

VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 40

(Pages 1901-END)

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.

OCTOBER-DECEMBER 1988

(For Workers' Compensation Board decisions
for the period from October 1 to November 29, 1988,
please see previous volume, covering pages 1557-1900.)

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CITE AS

40 Van Natta ____ (1988)

WILLIAM B. WOODRUFF, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Mitchell, Lang & Smith, Defense Attorneys

WCB 86-16153
November 29, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Podnar's order which upheld the self-insured employer's denial of his medical services claim for a low back condition. On review, claimant contends that his current need for treatment is compensable. We agree and reverse.

FINDINGS OF FACT

Claimant compensably injured his low back in August 1984. The diagnosis was an acute exacerbation of a chronic lumbar strain. Claimant missed a week of work and began treating conservatively with Dr. McCaffrey, a chiropractor.

In August 1985, Dr. McCaffrey declared that claimant's low back had stabilized and returned to pre-injury status. The claim was closed by Determination Order on October 2, 1985, with no permanent disability award.

In April 1986, claimant saw Dr. McCaffrey with complaints of low back pain. McCaffrey treated him for exacerbations of his chronic lumbar sprain/strain until October 1986. At that time, claimant changed his care to Dr. Simpson, a chiropractor. Simpson diagnosed chronic low back syndrome, lumbosacral compression strain and left radiculitis, and took claimant off work for two weeks.

On October 23, 1986, the employer issued its denial, wherein it denied payment of post-August 25, 1986 chiropractic treatments billed for claimant's "current condition." The denial was based on the employer's opinion that claimant's low back problems were the result of a weightlifting injury, rather than the industrial injury.

We find that the 1984 industrial injury was a material contributing cause of the claimant's need for medical treatment at the time of the denial.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the denial, citing the lack of evidence that the 1984 industrial injury was a factor in claimant's current need for treatment. We disagree with the Referee's decision and, instead, find the current treatment compensable.

To establish compensability, claimant must prove by a preponderance of the evidence that the industrial injury materially contributed to his need for medical services. Hutcheson v. Weyerhaeuser, 288 Or 51, 57 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987).

Both treating physicians, Drs. McCaffrey and Simpson, opined that claimant's present, low back condition was partially the result of the 1984 industrial injury. Only Dr. Gatterman, a chiropractic consultant who performed an independent medical examination in September 1986, found that the industrial injury had resolved and that there was no need for further treatment. We tend to give greater weight to the conclusions of treating physicians, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983).

The employer contends that the persuasiveness of Dr. McCaffrey's opinion should be discounted because of alleged, unexplained inconsistencies between his August 1985 and November 1986 reports. We disagree. In August 1985, Dr. McCaffrey wrote that claimant's low back had stabilized and returned to pre-injury status and that current treatments were directed to a weightlifting injury. In November 1986, Dr. McCaffrey wrote that claimant's need for palliative care was partially the result of the industrial injury. These reports are not inconsistent. Although the compensable low back condition was stable and asymptomatic in August 1985, it had not yet resolved. Four months later, in December 1985, Dr. McCaffrey noted decreased lumbosacral disc spaces which were related to his work injuries. By August 1986, claimant was experiencing exacerbations of his 1984 industrial injury. Dr. McCaffrey explained that it was not uncommon, in cases of soft tissue injury, for patients to experience exacerbations and remissions of their symptoms.

We find no reason to discount the persuasiveness of Dr. McCaffrey's opinion. Accordingly, based on the treating physicians' opinions, we conclude that the 1984 industrial injury was a material contributing cause of claimant's current need for low back treatment. The denied chiropractic services are therefore compensable.

Attorney Fee

Because claimant has prevailed over the employer's denial of his claim for compensation, claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee. See ORS 656.386(1). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Here, claimant's counsel submitted a statement of services which reported only services rendered on Board review. Accordingly, an assessed fee for only services rendered on Board review shall be approved. After reviewing the statement of services and attorney retainer agreement submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we award a reasonable fee in the amount of \$500.

ORDER

The Referee's order dated July 16, 1987 is reversed. The self-insured employer's denial, dated October 23, 1986, is set aside and the claim is remanded to the employer's adjuster for processing according to law. For services rendered on Board review, claimant's attorney is awarded a reasonable fee of \$500, to be paid by the self-insured employer.

SUZANNA D. BRAYERTON, Claimant
Francesconi & Cash, Claimant's Attorneys
Ray Smitke (SAIF), Defense Attorney

WCB 86-11305
November 30, 1988
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of that portion of Referee Podnar's order that upheld the SAIF Corporation's denial of her aggravation claim for a neck and back condition. If the Board affirms the Referee's ruling on the aggravation issue, claimant also requests review of that portion of the Referee's order that affirmed a Determination Order closing claimant's original injury claim with no award of permanent partial disability.

On review, the issues are aggravation and, alternatively, extent of unscheduled permanent partial disability. We reverse.

FINDINGS OF FACT

Claimant, 21 years of age at the time of hearing, sustained a cervical and lumbar strain as a result of two separate compensable injuries in September 1984. At that time, claimant was working as an aide in a nursing home operated by SAIF's insured. Her strains were superimposed on a congenital defect in the lumbar spine which had been asymptomatic prior to her compensable injuries.

Claimant received conservative treatment from Dr. Koosman, chiropractor. During the course of her treatment, she exhibited a mild to moderate degree of functional overlay. Dr. Koosman released claimant back to modified work in October 1984, and she became medically stationary on May 3, 1985. Objective findings at that time were limited to a mild loss in lumbar ranges of motion. However, she continued to experience symptomatic flare-ups of back, hip, neck and right shoulder pain with heavy lifting and prolonged sitting and standing.

Claimant continued receiving palliative care from Dr. Koosman through September 1985. A Determination Order, issued September 19, 1985, closed her claim with no award of permanent disability.

In October 1985, claimant went to work as a manager of a small apartment complex where her job responsibilities included yard work and cleaning apartments. Her residual neck, back, shoulder and hip symptoms worsened during the first three months of 1986, and they continued to worsen through the spring and after she gave birth to her third child in April 1986. Claimant also developed radiating pain into both legs and loss of feeling in the right side of her body. Her increased symptoms rendered her less able to perform yard work and cleaning activities, and she lost her apartment manager job in July 1986 because she was no longer able to carry out her job responsibilities.

Claimant did not initially seek additional medical treatment because she could not afford it and did not know that her employer was obligated to provide continuing medical services for her compensable injury. She eventually discovered that she was entitled to such services and sought further treatment from Dr. Breitenstein, chiropractor, on August 14, 1986. Objective findings at that time included decreased sensation in the right leg and moderate loss in lumbar ranges of motion. Dr. Breitenstein authorized time loss as of August 6, 1986.

In December 1986, claimant sought a second opinion from Dr. Bussanich, chiropractor. He reported moderate loss in cervical and lumbar ranges of motion, marked evidence of swelling and inflammation over both sacroiliac joints and the lower lumbar region, and decreased sensation in the left leg involving the L5 nerve root.

Claimant's condition had become medically stationary when she underwent an independent medical examination on February 13, 1987. At that time, she continued to experience residual low back pain.

SAIF issued a formal aggravation denial on February 20, 1987, and claimant requested a hearing. At the time of hearing, claimant was receiving palliative chiropractic care for her residual low back pain.

FINDINGS OF ULTIMATE FACT

Claimant credibly testified regarding her gradually worsening symptoms following claim closure.

Claimant was at least capable of medium level work when her claim was closed in September 1985.

Claimant's symptomatic exacerbation in August 1986 rendered her less able to work than she was when her claim was closed in September 1985.

Although some of claimant's increased symptoms in 1986 were attributable to her pregnancy, her compensable injury also continued to materially contribute to her symptomatic exacerbation.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the Referee erred in ruling that she had not demonstrated a compensable aggravation. Claimant further contends that she is entitled to temporary total disability retroactive to August 6, 1986, the date she initially sought treatment from Dr. Breitenstein.

In order to establish a compensable aggravation, claimant must prove a worsening of her condition since the last award of compensation, as well as a causal relation between the worsening and the original injury. ORS 656.273(1); Hoke v. Libby, McNeil & Libby, 73 Or App 44, 46 (1985). To prove a worsening, claimant must demonstrate that her increased symptoms or worsened condition have rendered her more disabled, meaning less able to work, either temporarily or permanently. Smith v. SAIF, 302 Or 396 (1986); Van Woesik v. Pacific Coca-Cola Co., 85 Or App 9 (1987). Moreover, if claimant has only experienced an increase in symptoms, she must demonstrate that her current exacerbation is greater than any disabling symptomatic flare-ups contemplated by her last award of compensation. See Gwynn v. SAIF, 304 Or 345 (1987).

Here, claimant's last award of compensation was the September 1985 Determination Order that closed her injury claim with no award of permanent disability. Therefore, claimant has received no award of permanent disability in contemplation of future disabling symptomatic flare-ups, and she need only demonstrate an injury-related worsening rendering her less able to work than she was in September 1985.

In support of her claim, claimant relies on the opinions of chiropractors Breitenstein and Bussanich. Treating physician Breitenstein opined that claimant's August 1986 exacerbation was an acute aggravation of her 1984 injury. Both doctors related claimant's aggravated condition to her compensable injury. Furthermore, Dr. Breitenstein authorized time loss as of August 6, 1986,

After de novo review of the record, we defer to the opinions of Drs. Breitenstein and Bussanich. In support of that decision, we note that the record contains no contrary medical opinion on the aggravation issue. We also note that their opinions are consistent with the record as a whole, including claimant's history of progressively worsening symptoms.

Furthermore, we reject SAIF's argument that the opinions of Drs. Breitenstein and Bussanich are not persuasive because they are

based on claimant's allegedly unreliable account of her initial injury and subsequent symptomatic history. We are aware that claimant is particularly sensitive to pain and exaggerates her symptoms. Nevertheless, the documented medical record supports her testimony of gradually worsening symptoms following claim closure, claimant provided a reasonable explanation for her delay in seeking further treatment, and the Referee made no adverse credibility finding. After considering these factors, we are not persuaded that claimant is capable of distinguishing between an increase in her symptoms or a decrease in her ability to perform strenuous work activity.

Moreover, Drs. Breitenstein and Bussanich did not render their opinions solely on the history provided by claimant. They also relied on Dr. Koosman's objective findings at the time of the initial injury, claimant's significant treatment record, and increased objective findings in August and December 1986. In particular, the latter increased findings included marked evidence of swelling and inflammation over both sacroiliac joints and the lower lumbar region, decreased sensation in the left leg involving the L5 nerve root, and greater loss in lumbar ranges of motion than claimant demonstrated when she was found medically stationary in May 1985.

In light of these factors, we defer to the opinions of Drs. Breitenstein and Bussanich. Consistent with their opinions, we find that claimant's compensable injury remained a material contributing factor of her symptomatic exacerbation in August 1986. Furthermore, in light of Dr. Breitenstein's authorization of time loss and the fact that claimant was at least capable of medium level work when her claim was closed in September 1985, we conclude that her August 1986 exacerbation rendered her less able to work than at the time of claim closure. Accordingly, we conclude that claimant has established a compensable aggravation as of August 6, 1986, and the claim is remanded to SAIF for further processing according to law. Inasmuch as the claim has been remanded for processing, the extent of disability issue will not be addressed.

ORDER

The Referee's order dated April 16, 1987 is reversed. The SAIF Corporation's denial of February 20, 1987 set aside, and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded an assessed fee of \$1,250 for services at hearing and on Board review regarding the aggravation issue, to be paid by the SAIF Corporation.

Board Member Ferris, dissenting:

I dissent. In concluding that claimant had established a compensable aggravation claim, the majority was persuaded by the medical reports from Drs. Breitenstein and Bussanich, the treating chiropractors. I am not so persuaded, and would affirm the Referee's order which: (1) upheld SAIF's denial of the aggravation claim; and (2) affirmed the Determination Order that closed the original injury claim with no permanent disability award.

This case should turn on claimant's credibility. In exercising de novo review, we may determine a witness's credibility based on an objective evaluation of the substance of that witness's testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Desi R. Davis, 40 Van Natta 540, 542 (1988); Robert W. Cooper, 40 Van Natta 486, 487 (1988). Here, there were significant

inconsistencies between claimant's testimony and the documentary evidence.

For example, her description of the original industrial accident, as well as the injury itself, has varied significantly since the accident. Throughout the course of her original injury claim, claimant consistently reported that she felt the onset of sharp pain in the low back, neck and right shoulder while turning a patient in bed. However, after claim closure and the birth of her third child, claimant sought treatment with Dr. Breitenstein for continuing complaints of pain, reporting that she sustained her original injury when a patient weighing over 200 pounds rolled out of bed and landed on her. She repeated the same version of the accident to Dr. Bussanich, adding that her immediate symptoms included tingling in both feet; however, contemporaneous medical reports do not document that symptom. Later, during an independent medical examination by Dr. Vigeland, claimant stated that she also had right leg pain after the accident. Yet, there is no previous record of leg pain; indeed, a consulting physician specifically reported the absence of leg symptoms. At hearing, claimant maintained that she injured her low back when a patient fell onto her. She gave no reason for the inconsistencies. Given the significance of the inconsistencies and the lack of explanation, I find claimant not credible.

Aggravation

In finding the requisite elements of an aggravation -- a worsening and a causal relationship -- the majority relied on the medical reports from Drs. Breitenstein and Bussanich. In so doing, the majority acknowledges that claimant may have given the doctors an exaggerated history of the initial injury and that they were influenced by her subjective symptoms. Nevertheless, the majority finds a worsening, based on the doctors' "objective findings," such as the greater loss in lumbar ranges of motion than claimant demonstrated when she was found medically stationary in May 1985. I disagree with that finding.

Dr. Breitenstein, the treating chiropractor since August 1986, diagnosed an acute exacerbation of claimant's original back injury and took claimant off work for approximately five months. Although we ordinarily give greater weight to the treating physician's conclusion, see Weiland v. SAIF, 64 Or App 810, 814 (1983), I find persuasive reasons not to do so here. In support of his conclusion, Breitenstein cited "subjective and objective findings," without further clarification. The objective findings, if any, are not readily apparent from the report. Contrary to the majority's assumption, we have previously noted that range-of-motion findings are subjective and can vary from day to day and from one examiner to the next. E.g., Jeffrey A. Mills, 36 Van Natta 714, 715 (1984); Leonard Wonslyd, 34 Van Natta 230 (1982). There is simply no basis for assuming that the findings upon which Breitenstein based his conclusion are objective. For that reason, Breitenstein's report is tainted by claimant's lack of credibility and should be discounted accordingly.

Dr. Bussanich's report is similarly suspect. Although he identified apparently objective findings of low back swelling and inflammation and decreased sensation in the left leg, it is unclear whether these symptoms are disabling. For that reason, they are not sufficient to establish a worsened condition. Without objective verification of claimant's complaints, I do not find that claimant sustained increased symptoms which rendered her more disabled than she was when her original claim was closed in September 1985.

Even assuming, arguendo, that there was sufficient objective medical evidence to establish a worsened condition, there is no credible evidence of a causal relationship between the worsening and the original compensable injury. Both of claimant's doctors, as well as the majority, rely on claimant's history that her symptoms have persisted and worsened since closure of the original claim. However, because claimant is not credible, her history should not be relied upon as the sole basis for finding a causal relationship. Accordingly, I would not find such a relationship. Lacking the requisite elements of an aggravation, I would affirm the Referee's decision to uphold SAIF's aggravation denial.

Extent of Disability

Next, I consider claimant's contention that she is entitled to an unscheduled permanent disability award for the compensable back injury. The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). Claimant has the burden of proving by a preponderance of the evidence that she sustained a loss of earning capacity due to the compensable injury. See Hutcheson v. Weyerhaeuser, 288 Or 51, 55-56 (1979).

Claimant became medically stationary on May 3, 1985. On that date, she saw Dr. Simpson for chiropractic consultation. Simpson found no measurable impairment due to the injury, but recommended against heavy lifting due to a congenital sacralization of L5, which is unrelated to the injury. Simpson observed that greater-than-average pain sensitivity and "other functional factors" tend to magnify claimant's perception of low back symptoms. Dr. Koosman, claimant's treating chiropractor at that time, concurred with Simpson's report, noting that claimant has a slight degree of residual pain due to the injury.

After the Determination Order issued with no permanent disability award, claimant saw Drs. Breitenstein and Bussanich. Although both doctors concluded that there was impairment, I decline to accept their conclusions for the reasons discussed in my opinion on the aggravation issue.

Finally, both Drs. Struckman and Vigeland found no objective evidence to substantiate claimant's subjective complaints.

Absent objective evidence of physical impairment, I decline to rely, either directly or indirectly, on the subjective complaints of claimant, who is not credible. For that reason, I conclude that claimant has not sustained her burden of proving any loss of earning capacity due to the compensable injury. Accordingly, I would affirm the Referee's decision affirming the Determination Order awarding no permanent disability award.

ALFONSO ROGERS, Claimant
Peter O. Hansen, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-01109
November 30, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Neal's order that (1) upheld the self-insured employer's denial of claimant's medical services claim for child care expenses; (2) upheld a "de facto" denial of claimant's claim for attendant care services; and (3) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. We affirm.

ISSUES

On review, the issues are: (1) compensability of child care services while claimant was hospitalized; (2) compensability of attendant care during claimant's recuperation from surgery; and (3) penalties and attorney fees for an alleged unreasonable failure to process claimant's request for attendant care.

FINDINGS

Claimant was employed as a city transit bus driver. On May 10, 1979, he compensably injured his left arm and mid and lower back. Claimant has had extensive treatment, including several surgeries to repair his elbow. He also has ongoing pain syndrome and resulting mental difficulties.

Claimant is a single parent of a 16 year old son. The son was born with physical handicaps, which have necessitated surgery and which make it difficult for him to walk.

Claimant is right-handed. He is able to do some household chores, simple cooking, shopping, and driving his son to school. He has trouble bathing, dressing himself or tying his shoes. His use of his left arm is severely limited.

In late 1986, claimant was scheduled for left elbow prosthesis surgery. On November 17, 1986, claimant wrote to the employer requesting child care payments for the minor son during this surgery and recuperation period. The employer had made similar payments during claimant's previous surgeries.

On November 19, 1986, Dr. Zimmerman, claimant's treating physician, sent a memo to the employer confirming claimant's surgery, and his need for child care benefits. A notation on this memo indicates that an advance of 9 days of child care amounting to \$225.00 was authorized. The evidence is unclear whether it was actually paid.

Claimant had surgery on December 2, 1986. On December 22, 1987, he wrote to the employer that he had not yet received the child care benefits, and again requested payment.

On January 8, 1987, the employer denied the request for child care benefits as not a compensable part of his May 1979 claim.

On February 26, 1987, claimant's attorney asked Dr. Zimmerman to provide claimant the necessary medical authorization for attendant care while claimant was recovering

from surgery. He informed Dr. Zimmerman that it was necessary to verify that the attendant care was related to the compensable injury, and was reasonable and necessary.

On March 11, 1987, Dr. Zimmerman reported that claimant was recovering from elbow surgery, and that if the surgery were to be successful, claimant should not use the left arm for anything but minimal activities. Requesting permission to refer claimant to a pain center, Dr. Zimmerman opined that claimant was unable to do his housework because of the pain in his elbow "without an attendant to help him with his handicapped child. . ."

On April 20, 1987, claimant requested attendant care as authorized by Dr. Zimmerman. On April 21, 1987, claimant was notified that he was being referred to the Pain Center for evaluation. Thereafter, he requested child care payments for the time he entered the Pain Center. Other than the January 8, 1987 denial, claimant received no other denial of his requests for child care and attendant care services.

CONCLUSIONS OF LAW AND OPINION

Claimant first contends that he is entitled to child care expenses. Claimant relies upon Bauman v. SAIF, 295 Or 778 (1983), and upon the fact that child care benefits were provided for past surgeries. We disagree.

Bauman deals with denials of claims for conditions which were previously specifically accepted. It does not apply to partial denials of continuing medical services. Clyde C. Wyant, 36 Van Natta 1067 (1984). Furthermore, the Court of Appeals has ruled that child care expenses are not "other related services" within the meaning of ORS 656.245. Lorenzen v. SAIF, 79 Or App 751, rev den 301 Or 667 (1986). The employer may provide a benefit which it is otherwise not required to provide. That past generosity does not create a future entitlement which the claimant can enforce. Claimant is not entitled to child care benefits.

Claimant next contends that he is entitled to attendant care under ORS 656.245. The statute authorizes payment for attendant care. However, we have held that claims must be "sufficient to give reasonable notice that claimant is requesting [further medical services] for conditions resulting from claimant's injury or disease." See, Douglas Dooley, 35 Van Natta 125 (1983). By logical extension, the notice should also be sufficient to give reasonable notice that compensable services are being sought.

Claimant's April 20, 1987 letter to the employer asking for attendant care refers to Dr. Zimmerman's letter of authorization. That letter from Dr. Zimmerman authorizes an attendant to help claimant with his handicapped child, which the employer had previously denied. The letter also states that claimant should not use his left arm, but does not indicate that claimant himself needs personal attendant care.

We find that claimant's April 20, 1987 letter did not provide the employer with reasonable notice that he was requesting personal attendant care, as opposed to the child care assistance he had previously requested. Therefore, we conclude that the employer's failure to process what appeared to be a previously denied claim was not unreasonable.

Claimant requests that we reverse the employer's "de facto" denial of attendant care services. He contends that the evidence supports his need for a personal attendant following his surgery. We disagree. Claimant testified that he could not perform his personal and household tasks. However, there is no medical evidence stating a need for personal attendant care; Dr. Zimmerman authorized child care only. Furthermore, the factual evidence appears to be that claimant did, in fact, get by without attendant care. Claimant has failed to prove his need for medical services in the form of personal attendant care.

Claimant's final contention is that he is entitled to penalties and attorney fees for the employer's alleged unreasonable failure to process his request for attendant care. Because we find that it was not unreasonable for the employer to fail to respond, claimant's request for penalties and attorney fees is moot.

ORDER

The Referee's order dated July 24, 1987 is affirmed.

RONALD L. MAY, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 88-0589M
December 1, 1988
Denial of Consent to Issuance of
Order Designating a Paying Agent
(ORS 656.307)

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the employers/insurers have provided their written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1976 injury claim have expired. Thus, that claim is subject to ORS 656.278.

Pursuant to OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent, if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. id.

The record fails to establish that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, claimant would not be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition.

Because the Board presently lacks Own Motion jurisdiction to award temporary disability compensation, it is without authority to consent to an order designating a paying agent. However, since responsibility for claimant's current condition is the only issue

in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. See OAR 436-60-180(14).

CARL W. BENNETT, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Williams, et al., Defense Attorneys

WCB 85-01558
December 2, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee Podnar's Order on Remand which granted claimant an award of permanent total disability for his September 9, 1982 back injury. The issue on review is whether claimant is entitled to an award of permanent total disability in connection with his September 9, 1982 back injury claim. We affirm.

FINDINGS OF FACT

Claimant injured his low back on September 9, 1982 as a result of his work as a truck driver for P.I.E./Ryder Transportation Services (hereinafter P.I.E.). The injury occurred when claimant ran into a power pole in the course of trying to avoid being hit by another truck (Ex. 3 Page 1 and Ex. 4).

Claimant injured his low back in the early 1970's and again in 1978. He completely recovered from these injuries and had no low back problems prior to September 9, 1982 (Ex. 12 Page 2, Ex 34 Page 4, and Tr. #1, Page 32).¹

Since his September 1982 work injury claimant has received conservative treatment for his low back, the diagnoses of which include lumbar strain/sprain and degenerative disc disease of the L4-5 and L5-S1 levels with bulging discs (Ex. 12 Page 4, Ex. 34, Page 6, Ex. 37 Page 3, and Ex. 44 Page 4). The degenerative disc disease preexisted claimant's September 1982 work injury, but was asymptomatic. Claimant's September 1982 injury aggravated the degenerative disc disease and made it permanently symptomatic.

Apart from his low back problems claimant has numerous other medical problems, none of which was caused or worsened by his September 1982 work injury: psoriasis, arthritis in the elbows and knees, sexual dysfunction, partial hearing loss, peripheral neuropathy, hypertension, and cardiac problems involving arrhythmia and angina. The psoriasis, elbow/knee arthritis, and sexual dysfunction problems are not disabling. The hearing loss, peripheral neuropathy, hypertension and cardiac problems each contribute to claimant's overall physical disability to some degree. The hearing loss disability has arisen since claimant's September 1982 injury. Said injury did not cause or contribute to the hearing disability. The peripheral neuropathy, hypertension and cardiac problems are all conditions which preexisted the September 1982 injury but which did not become symptomatic until after the injury. Claimant's September 1982 injury did not worsen these underlying conditions nor did said injury cause them to become symptomatic. None of the above referenced conditions has prevented claimant's injury-related back condition from

¹ The transcript of the September 24, 1985 hearing will hereinafter be referred to as Transcript #1, and the transcript of the February 9, 1987 hearing will be referred to as Transcript #2.

healing or interfered with the treatment of claimant's injury-related back condition.

Claimant returned to work as a truck driver for PIE in February 1983. He continued working in said capacity until November 1983, at which time he stopped working because he could no longer endure the resulting low back pain (Tr. #1 Pages 11 and 25). He has not worked or looked for work anywhere since then. He currently receives a monthly union pension and social security disability benefits (Tr. #2 Page 32).

Claimant's September 1982 back injury claim was first closed by a July 5, 1983 Determination Order. The claim was reopened thereafter and then closed again by a January 28, 1985 Determination Order. Claimant has been awarded temporary total disability from September 9, 1982 through February 13, 1983, November 9, 1983 through January 7, 1985, and a total of 30 percent unscheduled permanent partial disability for his low back (Exs. 20 and 40).

Claimant received vocational rehabilitation evaluation services in early 1984. No job search services were provided and no vocational retraining program was proposed (Exs. 30 and 31).

As a result of his September 1982 low back injury claimant has constant low back pain and substantial permanent activity limitations: he is limited to only very light lifting/carrying, no repetitive bending, and he can only sit, stand or walk for short periods of time before needing to rest/change positions.

Claimant was 62 at the time of the last hearing in this matter in February 1987. He has completed the 12th grade. He has no other education or training. He has worked as a truck driver for about 30 years. His only other past work experience has been as a farm laborer. His permanent low back impairment precludes his return to the work he has done in the past. He has no transferable vocational skills (Ex. 30 Pages 2 and 4 and Tr. #1 Pages 10-11).

Claimant requires vocational retraining in order to be employable (Ex. 30 Page 4). Looking for gainful employment without such retraining would be futile. Claimant has not unreasonably refused any offered vocational retraining program.

FINDINGS OF ULTIMATE FACT

As a result of his September 1982 injury claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

OPINION AND CONCLUSIONS

In order to establish his entitlement to permanent total disability claimant must prove by a preponderance of the evidence that as a result of his September 1982 injury, including consideration of any preexisting disability, he has become permanently incapacitated from regularly performing work at a gainful and suitable occupation. See ORS 656.206 (1)(a). Permanent total disability can be based upon total physical incapacity or less-than-total incapacity which, combined with such nonmedical factors as age, education, training, and work experience, renders the claimant unable to perform gainful work. See Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

The evidence in the record establishes that claimant has a

number of medical conditions apart from his low back problems: psoriasis, arthritis in the elbows and knees, sexual dysfunction, partial hearing loss, peripheral neuropathy, hypertension, and cardiac problems involving arrhythmia and angina. The medical evidence in the record does not establish that these conditions are causally related to claimant's September 1982 back injury. The question is whether any of these conditions can nevertheless be considered in assessing claimant's entitlement to permanent total disability.

Claimant credibly testified that his psoriasis condition and his arthritis in his elbows and knees do not disable him in any way at present (Tr. #2 Pages 33, 35 and 36). The only evidence in the record that even suggests that claimant's sexual dysfunction problem is disabling is a comment in the January 7, 1985 report of Dr. Leo Freiermuth, claimant's treating physician (Ex. 39). Therein Dr. Freiermuth implied that claimant's sexual dysfunction contributes to his disability. However, he did not explain in what way said problem actually disables claimant from performing any particular type of work. We find that the evidence in the record fails to establish that claimant's sexual dysfunction problem is disabling. Nor does the evidence establish that claimant's psoriasis, elbow/knee arthritis, or sexual dysfunction problems have prevented his injury-related back condition from healing or have interfered with treatment for the injury-related back condition. See Waremart v. White, 85 Or App 122, 126-127 (1987). Therefore, there is no basis for considering any of these medical problems in assessing claimant's entitlement to permanent total disability.

Claimant credibly testified that he has some difficulty hearing: he has to turn up his television set a little higher and he has problems hearing over the telephone. According to his testimony, this problem has arisen since his injury (Tr. #1 Page 18). There is no evidence in the record that claimant's hearing problem is causally related to his 1982 back injury. Therefore, this problem cannot be considered in assessing his entitlement to permanent total disability. See Emmons v. SAIF, 34 Or App 603 (1978).

The evidence establishes that claimant's peripheral neuropathy, hypertension, and cardiac conditions probably preexisted his 1982 back injury, although they did not manifest themselves until after the injury (Ex. 3 Pages 6, 7, and 18, Ex. 9, Ex. 21, Ex. 25 Page 1, Ex. 34 Page 4, Tr. #1 Page 27, and Tr. #2 Pages 12, 14, 15, 16, 17, 27, and 28). These conditions, particularly claimant's cardiac problems, do contribute to some extent to claimant's overall disability (Ex. 34 Page 7, Ex. 39, and Tr. #2 Page 14 lines 17-25 and Page 24). The medical evidence in the record does not establish that these conditions are causally related to claimant's 1982 back injury. The only way that these conditions could be considered in assessing claimant's permanent total disability is if the evidence established that one or more of said conditions has prevented claimant's injury-related back condition from healing and/or has interfered with the treatment of the injury-related back condition. See Waremart v. White, supra at Pages 126-127. However, such is not established by the evidence in this record. Dr. Freiermuth was asked during his testimony if the condition that predated claimant's injury had any effect on claimant's ability to recover from his injury. He responded affirmatively (Tr. #2 Pages 12-13). However, his subsequent comments indicate that he was testifying with regard to claimant's preexisting degenerative back condition (Tr. #2 Page 13, lines 8-14). Even if Dr. Freiermuth's answer could be construed as referring to claimant's non-back preexisting conditions, he did not convincingly explain how

said conditions have prevented claimant's low back from healing or impeded the treatment of the low back. Dr. Freiermuth's only other comment with regard to this point concerned claimant's peripheral neuropathy. He was asked if that condition affected claimant's ability to deal with the effects of his 1982 injury. He responded that the neuropathy would perhaps add to "the difficulty" (Tr. #2 Page 14 lines 21-23). He did not clearly explain what he meant in this regard. He did not state that he believed that claimant's peripheral neuropathy affected his low back problems in terms of preventing the back from healing or interfering with treatment for the back.

Based upon the evidence presented and for the foregoing reasons, we find that the present disabling effects of claimant's peripheral neuropathy, hypertension and cardiac problems cannot be considered in assessing his entitlement to permanent total disability. What remains to be determined is claimant's low back impairment. We are persuaded from the evidence in this record that claimant has a very substantial degree of permanent impairment regarding his low back. More specifically, he is limited to only very light lifting/carrying, no repetitive bending, and he can only sit, walk or stand for short periods of time before needing to rest/change positions. We base this finding on claimant's credible testimony regarding his residual pain and limitations and on the medical evidence in the record, which generally describes claimant's residual physical capacity as being in the light-sedentary range at best (Ex. 34 Page 7, Ex. 37 Page 3, Ex. 44 Page 4, and Tr. #2 Page 18).

We are further persuaded that claimant's back-related impairment is all attributable to his 1982 work injury. According to the medical evidence in the record, claimant suffers from severe disc disease at the L4-5 and L5-S1 levels. Dr. Puziss, the orthopedic surgeon who evaluated claimant in July 1984, has opined that claimant's September 1982 work injury clearly aggravated his preexisting degenerative disc disease at the L4-5 and L5-S1 levels (Ex. 34 Page 6). The Orthopaedic Consultants panels have not opined to the contrary. Even if the medical evidence did not support a finding that claimant's 1982 injury worsened his degenerative disc disease condition itself, claimant's credible testimony -- and there is no contrary evidence in the record -- establishes that he was having no back problems and was working without any restrictions regarding his back prior to his September 1982 injury (Tr. #1 Page 32). The evidence in the record further establishes that the 1982 injury has, at the very least, produced symptoms regarding claimant's low back degenerative disc disease and that these ongoing symptoms are the basis for the substantial physical impairment that claimant has with respect to his low back. Claimant's loss of earning capacity as a result of such back symptoms is therefore compensable. See Barrett v. D & H Drywall, 300 Or 325 (1985), and 300 Or 553, 555-556 (1986).

The remaining question is whether claimant is employable considering his less-than-total, though very substantial, low back impairment combined with the pertinent nonmedical factors. Claimant's age, 62 at the time of the last hearing, is a significant negative factor. He has completed the 12th grade but has had no other education or training. Almost his entire work history has been as a truck driver and the only other work he has done has been as a farm laborer. His permanent low back impairment precludes his return to such past work. According to the only vocational rehabilitation counselor who has seen claimant, he has no transferable skills. Said counselor indicated in her May 1984 evaluation that claimant would need a retraining program in order to become employable. Whatever

claimant's employability prospects might be after retraining, they cannot be considered in assessing his present level of disability. See Gettman v. SAIF, 289 Or 609 (1980).

The employer contends that claimant has failed to satisfy ORS 656.206 (3) because he has not made reasonable efforts to seek work and has simply retired. Claimant did make an effort to return to work in 1983, but after working for several months he stopped because he could no longer endure the resulting low back pain. Since he stopped working in late 1983 he has not looked for work anywhere else. The evidence in the record indicates that he has in essence retired and has been receiving a union pension and social security disability benefits. However, we are not persuaded that these facts bar claimant from permanent total disability in this case. Where the evidence establishes that given the claimant's physical incapacity combined with the pertinent nonmedical factors it would be futile for him to seek work, his "retirement" from the work force/failure to seek work does not bar permanent total disability. See SAIF v. Scholl, 92 Or App 594 (1988); SAIF v. Simpson, 88 Or App 638, 641 (1987). We are persuaded that the evidence in this record reflects just such a situation. Considering claimant's substantial injury-related impairment, his age, educational level, work history, lack of any transferable vocational skills, and the indication in the record from the only vocational counselor who has seen him that he will require retraining in order to be employable, we are persuaded that it would have been an exercise in utter futility for claimant to look for gainful work after he stopped truck driving in late 1983. We note further that the evidence does not establish that claimant has unreasonably refused to undertake or complete any offered vocational retraining program designed to make him employable. See Taylor v. SAIF, 67 Or App 193 (1984).

Based upon our findings of fact and ultimate fact in this case and the applicable law and for the foregoing reasons, we conclude that claimant has established his entitlement to permanent total disability for his 1982 back injury.

ORDER

The Referee's April 14, 1987 Opinion and Order on Remand is affirmed. Claimant's attorney is awarded a reasonable fee for services on Board review in the amount of \$1,500, to be paid by the self-insured employer. A client-paid fee, not to exceed \$170, is approved.

ALLEN B. COOPER, Claimant
Francesconi & Cash, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-08226
December 2, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of Referee Shebley's order that set aside its denial of claimant's upper back condition and related chiropractic treatment. On review, the employer contends that the Referee erred in finding the claim compensable under a "new injury" theory not argued by claimant at hearing. If the Board agrees, claimant requests that it remand the case to the Referee for the taking of additional evidence.

We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant argued that his current back condition was compensable as either an aggravation of a 1983 injury or an occupational disease. The Referee rejected both theories and, instead, found the condition compensable on the basis of a "new injury" in January 1986.

On review, the employer contends that the Referee erred in finding the condition compensable as a "new injury." Specifically, it argues that the Referee was precluded from addressing the new injury theory because the employer had no opportunity or reason to present evidence on that issue. We disagree.

In reaching this decision, we are aware that a Referee's scope of review is properly limited to the "issues" raised by the parties at hearing. See Sylvia M. Ewy, 35 Van Natta 89 (1983). Cf. Russell v. A & D Terminals, 50 Or App 27 (1981); Mavis v. SAIF, 45 Or App 1059 (1980). However, the "new injury" theory underlying the Referee's ruling in this case was not a "new issue." Rather, it was an alternative legal theory on the compensability issue raised by claimant at hearing. Accordingly, the Referee's ruling was not beyond the proper scope of his review. Cf. Anita A. Bade, 36 Van Natta 1093 (1984) (new legal theory raised on Board review is not "new issue" and Board is free to address). Accord Margaret F. Blakeley, 38 Van Natta 515 (1986).

Furthermore, we are not persuaded that the employer has been prejudiced by the Referee's ruling. We note that evidence concerning the January 1986 "new injury" was submitted by both parties in regard to the occupational disease theory advanced by claimant. See Neely v. SAIF, 43 Or App 319 (1979).

