael v. Nicolai Co.*, *supra*, the Court of Appeals referred to this case, stating that "the scope

of the acceptance of the back injury claim included the carpal tunnel syndrome, because employer had notice and knowledge that *it related* to the back injury." *Id.* at 601. (Emphasis added.)

The Court of Appeals read Dr. Tsai's report as relating claimant's carpal tunnel syndrome to her *injury* of September 5, 1982, thereby creating a single claim. However, the report shows that Dr. Tsai related both claimant's back injury *and* her bilateral carpal tunnel syndrome to her *work* at

Junction City Center. This is consistent with the opinion of Dr. Jewell.[5]

The reasoning of the Court of Appeals in this case would hinder the practice of "partial denials," in which an insurer denies one aspect of a claim while accepting another aspect of the same claim. In a partial denial, separate aspects of a single claim are treated as though they were separate claims. *See, e.g., Dean v. SAIF*, 72 Or App 16, 19, 695 P2d 90 (1985). Although no statute specifically authorizes partial denials, OAR 436-83-125 provides:

> "Every notice of partial denial shall set forth with particularity the injury or condition for which responsibility is denied and the factual and legal reasons therefor. The notice shall be in the form provided for in [OAR 436-]83-120. Hearing and appeal rights and procedures shall be as provided for claim denials in ORS 656.262(6) and (7), 656.319 and these Rules."

This court has recognized partial denials. *See Price v. SAIF*, 296 Or 311, 675 P2d 479 (1984); *Ohlig v. FMC Marine & Rail Equipment*, 291 Or 586, 596, 633 P2d 1279 (1981). Partial denials are litigated frequently at the Workers' Compensation Board. *See, e.g., Sidney M. Brooks*, 38 Van Natta 925, 926 (1986) ("SAIF's precautionary partial denial of carpal tunnel syndrome was appropriate to avoid the appearance of having accepted an unrelated condition because claimant's doctors were investigating it at the same time they were treating claimant's accepted low back strain injury."); *Leon E. Cowart*, 38 Van Natta 916, 918 (1986) (finding a partial denial proper and that "SAIF's silence regarding claimant's post-injury low back complaints * * * did not constitute an 'acceptance' of [a claim]").

In *Price v. SAIF, supra*, this court held that a claimant may appeal a partial denial. *Price* concerned a single claim that included a low back strain and a heart condition. Claimant appealed the Board's denial of the heart condition, contending that it was related to his accepted low back strain. While the appeal was pending, the referee had not yet determined the extent of disability caused by the back injury. The

Court of Appeals dismissed the appeal from the denial of the heart condition as premature. We reversed, holding that the denial was appealable: "An order which addresses two sepa-

[5] Dr. Jewell testified that claimant's carpal tunnel syndrome arose from her work at Marloc and the condition could have been exacerbated by her work at Junction City Center. *Johnson v. Spectra Physics*, 77 Or App 1, 4, 712 P2d 125 (1985).

rate aspects of the same claim, extent of disability on the accepted claim and compensability for an allegedly related disease, infection or injury, may finally determine one issue but not the other." 296 Or at 316.

A partial denial is appropriate when, as here, two or more injuries or conditions are separate aspects of the same claim. Under OAR 436-83-125, when a claimant makes a single claim encompassing two separate injuries or conditions, the insurer then may partially deny that claim by specifically denying one injury or condition while accepting the other.

Partial denials are consistent with the rule of *Bauman* because they promote timely closure of the accepted aspects of the claim. In a proper partial denial under OAR 436-83-125, the insurer should inform the claimant of the reasons for the partial denial, allowing the claimant to appeal the partial denial promptly. Under *Price v. SAIF*, *supra*, the claimant may appeal the partial denial even if the accepted injury or condition is being processed. If insurers could not partially deny claims, they might routinely deny entire claims to protect their interests, rather than accepting conditions or injuries that are clearly compensable.

To summarize, an insurer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). An insurer's failure to respond to a claim or one aspect of a claim is neither acceptance nor denial. The insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies. That specificity, which promotes timely closure of accepted conditions and prompt appeals of denied conditions, is the essence of a partial denial.

Here, at first EBI failed to respond to notice of claimant's carpal tunnel syndrome after accepting claimant's back injury. Because we conclude that EBI never accepted claimant's carpal tunnel syndrome, we reverse that part of the opinion of the Court of Appeals which held that EBI violated the *Bauman* rule. EBI eventually denied the carpal tunnel syndrome but this occurred more than 60 days after the claim was filed. ORS 656.262(6). EBI may be subject to penalties

under ORS 656.262(10)[6] for not responding to the carpal tunnel syndrome claim within 60 days.

The Court of Appeals is affirmed in its conclusion that claimant's disease arose out of and in the scope of her employment at Marloc. The Court of Appeals is reversed in its conclusion that the subsequent denial of responsibility for the carpal tunnel syndrome by Junction City Center was unlawful. The case must be remanded for a determination of whether claimant's carpal tunnel syndrome is compensable as to Junction City Center, and determination of penalties, if any, against EBI for failing to respond to claimant's claim within 60 days. If it is determined that claimant's occupational disease is compensable as to both Marloc and Junction City Center, then a determination of the responsible party must be made. We remand, therefore, to the Court of Appeals for such further proceedings as it may order in accordance with this opinion. In so doing, we intend to leave to the Court of Appeals a decision whether to resolve finally the case or to remand to the Board.

[6] ORS 656.262(10) provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

ORS 656.262(6) sets the 60-day acceptance or denial period from the date the employer has notice or knowledge of the claim. We conclude that the notice to the employer occurred not when the claim was filed but when EBI received Dr. Tsai's report. EBI received Dr. Tsai's letter on November 22, 1982, and did not deny claimant's carpal tunnel syndrome until February 10, 1983, 80 days later. On remand, determination should be made whether EBI's delay in responding to Dr. Tsai's report was unreasonable.

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