ORDER

The Referee's order dated March 20, 1987, is affirmed. Claimant's attorney is awarded an assessed fee of \$500 for services on Board review, to be paid by the insurer. The Board approves a supplemental client-paid fee for the self-insured employer's attorney for services on Board review, not to exceed \$150.

SHARON P. FOWLER, Claimant
S. David Eves, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Acker, et al., Defense Attorneys

WCB 86-06727, 86-03417 & 86-13120
December 2, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of those portions of Referee Michael Johnson's order that: (1) set aside its denial of claimant's aggravation claim for neck and low back conditions; and (2) upheld Liberty Northwest Insurance Company's denial of claimant's "new injury" claim for the same condition. Liberty Northwest cross-requests review of those portions of the order that: (1) awarded an insurer-paid attorney fee for claimant's participation at the hearing on the issue of responsibility; and (2) failed to discuss payment of deposition costs. We affirm those portions of the order pertaining to

the issues of responsibility and attorney fees and modify that portion of the Referee's order that failed to address the issue of the deposition cost to the extent that the cost is assessed against Liberty Northwest.

ISSUES

1. Whether claimant sustained an aggravation of her compensable 1981 condition or a "new injury" to that same condition.
2. Whether claimant's attorney is entitled to a fee for his efforts in setting aside SAIF's responsibility denial. If so, whether SAIF or Liberty Northwest should be assessed the fee.
3. Whether SAIF or Liberty Northwest should pay for Dr. Gallant's November 6, 1986 deposition.

FINDINGS OF FACT

Responsibility

On December 10, 1981, claimant, a certified nurses' aide at the time, compensably injured her head, neck, right shoulder and low back when she fell down a stairway while working for SAIF's insured. Her condition was diagnosed as acute contusion and sprain of the cervical and lumbar spine. Over the next several months, she received conservative medical care from Drs. Abel, Serbu, Englander, Ott and Roy. On May 18, 1982, she returned to part-time work. On August 6, 1982, a Determination awarded her 10 percent (32 degrees) unscheduled permanent disability. On December 6, 1982, a stipulation increased that award to 15 percent (48 degrees) unscheduled disability for injury to her neck and low back.

In April 1983 claimant suffered an exacerbation of her compensable condition while working as a floral arranger. She saw Dr. Arbeene who authorized time loss. In June 1983 SAIF accepted the aggravation claim. In July and August 1983 claimant was treated for dorsal and lumbar pain. In August 1983 SAIF denied claimant's second aggravation claim and claimant did not appeal that denial. In November 1983 she was again treated for head and shoulder pain.

In April 1984 claimant suffered from a spontaneous increase in her cervical, thoracic and lumbar pain. Dr. Kauffman diagnosed significant functional overlay.

Although claimant did not seek medical treatment during the next year and a half, her cervical, thoracic and lumbar pain did not resolve.

In November 1985 claimant returned to Dr. Englander with intermittent neck discomfort and occasional low back pain. Dr. Englander diagnosed persistent cervical strain. Claimant had been working as an office manager and had not missed work as a result of that pain. On February 5, 1986, however, she returned to her previous occupation of nurses' aide, working swing shift for Liberty Northwest's insured. On February 13, 1986, she returned to Dr. Englander with increased neck and shoulder symptoms.

On the evening of February 13, 1986, claimant was pushed by a patient into a bedrail and nightstand, injuring her low back. She did not immediately report the incident because she did not feel that it

was serious. On February 14 and 18, 1986, claimant did not report to work due to the flu. On February 24, 1986, Dr. Gallant diagnosed marked cervical and upper thoracic sprain/strain with a large degree of spasm secondary to exacerbation of her preexisting condition. On February 26, 1986, claimant filed an injury report regarding the February 13, 1986 incident.

Through March and April 1986 claimant continued treating with Drs. Gallant and Englander. In July 1986 she was examined by Dr. Martens who diagnosed: (1) right low back contusion; (2) recurrent cervicothoracic strain; (3) minimal degenerative arthritis of the cervical and lumbosacral spine; and (4) moderate obesity.

On May 5, 1986, Liberty Northwest denied compensability and responsibility of claimant's back condition, stating that there was insufficient evidence to establish that claimant had sustained a new injury on February 13, 1986.

On September 10, 1986, SAIF denied responsibility for an aggravation of claimant's compensable 1981 condition, stating that information indicated that she had suffered a new injury while employed by Liberty Northwest's insured in February 1986. SAIF did not deny the compensability of claimant's current condition.

On October 7, 1986, the Workers' Compensation Department denied the designation of a paying agent pursuant to ORS 656.307 since Liberty Northwest had raised the compensability of claimant's claim as an issue.

The February 13, 1986 incident did not independently contribute to a worsening of claimant cervical, thoracic or lumbar condition.

Deposition

On July 30, 1986, Dr. Martens examined claimant and opined that she had suffered only a symptomatic worsening of her neck condition, but a worsening of her low back condition. On August 20, 1986, Dr. Gallant indicated that, despite a waxing and waning of symptoms since claimant's initial 1981 injury, the February 13, 1986 injury did worsen her underlying back condition. When SAIF sent Dr. Gallant a copy of Dr. Martens July 30, 1986 report, Dr. Gallant concurred with his conclusions. SAIF received that letter of concurrence on October 1, 1986.

On October 8, 1986, Liberty Northwest's counsel wrote separate letters to Drs. Martens and Gallant providing new medical information and posing numerous questions in an attempt to elicit contrary responses regarding the causation of claimant's condition.

On October 9, 1986, Drs. Martens and Gallant sent narrative reports to Liberty Northwest. Both doctors reversed their positions regarding the causation of claimant's low back condition. Liberty Northwest proposed to offer the two new letters at the October 13 hearing. The hearing was postponed to allow SAIF to cross examine the doctors. On November 6, 1986, Drs. Martens and Gallant were deposed.

Liberty Northwest's October 8, 1986 letter to Dr. Gallant was not an attempt to merely seek clarification of his August 20, 1986 narrative report; it was an attempt to elicit an entirely contrary opinion regarding the causation of claimant's condition.

CONCLUSIONS OF LAW

Responsibility

The Referee concluded that the February 13, 1986 incident constituted an aggravation of her compensable 1981 condition and therefore set aside SAIF's denial of responsibility for claimant's aggravation claim. We agree.

In an aggravation/new injury context, allocation of responsibility is dependent on whether claimant's present condition is a continuation of her original injury or the result of a subsequent incident that independently contributed to her 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 a 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); Wayne N. Gentry, 39 Van Natta 35 (1987).

The medical evidence unequivocally establishes a pattern of waxing and waning of neck and low back symptoms since the compensable 1981 injury. At no time prior to the February 13, 1986 incident did claimant become free of her neck and low back symptoms. Although claimant sustained a low back contusion as a result of being pushed by a patient into a bedrail and nightstand, her underlying chronic cervical and lumbar strain/sprain was not worsened.

In June 1986 Dr. Englander reported that claimant's only objective findings subsequent to the February 1986 incident included some spasm in the trapezius paraspinous muscles, greater on the right than the left. Although he believed that the 1986 nursing home incident contributed to claimant's need for medical treatment of her condition, Dr. Englander concluded that it did not worsen that condition.

In July 1986 Dr. Martens also opined that claimant's underlying neck condition had not worsened as a result of the 1986 incident. However, based on a faulty history of no prior low back pain provided by claimant, he further opined that claimant's minimal lumbar impairment was due to the 1986 injury. In August 1986 Dr. Gallant stated that the 1986 injury had resulted in a worsening of claimant's underlying back condition. Yet, when Liberty Northwest provided an accurate medical history to Drs. Martens and Gallant, their opinions regarding causation changed. Dr. Martens retracted his opinion that the 1986 incident had caused claimant's minimal lumbar impairment, while Dr. Gallant characterized claimant's lumbosacral condition as a recurrent injury in an individual who would be susceptible to recurrent injury because of the preexisting condition.

When we disregard the medical opinions which were based upon an erroneous medical history provided by claimant, the record establishes that the February 13, 1986 incident did not independently contribute to a worsening of her underlying condition. Consequently, we conclude that claimant suffered an aggravation of her compensable 1981 injury, for which SAIF remains responsible.

Attorney fee

The Referee stated that "but for" the compensability denial of Liberty Northwest, a .307 Order would have issued and claimant would not have required representation at hearing. Therefore, he concluded that Liberty Northwest was responsible for claimant's attorney fee. We agree.

Liberty Northwest's denial of compensability prevented the issuance of a .307 Order. Thus, responsibility was not the sole issue at hearing. Moreover, Liberty Northwest'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 participated. Consequently, she is entitled to an insurer-paid attorney's fee for services rendered at the hearing level. See 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. ORS 656.386(1). 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. Karen J. Bates, 39 Van Natta 42, 43 (1987), citing Ronald J. Broussard, 38 Van Natta 59, 61 (1986), aff'd mem. Western Employers Insurance v. Broussard, 82 Or App 550 (1986). The basic policy underlying Bates is to encourage carriers to seek or accede to the issuance of a .307 Order if they do not seriously contest the claimant's entitlement to receive compensation by holding out the prospect that they will be being required to pay claimant's attorney fee. Ronald L. Warner, 40 Van Natta 1082, 1194 (1988).

We agree with the Referee that SAIF is responsible for claimant's compensation. However, SAIF only denied responsibility for claimant's cervical and lumbar condition. It was Liberty Northwest's denial of compensability which prompted claimant's participation at the hearing. Under these circumstances, we find that Liberty Northwest is responsible for claimant's entire attorney fee award.

Deposition costs

The Referee did not address the issue regarding which carrier was responsible for Dr. Gallant's deposition costs. On review, we find that Liberty Northwest is responsible for the deposition costs.

As a general rule, deposition costs are the responsibility of the party whose witness is the subject of the deposition. Gregg C. Sorbets, 38 Van Natta 39, 40 (1986), citing Michael M. McGarry, 34 Van Natta 1520 (1980); see Hanna v. McGrew Bros. Sawmill, 44 Or App 189, 194-95, modified on other grounds, 45 Or App 757 (1980). A witness who appears by means of written reports, see e.g., ORS 656.210(2), is the witness of the party that first submits the report which gives rise to the deposition request. See Hanna v. McGrew Bros. Sawmill, supra, 44 Or App at 194-95; Michael M. McGarry, supra, 34 Van Natta at 1520.

In the present case, a deposition of Dr. Gallant, claimant's treating physician, was requested by SAIF. Prior to the deposition, however, SAIF had initially elicited a narrative report from Dr. Gallant. This initial report was followed by Liberty Northwest providing Dr. Gallant with additional medical information and attempting to produce a second report from him with a contrary opinion,

which he provided. As a result of that second report, SAIF deposed Dr. Gallant.

The question, therefore, is whose witness was Dr. Gallant for purposes of taking his deposition. We conclude that Liberty Northwest was not merely seeking to cross examine Dr. Gallant when it: (1) provided him with additional medical information; and (2) elicited a medical opinion regarding causation contrary to that opinion which SAIF had previously evoked from the doctor. Accordingly, SAIF's deposition of Dr. Gallant was a cross-examination of Liberty Northwest's witness and Liberty Northwest remained responsible for the cost of that deposition.

ORDER

The Referee's Order dated January 22, 1987 is affirmed in part and modified in part. That portion of the Referee's order that failed to address which carrier was responsible for Dr. Gallant's deposition cost is modified to the extent that Liberty Northwest is found responsible for that cost. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a reasonable assessed fee of \$300, to be paid by Liberty Northwest. A client-paid fee, payable from Liberty Northwest to its counsel, is approved, not to exceed \$45.

RALPH S. NUTTING, Claimant	WCB 87-05355
Welch, Bruun & Green, Claimant's Attorneys	December 2, 1988
Cummins, Cummins, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of that portion of Referee Leahy's order that set aside its partial denial of claimant's left low back and hip condition. Claimant moves for remand to consider additional evidence. We deny the motion and affirm the order.

ISSUES

The issues on review are remand and compensability of claimant's low back and hip condition.

FINDINGS OF FACT

Claimant, 63, sustained an injury to his left hip, left knee and left ankle on July 3, 1986. He was seen by his long-time treating physician, Dr. Norquist, at the hospital emergency room. Dr. Norquist diagnosed contusion and sprain of the left hip, knee and ankle, superimposed on extensive osteoarthritis. Claimant's ankle sprain apparently resolved quickly.

Dr. Norquist referred claimant to Dr. Blackstone regarding his knee sprain. Dr. Blackstone had seen claimant on referral prior to his injury because of complaints of left buttock pain. After the injury, however, Dr. Blackstone did not treat claimant for his hip or back pain. He treated only claimant's knee, for which he recommended arthroscopic surgery.

Claimant was examined by the Orthopaedic Consultants on October 8, 1986. They had a history which included Dr. Norquist's original injury diagnosis, as well as claimant's prior history of low back and buttock pain. Their x-rays revealed severe lumbar scoliosis, severe osteoarthritic changes of the lumbosacral facet, and moderately

severe osteoarthritis of both hips. They diagnosed acute internal derangement of the knee, and concurred in the proposal for arthroscopic surgery.

Arthroscopic surgery was performed on claimant's left knee on November 17, 1986. Claimant's knee pain largely resolved following surgery.

Just prior to his arthroscopic surgery, claimant's complaints of left hip pain increased. On February 18, 1987, he was examined by Dr. Hummel, neurologist. Dr. Hummel recommended a myelogram, which was conducted on March 3, 1987. The myelogram revealed extradural compression at L3-4 and L4-5 secondary to scoliosis and lumbar spondylosis, as well as gross degenerative disc disease from L2-S1 inclusive.

On March 9, 1987, Dr. Norquist, reported to the insurer that claimant's present back disability did not result from his July 3, 1986 injury.

On March 18, 1987, the insurer issued a partial denial of treatment and time loss for claimant's back condition. The denial was based on the medical information that the back and hip condition was due to claimant's preexisting severe degenerative arthritis and spinal stenosis.

On March 23, 1987, Dr. Norquist wrote to the insurer to clarify his March 9 report. He stated that claimant's disability resulted from an acute exacerbation of the preexisting condition, and that the preexisting condition had been asymptomatic prior to the July 3, 1986 injury.

Dr. Hummel wrote the insurer on April 2, 1987, saying he had "no knowledge of any 'preexisting condition'", but that it was clear to him that the described injury at least exacerbated any condition, if not in fact constituted a new injury.

Dr. Hummel performed surgery on June 5, 1987. He performed foraminotomies on L5-S1 left, a lateral gutter decompression, and bilateral lumbar decompression laminectomy on the same discs. Postoperatively, he reported that claimant had severe lumbar scoliosis and degenerative changes, with bony growth significantly compromising the exiting nerve roots.

Claimant was examined by Dr. Robert Rosenbaum, neurologist, on June 9, 1987. The history he gave Dr. Rosenbaum included only one episode of back or hip symptoms prior to his injury. Dr. Rosenbaum diagnosed S1 radiculopathy, and continuing nerve root impingement at least at L5-S1. He found claimant's condition unrelated to his accidental injury.

Hearing in this matter was held on June 15, 1987. On November 6, 1987, while this matter was pending before the Board, claimant filed a "Motion to Remand for Additional Evidence," that evidence being a September 1987 report from Dr. Thomas Rosenbaum, neurologist.

ULTIMATE FINDING OF FACT

Claimant suffered from preexisting conditions in his low back and left hip which were aggravated by his injury of July 3, 1986. The exacerbation of these preexisting conditions by the industrial accident is a material contributing cause of his present low back and hip conditions.

CONCLUSIONS OF LAW AND OPINION

We may remand if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). We may then remand only if the newly discovered evidence was not obtainable with due diligence prior to hearing. George T. Calawa, 38 Van Natta 1319 (1986). Here, the evidence sought to be admitted is a report from a consulting physician. It was generated after the hearing, but with due diligence could have been generated prior to hearing. We also note that this physician testified at the hearing, after examining claimant. We conclude that the record was not insufficiently developed. Claimant's motion to remand is denied.

Claimant alternatively asserted accidental injury and occupational disease in this claim. Generally, injuries are caused by identifiable, discrete events. In contrast, an occupational disease usually has a gradual onset, and its existence is often not perceived until after the time of affliction. Crowe v. Jeld-Wen, 77 Or App 81 (1985). In this case, claimant was injured by one discrete act when he twisted to catch a shifting load of veneer. The fact that he also suffered from preexisting spinal conditions does not change our conclusion that he suffered an injury, and not an occupational disease.

Claimant must, therefore, prove that the injury was a material contributing factor in his disability. Summit v. Weyerhaeuser, 25 Or App 851 (1976). Claimant had a history of low back and left hip symptoms, dating back to 1978 and reported regularly to Dr. Norquist since 1984. In April 1986, Dr. Blackstone diagnosed severe arthritis and scoliosis in claimant's low back. This diagnosis continued, with minor variations, through claimant's back surgery up to the date of hearing.

Claimant, however, was not disabled by his preexisting conditions. He had worked for this employer since 1979, at the same position, and had done this same job for a prior employer. It was not until the injury in July, 1986, that claimant was disabled.

Claimant's treating physician reported to the insurer in March 1987 that claimant's then-present back disability was not a result of his July 1986 injury. He then clarified his opinion, saying that the disability stemmed from acute exacerbation of claimant's preexisting asymptomatic condition. We agree. The insurer relies on the opinion of Dr. Rosenbaum who opined that claimant's injury has resolved and that his present condition is due to preexisting conditions. We agree that his preexisting conditions are now the main cause of his low back and hip conditions. However, it was the exacerbation of those preexisting conditions by an industrial accident that led to claimant's present state of disability. We find that claimant has sustained the burden of proof. Summit v. Weyerhaeuser, supra.

ORDER

The Referee's order dated June 19, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of \$500, to be paid by the insurer. A client-paid fee, not to exceed \$247.50, is approved.

SHARON A. OSWALD, Claimant
Noreen K. Saltveit, Claimant's Attorney
David Smith (SAIF), Defense Attorney
Reviewed by Board Members Johnson and Crider.

WCB 87-05405
December 2, 1988
Order on Review

Claimant requests review of Referee Lipton's order which upheld the SAIF Corporation's partial denial of claimant's right hip condition. The issue on review is the propriety of said denial.

FINDINGS OF FACT

From our review of the record we agree with and adopt the Referee's findings regarding the credibility and reliability of claimant and the other witnesses at the hearing.

On December 5, 1983, claimant filed a workers' compensation claim with her employer, SAIF's insured, alleging that she had injured her left ankle and right hip that day when she fell at work, twisting her left foot and landing on her right hip. On January 19, 1984, SAIF accepted the claim.

Subsequent to her December 1983 work injury claimant received conservative treatment and was evaluated by numerous physicians for pain complaints involving her lower back, right hip, and right leg. She continued working except for short periods in the winter of 1984, late summer of 1984, and winter of 1985. Her claim was closed by a July 11, 1985 Determination Order. She was awarded temporary disability compensation for the aforementioned periods when she was off work. In addition, she was awarded 5 percent (16 degrees) unscheduled permanent partial disability.

Following claim closure, claimant continued to experience pain in her low back, right hip and leg. She was treated conservatively.

In August 1986 claimant received, pursuant to a stipulation, an additional 10 percent (32 degrees) unscheduled permanent partial disability for her 1983 injury.

Claimant's right hip symptoms persisted thereafter. She saw Drs. Gritzka, Zimmerman, and Gavlick in early 1987 for her right hip complaints. Surgery was recommended: a Chiari osteotomy. SAIF thereafter denied the compensability, in connection with the 1983 injury claim, of claimant's right hip condition and the proposed surgery. The Chiari osteotomy was performed on March 16, 1987.

Claimant had a congenital dysplasia of the right hip with degenerative arthritis that preexisted her 1983 work injury. Her right hip first became symptomatic in about 1981. At that time she began limping to some extent and had some right hip discomfort when she was on her feet a lot. She received conservative medical treatment in the form of medication. Her right hip symptoms did not limit her activities, on or off the job, prior to her 1983 injury.

Claimant's right hip pathology did not worsen, due to either industrial or nonindustrial causes, from December 5, 1983 to early 1987. However, claimant's December 5, 1983 injury significantly worsened her right hip symptoms and said symptoms never returned to the preinjury level.

Claimant's March 1987 right hip surgery was performed in

order to give her pain relief and also to delay future progression of her right hip degenerative arthritis.

OPINION AND CONCLUSIONS

In order to establish the compensability of the March 19, 1987 right hip surgery and related treatment and disability claimant must show that the surgery was at least materially related to her December 1983 injury. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987); Jordan v. SAIF, 86 Or App 29, 32 (1987).

The evidence does not establish that from December 5, 1983 to early 1987 claimant's right hip pathology worsened at all, either due to work or nonwork sources. In this regard, we find nothing in any of the medical reports that contains any comparative assessment, in terms of x-rays or other objective evidence, of claimant's right hip pathology in 1983 vs. 1987. What the lay and medical evidence does establish is that although claimant did have some mild right hip symptoms prior to her 1983 work injury, the injury significantly worsened her right hip symptoms and her symptomatology has never returned to the preinjury level. Further, claimant's credible testimony and the reports of her treating surgeon, Dr. Zimmerman, and a consulting surgeon, Dr. Gavlick, establish that a material purpose of claimant's March 1987 right hip surgery was to provide symptom relief (Ex. 31, Ex. 33A, Page 3, and Tr., Page 18, Lines 23-25, Page 19, Lines 1-2, and Page 21, Lines 3-4).

We conclude that because claimant's 1983 work injury caused a significant worsening of her right hip symptoms which never returned to the preinjury level and because a material purpose of the 1987 right hip surgery was to provide symptom relief, said surgery is compensably related to claimant's 1983 work injury. Claimant is therefore entitled to have her expenses for the 1987 right hip surgery, and any related treatment and disability, paid by SAIF in connection with the 1983 injury claim.

ORDER

The Referee's order dated August 20, 1987 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded \$1,500 for services at the hearing level and \$600 for services on Board review, to be paid by the SAIF Corporation.

WILLIAM E. WILLINGHAM, Claimant
Galton, et al., Claimant's Attorneys
Paul Mackey, Defense Attorney
Norman Cole (SAIF), Defense Attorney

WCB 86-02793 & 86-00515
December 2, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Mulder's order that upheld the SAIF Corporation's denial of his occupational disease claims for lead poisoning, hearing loss and tinnitus. We reverse with regard to the lead poisoning claim and affirm with regard to the hearing loss and tinnitus claims.

ISSUES

1. Compensability of claimant's lead poisoning, hearing loss, and tinnitus claims.

(a) Whether claimant has proven by a preponderance of the evidence that he suffers from lead poisoning, the major contributing cause of which was his exposure to lead in the workplace.

(b) Whether claimant has proven that his work exposure to noise was the major contributing cause of his documented hearing loss and his tinnitus condition.

FINDINGS OF FACT

Claimant was employed as a scrap iron burner and laborer for more than four years. During that time, he was exposed to inhaled toxins including asbestos and lead. Claimant was also exposed to high noise levels. All exposures were with varying frequencies, exposure levels and durations. Claimant, for the most part, wore no respirator or other special clothing or protective devices. He sometimes wore earplugs. The employer has been cited several times for unsafe working conditions, primarily for failure to deal properly with employee exposure to asbestos.

Claimant left work with the employer in April, 1985, to begin work as a bridge painter on a seasonal basis. As a painter, he routinely worked with lead-based paints and was exposed to high noise levels. However, he wore a respirator and ear plugs while so employed. Claimant was laid off from this job after October, 1985.

In August, 1985, claimant became concerned about increasing problems with shortness of breath, productive cough, and wheezing. Claimant had other complaints including short-term memory loss, fatigue, increased sleep requirements and increased irritability. He also experienced a two-year history of tinnitus. In addition, he had a three-year history of nocturnal leg cramps. These leg cramps disappeared almost completely after claimant left his job with the employer and began work as a painter.

As a result of his health concerns, claimant was examined at the Occupational Health Clinic at the Oregon Health Sciences University (OHSU) on August 27, 1985 by Drs. Scott, Morton and Feldstein. During August and September, 1985, claimant underwent laboratory and clinical tests for possible asbestosis, hearing loss, tinnitus and lead intoxication. The laboratory data revealed elevated lead levels and a high-frequency hearing loss. Tests for asbestosis were negative.

In November, 1985, claimant submitted a claim to SAIF for "blood, leg cramps, memory loss." Under the "Describe Accident Fully" section of his claim form, claimant stated "[exposure] to high noise levels, asbestoses [sic], leaded paints, hazardous [sic] fumes from galvanized iron, lead, copper, lead painted steel - aluminum and other metals."

A summary report issued by Dr. Morton in December, 1985, indicated that claimant's level of stored lead in the body required no treatment.

On January 3, 1986, SAIF issued a denial of claimant's claim for "lung, hearing loss, blood, leg cramps, memory loss and asbestos exposure."

The hearing in this case was held in two sessions. The first session convened in December, 1986. In the process of preparing

for his testimony at hearing, Dr. Morton discovered that claimant's lead level had been incorrectly calculated in September, 1985. Properly calculated, claimant's lead level at the time was sufficiently high to warrant treatment. In January, 1987, after the first hearing session and prior to the second session, claimant was admitted to the hospital for treatment in the form of chelation which allows individuals to excrete excess levels of toxins from their systems. Treatment lasted approximately five days.

Claimant smokes one to one and one-half packs of cigarettes per day. He smokes marijuana two to three times per week. He consumes five to seven beers per week. Claimant served in the Navy from 1973 to 1976.

Claimant underwent an audiogram at OHSU on August 28, 1985. A second audiogram was administered by Dr. Hicks, audiologist, on February 28, 1986. Dr. Hicks' audiogram revealed normal hearing in the right ear with a slight high-frequency loss in the left ear.

FINDINGS OF ULTIMATE FACT

Claimant's exposure to lead fumes while at work was the major contributing cause of his elevated lead burden requiring medical services.

We are unable to find the claimant's exposure to high noise levels at work was the major contributing cause of his tinnitus condition or hearing loss.

CONCLUSIONS OF LAW AND OPINION

Lead Poisoning

To establish a compensable occupational disease, claimant has the burden of proving that his employment as a scrap metal burner and laborer was the major contributing cause of the onset or a pathological worsening of a condition requiring medical services or resulting in disability. See former ORS 656.802(1)(a); 656.804; former 656.005(8); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988).

Claimant argues on review that his work exposure to lead fumes resulted in elevated lead levels which, in turn, resulted in many of the symptoms he was experiencing in August, 1985. SAIF contends that claimant's "low amount of excess lead" resulted in no disability and required no medical services. Therefore, SAIF argues, a compensable occupational disease has not been proven. SAIF cites Brown v. SAIF Corporation, 79 Or App 205, 208 (1986), in support of its position.

We turn first to the question whether claimant's employment resulted in elevated lead levels. Tests conducted at OHSU in September, 1985 were initially interpreted as indicating a mild elevation. Dr. Morton subsequently testified that the data from those tests was improperly computed. Properly computed, the data indicated a sufficiently high lead level to require treatment. Dr. Morton also opined that claimant's employment as a scrap metal burner was likely the major contributing cause of his elevated lead level.

Claimant was examined by Dr. Bayer, who specializes in clinical toxicology, on March 3, 1986. He interpreted claimant's earlier tests as disclosing a blood lead level which was slightly

higher than the average population, but normal when compared with the average worker pursuant to OSHA guidelines. Dr. Morton challenged Dr. Bayer's distinction between the general population and the average worker as "an outdated concept" with "no medical validity." In addition, Dr. Bayer moved out-of-state prior to Dr. Morton's discovery regarding the incorrect computation of claimant's lead level in September, 1985.

We need not resolve the dispute between Drs. Morton and Bayer as to the validity of Dr. Bayer's normal population/average worker distinction. Regardless of the outcome of that dispute, both physicians agree that claimant's blood lead level was elevated beyond what would be expected in the absence of an occupational exposure. There is no evidence in the record of any off-work exposure to lead. Moreover, Dr. Morton's opinion that claimant's work exposure to lead fumes was the major contributing cause of that elevated lead condition is essentially undisputed.

SAIF does not deny that claimant's lead level was at least slightly elevated in 1985. Instead, SAIF argues that claimant's condition neither required medical services nor resulted in disability. See former ORS 656.005(8)(a). In this regard, SAIF argues that claimant's chelation treatment was not "required" and that all other medical services were diagnostic only. SAIF argues that a need for diagnostic services alone, without a need for medical treatment, is insufficient to establish a compensable claim.

We do not agree with SAIF that claimant's chelation treatment in January, 1987 was not "required" as that term is used in former ORS 656.005(8)(a). Dr. Morton was sufficiently concerned about claimant's elevated lead level that he referred him to the nephrology department at OHSU. Dr. McCarron, nephrologist, diagnosed chronic lead intoxication resulting from "a significant body lead burden." Claimant then underwent five days of hospitalization and treatment. We conclude that claimant underwent required medical treatment to deal with a work-related condition.

However, even assuming that claimant's chelation treatment was not "required" by his condition, claimant nevertheless underwent multiple diagnostic medical services to determine what was wrong with him. While SAIF contends that diagnostic services alone do not qualify as "required medical services" pursuant to former ORS 656.005(8)(a), we do not agree.

The Court of Appeals has recently addressed this question. In Finch v. Stayton Canning Co., 93 Or App 168 (1988), claimant suffered from a work-related carpal tunnel condition. Claimant received diagnostic services for her condition. No treatment was recommended. We concluded that claimant's claim was not compensable because her condition required only diagnostic services.

On review, the court reversed. The court first recited language from former ORS 656.005(8)(a) which defines a compensable injury as "an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability or death." The court then noted that former ORS 656.005(8)(a) makes no distinction between diagnosis and treatment. The court further noted that the fact that no treatment is available for an injury or disease does not mean that a claimant is not injured or sick. The court concluded that claimant's diagnostic medical services were compensable as they were required to determine what was wrong with her, even though no treatment was recommended. Id at 173.

The same analysis applies here. Claimant's employment exposure to lead fumes was the major contributing cause of his elevated lead level. Claimant underwent diagnostic medical services in order to determine that was wrong with him. Pursuant to the court's decision in Finch, supra, claimant's occupational disease claim for lead poisoning is compensable. See also Collins v. Hygenic Corp. of Oregon, 86 Or App 484 (1987).

Hearing Loss and Tinnitus

On January 29, 1986, Drs. Morton and Feldstein reported that it was likely that claimant's tinnitus and hearing loss were due to his exposure to high noise levels without protection while performing his job duties as a scrap metal worker. Dr. Morton reiterated this opinion at hearing.

Dr. Hicks disagreed. Based upon interpretation of the audiogram he administered, included his finding of a one-sided high frequency loss, he opined that claimant's hearing loss was more suggestive of specific acoustic trauma such as an intense blast of noise rather than the more continual noise exposure characteristic of an occupational setting such as claimant's. He theorized that claimant's exposure to weapons fire in the military was a more likely explanation of his hearing loss. In addition, he noted that claimant presented several high risk factors for tinnitus including drug or alcohol abuse and smoking of tobacco. He essentially concluded that it was not probable that claimant's work exposure was the major cause of his tinnitus complaints.

We find Dr. Hicks' opinions more persuasive on these issues. He is a specialist in evaluating hearing disorders. In addition, his explanation of the trauma-induced character of claimant's hearing loss is better reasoned than Dr. Morton's more cursory explanation of the causal connection between claimant's conditions and his work exposures. While he theorized that claimant's military exposures caused his hearing loss, we do not interpret his opinion as dependent on that theory. Moreover, we are not convinced by claimant's testimony that he was not exposed to noise while in the Navy.

It is claimant's burden to prove the compensability of his claim. See Williams v. SAIF, 22 Or App 350 (1975). The evidence on this question is, at most, in equipoise. Claimant has, therefore, failed to sustain his burden on this issue.

ORDER

The Referee's order, dated May 8, 1987, is reversed in part and affirmed in part. That portion of the Referee's order that upheld the SAIF Corporation's denial of claimant's lead poisoning claim is reversed. Claimant's lead poisoning claim is remanded to SAIF for acceptance and processing in accordance with law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of \$1,800 for services provided at hearing and on review in prevailing on the lead poisoning issue, payable by the SAIF Corporation.

BARBARA J. BATCHELOR, Claimant
Minturn, et al., Claimant's Attorneys
Richard Barber (SAIF), Defense Attorney

WCB 86-12101
February 9, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The SAIF Corporation requests review of that portion of Referee Gruber's order that set aside its denial of claimant's industrial injury claim relating to her low back. Claimant cross-requests review of those portions of the order that: (1) rejected her request for interim compensation; (2) rejected her request for temporary disability compensation; and (3) rejected her request for penalties and attorney fees for SAIF's allegedly unreasonable failure to pay interim compensation or temporary disability compensation. The issues are compensability, interim compensation, temporary disability compensation, penalties and attorney fees.

The Board affirms the order of the Referee with the exception of that portion of the order which held that claimant was not entitled to temporary disability compensation because she was not entitled to interim compensation. We agree with the Referee that claimant was not entitled to interim compensation because SAIF did not receive notice of a potentially work-related injury resulting in disability until after claimant had recovered from the acute phase of her injury and had reported for regular work. ORS 656.005(6) (formerly subsection (7)); Donna J. Halsey, 39 Van Natta 116, 117-18 (1987); see Bono v. SAIF, 298 Or 405, 409-10 (1984). Now that the claim has been found compensable, however, the fact that claimant was not entitled to interim compensation does not preclude her from receiving temporary disability compensation for any period during which she was disabled due to the compensable injury. See Silsby v. SAIF, 39 Or App 555, 560-62 (1979); see Kosanke v. SAIF, 41 Or App 17, 21 n.2 (1979). Whether and to what extent claimant may be entitled to temporary disability compensation is, at this point, a claims processing matter for SAIF, see ORS 656.268, and thus will not be addressed by the Board.

ORDER

The Referee's order dated March 12, 1987, as supplemented by the order dated March 26, 1987, is reversed in part. That portion of the order that held that claimant was not entitled to temporary disability compensation is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded \$500 for services on Board review on the denial issue, to be paid by SAIF Corporation, as well as 25 percent of the temporary disability compensation which may accrue to claimant as a result of this order, not to exceed \$100.

BLYTHE A. CHESSELET, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Kate Donnelly (SAIF), Defense Attorney

WCB 86-15161
December 7, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of those portions of Referee Foster's order that: (1) increased claimant's unscheduled permanent disability award for a left flank injury from 5 percent (16 degrees), as awarded by a Determination Order, to 25 percent (80 degrees); and (2) assessed penalties and attorney fees for SAIF's

alleged unreasonable termination of temporary disability benefits. Claimant cross-requests review of those portions of the Referee's order that: (1) declined to award additional temporary disability beyond that awarded by a Determination Order; and (2) declined to assess penalties and attorney fees for SAIF's failure to earlier commence payment of temporary disability benefits. We affirm, modify, and reverse.

ISSUES

1. Extent of unscheduled permanent disability.
2. Extent of temporary disability.
3. Penalties and attorney fees for untimely commencement of temporary disability benefits.
4. Penalties and attorney fees for unilateral termination of temporary disability benefits.

FINDINGS OF FACT

Claimant was compensably injured in May 1985 while employed as a choker setter when he was struck in the side by a log. He subsequently experienced flank pain and hematuria, or blood in the urine.

Claimant was off work for more than one month following the accident. He then returned to work for the next six months, although he continued to experience left flank pain and hematuria.

In December 1985, he suffered a compensable right wrist injury. Dr. Mann, orthopedic surgeon, operated on claimant's wrist on January 17, 1986. He was off work as a result of this injury until March 1986.

On March 3, 1986, claimant was released to return to his regular work by Dr. Mann. He returned to work, but left either that same day or the following day for reasons unrelated to either injury.

Claimant appeared at the hospital emergency room on June 10, 1986, with complaints of severe flank pain. The following day, Dr. Purvis, his treating nephrologist, noted that claimant's condition was becoming more urgent. He repeated a prior recommendation for diagnostic surgery in the form of a renal biopsy.

SAIF authorized the surgery which was performed on August 14, 1986. The results of the biopsy were essentially normal.

Dr. Purvis reexamined claimant on September 8, 1986. He found claimant to be medically stationary. He cautioned against very heavy work.

In September 1986, SAIF reopened the claim to pay time loss from August 14 to August 21, 1986.

In October 1986, Dr. Purvis completed a release-from-work form retroactively releasing claimant from work for the period August 14 through August 21, 1986.

An October 20, 1986 Determination Order awarded claimant 5 percent unscheduled permanent partial disability and temporary

disability benefits for the period from May 9, 1985 through June 16, 1986. This order was amended ten days later by a Determination Order which awarded additional temporary benefits for the one-week period in August 1986 when claimant was recovering from the renal biopsy.

Claimant was 29 years old as of the date of hearing. He has completed the eighth grade in school and has obtained a GED. He was a sergeant in the army where he was a tank commander and supervised a motor pool. His primary vocational experiences have involved auto mechanics and medium-to-heavy employment in the woods.

As of the date of hearing, claimant had not returned to his at-injury employment. He had, however, performed work for an insurance company and as a part-time surveyor on an irregular basis. Since leaving his employment, he has applied for several jobs but received no job offers. These jobs were primarily in the field of automobile services.

Since his injury, claimant has gone hunting, has cut down trees with a chain saw, and has taken part in at least one boxing competition. He takes nonprescription pain medication. Excessive walking and driving long distances result in increased pain. He is now unable to perform very heavy labor. His impairment as a result of his compensable injury is in the mild range.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury or condition. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury 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, 269 (1982).

Due to his compensable injury, claimant is unable to perform very heavy physical labor. This precludes him from performing his at-injury job duties. However, he retains the ability to perform medium-to-heavy work. He is, therefore, capable of performing a variety of auto service-type jobs for which he has training. His limited educational background adversely affects his earning capacity. However, his relative youth is a moderately positive factor. After considering these factors, along with his mild impairment, we conclude that the 25 percent (80 degrees) unscheduled permanent partial disability awarded by the Referee appropriately compensates claimant for his compensable injury.

Temporary Disability Issues

The Referee found that, procedurally, SAIF should have continued to pay temporary disability benefits from August 21, 1986 until issuance of the October 30, 1986 Determination Order. However, the Referee further found that claimant was not substantively entitled to temporary benefits during that time. He, therefore, ordered SAIF to make payment of temporary benefits for the period from August 21, 1986 to October 30, 1986, but then allowed an offset of that payment against the increased permanent disability awarded in his order. He

also assessed a penalty and associated attorney fee against SAIF for unilaterally terminating payment of temporary benefits as of August 20, 1986.

On review, SAIF argues that claimant was released to return to work by Dr. Purvis as of August 21, 1986, and, therefore, that SAIF properly terminated his benefits as of that date. Claimant, on the other hand, contends that he was entitled to temporary benefits from June 11, 1986, the date upon which Dr. Purvis reported that his condition was becoming "more urgent" and again recommended diagnostic surgery, through September 8, 1986, the date on which Dr. Purvis found claimant to be medically stationary. Claimant further argues that SAIF's failure to commence payment of temporary benefits as of June 11, 1986 was unreasonable and, therefore, subject to assessment of a penalty and associated attorney fee pursuant to ORS 656.262(10).

We first examine claimant's substantive entitlement to temporary benefits commencing June 11, 1986. Whether claimant is entitled to temporary total disability commencing June 11, 1986 depends on whether the evidence shows that he was disabled as of that date due to the compensable claim. ORS 656.210; Botefur v. City of Creswell, 84 Or App 627 (1987). In this regard, claimant relies upon Dr. Purvis' June 11, 1986 letter to support his claim to entitlement. Dr. Purvis noted that claimant had been seen the night before at a hospital emergency room for "severe left flank pain." Dr. Purvis determined that "the situation [was] becoming more urgent in trying to get to the diagnosis and determine the causality of his problem and the appropriate treatment." He repeated a prior recommendation that a renal biopsy be performed.

SAIF argues that Dr. Mann released claimant to return to his regular work as of March 3, 1986, that claimant merely suffered a short-term, temporary flare-up of his symptoms on June 10, 1986, and that there is no evidence that claimant's condition worsened subsequent to Dr. Mann's release to return to work.

However, Dr. Mann was treating claimant for his right wrist injury. Consequently, his March 3, 1986 return-to-work release is directed to claimant's wrist problem and not his flank complaints. Moreover, a physician's release to return to regular work does not conclusively establish that claimant is able to return to his regular work. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 (1988). Here, subsequent to his June 11, 1986 letter, Dr. Purvis cautioned claimant against very heavy work. In December 1986, he rejected a choker setter job description as "too heavy." In February 1987, he reported that he had not released claimant to his at-injury employment. There is no indication in the record of a worsening of claimant's condition between June 11, 1986 and these later pronouncements. We conclude that claimant was disabled from performing his regular job as a choker setter as of June 11, 1986. Therefore, he is entitled to temporary disability benefits as of that date.

We next address claimant's argument that SAIF's failure to commence payment of temporary benefits as of June 11, 1986 was unreasonable and, consequently, warrants assessment of a penalty and associated attorney fee pursuant to ORS 656.262(10). Following his compensable injury, claimant returned to work. He continued to work at his regular job until December 1985 when he injured his wrist. After surgery and a period of convalescence, claimant was released to return to his regular work on March 3, 1986. He returned to work for

only a day or two before leaving work for reasons unrelated to his injury. In April 1986, he took part in a local boxing competition. In May 1986, Dr. Purvis reported that he was unconvinced that claimant's persistent hematuria was related to his compensable injury. He recommended a renal biopsy and stated that if the biopsy disclosed normal renal function, then he doubted that any other therapy would be provided. His June 11, 1986 report did not expressly state that claimant was unable to perform his regular job duties. Moreover, he expressed uncertainty as to whether claimant's continuing problems were related to his compensable injury.

SAIF authorized the requested biopsy. We have determined, based upon our retrospective examination of the medical record, that claimant was entitled to temporary benefits commencing June 11, 1986. However, under these circumstances, we find that SAIF's failure to commence payment of temporary benefits as of that date was not unreasonable. Consequently, imposition of a penalty and associated attorney fee is not warranted.

We next consider whether SAIF properly terminated claimant's temporary benefits as of August 21, 1986. SAIF argues in this regard that Dr. Purvis' October 3, 1986 retroactive authorization of time loss from August 14 to August 21, 1986 indicates, by negative inference, that Dr. Purvis released claimant to regular work subsequent to August 21, 1986. Claimant contends that SAIF's interpretation of Dr. Purvis' report is incorrect. However, we need not resolve this question because SAIF's legal premise that it may unilaterally terminate benefits as of the date claimant is released to return to regular work is incorrect.

The court recently held in Fazzolari v. United Beer Distributors, supra, that ORS 656.268 does not permit unilateral termination of temporary total disability benefits unless the claimant is both released for work and medically stationary. 91 Or App at 595. The record is clear that Dr. Purvis did not find claimant to be medically stationary until September 8, 1986. Therefore, pursuant to the court's holding in Fazzolari, supra, SAIF could not terminate payment of temporary benefits until that date.

The Referee assessed a penalty and attorney fee for SAIF's unilateral termination of time loss as of August 21, 1986. SAIF argues that its conduct was not unreasonable. We agree. We note in this regard that the court's decision in Fazzolari, supra, was not issued until June 22, 1988, well after SAIF's alleged unreasonable conduct. Prior to that date, we had consistently interpreted the Supreme Court's decision in Jackson v. SAIF, 7 Or App 109 (1971), to permit unilateral termination of temporary disability benefits where claimant had either returned to regular work or had been released to return to regular work. We had not required, as Fazzolari does, that claimant also be found to be medically stationary prior to termination of temporary benefits. See, e.g., David E. Noble, 39 Van Natta 1035, 1036 (1987). Moreover, it was only upon review of Dr. Purvis' subsequent reports that we have determined that claimant was unable to return to his choker setter duties during the period in question. Consequently, SAIF's belief at the time that claimant was only disabled from regular work during the period of convalescence from his biopsy was reasonable.

The Referee determined that SAIF was entitled to an offset of overpaid temporary disability from August 21, 1986 to October 30, 1986. We agree that an offset is appropriate. However, in accordance

with our decision herein, the authorized offset will be reduced to include only the period from the September 8, 1986 medically stationary date to October 30, 1986.

ORDER

The Referee's order dated May 20, 1987 is affirmed in part, reversed in part, and modified in part. In lieu of the Referee's award of temporary total disability benefits, claimant is awarded temporary total disability from June 11, 1986 through August 13, 1986 and from August 21, 1986 through September 7, 1986. Claimant's attorney is awarded 25 percent of the increased temporary disability compensation awarded herein, payable out of compensation, not to exceed \$3,800. The Referee's permanent partial disability award is affirmed. The SAIF Corporation is authorized to offset overpaid temporary disability compensation for the period from September 8, 1986 through October 10, 1986, against the increased permanent partial disability awarded by the Referee. The Referee's award of a penalty and attorney fee for SAIF's alleged unreasonable termination of temporary disability is reversed. Claimant's attorney is awarded an assessed fee of \$850, to be paid by SAIF, for prevailing on the extent of permanent partial disability issue on Board review.

JAMES A. COOPER, Claimant
Hayner, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB TP-87022
December 7, 1988
Order Withdrawing Abatement Order

On November 15, 1988, we abated our Third Party Order dated September 29, 1988, as amended October 19, 1988, to consider claimant's request for reconsideration. It has come to our attention that, on November 1, 1988, the paying agency filed a petition for judicial review of our September 29, 1988 order, as amended.

Jurisdiction to consider this matter vested with the Court of Appeals upon the filing of claimant's appeal. Inasmuch as claimant had perfected her appeal prior to the issuance of our abatement order, our November 15, 1988 order is a nullity.

We have previously held that it is possible to withdraw an order after the filing of a petition for judicial review. Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Under these circumstances, we decline to withdraw our September 29, 1988 Third Party Order, as amended. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

GLEN L. EDENS, Claimant
Francesconi & Cash, Claimant's Attorneys
Dan Steelhammer (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 84-07667, 82-09893, 82-09894
& 84-10890
December 7, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of those portions of Referee Baker's order that: (1) set aside its denial of claimant's low back and right sacroiliac conditions and (2) directed it to pay claimant's attorney a total fee of \$3,000 in connection with its denial of claimant's low back and sacroiliac conditions and its denial of a psychological condition which was the subject of a disputed claim settlement pending Board review. We affirm with the following exception.

ISSUES

1. Responsibility for claimant's low back condition.
2. Whether claimant's attorney is entitled to a carrier-paid fee in connection with SAIF's denial of claimant's low back and sacroiliac conditions.

FINDINGS OF FACT

Claimant injured both of his knees in the late 1970's in the course of his employment as a warehouse worker with a company insured by Fremont Indemnity Company (Fremont). Fremont accepted and processed claimant's claims for these injuries. In early 1983, claimant began to experience low back and left sacroiliac pain as a result of the altered gait associated with his knee injuries. X-rays taken in June 1983 showed a grade I spondylolisthesis at L5-S1.

In August 1983, claimant began receiving vocational assistance from the Vocational Rehabilitation Division of the Department of Human Resources in connection with his knee injuries. The vocational counselor noted that claimant had worked on a volunteer basis for the Umatilla County Sheriff's Office for several years and exhibited a strong interest in law enforcement. The counselor began to develop a authorized training program (ATP) for claimant in this area.

Before the ATP was finalized, claimant was hired as an auxiliary officer by the Umatilla County Sheriff's Office for a four-day period during the Pendleton Roundup. The Sheriff's Office was insured by SAIF. During claimant's first shift in this position on September 15, 1983, the patrol car in which he was a passenger was involved in a high speed chase, failed to negotiate a "T" intersection and flipped end over end several times. Claimant sustained a compression fracture of T12. Ever since that injury, claimant has experienced pain in his mid-back and hips and increased pain in his low back. (See Tr. 29-30, 34, 37-38, 40-41, 48-49, 51-52).

After an initial recovery period following the September 1983 patrol car accident, claimant proceeded with his ATP in law enforcement under the knee claims. As part of the ATP, claimant began training at a police academy in April 1984. Within a couple of weeks of beginning this training, claimant experienced disabling low back and right sacroiliac pain. The pain was associated with claimant's increased physical activity at the police academy, but not with any particular traumatic event.

In July 1984, SAIF issued a denial of responsibility for claimant's low back and sacroiliac episode and immediately requested that the Workers' Compensation Department issue an order pursuant to former ORS 656.307. Fremont joined in this request a few days later and a .307 order was issued on July 18, 1984. SAIF later issued a partial denial of a psychological condition which claimant claimed was related to his September 1983 injury.

At the beginning of the hearing, both SAIF and Fremont indicated that they would contest the compensability of claimant's low back and sacroiliac conditions as well as responsibility. The Referee held claimant's conditions compensable and assigned responsibility to SAIF. He also set aside SAIF's partial denial of claimant's psychological condition. He assessed a single attorney fee of \$3,000 payable by SAIF in connection with the low back, sacroiliac and psychological denials. SAIF requested Board review on the responsibility and attorney fee issues.

Pending Board review, claimant and SAIF entered into a disputed claim settlement regarding claimant's psychological condition. As part of that agreement, claimant and SAIF allocated half of the \$3,000 attorney fee assessed by the Referee to the psychological denial and the other half to the denial of the low back and sacroiliac conditions.

ULTIMATE FINDINGS OF FACT

1. Claimant's September 1983 accident materially worsened his underlying low back and right sacroiliac conditions. Claimant's activity at the police academy in April 1984 did not worsen his underlying low back and right sacroiliac conditions.

2. The compensability of claimant's low back and sacroiliac conditions was at issue at the hearing.

CONCLUSIONS OF LAW

Responsibility

Responsibility in successive injury cases is governed by the "last injurious exposure rule." Champion International v. Castilleja, 91 Or App 556, 560 (1988). Under that rule, the last carrier whose employment materially contributed to a worsening of the claimant's underlying condition is liable for the whole condition. Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986).

Two medical professionals gave opinions relevant to the responsibility issue. Dr. Weeks, claimant's treating orthopedic surgeon, and Dr. Newby, a consulting neurosurgeon, both opined that claimant's September 1983 compression fracture permanently altered the stresses on his L5-S1 spondylolisthesis, thereby causing a permanent worsening of the symptoms of that condition. (See Ex. 247, 252, R-1 at 5 & 12). Dr. Newby also indicated that the right sacroiliac symptoms were related to the worsening of the spondylolisthesis. (See Ex. R-1 at 9). Both doctors are less clear regarding the effect of claimant's activities at the police academy in April 1984, but appear to say that the activities worsened the symptoms of the conditions temporarily without worsening the underlying conditions. (See Ex. 160, 252, R-1 at 6 to 7). Claimant's testimony supports the above conclusions. (See Tr. 29-30, 34, 37-38, 40-41, 48-49, 51-52).

In view of the above evidence, we conclude that claimant's

September 1983 accident worsened claimant's underlying spondylolisthesis and sacroiliac conditions, but that claimant's activities at the police academy in April 1984 did not cause any further worsening of the underlying conditions. Under the last injurious exposure rule, therefore, we conclude that SAIF, the carrier on the risk at the time of the September 1983 accident, is the responsible carrier.

Attorney Fees

SAIF contends that the Referee erred in ordering it to pay an attorney fee in connection with its "responsibility denial" of claimant's low back and right sacroiliac conditions. As noted in our findings of fact, both carriers raised the issue of compensability at the beginning of the hearing. Despite the issuance of a .307 order, therefore, claimant's entitlement to receive compensation was at issue and a carrier-paid fee under ORS 656.386(1) was appropriate. Hanna v. McGrew Brothers Sawmill, Inc., 45 Or App 757 (1980). In accordance with the disputed claim settlement between claimant and SAIF, we allocate \$1,500 of the \$3,000 assessed by the Referee to the denial of the low back and sacroiliac conditions.

ORDER

The Referee's order dated December 23, 1986 is affirmed, with the exception of those portions of the order affected by the disputed claim settlement approved on April 5, 1988.

JAMES M. FREAR, Claimant	WCB 87-14904
Bischoff & Strooband, Claimant's Attorneys	December 7, 1988
David O. Horne, Defense Attorney	Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Miller's order that upheld the insurer's denial of home care services. We affirm.

ISSUE

1. Whether claimant's claim for home care services is compensable.

FINDINGS OF FACT

We adopt the Referee's Findings, as supplemented by the following additional findings of fact.

Claimant has failed to prove that home care services are the reasonable and necessary result of his 1973 compensable injury.

CONCLUSIONS OF LAW

Claimant asserts entitlement to home care services. Such services are "other related" medical services for purposes of OAR 436-10-005(17). See Albert Huntley, 39 Van Natta 120 (1987); William H. Brown, 38 Van Natta 1466 (1986). Thus, it is claimant's burden to prove that the home care he seeks is the reasonable and necessary result of his 1973 compensable injury. We find that it is not.

The evidence most favorable to claimant is not persuasive. First, the only medical support for the claim comes

from Dr. Womack's brief note, stating that claimant needs home health care because he is permanently and totally disabled. Womack's opinion does not explain whether claimant's need for such care is the result of his compensable injury. Neither can we determine from the remainder of the record whether claimant's need for home care materially flows from the injury that occurred 15 years ago. We find Womack's conclusory opinion alone insufficient to sustain claimant's burden of proof. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Second, claimant's testimony and that of his witnesses, while probative, Garbutt v. SAIF, 297 Or 148 (1984), are insufficient to sustain this claim for medical services, the resolution of which we find to be a matter of expert medical analysis. Kassahn v. Publishers Paper Co., 76 Or App 145 (1985).

ORDER

The Referee's order dated March 18, 1988 is affirmed.

ALLAN L. HARTNESS, Claimant	WCB 86-15765
Lester R. Huntsinger (SAIF), Defense Attorney	December 7, 1988
	Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant, pro se, requests review of Referee Emerson's order that affirmed a Determination Order of November 7, 1986 which did not award him additional scheduled or unscheduled permanent disability beyond that awarded by Stipulation dated October 13, 1983. No respondent's brief was filed. We affirm.

ISSUE

Extent of scheduled and unscheduled permanent partial disability.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own.

CONCLUSIONS OF LAW AND OPINION

Permanent disability

Claimant contends that he is entitled to an award of permanent disability for his sesamoidectomy. He is entitled to an award of permanent disability benefits only when permanent loss of use results. ORS 656.214(1)(a). The medical evidence indicates that the surgery was successful, and has resolved with no permanent loss of use. An award of permanent disability for that condition is therefore not appropriate.

He further requests an increase in his award of scheduled and unscheduled disability. In 1983, claimant signed a Stipulation accepting an award of 25 percent scheduled disability for each ankle, and 10 percent unscheduled disability for his low back. That Stipulation has become final.

In order to prove entitlement to an increase in disability now, claimant must show that his condition has worsened due to his compensable injury since 1983. Weyerhaeuser Co. v. Bettin, 84 Or App 140 (1987). His sesamoid fracture has resolved. The medical reports

of Dr. Hoff, claimant's treating orthopedist, indicates that whatever degree of instability he still suffers has not worsened since 1983.

Claimant testified that he has hurt various other parts of his body, including some fingers and his wrist, in falls caused by his unstable ankles. The Referee considered the entire record including claimant's testimony. The Referee found and concluded that the complaints of "diffuse symptomology involving nearly his entire body" were not related to the industrial injury. We adopt the Referee's findings and conclusions on this point. He is therefore not entitled to an additional award of permanent disability.

Overpayment

Claimant contends that there was no overpayment of temporary disability benefits. The transcript of the hearing indicates that, at hearing, claimant conceded both the fact and the amount of the overpayment. Because it was conceded, we will not undertake to redetermine the issue.

Vocational assistance

Claimant raises the issue of entitlement to vocational assistance for the first time on review. Because the issue was not raised before the Director first, we have no jurisdiction to reach it now. ORS 656.283(2).

ORDER

The Referee's order dated July 27, 1987 is affirmed.

DENNIS J. HARVEY, Claimant	WCB TP-88028
Malagon & Moore, Claimant's Attorney	December 7, 1988
MacMillan & Scholz, Defense Attorneys	Third Party Order on Review

The paying agency has petitioned the Board to resolve a dispute concerning the proper distribution of the proceeds from a proposed third-party settlement. See ORS 656.593. The paying agency contends that claimant's entitlement to a share of the proceeds of the proposed settlement is to be determined in accordance with the distribution scheme established pursuant to ORS 656.591(2). Claimant asserts that he is entitled to a share of the proceeds of the proposed settlement pursuant to the distribution scheme established in ORS 656.593(1). Claimant further argues that the paying agency's lien should not apply to that portion of the proposed settlement which represents a recovery of general damages.

We conclude that: (1) claimant is deemed to have assigned his "third party" rights to the paying agency; the agency's lien applies to the entire amount of the settlement; and (3) the settlement proceeds should be distributed in accordance with ORS 656.591(2).

FINDINGS OF FACT

In December 1985, while performing his employment duties as a trucker, claimant was injured when he tripped and fell due to a torn carpet on the premises of a third party. As a result of the incident, claimant sustained injuries to his left knee. The claim was accepted by the employer's insurer.

On March 3, 1986, the paying agency sent an "election notice" to claimant by certified mail. As relevant, that "election notice" stated:

"This letter will constitute an election notice. You have two alternatives: You may elect to recover damages yourself or you may elect to sign [sic] your third-party rights to [the paying agency]. If you assign your rights to [the paying agency], or do not elect at all, you lose all rights and voice in the handling and settlement of this claim. You have 60 days by law to advise us in writing as to whether or not you will pursue [the third-party action] yourself." (Emphasis in original).

Claimant received this letter on or about March 5, 1986. He did not make a written election within 60 days.

On February 10, 1987, the paying agency sent a second letter to claimant. This letter stated that, because claimant had not acted on the first letter, the paying agency was assuming that he was assigning his third party rights to it. The paying agency indicated that it would pursue the third party action itself.

On March 9, 1987, claimant informed the paying agency's claims representative that he did not want to "mess with" a third party action.

A September 28, 1987 interoffice memorandum drafted by a representative of the paying agency indicated that claimant had experienced a similar on-the-job injury in approximately 1983. Settlement of a third party action at that time had resulted in a recovery of \$500 by claimant. Claimant indicated to the representative that the third party action was a "big hassle" and that he did not wish to go through the same thing again.

In October 1987, the paying agency engaged legal counsel to bring a civil action against the third party defendant. Counsel sent a letter to claimant, dated November 16, 1987, informing claimant of the need to file a lawsuit prior to expiration of the statute of limitations. Counsel's letter indicated a desire to discuss the case with claimant and suggested the possibility of including a claim for general damages on behalf of claimant.

A civil action was commenced in claimant's name on December 29, 1987. Counsel wrote to claimant on December 30, 1987 to explain that a lawsuit had been filed, and to request his cooperation. A "blind" postscript at the bottom of that letter directed to the paying agency indicated that claimant was not interested in pursuing the action.

A tentative settlement agreement has been reached between the paying agency and the insurer for the third party defendant. The amount of that proposed settlement is \$40,500. The paying agency asserts a current lien of \$53,324. Claimant's consent to the proposed settlement is required before the third party defendant will agree to execute the agreement. Claimant refuses to consent to the agreement under the distribution scheme presently advanced by the paying agency.

CONTENTIONS

The paying agency contends that claimant's failure to notify it within 60 days of the "election notice" operates to assign his third party action to the paying agency as a matter of law. See ORS 656.583(2). Therefore, the paying agency argues, the proceeds of the settlement of that action are to be distributed in accordance with ORS 656.591(2).

Claimant asserts that he was led to believe by representatives of the paying agency that his interests would be protected if he assigned his cause of action to the paying agency. He also states that he was concerned that he would lose his right to continuing medical benefits should he elect to pursue the third party action himself. Claimant concluded that in the interest of "substantial justice," he should be awarded one-third of the proceeds from the proposed settlement. Claimant further argues that the proposed settlement necessarily includes a recovery of general damages, and that the paying agency's lien should not apply to that portion of the recovery.

CONCLUSIONS OF LAW AND OPINION

If a worker suffers a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. The paying agency may require the worker to exercise the right of election provided in ORS 656.578 by serving a written demand by registered or certified mail or by personal service upon such worker. ORS 656.583(1). Unless such election is made within 60 days from the receipt of service of such demand, the worker is deemed to have assigned the cause of action to the paying agency. ORS 656.583(2). The worker is entitled to any sum recovered by the paying agency in excess of the expenses incurred in making such recovery and the amount expended by the paying agency for compensation, first aid or other medical-related service, together with the present worth of future monthly payments of compensation. ORS 656.591(2).

On the other hand, when the worker elects to recover damages from the third party, the proceeds of any recovery shall be distributed as set forth in ORS 656.593(1). Pursuant to that provision, costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1). Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

It is undisputed that the paying agency served claimant by certified mail with written demand to exercise the right of election established in ORS 656.578. It is equally undisputed that claimant did not exercise that right of election within 60 days. On its face, ORS 656.583(2) requires a conclusion that claimant had de facto assigned his third party action to the paying agency. Consequently, the distribution scheme set forth in ORS 656.591(2)

would be applicable. Because it appears the paying agency's current lien exceeds the amount of the proposed settlement, claimant would thereby take nothing from the settlement.

Claimant argues, however, that "substantial justice" requires that the proceeds of the proposed settlement be distributed in accordance with ORS 656.593, pursuant to which he would receive one-third of the remaining settlement proceeds after deduction of the paying agency's costs incurred in obtaining that settlement. Claimant asserts in this regard that he was confused and ill-informed as to the consequences of his right of election. Specifically, he asserts by affidavit that he was concerned that his right to continuing medical benefits would terminate should he elect to pursue the third party action himself. Claimant further asserts that he expressed this concern to the paying agency's claims representative.

In reply, the paying agency submits the affidavit of the claims representative in charge of claimant's file. The claims representative states that claimant was explicitly informed that his right to time loss and medical benefits would be unaffected by his election to pursue a third party action. The affiant expressly denies having stated anything to the contrary. Also submitted were contemporaneous file memoranda indicating that claimant did not desire to pursue a third party action himself due to a prior unrelated third party action from which he had received unsatisfactory results. The unsatisfactory results were allegedly caused by poor legal representation.

We are persuaded by a preponderance of the evidence that claimant chose not to pursue a third party recovery because of his prior, unsatisfactory experience with third party claims. Our conclusion is supported, at least in part, by claimant's own affidavit wherein he states:

"As a result of that lawsuit and my experience with that attorney, I have been unwilling to seek additional legal services and have been frightened to aggressively pursue [sic] this claim for fear that a similar result might occur."

This conclusion is also supported by: (1) the March 9, 1987 statement to the claims representative that claimant did not wish to "mess with" a third party action; (2) the September 29, 1987 paying agency interoffice memorandum to the same effect; and (3) the "blind" postscript contained on the December 30, 1987 letter from counsel for the paying agency to claimant to the effect that claimant had no interest in the lawsuit filed by the paying agency.

Conversely, we are unpersuaded that claimant feared loss of his continuing workers' compensation benefits should he elect to proceed against the third party defendant. We note in this regard that the paying agency's election letter contained no such suggestion. Cf. James A. Cooper, 40 Van Natta 1201 (1988) (claimant may rescind election where election form is objectively misleading).

Moreover, claimant's affidavit does not assert that the paying agency's claims representative affirmatively misled him regarding his right to continuing benefits. Rather, assuming the truth of the assertion, the most that can be said from claimant's

affidavit is that the claims representative failed to dispel claimant's confusion regarding this question. We need not decide whether such alleged nonfeasance would be sufficient to permit rescission of claimant's de facto assignment, because we are not persuaded that claimant did, in fact, inform the claims representative of his concern. In addition, the claims representative stated that claimant was informed of his right to continuing benefits. Further, we have already concluded that claimant explained his reluctance to pursue a third party action on the basis of his prior unsatisfactory experience with such actions.

We conclude that claimant chose not to pursue the third party action for reasons unrelated to any concern over losing his right to continuing benefits. Even assuming that the clear dictates of the statute could be avoided in order to advance the aim of "substantial justice," we do not find that claimant's prior unsatisfactory experience with third party actions is a sufficient basis for establishing entitlement to such relief. In sum, we decline to allow claimant to rescind his prior de facto assignment of his cause of action to the paying agency.

Claimant also contends that the paying agency's lien should not apply to that portion of the proceeds of the proposed settlement which represent recovery of general damages. We addressed this same argument under similar circumstances in Kenneth Owens, 40 Van Natta 1049 (1988). We held that, pursuant to the "clear and unambiguous" language of ORS 656.593(1), a paying agency's lien applies to the proceeds of any damages recovered from the third party regardless of the composition of the judgment.

Here, in accordance with our decision, the paying agency's lien results from the operation of ORS 656.591(2). That provision establishes that the paying agency's lien applies to "any sum recovered" by the paying agency. We find that this language is as clear and unambiguous as the language considered in Owens, supra. Moreover, we find no policy reason to conclude that the paying agency's lien should be treated differently under the two statutes. We conclude that the paying agency's lien applies to the entire amount of the proposed settlement proceeds regardless of the characterization of those proceeds.

Accordingly, the paying agency is authorized to proceed with settlement and distribution of the proceeds of the third party action pursuant to ORS 656.591(2).

IT IS SO ORDERED.

PATRICIA A. HASELWOOD, Claimant
Bloom, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-13576, 87-12629 & 87-09815
December 7, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The self-insured employer requests review of that portion of Referee Jacobson's order that set aside its denial of claimant's claim for mental stress. The employer also seeks remand to the Referee for the taking of additional evidence. Claimant opposes remand and asks that the employer's brief be stricken as untimely filed. We reverse on the merits of claimant's mental stress claim.

ISSUES

1. Whether the self-insured employer's brief should be stricken as having been untimely filed.
2. Whether claimant's claim for mental stress is compensable.
3. If the claim is otherwise compensable, whether this case should be remanded to the Hearings Division for the consideration of additional evidence.

FINDINGS OF FACT

Claimant became employed by the self-insured employer in the early 1970's. She continued working until March 17, 1987. During her employment, claimant filed six claims for workers' compensation. The last, which was filed on the last day of claimant's employment, alleged the development of mental stress as a result of long-term harassment.

Claimant has longstanding mental/emotional problems. During the claim period, she was examined by three psychiatrists. She currently suffers from an adjustment disorder with mixed emotional features, along with paranoid and histrionic personality traits. Based on the report of Dr. Colbach, the employer issued a denial of claimant's mental stress claim on July 24, 1987.

The employer timely filed its brief on May 19, 1988 pursuant to OAR 438-05-046(1)(c).

The employer offered three additional exhibits after the hearing record was closed. One was a psychiatric report authored in 1979. The others were psychiatrists' responses to that report.

Claimant's employment was not the major contributing cause of the development of her mental disorder.

CONCLUSIONS OF LAW

1. Whether the employer's brief should be stricken as untimely filed

Claimant asserts that the employer did not comply with OAR 438-05-046(1)(b) when it filed its brief, and that the brief was, therefore, untimely filed. The rule cited by claimant, however, pertains to requests for hearing and requests for Board review of Referee's orders. For all other things filed, the applicable rule is OAR 438-05-046(1)(c), which provides that filing may be accomplished by mailing by first class mail. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on the date. In the present case, the employer's brief was due on May 19, 1988. The employer's counsel's certificate certifies that mailing was accomplished on the due date. The employer's brief was, therefore, timely filed.

2. Whether claimant's claim for mental stress is compensable

Claimant asserts that her working conditions caused the development of a compensable mental disorder. She presents her

claim alternatively as one flowing from a compensable injury or one based on a theory of occupational disease. The distinction is important, for if the claim is characterized as flowing from an injury, claimant need only prove that her injury was a material contributing cause of the development of her mental disorder. See Patitucci v. Boise Cascade Corp., 8 Or App 503 (1972). On the other hand, if claimant's claim is characterized as one for occupational disease, she must prove that real on-the-job events or conditions were the major contributing cause of her mental disorder. McGarrah v. SAIF, 296 Or 145 (1983).

After reviewing the record, we conclude that claimant's injury is properly characterized as one for occupational disease. Although her stress claim did follow an accepted claim for an accidental injury, it is clear that claimant is asserting that her stress arose from harassment, rather than the effects of her compensable injury. We conclude, therefore, that claimant must meet the test outlined in McGarrah, supra, in order to sustain her burden of proof.

At hearing, claimant outlined a series of events that, if real, were clearly capable of producing stress. They included, among other things, ongoing sexual harassment, religious persecution, threats of serious bodily harm, and several attempts on claimant's life. She related these same incidents to the examining psychiatrists. The Referee found claimant credible in that she "testified truthfully concerning her perception of the nature and extent of the harassment." Because the employer did not appear at hearing, either in person or through counsel, the Referee also found claimant's testimony un rebutted. Therefore, although the Referee acknowledged that the events outlined by claimant were "hard to imagine," she concluded that claimant's work caused the development of her mental disorder.

Claimant's condition involves a complex issue of medical causation. We, therefore, find that a resolution of this controversy can best be achieved through an appraisal of the medical opinions. Linda C. Viles, 39 Or App 14 (1987) aff'd mem Viles v. SAIF, 89 Or App 569 (1988). We have not discounted claimant's testimony, but find that the psychiatrists' evaluations of claimant's representations are at least, if not more, critical than claimant's testimony.

The examining psychiatrists acknowledge that claimant is alternately "almost delusional," "somewhat psychotic," and "paranoid." Each has questioned whether her history of severe persecution on the job is accurate. Dr. Colbach finds it "hard to accept" that claimant could have been subjected to the harassment she claims. He believes claimant "overreacted to things and misread situations." He felt that the compensability of claimant's claim depended on whether she was, in fact, subjected to the events she described. After reviewing more information, he found that he could not conclude that claimant's employment was the major contributing factor in the development of her mental disorder. Because of the expert analysis offered by Dr. Colbach, we accept his opinion as most persuasive.

The employer asserts that claimant misperceived the events she encountered on the job and that they were, therefore, not "real," as that term is used in McGarrah, supra. See Leary v. Pacific Northwest Bell, 67 Or App 766 (1984). Claimant responds that whether her perception of events was reasonable or

unreasonable is irrelevant to a determination of compensability, so long as the events she encountered were objectively real. See Duran v. SAIF, 87 Or App 509 (1987); Petersen v. SAIF, 78 Or App 167 (1986).

In Barbara T. Chilla, 39 Van Natta 284 (1987), aff'd mem Chilla v. Coos Bay School District #9, 90 Or App 193 (1988). We discussed the "real vs. misperception" issue. In Chilla, the claimant believed that there was a conspiracy to remove her from her job. She outlined several events that she claimed were "real" and argued that whether they were capable of producing stress was entirely dependent on her subjective reaction to those events. An independent examining psychiatrist found that the claimant misperceived her own actions, as well as the actions of others. We held that to allow a claimant's purely subjective reaction to determine compensability would be inconsistent with the test set forth in McGarrah, supra.

After reviewing claimant's testimony and the reports of the examining psychiatrists, we conclude that claimant has failed to sustain her burden of proof. As noted, Dr. Colbach's opinion is that the compensability of claimant's claim depends on the accuracy of her history. Yet, claimant's presentation is replete with delusions, misperceptions, paranoia and possible psychosis. It is, therefore, impossible to determine whether the events that claimant testified to actually occurred or whether they are manifestations of her mental illness. It is claimant's burden of proof, and we find that under the present circumstances, the claim fails without independent verification of the events outlined in claimant's testimony. Dr. Colbach needed such verification in order to support a finding of compensability. Claimant has offered none. The claim is not compensable.

3. Whether claimant's claim should be remanded

Because of our conclusion regarding compensability, the remand question is moot. We find, however, that had it been necessary to determine the remand question, we would have denied the employer's request for remand. We find that the evidence offered post-hearing could have been discovered and produced prior to or at the time of the hearing.

ORDER

The Referee's order dated February 1, 1988 is reversed in part and affirmed in part. That portion of the order that set aside the self-insured employer's denial of claimant's claim for mental stress is reversed and the employer's denial is reinstated. The remainder of the Referee's order is affirmed. A client-paid fee not to exceed \$3,856.25, is approved.

ELSIE L. HOBKIRK, Claimant
Roberts, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 85-12353
December 7, 1988
Second Order on Reconsideration

Claimant requested reconsideration of our Order on Reconsideration dated July 5, 1988 which: (1) adhered to our November 10, 1987 order affirming a Referee's award of permanent total disability; and (2) denied the SAIF Corporation's request, on Board review, for authorization to offset permanent partial disability benefits paid pursuant to a Determination Order against permanent total disability benefits payable over the same period under a Referee's order. See Elsie L. Hobkirk, 40 Van Natta 778 (1988). Claimant contends that her counsel is entitled to an

"attorney fee award in line with the benefits at stake and the efforts expended" on Board review for prevailing against SAIF's contentions that she was not permanently and totally disabled and, if she was, that SAIF should be permitted to apply the requested offset.

In order to allow sufficient time to consider claimant's request for an increased attorney fee from the \$500 awarded in our initial order, we withdrew our order and granted SAIF an opportunity to respond. Inasmuch as the time for submitting a response has expired, we proceed to address claimant's request.

If a request for Board review is initiated by an employer or insurer and the Board finds that the compensation awarded to claimant should not be disallowed or reduced, the employer or insurer shall be required to pay a reasonable attorney fee in an amount set by the Board. ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2).

Here, claimant has prevailed against SAIF's attempts to disallow or reduce her compensation. Therefore, she is entitled to an assessed fee for her counsel's services on Board review. Upon further reflection, we conclude that the fee should be increased from the \$500 previously awarded.

After review of the statement of services and the retainer agreement, as submitted by claimant's counsel, and considering the factors set forth in OAR 438-15-010(6), we conclude that a reasonable assessed fee for services before the Board is \$1,242.50. Consequently, claimant's attorney is awarded \$1,242.50, to be paid by SAIF. This fee is in lieu of, rather than in addition to, the \$500 attorney fee awarded in our November 10, 1987 Order on Review.

Accordingly, on reconsideration, except as modified herein, we adhere to and republish our July 5, 1988 Order on Reconsideration in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

KENNETH K. KESSEL, Claimant	WCB 85-03895
Michael B. Dye, Claimant	December 7, 1988
Brian R. Whitehead, Claimant's Attorney	Order on Review
Merrily McCabe (SAIF), Defense Attorney	

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Nichols' order on remand that: (1) upheld the SAIF Corporation's denial of claimant's low back condition; (2) declined to award claimant interim compensation benefits for three months beginning March 1983 and for one week in November 1984; and (3) declined to award a penalty and related attorney fee for SAIF's alleged unreasonable failure to pay interim compensation. We affirm.

ISSUES

1. Whether claimant's low back condition is compensable as either an injury or occupational disease.

2. Whether claimant is entitled to interim compensation benefits for three months beginning March 1983 and for one week in November 1984.

3. Whether claimant is entitled to penalties and attorney fees for SAIF's alleged unreasonable failure to pay interim compensation.

FINDINGS OF FACT

Claimant initially injured his back in 1968 while lifting the tongue of a trailer. The injury occurred when claimant was in the armed services. He was treated with muscle relaxants and 10 days in pelvic traction. He received 10 percent service-related disability due to high frequency hearing loss and lumbosacral strain. As of the date of hearing, claimant was engaged in an appeal process before the Veteran's Administration in an attempt to obtain an increase in the disability rating of his low back.

Claimant was discharged from the service in February 1975. During the months following his discharge, he was employed at a variety of jobs, including service station attendant, armored truck driver and dock hand. Each of these jobs required some repetitive lifting and bending, but claimant was able to avoid any significant back problems. Prior to 1981, heavy physical labor caused claimant to experience occasional muscle spasms lasting anywhere from one day to a week. His back problems remained minimal as long as he used proper body mechanics and continued to do his back exercises.

Claimant was initially employed by SAIF's insured from 1976 through 1978 as a general mechanic. He was dismissed in 1978 when he refused to work on Saturdays. In November 1981, after a period of self-employment, claimant returned to work for SAIF's insured as a shop manager. His job duties, which included customer service, supervising company personnel, pulling engines and performing tune-ups, required him to work 40 to 60 hours per week.

One morning in January 1983 claimant awoke with pain behind his left thigh. The pain soon increased to include his low back and entire left leg. In February 1983 claimant was seen and treated by Dr. Freeman, chiropractor, who diagnosed an acute moderate lumbosacral strain. Claimant gave no history of any cause for his complaints.

Claimant was then referred to Dr. White, neurological surgeon, who diagnosed an acute disc herniation and performed a laminectomy at L5-S1 on the left with excision of extruded disc fragments. Claimant's work activities at SAIF's insured were not the major contributing cause of his disc herniation.

Claimant improved with the surgery and returned to his job as a mechanic and shop foreman, performing full-time light duty work. He did not file a workers' compensation injury or occupational disease claim at that time; instead, he had his private health care insurer pay for the surgery. By July 1983 claimant began to have renewed complaints of stiffness and aching along the length of his back and returned to the care of Dr. White. Dr. White found no objective evidence to support claimant's complaints but noted that he was depressed and suspected job dissatisfaction. An examination performed in August 1983 by Dr. White again revealed no objective basis for claimant's complaints.

In September 1983 claimant was being helped down from a hydraulic hoist when the co-worker lost his grip and dropped him three or four feet to the floor. Claimant did not experience an increase in his symptoms as a result of this incident. He did not file a workers' compensation claim at that time, but he did apply to the Veteran's

Department for an increase in the award for his service-connected back condition. The increased award was denied because of the mild findings on examination. Claimant appealed that denial.

On October 24, 1983, claimant was involved in a rear-end collision while test driving a customer's truck. He was thrown around in the cab of the truck and hit his upper body on the steering wheel, causing his back to feel stiff and sore. Subsequent to the accident, claimant returned to his regular job duties. He missed no time from work as a result of either the hoist incident or the rear-end collision.

On January 9, 1984, claimant again returned to the care of Dr. White with complaints of recurrent low back pain and aching in his left leg. Claimant did not inform Dr. White of either the hoist incident or the rear-end collision which occurred in the fall of 1983. Neither claimant's work activities nor any new event or specific trauma caused this increase in his low back symptoms.

On February 6, 1984, claimant underwent a CT scan which Dr. White reviewed and found to be unremarkable. Nonetheless, claimant's symptoms continued to worsen. On March 12, 1984, a myelogram was performed which, except for mild annulus bulges at L4-5 and L5-S1, was also found to be unremarkable. Finally, on November 4, 1984, a second CT scan indicated that claimant was suffering from a recurrent disc herniation at L5-S1.

In March 1984 claimant was given a workers' compensation form to file, but at that time he did not make a claim. It was not until November 15, 1984 that claimant filed a workers' compensation claim form, alleging that his left leg and back condition was due to either: (1) the September 1983 hoist incident; (2) the October 1983 automobile accident; (3) the continuous pushing of cars while on the job; or (4) some combination of the above.

On November 23, 1984, Dr. White performed: (1) a laminectomy at L5-S1 and at L4-5 on the right; (2) a midline exploration and foraminotomies at both levels; and (3) fat pedicle grafts. No abnormality was discovered during surgery and no disc operation was done. In fact, claimant's back condition had not changed or worsened between March 1983 and November 1984. Subsequent to the surgery, claimant's symptoms did not abate. To account for claimant's continuing symptoms in the absence of any existing back pathology, Dr. White diagnosed his condition as entirely functional in nature.

Dr. White released claimant to regular work as of February 14, 1985.

On February 26, 1985, claimant changed physicians from Dr. White to Dr. Poulson, orthopedic surgeon. Dr. Poulson attributed claimant's continuing symptoms to unstable joints in claimant's spine. Claimant did not initially give a history of the hoist incident or rear-end collision to Dr. Poulson. On May 13, 1985, Dr. Poulson performed fusions at the L5-S1 and L4-L5 levels. Claimant reported a total remission of pain for about six weeks after the surgery, followed by increasing low back and leg pain. As of September 1985, claimant continued to experience pain in the left lower extremity but was showing some gradual improvement. Dr. Poulson expected that complete healing and a good result would not be apparent for six to twelve months following surgery.

CONCLUSIONS OF LAW

The Referee discounted the opinions of Dr. Poulson in regard to the cause of claimant's low back difficulties and relied instead upon the conclusions of Dr. White in finding that neither claimant's work activities with SAIF's insured nor the separate incidents in the fall of 1983 were the cause of claimant's need for medical care. She discounted the opinions of Dr. Poulson by reasoning that they were based on inaccurate facts.

The Referee also concluded that since claimant did not file a claim until November 15, 1984 and Dr. White never informed SAIF of a causal relationship between claimant's low back condition and his employment, claimant was not entitled to interim compensation benefits in March 1983. We agree on both accounts.

Credibility

The Referee found all of the witnesses who testified to be credible with the exception of Pam Vorseth, Bryon Anderson and claimant. She made no finding on the credibility of Ms. Vorseth. She found that both claimant and the employer lacked credibility and shaded their testimony to best represent their positions in the matter. As a result, she concluded that their testimony was not totally reliable. After reviewing the record, we defer to the Referee's credibility findings.

Compensability

To establish a compensable occupational disease, claimant has the burden of proving that the work activities were the major contributing cause of either the onset or worsening of his disease. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983).

To establish a compensable industrial injury, claimant has the burden of proving that a work event or series of events within a discrete time period was a material contributing cause of his disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-7 (1983).

Claimant argues that his claim is compensable under either or both of the above theories. First, he contends that the work activities at SAIF's insured were the major contributing cause of his initial L5-S1 disc herniation in early 1983. Second, he contends that the October 1983 hoist incident and/or the November 1983 rear-end collision were material contributing causes of his need for medical services in 1984 and 1985. The record, however, does not persuade us that claimant sustained either a compensable occupational disease or industrial injury.

Dr. White was claimant's treating physician from March 1983 through February 1985 and performed the initial laminectomy and second surgery in November 1984. Dr. Poulson, on the other hand, has been claimant's treating physician since February 1985. Each doctor offered contrary opinions regarding the cause of claimant's low back condition and need for medical care. Where there is a dispute between medical experts, more weight is given to those opinions which are both

well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). In the present case, we agree with the Referee that Dr. White's opinions are based on more complete information and are therefore more persuasive than the opinions of Dr. Poulson.

When claimant first saw Dr. Poulson in February 1985, he gave a history of a rear-end collision in October 1984. Claimant made no mention of either the rigorous nature of his work activities or the hoist incident as possible causes contributing to his back problems. The correct history was obtained by Dr. Poulson through the office of claimant's attorney shortly before his deposition was taken in this matter. With the correct history in mind, it was Dr. Poulson's belief that claimant's work activities were a major contributing cause of the degeneration of the disc which eventually ruptured in 1983. He further opined that the work activities played a major role in the herniation of the disc, thereby requiring surgery. Finally, Dr. Poulson believed that the 1983 surgery was a material contributing factor in claimant's subsequent need for medical treatment.

We do not adopt Dr. Poulson's opinion for a number of reasons. First, Dr. Poulson expressed his beliefs under the assumption that claimant was engaged in continuous repetitive bending and lifting on the job from 1981 to 1983. In fact, claimant was not engaged in continuous bending and lifting and did not experience any significant low back difficulties until January 1983. Second, Dr. White spoke with, examined and treated claimant when he first began having those low back symptoms. Therefore, he was in a better position to take an accurate history from claimant and formulate an appropriate diagnosis. Dr. Poulson even agreed in his deposition that Dr. White was in a better position to determine the cause of claimant's need for surgery in March 1983 and November 1984.

Dr. White did not relate the 1983 and 1984 surgeries to claimant's work activities. He obtained a history of claimant waking one morning in January 1983 with back pain. He was aware that claimant did some stooping and bending on the job, but he did not believe that claimant's ruptured disc was the result of his work. When claimant saw Dr. White in January 1984, he did not tell him about the hoist accident or the automobile collision. This lack of concern by claimant about those incidents plus the fact that he sought no medical treatment from September 1983 until January 1984 convinced Dr. White that neither the hoist accident nor the automobile collision were material causes of his low back condition.

Dr. White also did not believe claimant's condition had worsened between March 1983 and November 1984. He noted that during the November 1984 surgery he found no evidence of a ruptured disc nor any other physical explanation for claimant's symptoms. At that time, Dr. White felt that claimant's symptoms were entirely functional in nature and not related to any existing back pathology.

We rely upon the fully informed and well-reasoned opinions of Dr. White in concluding that claimant's work activities at SAIF's insured prior to 1983 were not the major contributing cause of his low back condition. Likewise, we also conclude that the two incidents in the fall of 1983, either separately or together, were not a material cause of claimant's need for medical care. The totality of the evidence supports neither a compensable occupational disease claim nor a compensable industrial injury claim.

Interim compensation

ORS 656.262(4) requires an employer to make interim

compensation payments no later than the 14th day after the subject employer has notice or knowledge of the claim until the claim is either accepted or denied. Jones v. Emanuel Hospital, 280 Or 147 (1977). Any claim for a disabling compensable injury will trigger the ORS 656.262(4) payments. Bono v. SAIF, 66 Or App 138 (1983).

We are not persuaded that claimant attempted to file a claim in March 1983. Interim compensation benefits are not due until a claim has been filed.

A claim may be filed by a doctor as well as by claimant. Dr. White, however, did not believe that claimant's condition was work-related. Even though claimant saw two other doctors before he saw Dr. White, there are no medical reports which indicate that his back condition was work-related.

Claimant was due interim compensation from November 15, 1984, the date of notice of the claim. Since he was paid on that basis, there are no interim compensation benefits due to him because of this claim.

Penalties and attorney fees

Since SAIF did not unreasonably fail to pay claimant interim compensation benefits, he is also not entitled to a penalty and related attorney fee.

ORDER

The Referee's order dated October 6, 1987, is affirmed.

THEODORE W. LINCICUM, Claimant
Pozzi, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-05611
December 7, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee T. Lavere Johnson's order that: (1) awarded temporary total disability benefits pursuant to a prior Referee's order; and (2) assessed penalties and accompanying attorney fees for a failure to comply with the aforementioned order. On review, the insurer contends that the Referee erred in enforcing the prior Referee's order. The insurer argues that the prior Referee lacked jurisdiction to enter his order. Alternatively, the insurer argues that claimant was entitled to temporary partial disability benefits, rather than temporary total disability benefits, and that temporary partial disability benefits are not payable pending review. The insurer requested leave to present oral argument in this matter. We deny the request for oral argument and affirm the Referee on the merits.

ISSUES

1. Request for oral argument.
2. Enforcement of prior order awarding temporary disability benefits.
3. Penalties and attorney fees.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation.

By Order on Review dated October 31, 1988, the Board reversed Referee Fink's March 6, 1987 order which set aside the insurer's August 29, 1986 denial. Theodore W. Lincicum, 40 Van Natta 1760 (October 31, 1988).

CONCLUSIONS OF LAW AND OPINION

Request for Oral Argument

The insurer requests that we entertain oral arguments in this matter. We normally do not entertain oral arguments. OAR 438-11-015(2). We find that this matter has been fully developed and briefed. Consequently, oral argument will not be necessary. The insurer's request is denied.

Payment Pending Board Review

The question we must decide is whether ORS 656.313(1) is applicable to the facts of this case. ORS 656.313(1) provides:

"Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant."

If ORS 656.313(1) is applicable, and if the recovery awarded by Referee Fink is "compensation" within the meaning of the statutory provision, then the insurer improperly withheld payment of compensation pending appeal.

(1) Jurisdictional argument

The insurer asserts that Referee Fink lacked jurisdiction to issue his March 6, 1987 order, and that compensation need not be paid pending appeal of a Referee's order where the Referee who issued the order lacked jurisdiction to do so. The insurer cites a series of cases culminating in the Court of Appeals' decision in Castro v. SAIF, 60 Or App 112 (1983), rev den 294 Or 491 (1983), in support of its position.

In Castro, SAIF had denied a claim as not compensable. Claimant requested a hearing. A Referee agreed that the claim was not compensable. The Board affirmed. On appeal, the Court of Appeals reversed. 44 Or App 296 (1980). SAIF petitioned for Supreme Court review. The Supreme Court accepted the case for review. The Court of Appeals withheld issuance of its mandate until the Supreme Court completed its review.

SAIF did not pay any compensation while the Supreme Court had the case under review. Claimant requested a hearing, contending that, pursuant to ORS 656.313(1), SAIF was obliged to begin paying compensation pending further review. In an enforcement proceeding, the Referee ordered SAIF to begin paying compensation. The Board affirmed.

On review, the Court of Appeals reversed. The court reasoned that a claimant may not enforce an appellate court

decision until the mandate is received, or at least until it is issued; and that action taken by a lower court before the receipt or issuance of a mandate is void. 60 Or App at 116.

The insurer argues that the case before us is analogous to the situation involved in the Castro cases. We do not agree. The court's holding in Castro was that SAIF need not pay compensation pending appeal of the court's decision on the merits because the court had not issued its mandate in the decision on the merits. Because no mandate had been issued, no enforceable order to pay compensation existed. 60 Or App at 116.

Here, by contrast, Referee Fink has issued a litigation order directing the insurer to pay compensation. No mandate need first issue as a prerequisite to enforceability. The order is enforceable upon issuance. Pursuant to the order, the insurer is required to pay compensation within 14 days of the date of the order. OAR 436-60-150(3)(e). The insurer has failed to do so.

The insurer nevertheless argues that Referee Fink lacked jurisdiction to enter his order because he decided the case on the basis of an issue not raised by the parties. To the contrary, the Referee expressly declined to decide the case on the basis of premature closure because that issue had not been raised by the parties. Instead, he decided the case on the basis of the issue raised by the parties -- aggravation. On review, we did not find that the Referee's order was void for lack of jurisdiction or for any other reason. Instead, we concluded that the Referee's conclusion was legally incorrect. Unlike the situation in Castro, supra, Referee Fink's order was an enforceable litigation order with which the insurer should have complied.

We are not unmindful of the practical consequences of our decision to the insurer. Should our decision on the merits prevail on any subsequent appeal, then the rule of the case will be that claimant was not substantively entitled to recovery of the temporary benefits awarded by Referee Fink. And yet, the insurer will have paid those benefits and will not be able to recover them from claimant. ORS 656.313(2).

However, this result must have been contemplated by the legislature when it enacted ORS 656.313(1) and (2). Moreover, as we stated in Oscar L. Drew, 38 Van Natta 934, 936 (1986):

"[T]o follow the [insurer's] contentions we would be overlooking its defiance of a clear direction from a prior Referee to pay compensation.... Should we accede to such an argument we would be sending a message that it is not always necessary to comply with a Referee's order. This is a message which could have severe repercussions to a system which relies, to a great extent, on the basic principle that Referee's orders will be followed."

We conclude that ORS 656.313 is applicable to Referee Fink's March 6, 1987 order.

(2) Temporary benefits

Alternatively, the insurer argues that Referee Fink's

order incorrectly awarded temporary total disability benefits. The insurer asserts that claimant was entitled to temporary partial disability benefits rather than total disability benefits. Such partial benefits, the insurer contends, need not be paid pending appeal.

Claimant argues that the insurer is barred from contesting Referee Fink's characterization of his entitlement to benefits as entitlement to temporary total disability benefits. Claimant asserts that the insurer should have raised this issue in its appeal of Referee Fink's order which culminated in our October 31, 1988 Order on Review. However, our conclusion with regard to the insurer's argument renders a decision on claimant's contention unnecessary.

The insurer relies upon ORS 656.313(4) in support of its argument that temporary partial disability benefits need not be paid pending review. That section provides:

"Notwithstanding ORS 656.005, for the purpose of this section, "compensation" means benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.214 and does not include the payment of medical services."

The insurer notes that temporary partial disability is dealt with at ORS 656.212. Because that statute is not among the statutes enumerated in ORS 656.313(4), the insurer contends that temporary partial disability is excluded from the definition of "compensation" for purposes of ORS 656.313(1).

The proper interpretation of ORS 656.313(4) was recently addressed by the Supreme Court in Georgia-Pacific v. Hughes, 305 Or 286 (1988). The issue was whether, pursuant to ORS 656.313(4), an employer or insurer must pay an award of "interim compensation" pending appeal of the award. Georgia-Pacific argued that interim compensation is paid pursuant to ORS 656.262 rather than one of the statutes specifically enumerated in ORS 656.313(4), and for this reason it is not subject to ORS 656.313(1). The Court rejected Georgia-Pacific's argument. The Court found, inter alia, that the legislature intended to exclude only medical services, and no other form of "compensation," from the dictates of ORS 656.313(1). 305 Or at 292-93.

Temporary partial disability benefits clearly are a form of compensation under the workers' compensation laws. The insurer does not argue otherwise. Pursuant to the Court's reasoning in Georgia-Pacific v. Hughes, supra, we conclude that temporary partial disability benefits must be paid pending appeal.

Penalties and Attorney Fees

Referee Johnson assessed a 25 percent penalty resulting from the insurer's failure to comply with Referee Fink's prior order. The insurer argues that it reasonably believed that its refusal to comply with Referee Fink's order was legally supported. It, therefore, contends that no penalty or attorney fees should be assessed.

Failure to pay compensation in the face of a clear order

to do so is an unreasonable delay or refusal in the payment of compensation and exposes an employer or insurer to liability for penalties and attorney fees. ORS 656.262(10); 656.382(1). The insurer here could not have been uncertain as to its duties under Referee Fink's order. See Irene M. Gonzalez, 38 Van Natta 954 (1986) (ambiguous order may give rise to reasonable uncertainty as to obligations). The insurer's duties under Referee Fink's order were clear. The insurer chose not to comply with that order. We conclude that the Referee's award of a 25 percent penalty was appropriate.

ORDER

The Referee's order dated October 1, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of \$850, payable by the insurer. The Board approves a client-paid fee, not to exceed \$800.

DONALD E. LOWRY, Claimant
Malagon & Moore, Claimant's Attorneys
Phillip Nyburg, Defense Attorney

WCB 87-01224
December 7, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of those portions of Referee Peterson's order which: (1) concluded that the insurer had erroneously calculated his time loss rate; and (2) assessed a penalty and attorney's fee for the insurer's failure to pay the correct time loss rate. We reverse.

ISSUES

The primary issue is whether the insurer properly calculated claimant's time loss rate based on OAR 436-60-020. The secondary issue is whether claimant is entitled to a penalty and associated attorney's fee for the insurer's allegedly unreasonable calculation of the time loss rate.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following supplementation: Claimant's wages were based upon the number of hours he actually worked.

ULTIMATE FINDINGS

Claimant was regularly employed by this employer. Claimant's remuneration was not based solely upon a daily or weekly wage.

CONCLUSIONS

ORS 656.210(2)(c) states:

"As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the director by rule, may

prescribe methods for establishing the worker's weekly wage."

The insurer argues that even though claimant was regularly employed as that phrase is used in ORS 656.210, it is entitled to compute his time loss rate based on OAR 436-60-020. It argues that claimant's remuneration is based upon the actual hours worked and not upon a specified daily or weekly wage. Consequently, it is entitled to calculate his average weekly wage based on the formula contained in OAR 436-60-020(7)(c).

The statute contemplates that the Director may, by rule, establish a formula for calculating time loss rates if a worker is regularly employed and does not receive all remuneration based upon a daily or weekly wage.

OAR 436-60-020(4) provides the mechanism for computing time loss rates for workers with "unscheduled, irregular or no earnings." Before January 1, 1986, the statute provided no authority for the Director's making rules setting time loss rates. Nevertheless, the substance of this rule had been promulgated. Since that time, the rule has been republished. Consequently, we conclude that the current version of the rule is within the Director's authority. We also agree with the insurer's argument that the legislature's action in granting the Director authority to promulgate rules concerning rates of time loss was an attempt to have time loss rates more accurately reflect the actual wage that injured workers were earning at the time of injury.

In Charles M. Poole, 40 Van Natta 41 (1988), we held that the mere fact that a claimant is an hourly worker does not mean that his time loss rate should be calculated under OAR 436-60-020. An hourly worker who works a regular shift with a consistent length is, in effect, paid by the day. However, in this case, even though claimant was expected to work a five day week, the employer and employee knew that due to the nature of the work he would be working varying days and hours. In this situation the administrative rule applies. Accordingly, the insurer properly calculated claimant's time loss rate under the applicable administrative rule.

Because we find that the insurer's action was reasonable, the penalty and associated attorney's fee will be set aside.

The insurer does not challenge that portion of the Referee's order which assessed an attorney's fee for late discovery. Accordingly, that portion of the Referee's order will be affirmed.

ORDER

The Referee's orders of October 1, 1987 and August 24, 1987 are affirmed in part and reversed in part. Those portions of the Referee's orders which required to the insurer to pay additional temporary disability benefits and which assessed a penalty and associated attorney's fee for the failure to pay those benefits are reversed. Those portions of the Referee's order which awarded an attorney's fee for late discovery are affirmed. A client-paid fee, not to exceed \$200, is approved.

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee Knapp's order that set aside a denial of claimant's occupational disease claim for mental stress. We affirm.

ISSUE

Compensability of claimant's mental stress condition.

FINDINGS OF FACT

Claimant, 26 at hearing, began working for the employer in December 1985. In January 1986 she voluntarily enrolled in an inpatient alcohol treatment program for 30 days. Thereafter, she returned to work in the employer's "deli" department.

Because of management and profitability problems at the store at which claimant worked, a new manager was assigned in August 1986. The manager was a dedicated company employee who instituted a management style and plan which he considered effective and efficient. Several incidents occurred between claimant and the manager which were stressful. Because of her difficulties with the manager, claimant sought a transfer to another store. The transfer did not take place. Claimant would leave work at night shaking and weepy because of her interactions with the manager.

On September 23, 1986, claimant saw her family osteopath, Dr. Levenberg. He authorized time loss for one day. On September 24, 1986, he authorized time loss for an indefinite period. The time loss authorization was made because of claimant's severe acute anxiety reaction. Claimant was off work for ten days. She then returned to work, and missed no more time due to stress.

Claimant was examined by Dr. Turco, psychiatrist, on December 4, 1986. She was examined by Dr. Colbach, psychiatrist, on May 21, 1987. Dr. Colbach's testing indicated that claimant had suffered from an adjustment disorder with anxiety and depression, and that she had dependent and inadequate personality traits.

Claimant is a single mother of three. Her divorce from her husband became final in September 1986. She has a history of difficult relationships which have fostered a sense of inadequacy.

Claimant was temporarily disabled by her reaction to work stressors.

CONCLUSIONS OF LAW AND OPINION

It is claimant's burden to prove by a preponderance of the evidence a compensable mental stress claim. A stress claim is compensable if the claimant establishes that she has suffered a mental disorder, the major contributing cause of which is her reaction to real on-the-job events or conditions. McGarrah v. SAIF, 296 OR 145 (1983). That is to say, the stress-causing work conditions must be "objective" in the sense that the conditions must be real, not imaginary, and are capable of producing stress. Their medical effect on claimant, however is measured by the actual reaction, rather than by an objective

standard of whether the conditions would have caused disability of an average worker. Duran v. SAIF, 87 Or App 509 (1987).

The events which caused claimant stress actually did occur. The manager and claimant agree that claimant was directed not to look at her work schedule during work time, and that this was a change from the policy of the previous manager. Both agree that claimant requested a transfer to another store, and that the manager's response included an unprofessional remark about not transferring "turkeys." Claimant was given additional work duties, and was given several warnings that she would be fired if her work performance did not improve. Claimant reacted adversely to these events.

Other employees felt, and claimant agreed, that claimant is a sensitive individual. By observation at hearing, the Referee corroborated this. He also observed the manager, and found that the manager projected an image which was rigid, inflexible, and confrontational.

Dr. Levenberg treated claimant for her reaction by authorizing a period of time loss. His diagnosis was severe adjustment reaction to work stressors. Claimant was off work for ten days, and was then able to return to work without subsequent disabling difficulties.

Dr. Turco and Dr. Colbach both examined claimant after her condition had resolved. Dr. Turco opined that claimant had had a psychosomatic reaction with anxiety and depression as a result of work stress. Dr. Colbach diagnosed adjustment disorder with anxiety and depression. He later downplayed this diagnosis by reporting that claimant suffered from temporary on-the-job anxiety which soon passed.

The law does not require that claimant suffer permanent disability in order to have a compensable claim. We find that claimant did suffer a mental disorder, at least if nothing else, temporarily.

The employer contends that claimant's life away from work was full of stress, and that her work was not the major contributing factor of her disorder. Claimant's life is not easy. She is a single parent. She has a tendency to abuse alcohol, which she is now able to control. She separated from her husband in early 1986, and her divorce became final in September 1986. However, the evidence shows that she coped with those facts of her life prior to August 1986 and the arrival of the new manager. Dr. Turco opined only that the off-work stressors predisposed her to sensitivity. Dr. Colbach reported that her coping skills were stretched. But both correctly noted that she was able to work without difficulty prior to August 1986. We find her work stressors, and not her off-the-job stressors, to be the major contributing factor of her mental disorder.

ORDER

The Referee's order dated August 10, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of \$700, to be paid by the self-insured employer.

BETTY J. RETHERFORD, Claimant
Malagon & Moore, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 85-14392
December 7, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of that portion of Referee Baker's order that set aside its "backup" denial of claimant's back injury claim. We affirm.

ISSUE

Whether the insurer's "backup" denial is supported by material misrepresentation.

FINDINGS OF FACT

On April 25, 1984, claimant filed an 801 claim for injury form, and alleged that she injured her back on March 24, 1984 while bending over a roller tray at work. The employer reported on that form that she doubted the validity of the claim because: (1) claimant had injured herself while lifting furniture on April 7 or 8, 1984; and (2) claimant's back had been injured since the birth of her last child 21 years ago. Although the employer told the insurer that claimant had injured her back moving furniture at home prior to March 24, 1984, she took the insurer's advice and wrote April 7-8 on the 801 form.

The insurer investigated the claim by talking with the employer and interviewing claimant. Claimant told the investigator that she experienced low back pain 21 years ago following the birth of her child and that she further injured her back the weekend of April 7-8, 1984 while moving furniture at home. The employer, however, was aware of evidence that claimant injured her back while moving furniture at home prior to March 24, 1984. She immediately informed the insurer that the claim should be denied on that basis and offered several witnesses to prove that claimant's back injury happened off the job prior to March 24, 1984. The insurer ignored the employer's information and conducted no further investigation into the matter.

Dr. Carroll's chart note dated May 8, 1984, which was mailed to the insurer, described a history of attacks of low back and right leg pain about every two to three years since the birth of claimant's last child 21 years ago.

The insurer subsequently accepted the claim. Claimant underwent two lumbar laminectomies and the claim was processed to closure by Determination Order dated November 4, 1985.

On October 20, 1986, the insurer issued a "backup" denial of the accepted March 24, 1984 injury on the basis that claimant injured her back at home moving furniture, rather than at work.

When the insurer accepted claimant's claim for low back injury, it was aware of the employer's belief, and the potential witnesses to corroborate that belief, that claimant injured her back while moving furniture at home prior to March 24, 1984.

CONCLUSIONS OF LAW

We adopt paragraphs 2 through 5 of the Referee's order as our conclusions of law.

ORDER

The Referee's order dated July 30, 1987 is affirmed. The Board approves a client-paid fee, not to exceed \$139. Claimant's attorney is awarded an assessed fee of \$800, to be paid by the insurer.

LISA L. ROSS, Claimant

WCB 86-05253

Allan Coons, Claimant's Attorney

December 7, 1988

Chuck Lisle (SAIF), Defense Attorney

Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Mongrain's order that: (1) declined to assess penalties and related attorney fees for the SAIF Corporation's alleged unreasonable failure to pay interim compensation; (2) awarded 10 percent (32 degrees) unscheduled permanent disability award for a low back injury whereas a Determination Order had awarded no permanent disability; (3) declined to grant claimant a scheduled disability award for her right wrist injury; and (4) assessed a combined attorney fee of \$75 for SAIF's unreasonable failure to timely pay two medical bills. We reverse and modify those portions of the Referee's order that: (1) declined to grant claimant a scheduled disability award for her right wrist injury; and (2) assessed a \$75 attorney fee for SAIF's unreasonable failure to timely pay two medical bills. We affirm the remainder of the Referee's order.

ISSUES

1. Whether claimant is entitled to penalties and related attorney fees for SAIF's alleged unreasonable failure to pay interim compensation.

2. Whether claimant is entitled to increased awards of permanent disability, either scheduled or unscheduled.

3. Whether the Referee's award of a \$75 attorney fee to claimant for SAIF's unreasonable failure to timely pay two medical bills was adequate.

FINDINGS OF FACT

On July 24, 1985, claimant, 21 years old at the time of hearing, fell on some stairs while performing clerical work for her employer. As a result of the fall, claimant sustained cervical and lumbar strains and de Quervain's disease (tendinitis) at the base of the right thumb and in the right wrist. Claimant was treated conservatively by Drs. McCarthy, Kendall, McIntosh, Corson, and Inkrote, a chiropractor. Claimant was referred by Dr. McCarthy to Dr. Kendall in late August 1985 and was seen by Dr. Kendall on August 28, 1985. On September 3, 1985, claimant was seen by Dr. Strukel, Dr. Kendall's partner. On September 10, 1985, Dr. Kendall diagnosed significant functional overlay, declined to perform additional diagnostic studies, and recommended psychiatric consultation and/or a pain center referral. On October 9, 1985, at SAIF's request, claimant was seen by Dr. Strukel in a follow-up examination. On November 5, 1985, she was again seen by Dr. Kendall.

On September 27, 1985, SAIF paid Dr. Kendall's office

\$225.95. On October 23, 1985, SAIF paid \$27 to his office. On November 21, 1985, SAIF paid \$354 to his office. However, SAIF did not pay Dr. Kendall's office for his November 5, 1985 examination because claimant failed to return an "829" change of attending physician form. On November 25, 1985, claimant signed an 829 form.

On March 14, 1986, a Determination Order awarded claimant temporary disability benefits from August 5, 1985 to February 25, 1986 but awarded no permanent disability.

In July 1986 claimant, 9 months pregnant, was twice seen by Dr. Corson due to low back pain. On August 2, 1986, Dr. McIntosh diagnosed a conversion reaction and recommended that claimant receive psychiatric help. On September 22, 1986, Dr. Corson diagnosed mechanical low back pain due to loss of claimant's abdominal muscles during pregnancy and subsequent cesarean section. On November 5, 1986, Dr. Corson additionally diagnosed a low grade de Quervain's disease and chronic sprain syndrome of the MP joint without gross instability of the ulnar collateral ligament.

Claimant's attorney advised SAIF by letter of November 12, 1986 that claimant was claiming an aggravation of her condition. On November 19, 1986, Dr. Corson requested SAIF to reopen claimant's claim. He did not authorize time loss or state that claimant was disabled from work. On December 23, 1986, SAIF reopened claimant's claim due to the worsening of her compensable low back and right thumb and wrist conditions.

As of October 3, 1986, SAIF continued to hold payment of Dr. Corson's bill for services rendered on July 9, 1986, pending receipt of an 829 form. On February 20, 1987, claimant was advised that SAIF had refused to pay for \$551.60 in charges from Dr. Corson's office generated between July 9, 1986 and December 29, 1986 because an 829 form had not been signed. On March 14, 1987, claimant was billed for those charges. On March 25, 1987, claimant signed an 829 form, citing Dr. Corson as her attending physician, and she has not been billed for those medical charges again.

By December 31, 1986, claimant's de Quervain's disease in her right thumb and wrist had resolved while she continued to suffer from mild mechanical low back pain.

On February 3, 1987, a Determination Order awarded claimant temporary disability for the period of September 22, 1986 through December 29, 1986.

No evidence was presented by either party regarding the payment or nonpayment of "interim" temporary disability benefits pending the decision by SAIF to reopen claimant's claim on December 23, 1986.

During the spring of 1987 claimant attempted to work for "Bear Essence," gluing together soft teddy bears and cutting away excess glue with scissors. She was only able to perform this job for two days before she quit due to pain in her right thumb and right wrist.

At the time of hearing, claimant was experiencing pain in her low back and hips with some occasional radiation into her legs. She was also experiencing occasional aching in her neck and headaches. Her right thumb and wrist became sore and stiff if she moved them much or applied pressure.

CONCLUSIONS OF LAW

Penalties and related attorney fees for SAIF's alleged unreasonable failure to pay "interim" compensation

The Referee concluded that claimant was not entitled to penalties and attorney fees since no evidence was presented that SAIF did not in fact pay "interim" compensation after being advised by Dr. Corson that claimant had sustained an aggravation of her compensable condition. We agree.

Claimant's supplemental request for hearing, dated November 6, 1986, inter alia, raised the issue of penalties and attorney fees due to "interim time loss not paid pending acceptance/denial of aggravation claim." On December 2, 1986, SAIF responded by alleging, inter alia, that: (1) claimant was not entitled to additional interim compensation; and (2) there was no known basis for an award of penalties and attorney fees.

Claimant argues in her brief that the burden was with SAIF to prove that she was not entitled to penalties and attorney fees. We disagree. The burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side. Harris v. SAIF, 292 Or 683, 690 (1982). Claimant raised the issue of entitlement to an award of penalties and attorney fees based on the alleged unreasonable failure of SAIF to pay interim compensation. SAIF defended its position regarding interim compensation payments by denying that claimant was entitled to penalties and attorney fees. Without proof of SAIF's failure to pay interim compensation, claimant cannot be successful on the penalty and fee issue. Therefore, claimant failed to carry her burden of proof. Claimant is not entitled to a penalty and attorney fee.

Unscheduled permanent partial disability

The Referee concluded that, due to the inconsistencies between the medical reports and claimant's testimony regarding the severity of her symptoms, claimant was probably exaggerating those symptoms to a great extent. Accordingly, he awarded her 10 percent unscheduled disability due to her inability to perform heavy labor or labor requiring extremely repetitious use of her back. We agree and adopt the Referee's findings with the following supplement.

In rating the extent of claimant's unscheduled permanent disability, we consider her loss of earning capacity and physical impairment attributable to the compensable injury, 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).

We are more persuaded by the contemporaneous medical reports of Dr. Corson, which describe claimant as suffering from mild mechanical low back pain, than claimant's testimony of more severe neck, low back and hip pain. Claimant's complaints at hearing were significantly worse than they had been prior to hearing and we agree with the Referee that they were probably exaggerated.

Therefore, following our review of the medical and lay evidence, and considering claimant's mild physical impairment, age, education and work experience, adaptability to lighter occupations, average mental capacity, and emotional and psychological condition, we conclude that an award of 10 percent unscheduled permanent disability appropriately compensates claimant for her compensable back injury.

Scheduled permanent partial disability

The Referee concluded that due to the difficulty claimant would have performing some heavy activities with her right hand, he awarded her 15 percent scheduled disability for loss of use of her right thumb. However, he declined to award scheduled permanent disability for the right wrist.

When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of each injured member due to the industrial injury. ORS 656.214(2). Lay testimony, without medical input, may establish permanent disability. Garbutt v. SAIF, 297 Or 148 (1984).

Although claimant's testimony at hearing regarding the severity of her symptoms was exaggerated, there is ample evidence to support claimant's position that she suffered permanent disability to both her right thumb and right wrist. Therefore, the Referee erred in not granting claimant a permanent disability award for the loss of use of her right wrist. In determining the appropriate award, we use the Guidelines for Rating Permanent Disability. In order to simplify the combined awards, we choose to convert claimant's right thumb and wrist disabilities to one award for the loss of use of her right forearm.

We agree with the Referee that claimant sustained a 15 percent impairment of her right thumb. That impairment converts to a 6 percent hand/forearm impairment. Based upon the medical and lay evidence, we also find that claimant has suffered a 10 percent loss of use of her right wrist (forearm). We use these figures only as a guideline and, after combining the impairment values of the right thumb and right wrist, award claimant 15 percent scheduled disability for the loss of use of her right forearm.

Adequacy of attorney fees

The Referee concluded that SAIF's refusal to pay Dr. Kendall's bill for his November 25, 1985 examination and a separate bill of \$551.60 from Dr. Corson's office due to claimant's failure to file an 829 form was unreasonable. Therefore, SAIF was assessed a 25 percent penalty and a \$75 attorney fee.

In determining the reasonableness of attorney fees, several factors must be considered. OAR 438-15-010(6). See also Barbara A. Wheeler, 37 Van Natta 122, 123 (1987). These factors include: (1) time devoted to the case; (2) complexity of the issues involved; (3) value of the interest involved; (4) skill and standing of the attorneys; (5) nature of the proceedings; (6) result secured for the represented party; (7) risk in a particular case that an attorney's efforts may go uncompensated; and (8) assertion of frivolous issues or defenses.

After further review, we conclude that claimant's attorney's fee should be increased. However, unlike the claimant's attorney in Clifford D. Howerton, 38 Van Natta 1425 (1986), little preparation was required by claimant's counsel in the present case in order to prove that SAIF unreasonably required claimant to supply it with an 829 form before payment of two medical bills was made. Consequently, after considering the efforts expended and the results obtained in establishing the unreasonableness of SAIF's refusal to pay for certain medical services, we conclude that an attorney's fee of \$300 is a reasonable award for services rendered at the hearing level.

ORDER

The Referee's order dated August 14, 1987 is reversed, modified, and affirmed. That portion of the order which declined to award scheduled permanent disability for loss of use or function of the right wrist is reversed. In addition, the Referee's award of 15 percent (7.2 degrees) scheduled permanent disability for loss of use or function of the right thumb is modified. Specifically, in lieu of the Referee's award of scheduled permanent disability, claimant is awarded 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of the right forearm. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total of attorney fees approved the Referee's and our order shall not exceed \$3,800. That portion of the Referee's order that awarded a \$75 attorney fee for SAIF's unreasonable failure to timely pay two medical bills is also modified. In lieu of the Referee's \$75 attorney fee award, claimant's attorney is awarded a reasonable fee of \$300, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

ELMIRA K. SATCHER, Claimant
Patrick K. Mackin, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 85-07300
December 7, 1988
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Wacker Siltronic Corporation v. Satcher, 91 Or App 654 (1988). The court concluded that the amount "then due" for purposes of assessing a penalty for an unreasonably late denial should be determined as of the time of the denial. Consequently, the court has remanded with instructions "to determine the amount that was due at that time and to assess an appropriate penalty."

The record concerning the aforementioned issue consists of a copy of a ledger account from Dr. Scott, claimant's treating chiropractor. Except for this exhibit, the record is silent regarding the amounts "then due" at the time of the denial.

Under these circumstances, we find that the record has been incompletely and insufficiently developed. Therefore, we conclude that this matter should be remanded to the Referee. See ORS 656.295(5). On remand, the Referee is instructed to take further evidence to determine the amounts "then due" at the time of the unreasonably late denial and to assess an appropriate penalty on those amounts, if any.

Accordingly, this matter is remanded to Referee Tuhy for action not inconsistent with the court's opinion and this order.

IT IS SO ORDERED.

CANDACE A. SAXBERG, Claimant
Roll & Westmoreland, Claimant's Attorneys
Rankin, Vavrosky, et al., Defense Attorneys
Beers, et al., Defense Attorneys

WCB 85-08185 & 85-09235
December 7, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

EBI Companies requests review of Referee St. Martin's order that awarded claimant a \$500 attorney fee, \$250 to be paid by each insurer. Liberty Northwest Insurance Corporation cross-requests review, to reduce claimant's attorney fee. Claimant also cross-requests review of the Referee's order, seeking an increase in the attorney fee award. On review, the sole issue is the amount of claimant's attorney fee. We lack jurisdiction to hear the matter and dismiss.

FINDINGS OF FACT

On April 5, 1983, claimant injured her right wrist while working for EBI's insured. On May 2, 1983, Dr. Silver diagnosed right carpal tunnel syndrome. On July 15, 1983, Dr. Wilson diagnosed probable tenosynovitis; the neurological and radicular component of the condition, however, suggested carpal tunnel syndrome and/or Guyon's canal involvement of the ulnar nerve. EBI accepted this condition as a disabling injury.

On December 14, 1984, claimant developed right forearm pain while working for Liberty Northwest's insured. Tendonitis was diagnosed. Liberty Northwest accepted this claim as nondisabling.

On June 6, 1985, EBI denied that claimant's current hand and shoulder problems were related to the April 5, 1983 injury.

Claimant timely filed a hearing request and during the next two years her attorney repeatedly attempted to discover the specific conditions that EBI and Liberty Northwest had accepted.

Prior to hearing, the parties resolved all issues except the amount of attorney fee to be paid to claimant for counsel's efforts in clarifying the scope of the two claims with EBI and Liberty Northwest.

On June 9, 1987, Claimant filed a Petition for Extraordinary Fee in the sum of \$1,550.00 for counsel's efforts in setting aside the insurers' "de facto" denials of continued medical services for accepted compensable conditions. On June 10, 1987, EBI filed its Response to Petition for Extraordinary Fee and, on June 19, 1987, Liberty Northwest filed its response.

The sole issue at hearing was the amount of claimant's attorney fee. On July 18, 1987, pursuant to Referee St. Martin's order, claimant was awarded a \$500 attorney fee, \$250 to be paid by each insurer. The Referee's characterization of the insurers' delay in clarifying claimant's accepted conditions as "de facto" denials provided a basis for claimant's attorney fee award under ORS 656.386.

On July 22, 1987, EBI timely requested review of the Referee's order. On July 30, 1987, claimant timely cross-requested review of the Referee's order. Finally, on August 12, 1987, Liberty Northwest timely cross-requested review, also. The only issue on Board review is the amount of claimant's attorney fee.

CONCLUSIONS OF LAW

In Greenslitt v. City of Lake Oswego, 305 Or 530, 533-4 (1988), the Court ruled that when a claimant prevails before a Referee on the denial of a claim for compensation and the Referee awards the claimant's attorney a fee under ORS 656.386(1), the Board is without jurisdiction to entertain an appeal regarding the amount of the fee if the denial was not also appealed on the merits. Review of the attorney fee in such cases must instead be sought in the appropriate circuit court under ORS 656.388(2). Id.

The Referee in the present case awarded claimant's attorney two carrier-paid fees in connection with the de facto denials of EBI and Liberty Northwest. The Referee cited no authority for his action, but the only authority for such a fee would be ORS 656.386(1). EBI, Liberty Northwest and claimant all sought Board review only on the issue of the amount of the attorney fee awarded by the Referee. Under these circumstances, Greenslitt mandates dismissal of the requests for review. Arbra Williams, 40 Van Natta 506, 507 (1988). A client-paid fee, payable from Liberty Northwest to its counsel, is approved, not to exceed \$113.

IT IS SO ORDERED.

MICHELE D. SMITH, Claimant
Emmons, et al., Claimant's Attorneys
Gary Wallmark (SAIF), Defense Attorney
Cliff, et al., Defense Attorneys

WCB 86-09065 & 86-08241
December 7, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Industrial Indemnity Company requests review of that portion of Referee Nichols' order that set aside its aggravation and responsibility denials relating to claimant's low back condition.

The Board affirms and adopts the order of the Referee with the following comment. In view of the fact that Industrial Indemnity acceded to the issuance of an order pursuant to former ORS 656.307, it is precluded under the rule of Bauman v. SAIF, 295 Or 788 (1983) from subsequently contending that claimant did not sustain a compensable aggravation absent evidence of fraud, misrepresentation or other illegal activity. See Judy Witham, 40 Van Natta 1982 (WCB Case Nos. 87-00640, 86-13903, Issued this date). No such fraud, misrepresentation or other illegal activity was shown in this case.

Claimant's attorney is entitled to a fee payable by Industrial Indemnity for services rendered on Board review. See ORS 656.382(2). No statement of services, however, has been received from claimant's attorney and thus no fee can be awarded at this time. See OAR 438-15-010(5).

ORDER

The Referee's order dated May 22, 1987 is affirmed.

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Knapp's order that: (1) upheld the insurer's denial of her scleroderma condition; and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable claims processing.

The Board reverses in part.

ISSUES

1. Whether claimant's scleroderma condition is compensable.
2. Whether claimant is entitled to interim compensation.
3. Whether penalties and attorney fees should be assessed.

FINDINGS OF FACT

Claimant, a 47-year old custodian, filed an industrial injury claim for "infected fingers" on January 15, 1986. The insurer initially deferred acceptance of her claim. On March 10, 1986, she was examined by Dr. Clifton, M.D. Clifton diagnosed her injury as including infection, ulcers, scleroderma, and Raynaud's disease. Later that month, the insurer accepted her claim by way of a Notice of Claim Acceptance. The record does not indicate what the insurer accepted.

In June 1986, claimant began to treat with Dr. Griffin, a rheumatologist. Griffin confirmed a diagnosis of scleroderma and treated claimant's infections with medication.

Claimant developed cellulitis in her left middle finger in May 1987. Shortly thereafter, she quit working and filed a second industrial injury claim for "[i]nfection" to her "Middle finger of left hand." The insurer accepted her claim by way of a written notice mailed on June 8, 1987. Again, the record does not indicate what the insurer accepted.

In a letter dated June 26, 1987, the insurer informed claimant that it had "cancelled" her recent claim for injury to her left middle finger, because it had inadvertently established two claims for the same injury.

In September 1987, claimant was examined by Dr. Moyer, a dermatologist. Later that month, the insurer issued a denial of compensability. The denial denied compensability of scleroderma. It did not indicate that it was a partial denial; it did not indicate that there was an accepted claim; and it did not specify what parts of the original claim had been accepted.

Claimant's scleroderma condition is an underlying disease, which makes claimant susceptible to infections on and about her fingers.

The employer first knew of claimant's hand infections on June 15, 1985. Shortly thereafter, it began paying claimant temporary disability benefits and continued to do so through the date of the hearing.

CONCLUSIONS OF LAW

Compensability

After accepting a claim for compensation, an insurer may not "back-up" and deny the same claim in the absence of fraud, misrepresentation, or other illegal activity. Bauman v. SAIF, 295 Or 788, 794 (1983). Bauman is limited to a claim "specifically" or "officially" accepted. Johnson v. Spectra Physics, 303 Or 49, 55 (1987). The Referee concluded that Bauman was not applicable because the insurer had not specifically accepted the scleroderma condition. We disagree.

An insurer may "partially deny" a condition which has not been specifically accepted; however, in order to do so, it must specify which injuries or conditions it accepts and which it denies. Johnson, supra at 58. In this case, the insurer failed to specify what conditions it had accepted and which conditions it was denying. Accordingly, the denial is not a partial denial. As the Court stated in Johnson:

"That specificity which promotes timely closure of accepted conditions and prompts appeals of denied conditions, is the essence of a partial denial." Id.

We conclude that absent the specificity required by Johnson, a denial such as this one is, in effect, a denial of the entire claim. As such, it is precluded under Bauman.

There is no evidence that the original acceptance was prompted by fraud, misrepresentation, or other illegal activity. Accordingly, we conclude that the insurer's denial of September 1987 was an impermissible "back-up" denial.

Interim Compensation

On this record, claimant has failed to prove that the insurer declined to pay interim compensation. In fact, her testimony indicates otherwise. (Tr. 20).

Penalties and Attorney Fees

Penalties and attorney fees may be assessed when an insurer unreasonably delays or refuses the payment of compensation or the timely acceptance or denial of a claim. ORS 656.262(6) & (10). A "claim" includes "any compensable injury of which a subject employer has notice or knowledge." Former ORS 656.005(7).

We are persuaded that the insurer's processing of claimant's claims was unreasonable. The insurer acknowledged on claimant's initial "801" claim form that it "first knew of [claimant's] injury" on June 15, 1985. It had 60 days thereafter in which to timely accept or deny the claim. Former ORS 656.005(7); ORS 656.262(6). It did not do so. Not until

March 27, 1986, or well after the 60-day period, did the insurer finally accept the claim.

Moreover, the insurer's letter of June 26, 1987, expressly "cancelled" its previous acceptance of claimant's May 1987 claim. In effect, the insurer's cancellation of a previously accepted claim was a "back-up" denial. Yet, its letter provided no notice of appeal rights to claimant, see ORS 656.262(8), and went so far as to inform her that such action would have "no impact on the eventual outcome [of her claim]."

Despite our finding that the insurer's claims processing was unreasonable, a penalty, unlike an attorney fee, can be assessed only if there are "amounts [of compensation] then due." ORS 656.262(10); Mischel v. Portland General Electric, 89 Or App 140, 142 (1987); Spivey v. SAIF, 79 Or App 568, 572 (1986). On this record, there is no compensation then due for the purposes of a penalty. (Tr. 20). Accordingly, a reasonable attorney fee can be awarded.

Although claimant's counsel is statutorily entitled to a reasonable assessed fee for his services at the hearing and on Board review, ORS 656.386(1); OAR 438-15-055(2), because no Statement of Services have been received to date, the Board cannot authorize an assessed fee. OAR 438-15-010(5).

ORDER

The Referee's order dated January 4, 1988, is reversed in part. That portion of the Referee's order that affirmed the insurer's denial of September 18, 1987, is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for further processing according to law. The remainder of the order is affirmed.

NORMAN M. THOMASSON, Claimant
Charles D. Maier, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 86-18246
December 7, 1988
Order on Review

Reviewed by Board Members Johnson and Crider (special concurrence).

The insurer requests review of those portions of Referee McCullough's order which: (1) set aside its denial of chiropractic treatment in excess of the administrative guidelines; and (2) awarded an attorney's fee for the insurer's late acceptance. We affirm.

ISSUES

The primary issue is compensability of chiropractic treatments in excess of the administrative guidelines. The insurer contends that claimant has failed to prove that chiropractic treatments in excess of the administrative guidelines are reasonable and necessary.

The insurer also contends that its late acceptance of the claim was not unreasonable; therefore, no attorney's fee should have been assessed for late acceptance.

FINDINGS OF FACT

Claimant compensably injured his low back and left hip on

October 23, 1986 in a motor vehicle accident. There is no question, and never has been any question, that claimant was injured in the accident or that the accident was in the course and scope of claimant's employment. A claim was filed on the day of the injury. The insurer did not accept the claim until January 15, 1987. The insurer's justification for not accepting the claim is that it was attempting to get a statement from claimant concerning the extent of his injury, any prior medical problems and whether there was any third party involvement. Claimant resisted giving a statement.

Claimant has treated with Dr. Arden, a chiropractor, since the compensable injury. On May 4, 1987, the insurer denied chiropractic treatments in excess of the administrative guidelines.

Chiropractic treatments alleviate claimant's pain and make it easier for him to work.

CONCLUSIONS OF LAW

Unreasonable delay

Because there was never any doubt that claimant's claim was compensable, the insurer's desire to interview claimant does not provide a reasonable excuse for its delay in accepting the claim.

Chiropractic treatments

We adopt the following conclusions from the Referee's order:

"The insurer has conceded, by the way that the issue was framed at the hearing, that there is no dispute regarding a causal connection between claimant's October 23, 1986 injury and the condition for which he has been receiving treatment from Dr. Arden. The only issue is whether four treatments per month, rather than the two visit per month guideline, is reasonable and necessary.

* * *

"Based upon claimant's credible testimony and Dr. Arden's opinion,...I find that claimant has established that his treatment frequency since the May 1987 denial has been reasonable and necessary to give him temporary pain relief and to help him to continue working."

ORDER

The Referee's order of November 4, 1987 is affirmed. Claimant's attorney is awarded a reasonable attorney's fee of \$650 for services on Board review in connection with the denial issue. A client paid fee, not to exceed \$778.50, is approved.

Board Member Crider, specially concurring.

I concur that the Referee's order setting aside the insurer's denial of all chiropractic treatment in excess of two per month after the date of the denial should be affirmed.

Chairman Johnson concludes that chiropractic treatment was efficacious and that Dr. Duncan's contrary opinion did not support the insurer's position that two treatments per month are reasonable and necessary but that four per month are not. While I find Dr. Duncan's opinion that no manipulative treatment is in fact valuable in the treatment of claimant's accepted condition worthy of consideration, the insurer has not denied manipulative treatment for claimant's condition as of the date of the denial. Instead, the insurer conceded that manipulation was appropriate and sought, without medical support, to limit only its frequency. For this reason alone, I concur with Chairman Johnson's opinion.

I also believe the denial must be set aside because it is purely prospective in nature; it does not address any treatment for which a claim has been made and instead denies all future treatment in excess of two per month without regard to any changes that may occur in claimant's condition. The Board has periodically observed that a denial speaks only to treatment claimed to the date of the denial. Arlene S. Pettit, 40 Van Natta (October 10, 1988); Patricia M. Dees, 35 Van Natta 120 (1983). This denial addresses no claim for treatment but simply seeks to cut off claimant's entitlement to future treatment on an accepted claim. It is, therefore, void. June Jelen, 40 Van Natta 1175 (1988).

CHERRY WALKER, Claimant
S. David Eves, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 86-10937
December 7, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Gary Peterson's order that set aside its denial of claimant accidental injury claim for a low back condition. It also contends that the Referee erred in admitting an exhibit. We affirm on the evidentiary issue, but reverse on the issue of compensability.

ISSUES

1. The admissibility of Exhibit 11.
2. The compensability of claimant's low back condition.

FINDINGS OF FACT

Claimant began working as an activity assistant for the employer, a nursing home, in July 1983. In this position, claimant helped plan and coordinate activities for the nursing home residents. The work generally was light in nature. In November 1985, however, after one of the activities was scheduled in the lunch room, claimant and her co-workers had to move about a dozen large tables weighing approximately 40 to 60 pounds apiece twice per day; once to clear the room for the activity and again to put the tables back in place.

Claimant sustained a nonindustrial injury to her low back prior to her employment at the nursing home and underwent a laminectomy at L3-4 in 1971. (See Tr. 8; see also reference to scar tissue at L3-4 in Ex. 1-16). Since that time, she had periodic bouts of low back and right leg pain. (See Ex. 7). During early 1986, claimant experienced a mild increase in low back pain. She mentioned this pain to her supervisor in late January 1986, but told him it was not work related. (Tr. 41).

Claimant contracted the flu on January 31, 1986 and was off work for about two weeks. Immediately after recovering from this illness, she sought treatment from a chiropractor, Dr. Pullen, for low back pain. Claimant told Dr. Pullen that her pain had begun about two weeks previously during her illness. (See Ex. 6). Chiropractic treatment did not improve claimant's condition and she began treating with Dr. Buza, a neurosurgeon, in March 1986. Claimant told Dr. Buza that her back pain had begun after an episode of coughing about five weeks earlier (i.e. during her illness). (Ex. 1-4; see also Ex. 1-25). After a myelogram, which revealed a herniated disc at L3-4, claimant underwent surgery at that level in mid-March 1986. She filed her claim with the employer about two months later. (See Ex. 2-1, 9; Tr. 14-16).

The hearing was held on November 5, 1986. At the beginning of the hearing, the parties agreed to leave the record open for receipt of a report from Dr. Buza, subject to the insurer's right to cross-examine him. (Tr. 1-3). A report by Dr. Buza dated November 4, 1986 was received by claimant's attorney a short time after the hearing and was forwarded to the Referee. (See Ex. 10). Subsequently, claimant's attorney obtained an additional report from Dr. Buza and submitted it as well. (Ex. 11). Claimant's attorney received the report on December 17, 1986. The Hearings Division received the report five days later. The insurer objected to this second report, (see Ex. 12), but the Referee admitted it along with Dr. Buza's first report after closing arguments on December 31, 1986. The insurer made no request to cross-examine Dr. Buza.

The coughing episode associated with claimant's bout with the flu in late January and early February 1986 was the cause of the herniation of her L3-4 disc. Her work activity was not a material contributing cause of the condition.

CONCLUSIONS OF LAW

Evidence

At the time of the hearing in this case, submission of documents at hearings was governed by former OAR 438-07-005. Under paragraph (3)(b) of that section, Referees were required to admit any document submitted by a party within seven days of the party's receipt of the document regardless of whether the document was submitted in accordance with the deadlines otherwise imposed by the section. See John M. Bowman, 37 Van Natta 1626 (1985); Merle Barry, 37 Van Natta 1492 (1985). Other subsections gave Referees broad discretion to admit any evidence untimely submitted, whether before or after closure of the record. Former OAR 438-07-005(4); 438-07-025(1). The Board and the courts have long encouraged the exercise of discretion in evidentiary matters in favor of admission so long as the fundamental fairness of the proceeding is not compromised. See Lucke v. Compensation Department, 254 Or 439, 442-43 (1969); Cristofano v. SAIF, 19 Or App 272, 273, 275 (1974); James Albers, 34 Van Natta 1621, 1623 (1982).

Claimant's attorney submitted Exhibit 11 to the Referee within seven days of receiving it. The record was still open at that time and remained open until the completion of closing arguments. If the Referee was not required to admit the exhibit under former OAR 438-07-005(3)(b), he certainly had discretion to do so. The Referee gave the insurer the opportunity to cross-examine the author of the exhibit, but the insurer declined to do so. Under these

circumstances, the admission of Exhibit 11 did not compromise the fundamental fairness of the proceeding and the insurer has no basis for its objection. See Richard O. Birkmaier, 38 Van Natta 450 (1986).

Compensability

The Referee found claimant's low back condition compensable using an accidental injury analysis. The insurer contends on Board review that the case should be analyzed under an occupational disease standard. We need not decide this question because we conclude that under either analysis, claimant's condition is not compensable.

To establish the compensability of her condition on an occupational disease theory, claimant has the burden of proving that her work activity for the employer was the major contributing cause of either the onset or a worsening of her condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., *supra*, 295 Or at 309-10; Clark v. Erdman Meat Packing, 88 Or App 1, 5 (1987). "Worsening" in the occupational disease context means pathological exacerbation of the underlying condition. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985); Weller v. Union Carbide Corp., 288 Or 27, 31-35 (1979).

To establish the compensability of her condition on an accidental injury theory, claimant has the burden of proving that her work activity was a material contributing cause of her disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Lobato v. SAIF, 75 Or App 488, 492 (1985). Claimant need not show a pathological exacerbation of her preexisting condition in order to prevail on an accidental injury theory. Harris v. Albertson's, Inc., *supra*, 65 Or App at 256-57.

There is no question that claimant's low back condition pathologically worsened and that the worsened condition resulted in disability and required medical services. The focus of the inquiry, therefore, is whether there is at least a material causal connection between the worsening and claimant's work activity. Because the worsening of claimant's condition was not directly associated with any particular event at work and occurred while claimant was at home with the flu, the question of the contribution of claimant's work activity to the worsening is primarily a medical question which requires expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The contemporary medical records attribute the worsening of claimant's condition solely to her bout with the flu. (Ex. 1-4, 1-25, 6). The only medical evidence which suggests any work contribution was Dr. Buza's post-hearing report. In that report, Dr. Buza endorsed a statement prepared by claimant's attorney to the effect that claimant's work activity was "a material contributing factor" in the worsening of her low back condition. (Ex. 11). We do not find this opinion persuasive, however, because the factual basis of the opinion was inaccurate.

Dr. Buza assumed for purposes of his opinion that claimant had never experienced right leg pain before November 1985 and that this pain gradually appeared in connection with her work activity after that time. (See Ex. 10, 11). Claimant's testimony on direct examination was to the same effect. (Tr. 12). On cross-examination, however, claimant conceded that this history was inaccurate and that she had experienced right leg pain since at least June of 1979. (Tr. 24-25). This concession is further confirmed by the chart notes of Dr. Pullen. (See Ex. 7). The inaccurate factual basis of Dr. Buza's opinion nullifies any probative value it might otherwise have had. See Somers v. SAIF, 77 Or App 259, 263 (1986). There is thus no probative medical support for claimant's claim.

To the extent that claimant's own testimony may be cited in favor of her claim, we find that testimony unreliable. Claimant did not attempt to attribute her condition to work activity until two months after her surgery. She later told Dr. Pullen that she had not filed a claim sooner because she was afraid that her employment would be terminated if she did. (Ex. 6). She abandoned this assertion at the hearing and conceded that she had filed a previous claim with the employer. (Tr. 10). Instead, she asserted that she had not filed her claim sooner because she did not think she was eligible for workers' compensation benefits due to her prior noncompensable low back surgery. (Tr. 14-15). These inconsistencies, along with the inconsistency concerning her right leg symptoms mentioned in the previous paragraph, prevent us from relying on claimant's testimony. We conclude that claimant has failed to carry her burden of proving a compensable injury.

ORDER

The Referee's order dated January 23, 1987, as supplemented by the Order on Reconsideration dated February 20, 1987, is reversed. The insurer's denial is reinstated and upheld.

ADOLPH W. WENDE, Claimant

WCB 86-16961

Brothers, Drew & Tiktin, Claimant's Attorneys

December 7, 1988

Schwabe, et al., Defense Attorneys

Order Denying Request

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 22, 1988 Order on Review. The request is denied.

FINDINGS

The Board's February 22, 1988 order affirmed a Referee's order that upheld the insurer's denial of claimant's injury claim and declined to assess a penalty and attorney fee for an alleged unreasonable denial. The order, which did not address either the amount of, or entitlement to, a client-paid fee, has not been appealed, abated, stayed, or republished.

On April 22, 1988, the insurer's counsel sought authorization of a client-paid fee for services rendered on Board review. The request did not include an executed retainer agreement.

CONCLUSIONS

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, 447 (1986).

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Furthermore, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988); Farmers Ins. Group v. SAIF, supra.

Relying upon these authorities, we have previously held that we have jurisdiction to consider requests for authorization of client-paid fees where our Order on Review did not address the issue of either the insurer's counsel's entitlement to, or the amount of, a client-paid fee. Jane E. Stanley, 40 Van Natta 831 (1988). However, we have concluded that to receive authorization, the request must be in compliance with the Board rules. Stanley, supra.

Consequently, requests must be accompanied by an executed retainer agreement and a statement of services, which shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-010(1); 438-15-010(5); 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003; Stanley, supra.

Here, the authorization request has not been accompanied by an executed retainer agreement or attorney referral letter. Under such circumstances, authorization cannot be given. See OAR 438-15-010(1). Even had acceptable documentation establishing legal representation been submitted, the request would still not receive our authorization. We reach this conclusion because the insurer's counsel has submitted a statement of services approximately two months after the issuance of the Board's February 22, 1988 order. Consequently, it is untimely. See OAR 438-15-027(1)(d); Stanley, supra.

As stated in Stanley, we recognize that administrative problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. However, we continue to believe that the difficulties occasioned by this adjustment should not cause us to ignore the very rules which have been implemented.

Accordingly, because the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and since our order on the merits has become final by operation of law, we decline to authorize the insurer's counsel's request.

IT IS SO ORDERED.

MICHAEL F. WEST, Claimant
Vick & Gutzler, Claimant's Attorneys
Brian L. Pocock, Defense Attorney
Garrett, et al., Defense Attorneys
Acker, Underwood, et al., Attorneys

WCB 85-08532 & 86-02729
December 7, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Peterson's order that set aside its denial of claimant's aggravation claim for his back condition. We affirm.

ISSUE

Responsibility for claimant's back condition.

FINDINGS OF FACT

Claimant, 28 at hearing, was originally injured while working for Liberty Northwest's insured. He sprained the thoracolumbar area of his back while lifting a wooden stool on May 1, 1984. He received conservative treatment from Dr. Martens, orthopedist, and returned to work on May 14, 1984. Dr. Martens released him to work without restrictions. He received no award of permanent disability.

In October 1984, claimant began working for an electrical contractor. At that time, and until April 1, 1985, the contractor was insured by State Farm Insurance. After April 1, 1985, the insurer at risk was Aetna Technical Services.

Claimant's work duties for the contractor were light to medium, and included sorting small electrical parts, pulling wire overhead, digging light pole holes, driving truck, and occasional carrying of 25 to 50 pound light fixtures.

Since his original injury, claimant's symptoms of back pain and spasms have progressively worsened. The worsening is not tied to his work activities for the electrical contractor; non-work activities aggravate his symptoms as well. As a result, claimant has foregone most of his active leisure-time hobbies.

In mid-April 1985, claimant was temporarily laid off. At about the same time, he became aware that he could receive medical treatment for his back injury, and he returned to Dr. Martens. Dr. Martens told claimant that he had no treatment to offer. Claimant then went to Dr. Holzapfel, chiropractor. Dr. Holzapfel took claimant off work and began a course of regular chiropractic treatment. Claimant has not returned to work.

Claimant's underlying condition has not worsened, but the symptoms of his original injury have worsened.

CONCLUSIONS OF LAW AND OPINION

The insurer on the risk at the time of the compensable injury remains responsible for the injury unless work activity at a time when a subsequent insurer is on the risk independently contributes to a worsening of the underlying condition. Boise Cascade v. Starbuck, 296 Or 238 (1984). A mere worsening of symptoms is insufficient to constitute a new injury, and to shift responsibility to a later insurer. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

Liberty contends that, under the last injurious exposure rule, Aetna bears the burden of proving that work activity while it was on the risk did not worsen claimant's underlying condition. It further contends that Aetna has not met that burden of proof. The Court of Appeals has recently attempted to clarify the application of the last injurious exposure rule to responsibility cases involving accidental injuries. Champion International v. Castilleja, 91 Or App 556 (1988). In Castilleja, the court stated that where the evidence shows only work-relatedness, but fails to establish actual responsibility, the finding is against the last insurer. However, if the evidence convinces the trier of fact that the disability was actually caused by the earlier employment and that the later employment did not independently contribute to it, such a finding may be made. Such is the case here.

Claimant was first injured while working as a janitor for Liberty's insured. He suffered a thoracolumbar strain which caused him to be off work for two weeks. Thereafter, he returned to work. His treating physician, Dr. Martens, told him that his symptoms would gradually resolve. They did not. Instead, they gradually worsened. His muscle spasms began occurring more frequently, and he began to lose sleep because of them.

In the fall of 1984, claimant took a new job as an electrician's assistant. He performed a variety of tasks for the electricians, from sorting parts to delivering inventory to digging holes and pulling wire. Dr. Martens testified that the more strenuous of these activities probably contributed independently to claimant's condition. However, he also testified that a temporal connection between activities and pain did not necessarily constitute a causal connection, and that claimant's underlying condition was not worse following his employment as an electrician's assistant. We find that, taken as a whole, Dr. Martens' testimony is that claimant's second job could have contributed to his condition but that there is no proof that it did. This is insufficient to shift the burden of responsibility from Liberty's insured.

Claimant's second treating physician, Dr. Holzapfel, concurred with Dr. Martens regarding probable contribution of claimant's second job to his condition. He admitted, however, that he did not treat claimant following his original compensable injury, and he therefore declined to opine whether claimant had an aggravation or a new injury.

Claimant himself did not consider that there was a causal relationship between his worsening symptoms and his work for the electrical contractor. He had spasms and pain as frequently off-work as on-work. He also noted no particular link between the strenuousness of his day's activities and the severity of his symptoms.

We find the evidence convincing that claimant's symptoms remain causally related to his compensable injury while Liberty was on the risk. We therefore decline to invoke the last injurious exposure rule to shift responsibility to Aetna.

ORDER

The Referee's order dated April 1, 1987 is affirmed. A client-paid fee, payable from Aetna to its counsel, is approved, not to exceed \$455.

DAVID L. WHITLOW, Claimant
Robert H. Grant, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB TP-88014
December 7, 1988
Third Party Partial Distribution
Order

Claimant has petitioned the Board to resolve a conflict concerning the distribution of proceeds from a third party settlement. See ORS 656.593(3). We find that the paying agency is entitled to receive reimbursement for its actual claim costs. However, disbursement of future claim costs is deferred as premature.

FINDINGS OF FACT

In September, 1983, claimant sustained a compensable injury to his low back. After a course of conservative medical treatment, his claim was eventually closed by a Determination Order on October 9, 1986, which awarded periods of temporary disability and 10 percent (32 degrees) unscheduled permanent disability. Claimant requested a hearing and a Referee awarded him an additional 10 percent (32 degrees) unscheduled permanent disability, for a total award of 20 percent (64 degrees). Thereafter, claimant requested Board review. The issue of his extent of permanent disability is presently pending review by the Board.

In addition to filing a workers' compensation claim, claimant elected to pursue a third party action. See ORS 656.576, et seq. After filing a civil suit against the third party, he and the third party's insurer agreed to settle the case for \$50,000. The paying agency, Argonaut Insurance Companies ("Argonaut"), approved the settlement. After deducting claimant's costs, attorney's fees, and his 1/3 share in accordance with ORS 656.593(1)(a) & (b), the balance remaining was \$20,179.88.

Thereafter, Argonaut entered into negotiations over disbursement of the \$20,179.88. On September 30, 1986, claimant tendered a check to Argonaut in the amount of \$9,395.37, which reimbursed Argonaut for its actual expenditures through that date.

Argonaut's actual claim costs incurred through September 30, 1986, totalled \$9,395.37. Thereafter, it incurred additional claim costs of \$6,039.29.

CONCLUSIONS OF LAW

If the worker or beneficiaries settle the third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). Thereafter, the paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. ORS 656.593(1)(c). Such other costs do not include any compensation which may become payable under ORS 656.273 or 656.278. Id. Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

The parties disagree as to whether the \$9,395.37 payment reimbursed Argonaut through only July 31, 1986, or through September 30, 1986. Argonaut asserts that it expended \$329 in medical expenses between August 27, 1986, and September 16, 1986, which were not included in the \$9,395.37 payment. Claimant, on the other hand, contends that the \$9,395.37 payment covered all of Argonaut's expenses through September 30, 1986.

Argonaut has presented no persuasive evidence that would establish that the \$9,395.37 payment did not reimburse it for all of claimant's medical expenses that had accrued through September 30, 1986. In the absence of such evidence, we conclude that the \$9,395.37 payment included reimbursement to Argonaut for the disputed \$329 in medical expenses incurred between August 27, 1986 and September 16, 1986. Therefore, the remaining balance for disbursement purposes is \$10,784.51.

The parties agree that after September 30, 1986, Argonaut paid out \$6,039.29 in permanent disability compensation and medical benefits. Therefore, claimant's attorney is directed to pay to Argonaut, as reimbursement for its actual claim costs incurred to date, beyond the initial reimbursement of September 30, 1986, the sum of \$6,039.29.

Because claimant's extent of permanent disability is presently pending Board review, there has been no final determination of that issue. We, therefore, defer ruling on the question of Argonaut's entitlement to a lien for anticipated future claim costs. John T. Elicker, 40 Van Natta 68 (1988).

Accordingly, claimant's attorney is directed to disburse \$6,039.29 to Argonaut Insurance Companies, as reimbursement for its actual claim costs incurred to date. The remaining balance of the proceeds from the third party settlement, \$4,745.22, shall be held by claimant's attorney in trust pending a final determination concerning the extent of claimant's permanent disability. Upon final resolution of the disability issue, the parties shall notify the Board of their respective positions. Should a dispute continue to exist, the Board will order distribution of the remaining balance.

IT IS SO ORDERED.

JUDY WITHAM, Claimant
Brink, Moore, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Edward C. Olson, Defense Attorney

WCB 87-00640 & 86-13903
December 7, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

North Pacific Insurance Company (North Pacific) requests review of those portions of Referee Neal's order that: (1) set aside its denials of responsibility and compensability of claimant's "new injury" claim for her low back and cervical conditions; and (2) assessed penalties and related attorney fees. We affirm.

ISSUES

1. Whether claimant's low back and cervical conditions are compensable.

3. Whether claimant's low back and cervical conditions are the result of an aggravation of a prior compensable injury or are new injuries.

3. Whether claimant is entitled to penalties and related attorney fees for the last employer's failure to provide a claim form.

FINDINGS OF FACT

On April 28, 1980, claimant, a nurse's aide for an employer insured by EBI Companies, compensably injured her neck and low back while lifting a patient. Claimant experienced immediate neck and low back pain which radiated down her left arm and left leg. She treated conservatively with Dr. Thomas, orthopedist, and then Dr. Blaylock. In December 1980 a myelogram revealed a small herniated disc at C5-6 on the left and a bulging L4-5 disc.

In February 1981, Dr. Nash, neurosurgeon, performed a cervical laminotomy at the C5-C6 level with a facetectomy for root relief and a posterior wire stabilization of the C4-5-6 spinous processes. Following surgery, claimant continued to treat with Dr. Blaylock. In July 1981 a CT scan of claimant's lumbar spine was negative for focal disc lesion. During 1981 claimant moved to Texas and was treated conservatively for neck and back pain. She returned to Oregon near the end of 1981. In December 1981 Dr. Nash reviewed a multiple level myelogram and diagnosed defects in the cervical area and a bulging disc at L4-5.

On April 8, 1982, claimant's claim was closed by a Determination Order that granted her 20 percent unscheduled permanent disability resulting from injury to her neck. As a result of that injury, she was unable to return to her former occupation as a nurse's aide.

Claimant was evaluated at the Callahan Center and referred for vocational assistance and an authorized training program to help her in returning to light work. Claimant took courses at the community college in typing and math. She continued to have neck pain that radiated down her left arm and less severe low back pain that radiated down both her legs at times, although mainly down her left leg.

In the fall of 1982 Dr. Fisher, neurologist, reported that claimant exhibited a severe depression of her left ankle reflex. Dr. Nash stated that claimant was not medically stationary as a result of her herniated L4-5 disc, but he did not recommend surgery at the time. Instead, he suggested that she be referred to the Northwest Pain Center (NWPC).

In November 1982 claimant was evaluated at the NWPC, but was not admitted to the program due to her focus on obtaining additional surgery to her neck and low back.

In December 1982 Dr. Milleson, radiologist, reviewed x-rays of claimant's cervical area and diagnosed small anterior extradural defects at C5-6 and C6-7. In January 1983, Dr. Nash performed surgery to remove the wire, which had broken from claimant's neck.

On September 20, 1983, a second Determination Order increased claimant's unscheduled permanent disability of her neck to 40 percent. On November 2, 1984, her unscheduled permanent disability award was increased by stipulation to 52.5 percent.

In March 1984 claimant finished her basic skills "brush-up" course and "entry clerical" classes at the community college and began looking for employment. At that time, she continued to experience occasional low back and neck pain.

In May 1984 claimant began working two jobs. She worked full-time as a retail sales demonstrator for another employer until approximately January 1986, maintaining inventory, stocking shelves and demonstrating products to the public. She also worked part-time for a pizza parlor, bartending and bussing tables. At the start of 1986 she worked at a convenience store, stocking shelves and waiting on customers. During that entire period, claimant sought no medical treatment and had no serious recurrent neck or low back pain which limited her ability to perform those jobs. She experienced occasional low back and neck pain with no radiating pain into her extremities. She also had mild bimonthly headaches.

On May 1, 1986, claimant began working for International Bulk Wines (IBW), insured by North Pacific. Her duties included light clerical and warehouse work. The warehouse work involved stacking 30 pound cases of wine. They were stacked in the warehouse on pallets which averaged three feet in height. Pallets were stacked one on top of another. In order to retrieve cases of wine from these stacked pallets, claimant was required to climb up the side without the aid of a ladder and slide the cases off the top. A cart was available to move the cases of wine from the warehouse to the staging area. The work at IBW was only slightly more physically demanding than claimant's three prior jobs.

Claimant had been working for IBW for approximately two and a half weeks when she began to develop increasing sharp pain and burning in the low back, muscle spasms in her neck and worsening headaches. No specific incident occurred to account for this increase in symptoms. About a week prior to her termination from IBW, claimant reported to her supervisor that she had headaches or did not feel well. Claimant, however, did not relate these symptoms to her work. On June 2, 1986, her back and neck pain worsened after stacking cases of wine. On June 3, 1986, claimant's employer discussed her poor job performance with her.

On June 4, 1986, claimant was terminated from her position because of her inability to handle the clerical tasks. Claimant felt fairly well that day, although she had experienced headaches and low back pain the night before. Following claimant's termination, she informed her employer that she had experienced headaches and back pain while moving cases of wine. Claimant asked her employer for an injury claim form, but was told that there were no forms at the office and the employer needed to see a doctor's report before one would be provided.

Claimant immediately sought treatment from Dr. Ott, osteopath. He diagnosed an acute cervical and back strain with a previous history of a cervical laminectomy. He treated claimant twice a week with medication, manipulation and physical therapy. Notwithstanding Dr. Ott's treatment, claimant's symptoms remained constant. She suffered painful headaches three to four times per week and her low back pain radiated into both legs, although mainly in the left.

On June 27, 1986, claimant signed a work injury form which she had obtained through the Workers' Compensation Department. On July 7, 1986, North Pacific, IBW's insurer, received the form.

On July 29, 1986, claimant was examined by Dr. Fisher, neurologist, who found focal tenderness at C5-6, over the lumbosacral junction and the greater sciatic notch on the left. Given these positive findings, Dr. Fisher referred claimant back to Dr. Nash.

On September 26, 1986, North Pacific denied responsibility for claimant's condition, contending that medical information indicated that it was an aggravation of her 1980 compensable injury with EBI.

By the fall of 1986, claimant exhibited: (1) an absent ankle reflex on the left; and (2) weakness of the left posterior tibial musculature. Although claimant had exhibited a severe depression of her left ankle reflex in November 1984, neither of these two positive findings existed prior to claimant's employment with IBW.

On October 6, 1986, Dr. Quilici, radiologist, reviewed a nuclear magnetic imaging study (MRI) of claimant's lumbar spine and diagnosed a broad-based disc bulge at L4-5, more prominent to the left of midline, with mild left foraminal stenosis and a mild disc protrusion on the left at L5-S1.

On January 9, 1987, EBI denied responsibility for claimant's condition based upon medical information which indicated that claimant had sustained a new injury.

On January 12, 1987, at the request of North Pacific, an ORS 656.307 Order was issued which: (1) stated that both insurers agreed responsibility was the only issue; and (2) designated EBI as paying agent.

On April 9, 1987, North Pacific modified its denial of responsibility to deny compensability as well.

At the time of hearing, claimant, who was a credible

witness, had finished her course of physical therapy. She was not working nor had she been released to work. She was wearing a cervical collar on the advice of Dr. Nash.

Claimant's work activities at IBW were the sole cause of her L5-S1 disc herniation and worsening low back symptoms. Those same work activities independently contributed to claimant's cervical disability.

CONCLUSIONS OF LAW

Compensability of claimant's low back and neck conditions

The Referee found that claimant had proven the compensability of her condition since she had worked for almost two years without either physical problems or need for medical treatment, but after June 1986 needed treatment again, was not stationary and had objective evidence of injury. We agree that claimant's claim was compensable, but for different reasons.

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987). Before proceeding to the issue of compensability, however, we first must determine whether compensability is even at issue.

ORS 656.307(1)(c), in effect at pertinent times herein, stated that where there is an issue regarding responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries, the director shall, by order, designate who shall pay the claim, if the claim is otherwise compensable.

OAR 436-60-190(5), in effect at pertinent times herein, stated that when the compensability of a claim becomes an issue subsequent to the designation of a paying agent, the Compliance Division shall order termination of any further benefits due from the original order designating a paying agent. Although the rule allows the withdrawal of a .307 Order prior to hearing, it does not specify under what circumstances, if any, that withdrawal may be effectuated. To answer that question, we turn to the caselaw.

In Bauman v. SAIF, 295 Or 788 (1983), SAIF specifically accepted a claim as compensable by providing the claimant with an acceptance letter and subsequently paying medical benefits for a three-year period. Id. at 793. It was only after claimant attempted to reopen his claim for aggravation that SAIF suddenly reversed its decision and denied compensability for the original claim. Id. The court concluded that SAIF could not subsequently deny the claim, since to allow or encourage the employer or insurer to engage in such vacillating activity would encourage degrees of instability in the worker's compensation system that they did not believe the statute contemplated. Id. See Ebbtide Enterprises v. Tucker, 303 Or 459, 463 (1987). The Court held that if the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days from notice of the claim have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. (Emphasis added). Id. at 794. See Johnson v. Spectra Physics, 303 Or 49 (1987).

On September 26, 1986, North Pacific, denied responsibility for claimant's neck and low back condition since medical information indicated that her condition was not a new injury, but rather an aggravation of her 1980 compensable injury. On January 9, 1987, EBI also denied responsibility for claimant's neck and low back condition. Both insurers conceded the compensability of claimant's neck and low back claim. On January 12, 1987, as a result of those concessions, the director issued a .307 Order designating EBI as the paying agent until the issue of responsibility could be resolved. Both insurers specifically agreed that responsibility was the only issue. On April 9, 1987, however, North Pacific amended its denial of responsibility to include compensability as well.

The Director's issuance of the .307 Order, which specifically stated that both insurers agreed responsibility was the only issue, memorialized a specific acceptance of the compensability of claimant's neck and low back condition by both insurers. When North Pacific amended its denial of responsibility to include compensability, more than 60 days had elapsed since it had received notice of claimant's claim. It could not thereafter deny the compensability of claimant's claim unless it established fraud, misrepresentation or some other illegal activity. The issuance of a .307 Order constitutes a specific formal acceptance by both insurers. The insurers could not subsequently deny the compensability of claimant's condition because such vacillation would encourage a degree of instability in the workers' compensation system that the statute does not contemplate. See Johnson v. Spectra Physics, supra at 54.

Therefore, where the insurers concede compensability and a .307 subsequently issues, the Board will treat that order as a final resolution of the compensability issue. An insurer may back out of its acceptance of compensability, as formalized by the .307 order, and successfully raise a compensability issue, only if one of the Bauman exceptions is established.

In the present case, although claimant did not immediately inform her employer at IBW when she initially began to experience increasing neck and back pain, we agree with the Referee that claimant did have increased problems on June 2, 1986, especially in her low back, after lifting cases of wine. Claimant specifically gave a history to physicians and investigators of increased pain after lifting boxes on that date. Since she ordinarily filled the staging area with wine cases before the employer or the supervisor reported to work, they may not have known if claimant lifted wine on that date. We accept claimant's testimony that she did. Finally, claimant had not had medical treatment for her condition and had worked for almost two years without problems. After June 1986, however, she needed treatment again, was not stationary and had objective evidence of injury. The employer presented no evidence to establish fraud, misrepresentation or other illegal activity by claimant. Therefore, the compensability issued cannot be litigated.

Assuming arguendo that the issuance of the .307 Order did not constitute a formal acceptance of compensability, claimant still proved by a preponderance of the evidence that her neck and low back condition is compensable. Therefore, in either case, the claim is compensable.

Responsibility

The Referee found North Pacific to be the responsible insurer for claimant's neck and low back condition. She based her conclusion that claimant had sustained a new injury upon the medical evidence and claimant's testimony. We agree that claimant suffered new injuries to her low back and neck.

Responsibility will shift to the last employer if the second incident contributes independently to the injury. Hensel Phelps Const. v. Mirich, 81 Or App 290, 294 (1986). Worsened symptoms alone are not enough to place responsibility on the second employer; there must be a worsening of the underlying condition. Id.

Responsibility for low back condition

When claimant's claim was closed by stipulation in November 1984, she was exhibiting a severe depression of her left ankle reflex as well as a bulging disc at the L4-5 level. There was no evidence of lumbar nerve root compromise nor a disc involvement at the L5-S1 level. In June 1986, however, claimant's left ankle reflex was completely absent and she exhibited a disc protrusion at L5-S1 as well as L4-5.

Initially following the June 1986 injury, Dr. Nash believed that claimant had merely suffered an aggravation of her compensable low back condition. However, at that time, Dr. Nash had not seen claimant since March 1983. Based upon a complete review of the medical records, which chronicled claimant's condition from 1983 to 1986, specifically those from the Orthopaedic Consultants, Dr. Nash later concluded that claimant's low back condition was due entirely to the 1986 injury at IBW. That opinion was based upon claimant's 1986 positive objective findings of an absent left ankle reflex and a previously unrecorded bulging disc at the L5-S1 level. On October 2, 1986, Dr. Nash opined that claimant had signs and symptoms of preforaminal and/or foraminal nerve root compression involving the L5 nerve root on the left.

Claimant herself testified that she had experienced no significant low back difficulty for approximately two years prior to June 1986. Although she felt occasional pain, it did not limit her activities and she never sought medical care during that time. Approximately two weeks after starting work for IBW, however, claimant began to notice increasing sharp pain and burning in the low back and legs and worsening headaches. Stacking cases of wine caused this increase in symptoms. On June 2, 1986, after stacking cases of wine, claimant experienced a significant worsening of her low back symptoms and finally sought medical treatment on June 4, 1986.

Based upon the positive objective changes in claimant's low back and claimant's credible testimony that she experienced no disabling symptoms prior to her work at IBW, we are persuaded that the work activities at IBW independently contributed to the causation of claimant's low back condition and North Pacific is now responsible for that condition.

Responsibility for neck condition

In 1981 Dr. Nash performed a cervical laminotomy at C5-6
-1987-

on the left with a medial facetectomy at C5-6 on the left for root relief and a posterior wire stabilization of the C4-5-6 spinous processes. In February 1982 the Orthopaedic Consultants diagnosed, among other things, chronic cervical strain syndrome with radiation of pain into the left upper extremity. In 1982 Dr. Milleson reviewed a cervical myelogram and diagnosed small anterior extradural defects at C5-6 and C6-7. In 1983 Dr. Nash removed the wire in claimant's neck. In November 1983 claimant received a total of 52.5 percent unscheduled disability for injury to her neck. At that time, her symptoms included bimonthly headaches and pain and numbness in her neck, radiating down her left arm. In March 1984 the Orthopaedic Consultants again diagnosed chronic cervical strain.

During the next two years claimant continued to experience the headaches and neck pain. However, she was able to function and worked at three different jobs, although all three involved bending, standing and lifting. She did not miss work due to her neck condition nor did she seek medical treatment. Claimant's credible testimony was corroborated by the testimony of her daughter and a former supervisor.

When claimant began working for IBW, her headaches gradually increased. When she finally sought medical treatment on June 4, 1986, it was for both her low back symptoms and headaches.

On June 4, 1986, Dr. Hornick reviewed cervical spine x-rays and observed no abnormalities. On June 5, 1986, Dr. Ott, diagnosed acute cervical strain and attributed this condition to a date of injury of June 3, 1986. On July 29, 1986, Dr. Nash found that claimant had focal tenderness at C5-6 and diminished cervical motion of all parameters due to pain. On March 24, 1987, Dr. Lewin, radiologist, reviewed a CT scan of claimant's cervical spine and observed no abnormalities.

Based upon the medical and lay evidence, we are persuaded that claimant's work activities at IBW independently contributed to the causation of her cervical condition. Hensel Phelps v. Mirich, supra. For two years prior to her job at IBW, she had functioned well with only slight neck pain and occasional headaches. She sought no medical treatment during that time nor did she miss any work as a result of that pain. Claimant had been working for IBW for approximately two and a half weeks when she began to develop muscle spasms in her neck and worsening headaches, occurring at a rate of three to four times per week. On June 5, 1986, Dr. Ott verified an acute cervical strain. Even though claimant's cervical condition would probably have been much less severe in the absence of her prior condition, and even though the prior injury contributed the major part to the final condition, we find that the work activities at IBW independently contributed to the injury by causing an acute cervical strain. Therefore, responsibility for claimant's cervical condition shifts to North Pacific.

Penalties and attorney fees

The Referee assessed a penalty and attorney fees against North Pacific for the unreasonable failure of its insured to provide claimant with a claim form. We agree.

their insurers in processing claims. Subsection (3) states that employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. Failure to comply with those provisions subjects the offending employer to a charge for reimbursing the insurer for any penalty the insurer is required to pay under ORS 656.262(10). ORS 656.262(10) allows for a penalty up to 25 percent of amounts then due for unreasonable delays or refusal to pay compensation, and unreasonable delays in accepting or denying a claim.

Claimant's compensation payments were necessarily late since North Pacific did not receive the claim until July 7, 1986, and the employer first had knowledge of the claim on June 4, 1986. The first installment of compensation is due 14 days after the employer has notice or knowledge of the claim. North Pacific's denial on September 26, 1986 was late since it was not filed within 60 days of the date the employer had notice or knowledge of the claim. Therefore, we agree with the Referee that claimant is entitled to a 25 percent penalty of the untimely paid time loss compensation and a separate attorney fee of \$150.

ORDER

The Referee's order dated July 27, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of \$550, to be paid by North Pacific. The Board also approves a client paid fee from EBI to its counsel, not to exceed \$150.

KAROL K. WOOD, Claimant
Ackerman, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 85-06272 & 86-01877
December 7, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of those portions of Referee Nichols' order that: (1) set aside its denial insofar as it denied responsibility for claimant's upper extremity and neck and back conditions; and (2) found that claimant's January 1984 injury claim was prematurely closed by a September 5, 1984 Determination Order. Claimant cross-requests review of that portion of the order that upheld the employer's partial denial of her claim for a mood and sleep disorder. Should we find that her upper extremity, neck and back conditions are not compensable, claimant also contends that the employer's denial is an improper "back-up" denial. In addition, should we find that her claim was not prematurely closed, claimant contends that: (1) she experienced a compensable aggravation of her condition in August 1984; (2) she is entitled to a penalty and attorney fee for the employer's alleged unreasonable failure to process her aggravation claim; and (3) she is entitled to scheduled and unscheduled permanent disability awards, for her hands, forearms, neck, back and psychiatric conditions, in addition to her current award of 5 percent (16 degrees) unscheduled permanent disability for her back condition.

On review, the issues are compensability, propriety of the employer's denial, premature closure, penalties, attorney fees and extent of permanent disability.

We reverse the Referee's ruling on the compensability of claimant's mood and sleep disorder. We affirm on the remaining issues.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the finding that a carpal tunnel release was performed on claimant's left hand. We instead find that the surgery was performed on the right hand. We make the following additional findings.

Claimant has worked in the employer's mill since 1977. In late 1982, she developed bilateral carpal tunnel syndrome. Her claim for that condition was accepted as a work-related injury. She aggravated her carpal tunnel condition when she strained her wrists in November 1983. The claim for that injury was closed by Notice of Closure issued on August 9, 1984.

Claimant's work-related fall in January 1984 was processed as a new injury. As a result of that fall, she sustained a new, strain-type injury to her neck, additional strains in her wrist and back and further aggravation of her carpal tunnel condition.

Following claimant's symptomatic flare-up in August 1984, she was diagnosed with a fibrositis condition in her neck and back. Fibrositis is a condition involving subjective muscular pain with minimal or no objective physical findings. This condition may be initiated by physical injury or emotional factors, and once developed, it can be self-perpetuating, even in the absence of ongoing injury, and even if the initial injury is resolved.

Following her August 1984 symptomatic flare-up, she developed a mood disorder characterized by symptoms of depression and anxiety. She also began experiencing sleeping problems on a regular basis. In the fall of 1984, Dr. Randle began treating claimant's mood and sleep disorders with anti-depressants. Claimant had been previously diagnosed with a depressive disorder in 1983. However, that depression was of short duration, and she did not experience any further mood disorder until the fall of 1984. She had previously reported trouble sleeping on one occasion in early January 1984.

Claimant developed her fibrositis condition and sleep and mood disorder at a time when she was experiencing injury-related emotional stressors, including chronic neck and back pain, loss of her job at injury because of physical restrictions related to her fibrositis and carpal tunnel conditions, and a related loss of financial security. She continued to experience those stressors to a lesser degree up to the time of hearing. Claimant had also recently experienced significant emotional stress over the termination of a personal relationship in the fall of 1983. However, she had come to terms with the end of that relationship by the spring of 1984.

Claimant requested a hearing on the September 5, 1984 Determination Order. The 5 percent unscheduled permanent disability awarded under that order was for claimant's back condition.

The employer's denial of claimant's psychiatric, fibrositis and carpal tunnel conditions was issued on July 26, 1985. That denial expressly denied any psychiatric or fibrositis condition for which claimant had received treatment. She requested a hearing on the denial.

Claimant credibly testified regarding her work injuries, ongoing symptoms and physical limitations. At the time of hearing, claimant continued to experience discomfort in her neck and back, and

occasional flare-ups of pain in her hands and wrists brought on by repetitive, heavy lifting and cold weather. She had no numbness or tingling sensation in her hands but did have a loss of grip strength.

FINDINGS OF ULTIMATE FACT

Claimant's current wrist symptoms are attributable to a compensable bilateral carpal tunnel syndrome dating back to 1982.

The residuals of claimant's compensable injuries in 1982, 1983 and 1984 materially contributed to the causation of her fibrositis condition and the symptomatic worsening of her underlying sleep and mood disorders.

Claimant was not medically stationary when her January 1984 injury claim was closed by the September 1984 Determination Order.

CONCLUSIONS OF LAW AND OPINION

Compensability of Neck and Back Condition

We adopt the Referee's opinion on this issue with the following comment.

We agree with the employer's contention that Dr. Holmes' opinion was based on an inaccurate history, and we discount his opinion for that reason. The employer also correctly notes that the Referee erred in finding that Dr. Voiss was the only doctor who did not relate claimant's neck and back symptoms to her injury. We note that the Diagnostic Panel apparently shared Dr. Voiss' opinion.

Notwithstanding our disagreement with the Referee in these areas, we affirm her ultimate conclusion that claimant's fibrositis condition was compensable. In reaching this decision, we rely on the opinions of Drs. Randle and Henderson that claimant's compensable injuries materially contributed to her current fibrositis condition. Contrary to the employer's assertion, their reports are not based on an inaccurate history. Both doctors confirmed their opinions after reviewing the indepth discussion of claimant's personal life and off-work stressors contained in Dr. Voiss' report of August 7, 1985 .

Furthermore, as claimant's treating physician, Dr. Randle has had the greatest opportunity to observe her condition. The opinions of both physicians are well-reasoned and consistent with the record as a whole. In particular, both doctors acknowledged that claimant's psychological makeup and prior emotional problems may have predisposed her to becoming more disabled by her industrial injuries. Nevertheless, they both concluded that the sequelae of her compensable injuries aggravated any preexisting emotional instability and materially contributed to her current fibrositis condition.

Moreover, contrary to the employer's contention, their opinion is shared by Dr. Parvaresh. He testified that claimant used her industrial injuries as a vehicle for somatizing her emotional problems into physical complaints. Under those circumstances, such a reaction would be compensable. See Kobayoshi v. Siuslaw Care Center, et al, 76 Or App 320 (1985).

Finally, the contrary opinion expressed by Dr. Voiss and the Diagnostic Panel is not as well-reasoned. In particular, Dr. Voiss attached great significance to the emotional stress claimant

experienced as a result of the termination of a personal relationship. However, claimant credibly testified that she had come to terms with the end of that relationship by the spring of 1984 -- fully five months before her fibrositis condition was diagnosed.

Accordingly, we agree with the Referee that claimant's fibrositis condition is compensable.

Compensability of Upper Extremity Condition

The Referee set aside the employer's denial of claimant's current upper extremity condition. Her decision was based on a continuing material relationship between claimant's condition and her work injuries, including her compensable wrist sprains in 1983 and 1984 and her carpal tunnel condition. On review, the employer contends that claimant's wrist sprains had totally resolved when it issued its denial in July 1985.

The record supports the employer's contention. Nevertheless, the Referee also based her decision on a continuing material contribution from claimant's compensable carpal tunnel condition. The record supports that relationship.

In reaching this decision, we are aware that claimant's carpal tunnel condition initially resolved with rest and conservative treatment. However, the record indicates that she has experienced repeated symptomatic flare-ups associated with repetitive or strenuous use of her forearms. Drs. Bamforth and Rosenbaum both opined that the same work activity which resulted in claimant's compensable strains also resulted in a mild aggravation of her carpal tunnel condition. Claimant experienced an additional flare-up of carpal tunnel symptoms when she subsequently returned to a light duty position requiring repetitive sweeping. She demonstrated objective findings of her carpal tunnel disease as recently as June 1985, when she was examined by Dr. Nathan. Moreover, contrary to the employer's contention, both Drs. Nathan and Jewell attributed claimant's current symptoms to her work activities.

Accordingly, we agree with the Referee's ultimate conclusion that claimant's current wrist condition is compensable.

Back-up Denial

As we have affirmed the Referee's decision that claimant's upper extremity and neck and back conditions are compensable, it is not necessary to reach the alternative "back-up denial" issue raised by claimant.

Compensability of Mood and Sleep Disorder

On review, claimant contends that the Referee erred in upholding the employer's denial of "any psychiatric . . . condition" for which claimant had received treatment. We agree.

The record indicates that claimant had a prior bout of depression in 1983. Furthermore, she reported sleep problems in early 1984, several days prior to her work injury on January 13, 1984. As a result, we are persuaded that her sleep and mood disorder pre-existed her work injuries in 1984. She must, therefore, demonstrate that the sequelae of her 1984 work injuries contributed to a worsening of her emotional disorder. Jeld-Wen, Inc. v. Page, 73 Or App 136, 139 (1985).

Here, claimant credibly testified that she did not have a regular problem with sleeping until September 1984, the record contains no further report of sleeping problems between early 1984 and October of that year, and her treating physicians did not feel that her sleeping problem warranted treatment until October 1984. Similarly, the record indicates that claimant's bout of depression in 1983 was of short duration, and there is no documentation of any further significant mood disorder prior to her report of depressive symptoms in October 1984. In light of these factors, we are persuaded that claimant's experienced a worsening of her underlying sleep and mood disorder.

We further conclude that claimant's work injuries materially contributed to that worsening. In reaching this decision, we rely on the opinion of Dr. Henderson, claimant's treating psychiatrist, and Dr. Randle, the treating neurologist. They opined that the sequelae of claimant's work injuries materially contributed to her current mood and sleep disorder. Both doctors also believed that claimant's disorder was interfering with her recovery from her injuries and required treatment. Moreover, as recently as December 1985, both doctors opined that claimant's disorder had not totally resolved and required further curative treatment.

We defer to the opinion of Drs. Randle and Henderson for many of the same reasons we relied on their opinion regarding the emotional aspects of claimant's fibrositis condition. As treating physicians, both doctors have had significant opportunity to observe claimant. In addition, both doctors confirmed their opinion after giving full consideration to claimant's preexisting personality disorder and off-work emotional stressors.

Furthermore, the contrary opinions rendered by independent psychiatric examiners Paravesh and Voiss are less persuasive. These doctors opined that claimant's emotional disorders are totally attributable to preexisting personality problems and non-work stressors. We discount their opinions both because they have had less opportunity to observe claimant and because their opinions are not as well-reasoned. In particular, both doctors attach great significance to claimant's previous bout of depression and her recent emotional distress over the termination of a personal relationship. However, as noted above, claimant has not received treatment or been diagnosed with a depressive disorder since 1983. Moreover, claimant credibly testified that she had come to terms with the end of that personal relationship fully five months before she began reporting symptoms of depression in the fall of 1984.

We, therefore, defer to the opinion of claimant's treating physicians, and we analyze the Referee's order for consistency with that opinion. The Referee concluded that claimant experienced a compensable depressive disorder following her symptomatic exacerbation in August 1984, and she directed the employer to pay for Dr. Henderson's treatment. Nevertheless, she upheld the employer's denial because she was persuaded that claimant's emotional problems had resolved without permanent impairment at the time of the employer's July 1985 denial.

The opinion of the treating physicians supports the Referee's conclusion that claimant experienced a compensable depressive disorder following her symptomatic exacerbation in August 1984. However, their reports do not support her finding that

claimant's emotional problems had resolved at the time of the July 1985 denial. To the contrary, both doctors continued to recommend curative treatment as recently as December 1985. In addition, the question of whether claimant sustained permanent impairment is irrelevant to the issue of compensability. Furthermore, ordering the employer to pay for Dr. Henderson's treatment is logically inconsistent with her decision to uphold the employer's denial of all psychiatric conditions for which claimant had been treated.

Accordingly, we reverse the Referee on this issue and set aside the employer's denial of claimant's sleep and mood disorder.

Premature Closure

We adopt the Referee's opinion on this issue with the following comment. On review, the employer argues that the validity of a Determination Order must be judged by the evidence available at the time of closure. Since Dr. Bamforth's letter and Dr. Gosch's Form 827 were not received until after the September 1985 Determination Order issued, it argues that their reports are irrelevant in determining whether claimant's claim was prematurely closed. We disagree. The Referee appropriately considered any evidence available at the time of hearing. See Scheuning v. J. R. Simplot & Company, 84 Or App 622 (1987).

Aggravation, Extent of Permanent Disability, Penalties and Attorney Fees

As we have affirmed the Referee's ruling that claimant's injury claim was prematurely closed, it is not necessary to address the remaining issues raised by claimant.

Attorney Fees on Board Review

Finally, claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review regarding compensability of claimant's sleep and mood disorder. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee for services on Board review shall not be authorized. See OAR 438-15-010(5).

ORDER

The Referee's order dated January 16, 1987 is affirmed in part and reversed in part. That portion of the order that upheld the self-insured employer's denial of claimant's sleep and mood disorders is reversed. The denial is set aside, and the claim is remanded to the employer for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of \$1,250 for services at hearing regarding the compensability of claimant's sleep and mood disorders. The Board approves a supplemental client-paid fee, not to exceed \$177.50.

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Higashi's order that denied his request for "separate adjudication" of a February 25, 1976 upper back injury claim on the basis that the issues had been previously adjudicated pursuant to an October 6, 1975 low back injury claim, or, assuming that the issues had not been previously adjudicated, were barred from current litigation by application of the doctrine of res judicata. The SAIF Corporation filed no brief on review.

ISSUES

1. Whether claimant's requested relief is barred by application of the doctrine of res judicata.

2. If not, whether SAIF improperly treated claimant's February 25, 1976 upper back injury claim as an exacerbation of his prior claim for an October 6, 1975 low back injury. We affirm.

FINDINGS OF FACT

Claimant, 54 years old at the time of hearing, compensably injured his low back on October 6, 1975 while employed as a lumber grader. He continued working for several months following the injury without seeking medical treatment. However, on January 19, 1976, he commenced treatment with Dr. Butt, chiropractor and naturopath, due to progressive right leg, groin and low back pain. Dr. Butt diagnosed lumbosacral sprain with suspected intervertebral disc derangement and concurrent spondylolisthesis of L-5 on S-1.

Claimant subsequently filed a claim for an injury to his "back" which was accepted by SAIF as a disabling injury ("first claim"). The claim was assigned claim number D-135901.

Dr. Butt took claimant off work. On February 4, 1976, SAIF paid claimant temporary total disability benefits for the period January 20, 1976 through January 26, 1976. Upon returning to work in late January 1976, claimant altered the manner in which he performed his job duties. Specifically, he relied upon his upper body to a greater extent than he had prior to the injury.

On February 25, 1976, claimant left work due to right upper back complaints. He was examined by his family physician, Dr. Willeford, the following day. Dr. Willeford noted claimant's right upper back complaints and diagnosed myositis.

Approximately one week later, on March 4, 1976, claimant was examined by Dr. Gambee, orthopedic surgeon. Claimant reported to Dr. Gambee that his back symptoms were located in his low back. Upper back complaints are not mentioned in the report. Nor are upper back or neck complaints mentioned in any of the medical reports for the ensuing five years.

On March 5, 1976, claimant submitted a second injury claim to SAIF. This claim was numbered D-144080 ("second claim"). The claim form indicated a February 25, 1976 injury date and again stated that claimant's "back" was the body part affected. The claim form

further noted that "[claimant] was grading lumber and felt pressure on his right upper back."

By letter dated March 8, 1976, Dr. Butt informed SAIF that he had examined claimant on March 5, 1976. He reported that claimant had a flare-up of his low back condition which was "an exacerbation of his original injury site."

On March 10, 1976, after receiving Dr. Butt's report, SAIF "killed and combined" the second claim into the first claim. Thereafter, all benefits, including time loss occasioned by the February 25, 1976 incident, were provided to claimant under the first claim. SAIF notified the Workers' Compensation Department of this fact, but claimant was not officially notified.

In September 1977, the employer requested reimbursement from the Second Injury Reserve for all hospitalization and time loss since February 25, 1976. The record does not reflect the disposition of this request.

The first claim (now combined with the second claim) was closed by an October 13, 1978 Determination Order awarding 20 percent unscheduled permanent partial disability "resulting from injury to [claimant's] low back." The Determination Order referred to the October 6, 1975 injury date.

Claimant appealed the Determination Order. A hearing was held on April 5, 1979. The Referee's opinion, issued April 13, 1979, noted that claimant was appealing the Determination Order wherein claimant was awarded 20 percent unscheduled disability resulting from "injury to his low back occasioned by injuries of October 6, 1975 and February 25, 1976." The order, which noted only low back complaints, awarded claimant an additional 20 percent unscheduled permanent partial disability for impairment to his back.

Following a request for review by SAIF, we reversed the order of the Referee, finding the award excessive. We referred in our order to both the October 6, 1975 injury and the February 25, 1976 injury.

Claimant continued to suffer low back and right leg problems. His claim was opened and closed by a second Determination Order on April 16, 1981. A later claim for aggravation was denied on December 1, 1981. Claimant appealed the denial, and the matter was ultimately settled by an increased award of 44.4 percent unscheduled permanent partial disability, for a total award to that date of 64.4 percent.

References in the medical records to thoracic and cervical pain began to appear in 1981. X-rays of the thoracic spine in July 1981 revealed minimal degenerative changes. Claimant reported to his treating psychologist in October 1982 that his upper back pain was greater than his low back pain.

Claimant began treating with Dr. Nash, neurosurgeon, in July 1983. In addition to lumbosacral findings, Dr. Nash diagnosed cervical spondylosis with cervical neuroradiculopathy.

By letter dated November 1, 1983, SAIF denied responsibility for claimant's thoracic, cervical, scapular and neck symptoms and for any treatment directed to those areas. The letter went on to state:

"Your claim was established for a low back injury only on October 6, 1975, and there is no medical evidence in your file that establishes or supports any relationship of your mid and upper body symptoms to your low back injury...."

A hearing was held in July 1985. The propriety of the denial was one of several issues at hearing. A prior Referee found that SAIF had, in 1976, elected to treat the disability period, following the February 25, 1976 incident, as an aggravation of the October 6, 1975 injury. He further concluded, "All medical benefits and time loss were paid. SAIF's conduct amounted to an acceptance of the claim." Citing Bauman v. SAIF, 295 Or 788 (1983), the Referee further reasoned that after accepting the claim, SAIF could subsequently deny the claim only by proof of fraud, misrepresentation or other illegal activity, none of which had been alleged or proven. The Referee set aside the denial and ordered that the claim be remanded to SAIF "for acceptance and payment of benefits required by law."

By letter to claimant's attorney dated August 27, 1985, SAIF noted that the Referee had ordered it to accept the cervical condition. SAIF contended that in order to reopen "the claim" claimant would need to petition the Board for Own Motion relief. See 656.278.

On September 19, 1985, Dr. Nash reported to SAIF the surgeries he felt were required to correct claimant's cervical problems.

By letter to the Board dated October 9, 1985, claimant's counsel noted that claimant had undergone surgery by Dr. Nash on October 1, 1985. Claimant's attorney requested that the Board exercise its Own Motion jurisdiction and reopen the claim. The letter referred to the February 25, 1976 "upper back" injury date.

The request was granted on February 14, 1986. Claimant was awarded temporary total disability benefits for the period of time he was disabled due to the surgery. The claim was closed by an April 23, 1986 Own Motion Determination granting claimant a total award of 85 percent unscheduled permanent partial disability. The caption of the Own Motion Determination referenced only the October 6, 1975 injury.

CONCLUSIONS OF LAW AND OPINION

In North Clackamas School Dist. v. White, 305 Or 48, 52 (1988), the Supreme Court considered the application of res judicata principles to workers' compensation cases. The Court adopted the phraseology found in the Restatement (Second) of Judgments which refers to the preclusive effect of res judicata principles on the claim as "claim preclusion" and the preclusive effect on an issue as "issue preclusion." See Restatement (Second) of Judgments, Introduction at 1-5 (1980). Here, although not expressly so stating, the Referee applied both claim preclusion and issue preclusion principles to bar adjudication of the issues raised by claimant. We affirm the Referee insofar as he found that claimant's claim is barred by the principle of claim preclusion.

The rule of claim preclusion operates to bar subsequent

litigation concerning claims which could have been, but were not, litigated in a prior proceeding. Carr v. Allied Plating Co., 81 Or App 306, 309 (1986). The rule applies "to every claim which could have been alleged under the same 'aggregate of operative facts which compose a single occasion for judicial relief.' [citations omitted]." Million v. SAIF, 45 Or App 1097, 1102 (1980).

Claimant's hearing request lists ten issues. The Referee, summarizing those issues, characterized claimant's position as a challenge to SAIF's action in combining the two injury claims and as a request for remedies for SAIF's failure to process the second claim separately to closure. We concur with this characterization.

Claimant argues that he could not have raised this issue any sooner than he did. In this regard, he asserts that he did not have an opportunity to deal with his upper back claim until he had notice of its actual status which, he asserts, was not revealed to him until after the August 8, 1985 Referee's order which directed SAIF to accept the second claim. We find, however, that claimant had notice of the status of his second claim not later than April 13, 1979. This is the date on which a Referee's order issued awarding him an additional 20 percent permanent disability resulting from both the October 6, 1975 injury and the February 25, 1976 injury.

Claimant notes that the April 13, 1979 Referee's order refers only to claimant's low back condition. It is apparent, however, that claimant submitted no evidence at that hearing of any complaints other than low back complaints. The medical records do not mention upper back complaints until two years after the hearing. Further, claimant's testimony, as recited in the order, discusses only low back complaints. In sum, the order does not refer to claimant's upper back because claimant presented no evidence of upper back complaints.

As previously mentioned, SAIF requested Board review of the Referee's April 13, 1979 order. On review, we too referenced both the October 1975 and the February 1976 injuries. Claimant did not appeal either the April 13, 1979 Referee's order or our subsequent order on review. We conclude that claimant then had notice that his two claims had been combined for purposes of processing. Claimant's assertion regarding the alleged impropriety of SAIF's conduct was raisable at that time. Claimant did not raise the issue. He is, therefore, precluded from doing so now.

Events subsequent to the onset of documented upper back and neck complaints in 1981 also support the Referee's conclusion that claimant is precluded from pursuing his claims.

SAIF issued its denial of claimant's progressive upper back complaints in 1983. The denial went to hearing in July 1985. Claimant did not raise the propriety of SAIF's conduct as an issue at that hearing. Moreover, the Referee's subsequent order establishes positively that claimant was on notice that SAIF had combined his claims for purposes of processing. We conclude that the 1985 hearing involved the same "aggregate of operative facts" and that claimant's failure to raise his present claim at that time bars him from doing so now.

In conclusion, we find that the doctrine of claim preclusion is applicable. Claimant's failure to raise the issue of the propriety of SAIF's conduct at either the 1979 hearing or the 1985 hearing operates to preclude him from raising the issue now. We conclude that claimant is not entitled to the relief he seeks.

ORDER

The Referee's order dated October 12, 1987 is affirmed.

DONALD J. BIDNEY, Claimant
Bloom, et al., Claimant's Attorneys
Judy L. Johnson (SAIF), Defense Attorney

Own Motion 87-0721M
December 9, 1988
Own Motion Order on Reconsideration

Claimant has requested reconsideration of our January 21, 1988 Own Motion Order which concluded that we lacked authority to grant claimant's request for permanent total disability. We reasoned that because claimant's injury claim was currently closed, his request for Own Motion relief must be considered under the present version of ORS 656.278(1)(a), which became effective January 1, 1988. Inasmuch as we lack authority to award permanent partial or permanent total disability under the aforementioned statute, we denied claimant's request.

Claimant contends that the Board failed to consider the law in effect at the time of his 1975 and 1976 injuries. In support of his contention, claimant cites ORS 656.202(2), which provides that:

"Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.001 to 656.794 shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred."

Furthermore, claimant submits that House Bill 2900 (which became Oregon Laws 1987, Chapter 884) did not amend, modify or otherwise alter the aforementioned statute. Consequently, claimant asserts that the Board's Own Motion authority in this claim is not limited by Section 37 of Chapter 884. (Which amended ORS 656.278(1) by limiting disability awards to temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary as determined by the Board).

Contending that the Board had authority to award additional permanent partial or permanent total disability at the time of his 1975 and 1976 injuries and at the time of his 1987 request for Own Motion relief, claimant argues that the Board is empowered to grant his request. We disagree.

Section 37 of Chapter 884, which amended ORS 656.278(1) as previously described, became operative January 1, 1988. See Section 63. Moreover, these amendments became operative on January 1, 1988, "[n]otwithstanding ORS 656.202." See Oregon Laws 1987, Chapter 884, Section 62. (Emphasis added).

In addition to the amendments to ORS 656.278(1), Chapter 884 also created ORS 656.625, the "Reopened Claims Reserve." See Oregon Laws 1987, Chapter 884, Section 39. ORS 656.625(1) provides that the Director "shall establish a Reopened Claims Reserve within the Insurance and Finance Fund for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the board pursuant to ORS 656.278 after January 1, 1988." ORS 656.625(2) further states that "[n]otwithstanding any other provision of law, any reimbursement from

the Reopened Claims Reserve shall be in such amounts as the board prescribes and only to the extent that funds are available in the reserve." As with the other sections of Chapter 884, Section 39 became operative January 1, 1988. See Chapter 884, Section 63.

The language of the aforementioned statutes unambiguously expresses the intent of the legislature that the Board's authority to award compensation for post 1966 injuries after January 1, 1988 is limited to temporary disability benefits. Thus, it is not necessary to resort to statutory construction principles or to legislative history to determine the intent of the legislature. Whipple v. Howser, 291 Or 475 (1981). Even assuming that ambiguities exist, the legislative history supports the conclusion that the legislature intended to limit all awards for claims filed on post 1966 injuries in which the worker's aggravation rights had expired to temporary disability only and to create a reserve for the payment of such benefits. See Minutes, Senate Committee on Labor, Pages 30-35, (June 10, 1987).

Claimant also argues that, pursuant to his December 9, 1987 Own Motion request, he "invoked" our jurisdiction prior to the effective date of Section 37 of Chapter 884. We note in this regard that the Board, "in the exercise of its continuing jurisdiction ... alone can originate proceedings to modify former orders." Verban v. Ind. Acc. Com., 168 Or 394, 404 (1942). We conclude that claimant has no right to "invoke" our Own Motion jurisdiction.

Finally, claimant objects to the issuance of our order with notice of appeal rights pursuant to ORS 656.278(3). At a minimum, claimant suggests that our order be modified to allow him the right to petition for judicial review. We are without authority to grant claimant's request.

Inasmuch as claimant has requested relief under our Own Motion authority, we are obliged to issue an order pursuant to that authority. Therefore, in accordance with ORS 656.278(3), we are required to advise the parties of their respective rights of appeal from our Own Motion order.

Accordingly, the request for reconsideration is granted. On reconsideration, as supplemented herein, we adhere to and republish our January 21, 1988 order, effective this date.

IT IS SO ORDERED.

DONALD D. DAVIS, Claimant
Pozzi, et al., Claimant's Attorneys
Raymond Smitke (SAIF), Defense Attorney
Kevin Mannix, Defense Attorney
Davis, et al., Defense Attorneys

WCB 86-12438, 86-07689 & 86-09720
December 9, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Aetna Casualty Company requests review of those portions of Referee Neal's order that: (1) set aside its denial of responsibility for claimant's elbow conditions; and (2) directed it to pay claimant's attorney an associated attorney fee of \$1,900. Claimant filed a nonspecific cross-request for Board review, but in his brief argues that the Referee's order should be affirmed. Claimant's attorney also has submitted a statement of services performed on Board review and requests a carrier-paid fee for those services.

ISSUES

1. Responsibility for claimant's elbow conditions.
2. The entitlement of claimant's attorney to a carrier-paid attorney fee for services at the hearing.
3. The entitlement of claimant's attorney to a carrier-paid attorney fee for services on Board review.

FINDINGS OF FACT

Responsibility

The Board adopts the second page and the first two paragraphs of the third page of the Referee's Opinion and Order. In addition, the Board makes the following findings.

The employer was insured by Aetna Casualty Company from the date that claimant began his employment through March 31, 1984, by SAIF Corporation from April 1, 1984 through March 30, 1985 and by Liberty Northwest Insurance Corporation from March 31, 1985 through the date of the hearing.

Claimant continued to experience episodes of pain and swelling in his elbows after the closure of his claim in December 1982 and occasionally received medical treatment. His elbow conditions improved after he was transferred from his regular work to a janitorial position in early 1983 but did not fully resolve.

Claimant's work activity after March 31, 1984 did not worsen his underlying conditions.

Attorney Fees

After the episode of increased symptoms which gave rise to the responsibility dispute, claimant retained an attorney and filed a claim against Liberty Northwest. Liberty Northwest issued a denial of responsibility on May 14, 1986 and later requested that the Compliance Division issue an order pursuant to former ORS 656.307. In July 1986, the Compliance Division informed Aetna of claimant's claim and inquired regarding its position on the issue of compensability. On July 7, 1986, Aetna denied responsibility for both of claimant's elbow conditions and also denied the compensability of the left elbow condition. Claimant filed a request for hearing on this denial on July 16, 1986. On July 21, 1986, the Compliance Division issued an order denying the designation of a paying agent on the ground that Aetna had denied compensability. SAIF did not learn of the claim until September 1986. It issued a denial of responsibility on September 12, 1986 and on the same date informed the Compliance Division that it would accede to the issuance of a .307 order.

Dr. Wisdom, claimant's treating orthopedist, was deposed at Aetna's request on November 21, 1986. Claimant's attorney participated in the deposition. In December 1986, Aetna informed the Compliance Division that it was denying responsibility only and requested the designation of a paying agent. The Compliance Division issued a .307 order on December 29, 1986.

The case came to hearing on February 25, 1987. None of

the insurers raised the issue of compensability. Claimant's attorney took no clear position regarding which insurer was responsible, but participated in the hearing by questioning claimant on direct examination. During closing arguments, claimant's attorney made some comments which suggest that he thought responsibility should be assigned to Liberty Northwest. The Referee held Aetna responsible and awarded claimant's attorney a fee of \$1,900, payable by Aetna.

Aetna requested Board review and raised the issues of responsibility and attorney fees in its briefs. In his respondent's brief, claimant stated that he took no position on the responsibility issue, but urged that the attorney fee awarded by the Referee be affirmed. Claimant's attorney also filed a statement of services rendered on Board review and requests a carrier-paid fee for those services.

Claimant's weekly temporary total disability rate on the Aetna claim is \$293.05. The rate on the SAIF and Liberty Northwest claims is \$311.09.

CONCLUSIONS OF LAW

Responsibility

The Board adopts the first five paragraphs of the Referee's "Opinion" section with the following comment. At one point, the Referee stated:

"[R]esponsibility remains with the first employer unless a second period of employment contributes independently to claimant's condition, or worsens his underlying condition; Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); worsening of symptoms alone is not sufficient to shift responsibility to a later employer; Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986)."

The Referee's statement of the law was in accord with our decision in Eva L. (Doner) Staley, 38 Van Natta 1280 (1986). We ruled in that case that the burden of persuasion in a successive injury responsibility dispute is on the first or aggravation carrier, and absent sufficient proof of an actual contribution to a worsening of the claimant's underlying condition by employment activity covered by a subsequent carrier, the aggravation carrier remains responsible. Id. at 1281-82.

Since the Referee issued her order, the Court of Appeals effectively overruled our Staley decision in Champion International v. Castilleja, 91 Or App 556 (1988). In that case, the court ruled that when the trier of fact is convinced that a claimant's disability was caused by successive work-related exposures but is unconvinced that any one employment is the more likely cause of the disability, the last injurious exposure rule operates to place liability on the last employer. Id. at 560. In effect, the court's decision places the burden of persuasion in successive injury cases on the last carrier. Absent sufficient proof by the last carrier of the lack of an independent contribution to a worsening of the claimant's underlying condition, responsibility remains with the last carrier.

Although Castilleja requires this caveat, it does not require that we alter the result reached by the Referee. Liberty Northwest was the last carrier with potentially causal conditions and thus initially is deemed responsible under the last injurious exposure rule. However, Liberty Northwest successfully established that work activity during its period of coverage did not worsen claimant's underlying condition. In doing so, it may not be held responsible. SAIF, then, is the last potentially-responsible employer. The evidence likewise established that claimant's work activity during SAIF's period of coverage did not worsen claimant's underlying condition. Thus, Aetna, having conceded compensability, is responsible.

Attorney Fee for the Hearing Level

The Referee awarded claimant's attorney a fee payable by Aetna for "his efforts in overturning Aetna's denial." The Referee cited no authority for this award, but the only potential authority is ORS 656.386(1). The attorney fee provision of ORS 656.307(5) did not become effective until January 1, 1988, see Or Laws 1987, ch 713, §§ 5, 8, and thus is inapplicable.

Under ORS 656.386(1), an attorney fee may be awarded for services at the hearing level if the claimant prevails finally in a "rejected case." A rejected case is a case in which the claimant's entitlement to receive compensation, as opposed to the amount of compensation or the extent of disability, is at issue. Short v. SAIF, 305 Or 541, 545-46 (1988); see Ohlig v. FMC Marine & Rail Equipment, 291 Or 586, 591-98 (1981); see also Shoulders v. SAIF, 300 Or 606, 611-16 (1986). But see SAIF v. Phipps, 85 Or App 436 (1987).

Claimant's entitlement to receive compensation in this case was resolved prior to the hearing through the issuance of a .307 order. See former ORS 656.307(1); Hunt v. Garrett Freightliners, 92 Or App 40, 42 (1988); Wilson v. Geddes, 90 Or App 64, 66 (1988); Anfora v. Liberty Communications, 88 Or App 30, 32-33 (1987); Petshow v. Farm Bureau Insurance Co., 76 Or App 563, 569 (1985), rev den 300 Or 722 (1986). After the issuance of the .307 order, compensability was not at issue. Thus, no fee may be awarded for services at hearing on the compensability issue. Moreover, if a claimant is ever entitled to a 656.386(1) fee in a pure responsibility case, he is not here; for he did not prevail on the responsibility issue. Petshow v. Farm Bureau, Inc., 76 Or App 503 (1985). To the extent, therefore, that the Referee awarded a carrier-paid fee under ORS 656.386(1) for services rendered after the issuance of the .307 order, the Referee erred.

Although claimant's attorney is not entitled to a carrier-paid fee under ORS 656.386(1) for services rendered after the issuance of the .307 order, we conclude that such a fee is appropriate for services rendered before the issuance of the .307 order. Aetna's original denial raised an issue of compensability as well as responsibility. Only after claimant's attorney requested a hearing on Aetna's denial and participated in the deposition of Dr. Wisdom did Aetna concede compensability and accede to the issuance of a .307 order. The efforts of claimant's attorney were instrumental in overcoming Aetna's denial of compensability and in securing claimant's entitlement to receive compensation through the issuance of a .307 order. A fee payable by Aetna for those services is appropriate under ORS 656.386(1).

See former OAR 438-47-015; Dennis S. Current, 38 Van Natta 858, 859 (1986). Given the circumstances of this case and considering the factors set forth in OAR 438-15-010(6), we award a fee of \$500.

Attorney Fee for Board Review

Under ORS 656.382(2), a carrier-paid attorney fee may be awarded when a carrier initiates a request for Board review and the Board determines that "the compensation awarded to the claimant should not be disallowed or reduced." Aetna initiated Board review on two issues, responsibility and attorney fees. We conclude that claimant is not entitled to an attorney fee for services on Board review on either of these issues under the circumstances of this case.

The responsibility issue did not pose a threat either to claimant's entitlement to receive compensation or to the amount of that compensation. Claimant's entitlement to compensation was secured by a .307 order and was not questioned by any of the carriers, either at the hearing or on Board review. The amount of claimant's compensation was not threatened because Aetna had the lowest temporary disability rate. Had Aetna been successful in shifting responsibility from itself to SAIF or Liberty Northwest, claimant's compensation would have been increased, not decreased. ORS 656.382(2) does not contemplate an award of attorney fees if neither the claimant's entitlement to compensation nor the amount of that compensation is threatened. See Bahler v. Mail-Well Envelope Co., 60 Or App 90, 93-94 (1982).

Regarding the attorney fee issue, the attorney fee awarded by the Referee was not compensation. Dotson v. Bohemia, Inc., 80 Or App 233, 236, rev den 302 Or 35 (1986). Aetna's challenge to that fee, therefore, did not threaten claimant's compensation and no fee may be assessed under ORS 656.382(2) on the attorney fee issue. Id.

ORDER

The Referee's order dated March 9, 1987 is affirmed in part and modified in part. That portion of the Referee's order that awarded claimant's attorney an attorney fee of \$1,900 payable by Aetna is modified. The attorney fee award is reduced from \$1,900 to \$500. The remainder of the Referee's order is affirmed. A client-paid fee, payable from Liberty Northwest to its counsel, not to exceed \$300, is approved.

CHRISTOPHER GASTALDI, Claimant
Malagon, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 88-0758M
December 9, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his June 29, 1978 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the recent leg surgery, but contends claimant has submitted insufficient proof of employment and, therefore, is not entitled to compensation for temporary disability during his recovery from surgery.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient

surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Claimant compensable condition did worsen and surgery was performed on October 10, 1988. He has submitted a letter in which he states the type and amount of work he has done over the past two years. The Board finds that although claimant has not worked a significant amount recently, he has not removed himself from the work force. Accordingly, claimant claim is reopened with temporary disability benefits to commence October 10, 1988 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed \$400 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

WILLIAM WARNER, Claimant
Mel Kosta, Claimant's Attorney
SAIF, Insurance Carrier

Own Motion 88-0642M
December 9, 1988
Own Motion Order

The Board issued an Own Motion Determination on November 9, 1988 whereby claimant's claim was closed with an increased award equal to 10 percent for a total award of 55 percent unscheduled disability to his back. Claimant has asked the Board to abate the November 9 order to allow him the opportunity to present further evidence to support his contention that he is permanently and totally disabled.

The Board has considered claimant's request and declines to abate the order to allow further consideration of claimant's permanent disability status. We recently ruled in Donald Wincer, Own Motion Determination on Reconsideration, September 28, 1988, that all requests for further own motion relief on closed claims are subject to the new own motion law. The Board has determined that the new law limits its authority to the granting of medical services in pre-1966 claims and temporary disability benefits under certain specified circumstances. See Orville D. Shipman, 40 Van Natta 537 (1988). Claimant's claim is currently in a closed status. We have no authority to grant permanent disability awards under the new own motion law. ORS 656.278(1)(a). Therefore, claimant's request for further benefits is denied.

IT IS SO ORDERED.

KURT DUPRE, Claimant
Royce, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-12966
December 14, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of Referee Schultz's order which: (1) increased claimant's unscheduled permanent disability award for a low back injury from 25 percent (80 degrees), as awarded by Determination Order, to 60 percent

(192 degrees); and (2) assessed a penalty and attorney fee for its failure to provide timely discovery.

ISSUES

1. Extent of unscheduled permanent disability for low back injury.

2. Penalty and attorney fee for failure to provide timely discovery.

We affirm the Referee's unscheduled disability award, but we modify his assessment of a penalty and related attorney fee.

FINDINGS OF FACT

We adopt the Referee's findings of fact and make the following additional findings: Claimant filed his hearing request on August 20, 1987, demanding all documents pertaining to his claim which were then, or came to be, in the employer's possession. Despite the demand, claimant received no documents from the employer between June 22 and December 11, 1987. On the latter date, claimant received a copy of the employer's exhibit list, which contained 67 exhibits. Prior to that date, claimant had not been provided with copies of 15 of those exhibits. As of December 18, 1987, the hearing date, claimant had not yet received copies of ledger sheets indicating the dates and amounts of compensation payments, despite his specific request for those documents on December 4, 1987.

FINDINGS OF ULTIMATE FACT

The employer's delay in providing full disclosure of documents pertaining to claimant's claim was unreasonable. We do not find, however, that there were any amounts of compensation due during this delay.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and opinion on the extent of disability issue.

We turn to the penalty issue. The employer clearly did not comply with the disclosure requirements of former OAR 438-07-015(2) and (4), and gave no reasonable explanation for failing to do so. Under those provisions, noncompliance "may be considered unreasonable delay or refusal under ORS 656.262(10)." That statutory provision provides for the assessment of a penalty "up to 25 percent of the amounts then due" plus a related attorney fee. To assess a penalty, there must be an unpaid amount of compensation "then due." Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988).

Here, the record is devoid of evidence that there were any amounts of compensation due or owed claimant at the time of the violation. Indeed, the claim documents in the record indicate that the employer continued to pay compensation at least through July, 1987. Absent evidence of any "amounts then due," a penalty should not have been assessed. In any event, claimant is entitled to an employer-paid attorney fee for the employer's unreasonable delay in providing full disclosure. See Spivey v. SAIF, 79 Or App 568, 572 (1986).

ORDER

The Referee's order dated January 19, 1988 is modified in part and affirmed in part. That portion of the order which assessed a \$250 penalty and related attorney fee is modified to exclude the penalty. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of \$900, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed \$800.

ALBERTO FLORES, Claimant
Michael Dye, Claimant's Attorney
Beers, et al., Defense Attorneys

WCB 88-07819
December 14, 1988
Order of Dismissal (Remanding)

The insurer has requested Board review of Referee Bennett's September 14, 1988 order, as reconsidered September 27, 1988. Claimant has moved for an order dismissing the insurer's request on the ground that it was untimely filed. We deny claimant's motion. However, because we conclude that the request is premature, we remand to the Referee.

FINDINGS OF FACT

The Referee's Opinion and Order issued September 14, 1988. The Referee affirmed a Determination Order award of 50 percent unscheduled permanent disability, assessed a penalty for the insurer's late payment of interim compensation, and declined the insurer's request for authorization to offset an alleged overpayment of temporary disability.

On September 21, 1988, claimant requested reconsideration. Enclosing a statement of services, he sought an attorney fee for prevailing against the insurer's attempt to reduce the Determination Order award and for efforts expended concerning the penalty issue.

On September 27, 1988, the Referee issued an "Order on Reconsideration." The Referee stated that a penalty-associated attorney fee had not previously been awarded because a statement of services had not been submitted. Since the statement had now been received, the Referee concluded that a fee should be awarded. Consequently, the Referee awarded insurer-paid attorney fees, for the penalty and permanent disability issues. As with the September 14, 1988 order, the Referee's Order on Reconsideration contained a statement explaining the parties' rights of appeal under ORS 656.289 and 656.295.

On September 30, 1988, the insurer requested reconsideration of the Referee's orders. The insurer contended that the attorney fee awards were excessive, the permanent disability award should be reduced, and that claimant's temporary disability benefits had been overpaid. On October 10, 1988, claimant responded to the insurer's request for reconsideration.

On October 19, 1988, the Board received the insurer's request for review of the Referee's September 14, 1988 and September 27, 1988 orders. The request was not mailed by certified or registered mail. A certificate of service, submitted with the request, indicated that copies of the request had been mailed to all parties to the proceeding. Also on October 19, 1988, the Referee abated his September 14, 1988 and September 27, 1988 orders to consider the insurer's motion for reconsideration.

CONCLUSIONS OF LAW

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

The time within which to appeal an order continues to run, unless the order has been stayed, withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1985). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, the Referee's September 14, 1988 order was neither abated, stayed, nor withdrawn. However, the order was expressly modified by the Referee's September 27, 1988 Order on Reconsideration. Specifically, the Referee stated that the September 14, 1988 order had not awarded an insurer-paid attorney fee for claimant's attorney's efforts concerning the issues of penalties and permanent disability. Yet, on September 27, 1988, after considering claimant's motion for reconsideration and statement of services, the Referee concluded that an attorney fee award for these issues was appropriate.

Under these circumstances, we find that the Referee's September 14, 1988 order was modified by the September 27, 1988 Order on Reconsideration. Inasmuch as the reconsideration order contained a notice of appeal rights, we conclude that the 30-day statutory period from which to appeal the Referee's orders commenced September 27, 1988, the date of the reconsideration order.

Since the insurer's request for review was not accomplished by registered or certified mail, it was filed on October 19, 1988, the date it was received by the Board. See OAR 438-05-046(1)(b). Because the request was filed within 30 days of the Referee's September 27, 1988 order, jurisdiction to consider this matter would generally rest with us. However, also on October 19, 1988, the Referee had issued an Order of Abatement to consider the insurer's request for reconsideration.

Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. James D. Whitney, 37 Van Natta 1463 (1985).

Inasmuch as the Referee abated his order simultaneously with the insurer's request for Board review, we shall give effect to the Order of Abatement. Accordingly, the request for review is dismissed as premature. This matter is remanded to Referee Bennett for further consideration.

IT IS SO ORDERED.

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Fink's order that upheld the insurer's partial denial of claimant's current left knee condition. The issue on review is whether claimant's accepted 1983 left knee nondisabling injury remains a material contributing factor in her current need for medical services. We affirm.

FINDINGS OF FACT

In 1978 claimant sustained an injury to the lateral aspect of her left knee when she struck it against a bed. The injury resulted in a bruise which subsided after approximately one week. Claimant did not seek medical attention or lose time from work. Claimant worked for the employer as a delivery driver from October through December of 1980 and again from March 1981 through September 1983. On April 7, 1983, claimant sought medical treatment from Dr. South for swelling and discomfort in the posterior left knee. A claim was made and accepted for a nondisabling injury. On October 5, 1983, claimant again sought medical treatment from Dr. Post for pain in the popliteal and posterior lateral left knee.

For the next two years claimant attended college and daily commuted six miles round trip on a bicycle. She also rides bicycles recreationally an average of 20 miles per week. In 1985, 1986 and 1987 she participated in a bicycle ride from Seattle, Washington to Portland, Oregon, a distance of about 200 miles. Prior to the rides she engaged in training for several months. In 1986 she toured Eastern Oregon on her bicycle, traveling about 450 miles in one week. In September 1987 claimant engaged in rowing twice a week for three weeks. All of these activities result in a swollen and uncomfortable sensation in claimant's posterior left knee. Claimant again sought medical treatment for left knee swelling and discomfort from Dr. Erde on July 14, 1987.

Claimant has a popliteal cyst in the left knee which is recurrent based upon the level of her activity. The left knee popliteal cyst developed as a result of the 1978 left knee trauma.

FINDING OF ULTIMATE FACT

The accepted 1983 nondisabling injury is not a material contributing factor to claimant's current need for medical services for left knee swelling and discomfort.

CONCLUSIONS AND OPINION

There really is no dispute as to the material facts. The cause of claimant's current need for medical treatment is a matter for expert medical opinion. In this case there is disagreement between Dr. Erde, the attending physician, and Dr. Martens, the independent medical examiner who examined claimant on the insurer's behalf. Ordinarily we would defer to the opinion of the attending physician, absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810, 814 (1983). We conclude that such persuasive reasons are present in this case.

Dr. Erde is a family practitioner and Dr. Martens is a board certified orthopedic surgeon. While Dr. Erde's competency to give a medical opinion is unquestioned, we find her opinion unpersuasive. Dr. Erde formed her opinion originally on the basis of a medical history that was deficient in two material respects: (1) lack of information about the 1978 trauma; and (2) lack of information about claimant's extensive physical activities in bicycling and rowing. Dr. Martens' opinion was formed with full knowledge of claimant's correct medical history and was based upon his 20 years of experience as an orthopedic surgeon. We accept as more persuasive Dr. Martens' opinion that, in probability, claimant developed popliteal problems as a result of the 1978 trauma and that subsequent activities caused a need for medical services at intervals. While claimant's employment in April of 1983 caused her to seek medical services she ordinarily would not have required, and thus was compensable at the time, we conclude that claimant's current need for medical services is related to her extensive physical activities and not to the temporary exacerbation in April of 1983.

ORDER

The Referee's order dated February 18, 1988 is affirmed. A client-paid fee, not to exceed \$366, is approved.

WESLEY R. HARGROVE, Claimant
Pozzi, et al., Claimant's Attorneys
William Blitz (SAIF), Defense Attorney
E. Jay Perry, Defense Attorney

WCB 87-02858 & 87-14778
December 14, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of Referee Paulus' order that held it responsible for claimant's herniated lumbar disc claim and awarded claimant an attorney fee. The issues on review are responsibility between employers and attorney fees. We reverse.

FINDINGS OF FACT

The relevant employers are Bohemia, Inc., insured by Liberty Northwest Insurance Corporation, and Dailey Brothers, insured by the SAIF Corporation. Claimant began working for Bohemia in 1976. His primary work was as a choker setter but he also performed other heavy-logging work. On July 27, 1984, he sustained a twisting injury to the low back when pulling a choker. The claim was accepted as a disabling injury. Claimant was treated conservatively and lost 30 days of work. X-rays revealed an unusual configuration of the L4 and L5 vertebrae with disc spaces within normal limits. No other diagnostic approaches were taken. Claimant's symptoms were primarily low back pain but he also had some pain into both legs to the knees. He was released to return to his normal work as of August 27, 1984 and did so. His claim was closed without permanent disability.

Claimant continued to work as a choker setter for Bohemia until he was laid off in February 1985. He continued to experience low back and bilateral leg pain but did not lose any time from work and did not complain to his coworkers or supervisors. After the layoff claimant worked for another employer as a choker setter for about two months. In the summer

of 1985 he began working for Dailey Brothers as a log marker and buckler. He also performed other heavy work associated with logging. He continued to experience low back and bilateral leg pain depending upon his activity. He occasionally mentioned the pain to his employers.

On September 29, 1986, claimant jumped off a log while working for Dailey Brothers and experienced an acute increase in low back and leg pain and numbness. A few days later he sought medical attention and lost three days of work. He then returned to his normal work. In December 1986 claimant experienced another acute increase in low back and leg pain and numbness when he picked up a large log for a campfire. He stopped working as of December 24, 1986. When his symptoms did not abate, he sought treatment from Dr. Bert, orthopedic surgeon. A myelogram disclosed a complete extradural block due to a herniated L4-5 disc. Dr. Bert performed an L4-5 discectomy and related procedures on February 3, 1987. The surgery relieved claimant's symptoms. Claimant was released to his regular work as of May 5, 1987.

CONCLUSIONS AND OPINION

The Referee rejected Dr. Bert's opinion that claimant's disability and need for medical services in January 1987 was related to his 1984 low back injury at Bohemia, Inc., as inconsistent with the chronology of claimant's work incidents and medical history. We do not agree. While Dr. Bert's narrative opinion is brief and conclusory, read together with the neurological workup by Dr. Bernstein, Dr. Bert's operative report and Dr. Hosack's pathology report, it clearly establishes that claimant's herniated L4-5 disc significantly predated the incidents that occurred in September and December of 1986. There is no medical evidence to the contrary. Claimant had no other injuries between 1984 and 1986. His and his spouse's testimony that claimant had continuous low back and leg pain after the 1984 injury is un rebutted and is entirely consistent with the histories given Dr. Bert and Dr. Bernstein in January 1987. It is very apparent from the entire record that claimant is a person who does not seek medical treatment lightly and continues to work with as much pain as he can tolerate.

We conclude that this is a case in which claimant sustained a back injury in 1984 which was followed by a period of work with continuing symptoms indicating a continuation of the condition, followed by a subsequent period of disability precipitated by normal activities. The last of these precipitating activities occurred in December 1986 when claimant lifted a log for a campfire. The only evidence in the record about this incident is probative that it occurred off the job. There is no persuasive evidence that claimant's employment with Dailey Brothers independently contributed to claimant's disability and need for medical services. We conclude that Liberty Northwest Insurance Corporation is responsible for claimant's 1987 surgery and disability as an aggravation of the 1984 accepted low back injury.

The Referee awarded claimant's attorney an attorney fee of \$1,620 to be paid by the SAIF Corporation. As we have assigned responsibility to Liberty Northwest, it follows that SAIF should not have to pay claimant's attorney fee. The compensability of

claimant's condition was in issue at the hearing and no order designating paying agent was entered. Claimant's attorney is entitled to an assessed attorney fee for services at the hearing, payable by Liberty Northwest, pursuant to ORS 656.386(1).

ORDER

The Referee's order dated February 18, 1988 is reversed. The SAIF Corporation's denial dated September 1, 1987 is reinstated and upheld. Liberty Northwest Insurance Corporation's denial dated February 9, 1987 is set aside and claimant's claim is remanded to Liberty Northwest for acceptance as a claim for aggravation of the July 27, 1984 injury. Claimant's attorney is awarded a reasonable assessed attorney fee for services at hearing in the amount of \$1,620, to be paid by Liberty Northwest Insurance Corporation in addition to claimant's compensation. Counsel for Liberty Northwest Insurance Corporation is authorized a client-paid attorney fee not to exceed \$816 for services on Board review.

DAVID W. HUNTLEY, Claimant
Bottini, et al., Claimant's Attorneys
Lester Huntsinger (SAIF), Defense Attorney

WCB 87-02893
December 14, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Tenenbaum's order which: (1) upheld the SAIF Corporation's partial denial of psychiatric treatment; (2) found that claimant's back injury claim was not prematurely closed; (3) affirmed a Determination Order that did not award any unscheduled permanent disability for his back injury; and (4) declined to admit two reports offered by claimant into evidence. On review, the issues are compensability of medical treatment, premature closure, extent of permanent disability, and admission of evidence. We agree with the Referee's evidentiary ruling, but reverse the remainder of the decisions.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the following supplementation.

Claimant's August 1984 compensable injury is a material contributing cause of his current psychological condition.

Claimant's psychological condition is not medically stationary.

CONCLUSIONS OF LAW

At the outset, claimant argues that the Referee erred in excluding two documents from the record. Those documents were a March 27, 1987 medical report and a July 1, 1987 report from Dr. Thompson. Both documents were submitted in violation of former OAR 438-07-005(3)(b). The Referee made a finding on the record that good cause did not exist for this late submission and excluded the exhibits pursuant to former OAR 438-07-005(4). We agree with the Referee's decision based on the following reasoning.

Claimant argues that the March 27, 1987 report should have been admitted as: (1) the late submission was made inadvertently; (2) SAIF was in possession of the report; and (3) SAIF was not prejudiced. We are not persuaded by claimant's argument. Inadvertence does not rise to the level of good cause. Further, under former OAR 438-07-005(3)(a), an insurer was not required to submit all documents relevant to the claim as exhibits, but rather only those upon which it intended to rely. Finally, although it may be true that SAIF would not be prejudiced, consideration of prejudice is recommended, but not required. Accordingly, the Referee was within her discretion to exclude the March 27, 1987 report.

In regard to the July 1, 1987 report, it was submitted approximately 3 days prior to the hearing. It was authored by Dr. Thompson, and could have been requested at a more timely date. Accordingly, under former OAR 438-07-005(3)(b), the report should not have been admitted and the Referee did not err in excluding it. Under these circumstances, the Referee was within her discretion in refusing to admit the aforementioned reports. See former OAR 438-07-005(4). Accordingly, we have not considered these documents on review. We now proceed to the merits of the case.

Based on a totality of the evidence, the Referee concluded that claimant's compensable injury was not a material contributing cause of his psychological condition. We disagree.

To establish compensability of his psychological condition, claimant must prove, by a preponderance of the evidence, that his compensable injury is a material contributing cause of his psychological condition. Grace v. SAIF, 76 Or App 511 (1985). Following our de novo review of the evidence, we conclude that claimant has met that burden.

In rendering her decision, the Referee was persuaded by the opinion of Dr. Klein, rather than the opinion of claimant's treating psychologist, Dr. Flemming. Dr. Klein opines that the industrial injury was not a material contributing factor to claimant's psychological condition. Yet, Dr. Klein examined claimant once, and by her own admission was unable to perform an adequate exam due to claimant's anger and noncooperation. Given these facts, we find her opinion unpersuasive. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

Conversely, Dr. Flemming, psychologist, treated claimant before and after his industrial injury. Although claimant does have preexisting personality problems, it is Dr. Flemming's opinion claimant has significant psychological problems directly attributable to the continuing problems he experiences as a result of the compensable injury. In light of the fact that Dr. Flemming has treated claimant on numerous occasions, both prior to and following the original injury, we find his well-reasoned opinion persuasive. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986).

Since we have concluded that claimant's psychological condition is compensable, we now turn to the issue of premature closure. It is apparent from the record that although claimant's physical condition may be stationary, his psychological condition is not. Both Drs. Thompson and Flemming indicate that further

psychological treatment is needed before claimant's condition can reach a stationary status. Further, SAIF has recognized that claimant is unable to return to work without further treatment. Accordingly, we find that claimant's claim was closed prematurely. Rogers v. Tri-Met, 75 Or App 470, 473 (1985).

As we have found claimant's claim to have been closed prematurely, we do not reach the issue of permanent disability.

ORDER

The Referee's order dated August 11, 1987 is reversed. The SAIF Corporation's denial of claimant's psychological condition is set aside and the claim is remanded to SAIF for processing according to law. The March 9, 1987 Determination Order is set aside as premature. Claimant's attorney is awarded a reasonable assessed fee of \$1,900 for services at the Hearing and Board levels, to be paid by SAIF.

JAN H. KATAFIAS, Claimant	WCB 87-10694
Durham, et al., Claimant's Attorneys	December 14, 1988
Mark B. Williams, Defense Attorney	Order on Review
Reviewed by the Board en banc.	

The self-insured employer requests review of Referee Galloway's order that set aside its partial denial of allergic pollenosis, chronic sinusitis and bronchial asthma. The only issue is compensability of the denied conditions. We reverse.

FINDINGS OF FACT

Claimant is a 44-year old corrections supervisor, who has worked for this employer since December 1971. He has a lifelong history of allergic pollenosis expressed by allergic rhinitis (hayfever) and allergic conjunctivitis. He also has a lifelong history of bronchial asthma with allergic component. He experiences the worst symptoms during high pollen times of the year, usually from late spring until early autumn. He takes both oral and injected medication for these conditions. Prior to December 1986 he used the injections only for six months out of the year, during the heavy pollen season. Since December 1986 he has used the injections year around.

Claimant does not smoke, has never smoked and, to the greatest extent possible, is not around people who smoke when he is away from his job. When he is on the job he is exposed to heavy concentrations of cigarette smoke. On or about December 8, 1986 claimant developed an upper respiratory viral illness which expressed as a sore throat, laryngitis and sinusitis. The viral illness combined with his preexisting conditions were exacerbated by the exposure to cigarette smoke, resulting in a respiratory annoyance and irritational syndrome. On July 6, 1987, the self-insured employer accepted responsibility for the respiratory annoyance and irritational syndrome and denied responsibility for the preexisting conditions of allergic pollenosis, chronic sinusitis and bronchial asthma.

FINDING OF ULTIMATE FACT

Claimant's work exposure to cigarette smoke did not cause or worsen the pathology of his preexisting allergic pollenosis, chronic sinusitis or bronchial asthma.

CONCLUSIONS OF LAW

Claimant suggested at the hearing that the employer's partial denial was invalid as a matter of law. (Tr. 67.) We reject that argument. See Johnson v. Spectra Physics, 303 Or 49 (1987).

This is a claim for occupational disease. To prevail, claimant must establish by a preponderance of the evidence that the denied conditions either were caused by exposure at work or that the preexisting conditions were worsened pathologically by his work exposure. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985). The medical and lay evidence is unanimous that claimant has preexisting allergic pollenosis, chronic sinusitis and bronchial asthma. The medical evidence also is unanimous that claimant's work exposure did not cause any of these conditions. The question is whether the on-the-job exposure to cigarette smoke pathologically worsened any of these conditions. We view this as a complex medical question.

Dr. Bardana views the onset of claimant's viral illness as nonoccupational. The symptoms of the preexisting conditions, according to Dr. Bardana, increased after acquisition of the viral illness, making claimant more vulnerable to the cigarette smoke, resulting in the symptom complex he describes as respiratory annoyance and irritational syndrome. It is this last syndrome only that he ascribes to claimant's on-the-job exposure to cigarette smoke. Dr. Bardana does not, as claimant argues, assign the development of the viral illness to the exposure to smoke. It was instead the combination of the viral illness with the underlying conditions that, when the smoke was added, resulted in the syndrome that the employer has accepted. Dr. O'Halloran, claimant's attending physician, also notes that the irritant effects of continuous exposure to airborne cigarette smoke worsen the symptoms of conditions such as claimant's. Neither physician has stated that the underlying conditions themselves have worsened other than symptomatically.

The symptom complex that actually was caused by the on-the-job exposure has been accepted without reservation by the employer. Claimant has not proven that his preexisting allergic pollenosis, chronic sinusitis and bronchial asthma have worsened other than symptomatically. We conclude that the partial denial was correct.

ORDER

The Referee's order dated January 12, 1988 is reversed. The self-insured employer's partial denial dated July 6, 1987 is reinstated and upheld.

Board Member Crider dissenting.

Claimant filed a claim for respiratory disease resulting from environmental smoke in the workplace. The employer accepted what it described as "upper respiratory annoyance and irritational syndrome" but denied "allergic pollenosis, chronic sinusitis and bronchial asthma." The Referee set aside the denial. The Board reverses. I dissent.

The evidence unequivocally establishes that claimant had suffered for many years from allergic pollenosis, at least during

the summer months, and from bronchial asthma, although the latter was well controlled in recent years. It is also clear that claimant's "chronic" sinusitis did not develop until December, 1986, as a result of a viral infection. Ex. 4-8. Exposure to smoke interacted with the infection. According to Dr. Bardana, upon whom the majority relies, "it is probable that this irritant-induced inflammation intensified the infection and temporarily worsened the rhino-sinusitis". Ex. 6-2.

On the basis of Dr. Bardana's opinion, the self-insured employer accepted a symptom complex which it described as "respiratory annoyance and irritational syndrome."

The majority would permit the employer to accept, as an occupational disease, this symptom complex which, according to the medical evidence, represents a worsening of an identical symptom complex which it characterizes as preexisting. The preexisting condition is described by Dr. Bardana at one point as "chronic sinusitis" of recent etiology (Ex. 4) and at another as "rhino-sinusitis" of longstanding duration (Ex. 6-1). Whichever it is, it is obvious that the preexisting condition is identical to the condition which the employer accepted, albeit perhaps less severe.

The employer apparently believed, based on the opinion of Dr. Bardana, that the irritant-induced worsening of claimant's sinusitis or rhinitis, was temporary and "would have resolved" in four to six weeks. Ex. 6-1. If the employer in fact believes claimant's accepted condition is medically stationary and has resolved, the employer should submit the accepted claim for closure. At that point, the Evaluation Section may determine whether or not there are permanent residuals. The employer should not be permitted to short circuit the claim closure process by accepting a condition, postulating that it is only temporary, and at the same time denying an identical condition, postulating that the denied component is permanent. This preclosure partial denial of an accepted inseparable condition must be set aside. Acquillon v. CNA Insurance, 60 Or App 231 (1982).

I observe that the majority is drawn into error by asking the wrong question. The majority asks whether or not claimant's preexisting condition has worsened. This is the wrong question because the employer has already accepted the worsening. The question is not whether the employer was legally required to have accepted the worsening but whether, once accepted, the employer may turn around and deny the same symptom complex that it has accepted without allowing claimant to establish via the closure process what portion of his permanent symptoms are related to the accepted condition and what portion to the preexisting condition. The answer to that question is no.

For this reason, I would affirm the Referee's order.

Reviewed by Board Members Johnson and Crider.

Claimant requests Board review of Referee Daughtry's order which dismissed claimant's hearing request for the reason that no response was received from claimant subsequent to an Order to Show Cause.

ISSUES

1. Whether claimant timely requested Board review.
2. Whether the Referee properly dismissed claimant's case for his failure to show cause.

FINDINGS OF FACT

On February 13, 1986, claimant requested a hearing and submitted his application to schedule. On February 19, 1986, the Workers' Compensation Board acknowledged receipt of the request and application. On May 6, 1986, copies of the Notice of Hearing, set for August 28, 1986, were issued and mailed to the parties. On September 17, 1986, claimant's claim was placed in inactive status until June 17, 1987 due to pending concurrent litigation, the outcome of which could materially affect claimant's hearing. The order required claimant to submit an application to schedule or a request for extension of inactive status prior to June 17, 1987.

On July 2, 1987, Referee Daughtry issued an Order to Show Cause, if any, within 30 days of the Order why the case should not be dismissed as abandoned. It further stated that "an Application to Schedule a Hearing date indicating a present readiness to proceed is NOT an adequate response to this Order. YOU MUST SHOW WHY THE DELAY OCCURRING PRIOR TO THE ENTRY OF THIS ORDER SHOULD NOT RESULT IN DISMISSAL." (Emphasis in original).

On August 21, 1987, Referee Daughtry entered an Order of Dismissal since claimant had not responded to the Order to Show Cause. The Dismissal Order stated that if claimant was dissatisfied with the decision, he could, not later than 30 days after the mailing date of the Order, request a review by the Workers' Compensation Board. It further stated that failure to mail such a request for review within 30 days after the mailing date of the Order would result in his "LOSS OF RIGHT TO APPEAL FROM THIS ORDER."

On August 24, 1987, claimant's counsel mailed a letter to Referee Daughtry requesting that the Order of Dismissal be set aside and that the matter be scheduled for hearing. Along with that letter, counsel attached a copy of a letter dated July 31, 1987, addressed to Referee Daughtry and written by counsel in response to the Order to Show Cause. The record does not indicate whether the July 31 letter was mailed by claimant's counsel to the Referee prior to August 24, 1987 and, if so, when.

In the July 31, 1987 letter, claimant's counsel stated that claimant's case had been placed in inactive status so that he could undergo additional medical testing regarding his claim.

Counsel explained that a liver biopsy was recently accomplished and the test results were received by claimant on July 1, 1987. Therefore, claimant was at that time ready to proceed to hearing.

On September 21, 1987, Claimant's counsel mailed a Request for Review to the Workers' Compensation Board requesting that the Board review the Referee's August 21, 1987 Order of Dismissal.

CONCLUSIONS OF LAW

Board jurisdiction

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

If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b).

Here, the thirtieth day after the Referee's August 21, 1987 Order of Dismissal was September 20, 1987, a Sunday. Therefore, the last day to timely file a request for Board review was Monday, September 21, 1987. See ORS 174.120. Claimant's September 21, 1987 request for Board review of the Referee's August 21, 1987 Order of Dismissal was sent by certified mail on September 21, 1987. Therefore, the request was timely. See Walter D. Henneberg, 40 Van Natta 109 (1988).

Propriety of the Referee's Order of Dismissal

Claimant contends, contrary to the Referee's statement in the Order of Dismissal that, by his letter to Referee Daughtry, dated July 31, 1987, he did show good cause why his claim should not be dismissed as abandoned. No hearing was held and there is nothing in the record to indicate that Referee Daughtry ever received that letter.

Claimant contends that he mailed his July 31, 1987 letter to Referee Daughtry within 30 days of the July 2, 1987 Order to Show Cause. Referee Daughtry issued his Order of Dismissal because he had received no response to the Order to Show Cause. We cannot discern from the record whether claimant's July 31, 1987 letter was mailed within the statutory time limits since claimant has not provided proof from the post office of the mailing date.

On review of the record before us, we conclude that the case has been incompletely or otherwise insufficiently developed. See ORS 656.295(5). Accordingly, the Order of Dismissal shall be vacated and set aside and the case shall be remanded to the Hearings Division for a hearing to determine whether or not claimant's July 31, 1987 letter was a timely and sufficient response to the July 2, 1987 Order to Show Cause.

ORDER

The August 21, 1987 Order of Dismissal is vacated. This matter is remanded to the Hearings Division for a hearing to determine whether or not claimant's July 31, 1987 response to Referee Daughtry's Order to Show Cause was timely filed. If the response was timely filed, the Referee is directed to decide the sufficiency of that response.

GARY G. LEMERE, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 87-02647
December 14, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee T. Lavere Johnson's order that: (1) upheld the SAIF Corporation's partial denial of claimant's ulcer condition; and (2) declined to assess a penalty for alleged unreasonable conduct, but awarded claimant an attorney fee. Neither party filed briefs in this matter. We affirm in part and modify in part.

ISSUES

1. Whether claimant's ulcer condition was materially caused or worsened by his compensable low back injury.

2. Whether claimant is entitled to a penalty and related attorney fee for SAIF's alleged unreasonable delay in payment of temporary disability benefits.

FINDINGS OF FACT

On October 20, 1986, claimant compensably injured his back while employed at SAIF's insured. The condition was diagnosed as a lumbar strain and a disc herniation at L4-5, right, with radiculopathy. On May 29, 1987, surgery was performed to correct the condition. The claim remained in open status at the time of the hearing of August 14, 1987.

Claimant has experienced symptoms of back pain since the industrial injury. The symptom complex has resulted in limitations on his activities of bending, stooping and standing. The use of crutches has been required throughout the course of claimant's medical treatment.

Claimant has experienced mental distress because of: (1) his symptom complex; (2) inability to return to work; and (3) the impact the industrial injury has had on his present and future prospective financial condition.

Claimant was hospitalized during November 1986 and during January 1987 for abdominal complaints of pain, nausea and vomiting. Medical attention was received for the complaints. The condition was diagnosed variously as recurring pancreatitis, acute gastro-enteritis and a duodenal ulcer. Claimant had a prior history of pancreatitis.

On February 23, 1987, SAIF denied claimant's duodenal ulcer claim and stated that the condition was neither caused nor worsened by the industrial injury or its sequelae.

Claimant has exhibited functional overlay and probable manipulative motives throughout the course of his medical treatment.

Time loss benefits were paid to claimant on the accepted back claim. The first payment of time loss benefits was made on October 31, 1986 in the sum of \$128.01. The second payment of time loss benefits was made on November 17, 1986, two days late, in the amount of \$256.02.

Claimant's duodenal ulcer condition was neither materially caused nor worsened by his compensable injury or its sequelae.

CONCLUSIONS OF LAW

Compensability

The Referee concluded that claimant failed to prove a causal relationship between his compensable back injury or its sequelae and his duodenal ulcer condition. We agree and adopt the Referee's conclusions with the following supplement.

Dr. Ward, a chiropractic physician, causally related claimant's condition diagnosed as a duodenal ulcer to the industrial injury, in terms of the condition being secondary to the physical and emotional stress of the injury. Dr. Bulger did not; he believed that the condition was caused by a severe anxiety response which was not attributable to any accident, injury or preexisting condition. In short, Dr. Bulger felt that the condition was an "expression of an individual's particular personality and characteristic behavior." Dr. Girod, a specialist certified in internal medicine and infectious diseases, also did not relate the condition to the industrial injury or its sequelae, although he conceded that mental stress could exacerbate the symptoms of an ulcer condition.

Penalties and attorney fees

Pursuant to ORS 656.262(10), an insurer shall be liable for a penalty when it unreasonably delays the payment of compensation, plus an attorney fee which may be assessed under ORS 656.382.

SAIF's November 17, 1986 payment of \$256.02 was two days late. Although the Referee awarded claimant an attorney fee for SAIF's unreasonable conduct, he declined to award a penalty, concluding that no amounts were then due upon which to assess a penalty. We modify.

For purposes of assessing a penalty, the amount "then due" is calculated as of the time of the denial, not the time of hearing. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). Therefore, the amount then due to claimant was \$256.02.

ORDER

The Referee's order dated September 28, 1987 is affirmed in part and modified in part. That portion of the Referee's order that declined to award claimant a penalty for the SAIF Corporation's unreasonable delay in the payment of temporary disability benefits is modified. SAIF is assessed a 10 percent penalty based on its late payment of \$256.02. The remainder of the Referee's order is affirmed.

MELANIE D. MONROE, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heyse, Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Acker, et al., Defense Attorneys

WCB 87-00543, 87-05910, 87-08026
& 87-08027
December 14, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Fireman's Fund Insurance requests review of Referee Mellum's order which set aside its "de facto" denial of surgery. We affirm.

ISSUES

The sole issue is whether claimant has proven by a preponderance of the evidence that proposed surgery is reasonable and necessary and therefore compensable under ORS 656.245.

FINDINGS OF FACT

Claimant compensably injured her low back on November 16, 1979. Fireman's Fund accepted a back injury. The initial diagnoses were cervical and lumbar sprains.

Claimant has had persistent chronic low back pain with radiating right leg pain. Numerous conservative treatments have been tried with no success. Diagnostic studies have been somewhat inconclusive; however, claimant has atrophy of her right calf. Studies performed in February 1985 demonstrate that there is probably impingement of the L5 nerve root beneath the pedicle or facet joints. (Ex. 71). Drs. Maukonen, Yamodis and Peterson are all involved in claimant's treatment. All three recommend surgery. Drs. Rosenbaum and Langston and the Orthopaedic Consultants, all independent examiners, all recommend against surgery.

In view of claimant's clinical findings, increased disability and increased problems performing activities of daily living, surgery is warranted to try to relieve claimant's disability. (Ex. 74). Claimant's current low back problems and need for surgery are caused by her compensable injury.

ULTIMATE FINDING OF FACT

The proposed surgery is a reasonable and necessary treatment for claimant's compensable injury.

CONCLUSIONS

The Board adopts the Referee's opinion.

ORDER

The Referee's order of February 11, 1988 is affirmed. Claimant's attorney is awarded a reasonable attorney's fee of \$300 for services on Board review, to be paid by Fireman's Fund. A client-paid fee payable from Fireman's Fund to its counsel, not to exceed \$1,326.50, is approved.

JOHN PARTIBLE, Claimant
Tamblyn & Bush, Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney

WCB 87-14305 & 87-08931
December 14, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Knapp's order that: (1) held that claimant's July 9, 1986 injury was not an aggravation of his December 6, 1979 injury; (2) held that claimant's July 9, 1986 neck and upper back injury was merged with his accepted February 7, 1980 low back injury claim; (3) held that the March 30, 1987 stipulation settled all claims arising out of the July 9, 1986 injury and denied claimant's request to set aside the stipulation; and (4) denied claimant's request for a penalty and attorney fee for nonpayment of medical services. We reverse in part and affirm in part.

ISSUES ON REVIEW

1. Whether claimant's July 9, 1986 neck and upper back injury was correctly processed as a part of the February 7, 1980 low back injury claim.

2. Whether the March 30, 1987 stipulation settled all issues arising out of the July 9, 1986 injury and, if so, whether the stipulation should be set aside.

FINDINGS OF FACT

Claimant sustained a nondisabling neck injury on December 6, 1979. The claim was accepted by the SAIF Corporation as nondisabling. Claimant has six lumbar vertebrae. On February 7, 1980, he slipped and twisted his low back resulting in traumatic aggravation of a spondylolisthesis at L6-S1. The claim was accepted by SAIF as disabling. Claimant was not an acceptable surgical candidate and all initial treatment was conservative. The first claim closure was by Determination Order dated April 16, 1981. Claimant entered an extended period of vocational assistance programs. Training was suspended in August 1982 and claimant underwent a lumbosacral fusion. As of May 17, 1984, claimant had been awarded compensation of 192 degrees for 60 percent unscheduled permanent partial disability for injury to the low back. By virtue of a disputed claim settlement approved May 17, 1984, claimant agreed that his then pending claim for aggravation and his claim for benefits on account of a psychological condition were not compensable.

Claimant began an authorized training program as a short order cook in January 1986. The program was interrupted and resumed in June 1986. Claimant's low back condition was medically stationary as of June 4, 1986. On July 9, 1986 claimant sustained a neck and upper back injury while emptying a milk container into a vat while engaged in his authorized training program. SAIF accepted responsibility for the neck and upper back injury as a part of the 1980 low back injury claim. Claimant completed the authorized training program in December 1986. On January 14, 1987, a Determination Order closed the low back claim and awarded temporary disability compensation during the period of training.

In March 1987 claimant undertook unrepresented negotiations with John Hayenga, a SAIF claims examiner. The

result was a stipulation that was approved by a prior Referee on March 30, 1987. The stipulation refers only to claimant's 1980 injury and the Determination Order dated January 14, 1987. Claimant was informed by Mr. Hayenga that any issues relating to the July 9, 1986 injury would not be discussed during negotiations and would be the subject of another case. The stipulation provided that claimant would receive additional unscheduled permanent partial disability compensation of 59.68 degrees for 18.65 percent for a total award of 251.68 degrees for 78.65 percent unscheduled permanent partial disability "to claimant's low back," subject to the offset of an overpayment of \$3,033.98, and that, "The Determination Order dated January 14, 1987 is otherwise approved in all respects and all issues raised or raisable are hereby resolved." (Ex. 162.)

CONCLUSIONS AND OPINION

1. Processing of the 1986 injury claim.

SAIF concedes that it has some responsibility for claimant's July 9, 1986 injury. It relies upon Firkus v. Alder Cr. Lbr., 48 Or App 251 (1980), to support its contention that the 1986 injury became a part of the 1980 claim. Claimant also relies on Firkus v. Alder Cr. Lbr., supra, but contends that Firkus addresses only the question of responsibility for injuries incurred during authorized training programs and is silent on how these kinds of claims should be processed. The Referee ruled in accordance with SAIF's position. Both parties agree that this is a matter of first impression.

The Firkus court held that, where a second injury occurs during an authorized training program sponsored by a claim for an earlier injury, the injured worker is entitled to seek compensation for the second injury from the original insurer under the doctrine expressed in Wood v. SAIF, 30 Or App 1103 (1977) rev den 282 Or 189 (1978). Neither Firkus nor Wood directly addressed the question raised in this case, i.e. is the second event in effect merged with the original injury for purposes of processing and calculation of aggravation rights, or is the second event evaluated and processed either as an aggravation of the original injury or as a new injury with attendant aggravation rights of its own.

We conclude that the second event must be evaluated independently and, depending on the facts of the case, processed either as an aggravation of the first injury or as a new injury with new aggravation rights. In reaching this conclusion we are guided in part by the court's statement in Wood v. SAIF, supra, 30 Or App at 1107, that the facts of the Wood case established that there was a new injury and that the original insurer was not liable for compensation on a theory of aggravation. We infer from that statement that the original insurer was liable for a new injury. The facts of this case clearly establish that claimant sustained a new injury. There was a discrete accident that resulted in injury to a different part of claimant's body.

SAIF's position is that it is the original claim that bears responsibility for the new injury. Under this theory, any subsequent compensable injury would relate back to the date of the original injury for all purposes. As an illustration of the potential extremity of SAIF's approach, if the subsequent injury resulted in a worker's death, the worker would be deemed to have

died as of the date of the original injury. This would place the majority of the risk of future injury in an authorized training program upon the worker, with the risk increasing with the passage of time. The result in this case, if SAIF's reasoning is accepted, would be that it is liable for neither an aggravation nor a new injury.

We conclude that this approach is inconsistent with the purpose of the Workers' Compensation Law, as set forth in ORS 656.012(2). The better approach, which we adopt, is that a subsequent event remains the responsibility of the original insurer, but that whether it relates to the original claim depends upon whether the subsequent event is an aggravation or a new injury. If it is a new injury, as it is in this case, it is a new claim, with all of the attendant attributes, including a new aggravation period. We conclude that the July 9, 1986 injury should have been accepted and processed as a claim for a new injury.

2. Effect of the March 30, 1987 Stipulation.

Claimant testified that he understood the stipulation was intended to resolve only the matter of the extent of his permanent disability to the low back under the 1980 claim. He further testified that, when he asked the examiner about the 1986 injury during the course of discussions, he was told that the 1986 injury was not a part of the discussions and would have to be dealt with separately. Claimant's testimony is not controverted. Claimant asks that the stipulation be set aside on account of a material misrepresentation regarding its effect upon the 1986 injury. The Referee found that the stipulation was executed in good faith with full understanding by the parties and declined to set it aside.

Claimant's version of events is entirely consistent with our finding that the 1986 injury is a claim separate from the 1980 claim. If we had adopted SAIF's processing theory, i.e. that the 1986 injury merged into the 1980 claim, claimant's argument might be persuasive. As we have concluded that the 1980 and 1986 injuries should have been the subjects of separate claims, we need not further pursue claimant's argument.

We addressed a similar situation in Tana L. Wilson, 40 Van Natta 476, 478 (1988), in which we concluded that a claim which was not addressed in a disputed claim settlement was not barred by the settlement. The operative language of the settlement in this case is as follows: "The Determination Order dated January 14, 1987 is otherwise approved in all respects and all issues raised or raisable are hereby resolved." (Ex. 162-2.) We conclude that the stipulation resolved only issues relating to the 1980 injury claim, which was closed by the January 14, 1987 Determination Order. The 1980 claim was for a low back injury. Claimant does not attack the stipulation insofar as it deals with the low back claim. We conclude that issues related to the 1986 injury were neither raised nor raisable in connection with the settlement of the January 14, 1987 Determination Order. For this reason, we affirm the Referee's decision.

ORDER

The Referee's order dated January 26, 1988 is reversed in part and affirmed in part. That portion of the Referee's order

holding that claimant's 1986 injury merged with the 1980 low back claim is reversed. The SAIF Corporation is ordered to accept the July 9, 1986 injury as a new injury claim and process it in accordance with law. Claimant's attorney is entitled to 25 percent of the compensation for temporary and permanent disability resulting from this order under the 1986 injury claim, not to exceed \$3,800, as an attorney fee to be paid out of claimant's compensation and not in addition thereto. The remainder of the Referee's order is affirmed.

MICHELLE RABIDEAU, Claimant
Velure & Yates, Claimant's Attorneys
Jim Northrup (SAIF), Defense Attorney
Fenner, et al., Attorneys
Nelson, et al., Defense Attorneys

WCB 87-08860 & 87-11499
December 14, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Mills' order which set aside its denial of claimant's occupational disease claim for a bilateral arm condition. We reverse in part.

ISSUES

Compensability of bilateral arm condition.

FACTS

Claimant worked for the employer, a poultry processing firm, during two periods from December of 1983 through June 19, 1984 and from September 13, 1985 through October 23, 1985. Between those periods, claimant was on maternity leave. The SAIF Corporation insured the employer during the first period of employment and Liberty Northwest was the insurer during the second period.

During the first period of employment, claimant worked in a cold room as a production worker responsible for chicken processing and packaging. In that capacity, she rotated among several positions with a variety of specialized tasks. These tasks required heavy lifting and rapid and repetitive use of her hands, wrists, arms and shoulders. During this time, she developed sharp pains and numbness radiating from the hands through the arms and into the shoulders. She complained to her supervisor and was given wrist bands to wear during the day and wrist braces to wear at night. She wore them regularly, but they provided no relief.

The symptoms persisted after she left work in June of 1984 and throughout her maternity leave, yet she did not seek treatment for this condition. When she returned to work in September of 1985, she was assigned to a kitchen where chickens were skinned, deboned and processed for chicken nuggets and other specialty cuts. While deboning, she used her right hand to manipulate the knife while her left hand supported and manipulated the chicken. The job required heavy lifting and repetitive use of the hands and wrists. Her symptoms worsened during this time, but she wore no wrist bands or braces. She eventually left the job due to symptoms and scheduling difficulties. She has not worked since October of 1985.

The symptoms nevertheless persisted after she left work. She finally sought medical treatment for these symptoms on May 15, 1987, when she saw Dr. Throop for a neurological consultation. Throop examined her upper and lower extremities and conducted electrodiagnostic tests on the right arm, and found no neurological abnormalities. He noted that claimant was overweight, particularly about the shoulder girdles, and diagnosed "vascular thoracic outlet syndrome due to tightness of the musculature about the shoulder girdles bilaterally worsened by [claimant's] body habitus." He also noted diffuse joint tenderness and pain on movement which he attributed to a degenerative or arthritic process. He released claimant for modified work that required no repetitive hand movement. Dr. Throop has neither treated nor reexamined claimant since the sole examination on May 15, 1987.

On October 15, 1987, claimant underwent an independent medical examination (IME) by Dr. Nathan, a hand surgeon. Nathan examined both upper extremities and referred claimant for nerve conduction studies of both arms and a hand function evaluation. He diagnosed bilateral carpal tunnel syndrome, long-term and idiopathic, and focal slowing in the right ulnar nerve at the elbow, mild and idiopathic.

Claimant filed occupational disease claims for this condition with SAIF and Liberty Northwest. Each insurer denied the compensability of and responsibility for the claim.

We do not find that claimant's bilateral arm condition is related to her work activities.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the claim was compensable and that Liberty Northwest was the responsible insurer. On review, Liberty Northwest contends that the claim was not compensable. We agree and reverse accordingly.

Claimant must prove an occupational disease by a preponderance of the evidence. Former ORS 656.802(1)(a); Clark v. Erdman Meat Packing, 88 Or App 1, 5 (1987), rev den 305 Or 102 (1988). There are two prerequisites for establishing an occupational disease: (1) The disease must arise out of and in the scope of employment; and (2) the disease must be one to which the employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein. Former ORS 656.802(1)(a). The first prerequisite involves the application of a unitary work-connection analysis to determine whether the disease is sufficiently work-related. SAIF v. Noffsinger, 80 Or App 640, 645, rev den 302 Or 342 (1986). In applying this analysis, we consider idiopathic factors, in addition to on-the-job and off-the-job activities and exposures. If the first prerequisite is satisfied, claimant must then prove that work activities or exposures, when compared to non-work activities or exposures, were the major contributing cause of the disease. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); SAIF v. Noffsinger, supra, 80 Or App at 645-656; Clark v. Erdman Meat Packing, supra.

The causation of claimant's condition presents a complex

medical question. Hence, although her credible testimony is probative, resolution of this case turns largely on the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical evidence is evenly divided. Dr. Throop diagnosed vascular thoracic outlet syndrome, based primarily on a positive Adson's maneuver. Initially, he related the condition to claimant's build and the distribution of her body weight. He could not determine "whether the joint problems were exacerbated or brought on by [work] activities," but he noted that thoracic outlet syndrome can be brought on by excessive overhead shoulder girdle activity. Later, he opined by check-the-box responses on Forms 827 (First Medical Report) that claimant's condition was work related.

Dr. Nathan, on the other hand, diagnosed bilateral carpal tunnel syndrome and mild focal slowing in the right ulnar nerve at the elbow, based on nerve conduction studies. He noted the persistence of symptoms even after claimant quit work in 1985 and opined that the presence of nerve entrapments in both median nerves strongly suggested that she had an idiopathic process. He opined that the condition was not related to work activities. Nathan also questioned the reliability of Dr. Throop's diagnosis, stating that a finding of positive Adson's maneuver is frequently present in persons without thoracic outlet syndrome. Throop responded by reiterating his diagnosis of vascular thoracic outlet syndrome based on the positive Adson's maneuver and by opining that nerve conduction studies were within normal limits.

The Referee gave two reasons for his decision. First, he assigned greater weight to Dr. Throop's opinion, based on the finding that Throop was the treating physician. Second, he discounted the persuasiveness of Dr. Nathan's opinion, disagreeing with Nathan's conclusion that the condition was entirely idiopathic. We disagree with both reasons for the decision.

We find no reason to assign Dr. Throop the status of treating physician. Throop examined claimant only once, on referral from Dr. Gibbens, and administered no treatment. Moreover, that examination took place more than one year after claimant quit her job. Consequently, Throop's opinion is not entitled to greater weight.

After reviewing the medical evidence on the question of whether claimant's condition is work related, we conclude that Dr. Nathan's opinion is at least as well explained as Dr. Throop's. Indeed, Throop's check-the-box opinion lacks any explanation or analysis. We can only presume that Throop based his opinion on the temporal relationship between claimant's symptoms and work activities. However, we decline to infer causation from mere chronological sequence where, as here, there is medical evidence of alternative causes for the condition. See Bradshaw v. SAIF, 69 Or App 587, 589-90 (1984); Edwards v. SAIF, 30 Or App 21, 24, rev den 279 Or 301 (1977). Nathan related the condition to an idiopathic process. Throop himself initially related the condition to claimant's build and distribution of weight. We conclude, therefore, that the evidence on work relation is, at best, in equipoise. Consequently, claimant has not sustained her burden of proving that her condition is work related. Because we do not find the bilateral arm condition to be

work related, we conclude that it is not a compensable occupational disease.

ORDER

The Referee's order dated February 1, 1988 is reversed in part. Liberty Northwest Insurance Corporation's denial dated June 4, 1987 is reinstated and upheld. The Referee's award of an assessed fee on the denial is disallowed. The remainder of the order is affirmed. A client-paid fee, payable from Liberty Northwest to its counsel, is approved not to exceed \$1,4878.50.

JOSE RODRIGUEZ, Claimant	WCB 87-02745
Welch, Bruun & Green, Claimant's Attorneys	December 14, 1988
Gail Gage (SAIF), Defense Attorney	Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Baker's order that upheld the SAIF Corporation's denial of claimant's injury claim for his groin and back condition. On review, the issues are remand and compensability. We affirm.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

We affirm and adopt the Referee's opinion and order with the following comment:

Claimant requests remand to the Referee on the grounds that certain translated statements of the claimant are so disjointed by the translation as to be "unintelligible." He particularly objects to the admission of a recorded statement of claimant dated January 30, 1987. We note that claimant did not object to the admission of this statement at hearing. Further, we do not agree that the evidence regarding claimant's injury is either unintelligible or the record insufficiently developed. See ORS 656.295(5). Consequently, the request is denied.

ORDER

The Referee's order dated May 27, 1987 is affirmed.

EWART W. SMITH, Claimant	WCB 86-07029
Roll, et al., Claimant's Attorneys	December 14, 1988
Garrett, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Fink's order that upheld the SAIF Corporation's denial of claimant's injury claim on behalf of a noncomplying employer. Claimant asserts that he was a subject worker of the employer and that he compensably injured his low back in September 1985. We affirm.

ISSUE

The compensability of claimant's alleged low back injury.

FINDINGS OF FACT

The employer owns a home in Tillamook County. She and her husband operate businesses out of state, and a dairy farm in Oregon.

In mid-1985, the employer hired claimant to paint a deck and to do other minor maintenance work, such as pulling weeds. The employer also hired two other men, who also did routine maintenance. A garage was being built on the employer's premises at the time claimant did maintenance work. However, neither he nor the other two men worked on the garage, although Mr. Dunigan did construction labor. Mr. King worked on the employer's dairy farm at one time, although claimant did not.

On September 25, 1985, claimant was painting the employer's deck. In order to reach the area needing paint, he climbed on top of a tractor parked next to the structure. The employer and Dave Dunigan, claimant's brother-in-law, saw claimant climb down off the tractor and walk to the employer's house. Claimant spoke with the employer and told her he had fallen from the tractor onto his low back. The employer told him to go home and rest.

Claimant visited an emergency room for three consecutive days after his alleged accident. Because the emergency room reports are not in evidence, it is unclear what, if any, treatment claimant received. Claimant sought no further medical attention until approximately six weeks after his alleged fall, when he received a few chiropractic treatments in Texas.

A few days after claimant's alleged fall, he called the employer and told her that he would "forget" the accident if he were paid \$500. He also represented that he had ruptured his spleen as a result of his fall.

Claimant was not a subject worker at the time of his alleged fall.

Claimant neither fell from the employer's tractor nor injured his low back on September 25, 1985.

CONCLUSIONS OF LAW

Claimant asserts that he was a subject worker on September 25, 1985 and that he compensably injured his low back as a result of falling from the employer's tractor. It is claimant's burden to prove the compensability of his claim. Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979). After reviewing this record, we conclude that claimant has failed to meet his burden of proof.

Under ORS 656.027(2), a worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker is excluded from coverage under the Workers' Compensation Act. Thus, if claimant performed only the maintenance tasks of painting a deck and pulling weeds, he was not a subject employee. Claimant asserts, however, that he performed carpentry on the employer's garage, which was under construction at the time of the alleged injury. The employer refutes claimant's assertion.

The Referee impliedly found claimant not credible when he stated: "Therefore, whether or not [claimant] fell (and I don't believe he did) he is not entitled to Workers' Compensation benefits." Although we cannot determine from the Referee's order whether he found claimant not credible based on demeanor, substance or both, we give deference to his finding of noncredibility. See e.g., Bush v. SAIF, 68 Or App 230 (1984). Considering that finding, and the testimony of the employer and Mr. Dunigan, which directly refute

claimant's version of the facts, we find that claimant was hired to do only maintenance work and that he was not a subject employee at the time of his alleged injury.

Claimant asserts that because the employer had multiple employees, one of whom worked on the employer's dairy farm, the entire workforce was composed of subject employees. Claimant cites Anfilofieff v. SAIF, 52 Or App 127 (1981), as authority. In Anfilofieff, however, the claimant was actually hired to perform both subject and nonsubject employment. When he sustained an injury while performing employment that would have been nonsubject, the court found the work "incidental" to the subject employment and found the injury compensable. By contrast, the present claimant was hired only to do nonsubject work and his injury during that employment is not compensable.

We also agree with the Referee that claimant did not suffer an injury on the employer's premises on September 25, 1985. Again, claimant is not credible and his testimony is directly refuted by two eyewitnesses to the events to which claimant testified. Therefore, even if claimant was a subject worker on September 25, 1985, he did not suffer an injury that would entitle him to compensation.

ORDER

The Referee's order dated July 2, 1987 is affirmed.

The Beneficiaries of

JOHN L. TOYCEN, Claimant

Royce, et al., Claimant's Attorneys

Williams, et al., Defense Attorneys

WCB 86-12684

December 14, 1988

Order on Review

Reviewed by Board Members Johnson and Ferris.

The self-insured employer requests review of Referee Fink's order that set aside its "de facto" denial of claimant's medical services claim. The employer contends that claimant is foreclosed from receiving further benefits by virtue of a May 14, 1985 Disputed Claim Settlement. In his brief on review, claimant raises the issue of penalties and attorney fees for the employer's allegedly unreasonable denial. This issue was raised at hearing, but not decided by the Referee. The issues are medical services and penalties and attorney fees.

The Board affirms and adopts the order of the Referee with regard to the medical services issue. See David Niemann, 39 Van Natta 150 (1987).

Furthermore, we find that the employer's refusal to pay medical services was not unreasonable. The denial was apparently precipitated by a medical report from claimant's treating physician indicating a need for further cervical surgery. A prior independent medical examiner had opined that surgery was not indicated.

The employer contends that the recommended surgery was contemplated by the prior disputed claim settlement and that, therefore, to rule in claimant's favor would be to require the employer to pay again for what it has already paid. See Proctor v. SAIF Corporation, 68 Or App 333 (1984). We do not agree with the employer's interpretation of the settlement agreement. We find, however, that the settlement agreement is sufficiently ambiguous so as not to warrant imposition of a penalty and attorney fees.

Claimant's counsel is entitled to a reasonable carrier-paid attorney fee for services rendered on review concerning the medical services issue. ORS 656.382(2). However, we cannot such a fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Inasmuch as no statement has been received, an attorney fee shall not be awarded.

ORDER

The Referee's order dated May 15, 1987 is affirmed. A client-paid fee, not to exceed \$161, is approved.

The Beneficiaries of

JOHN L. TOYCEN, Claimant

Royce, et al., Claimant's Attorneys

Williams, et al., Defense Attorneys

Own Motion 86-0698M

December 14, 1988

Own Motion Order

Claimant requested that the Board exercise its own motion authority and reopen his claim for a 1972 injury. Claimant's aggravation rights have expired. Because of a pending hearing (WCB 86-12684), the Board referred this matter to the Referee for a consolidated hearing. John L. Toycen, WCB No 86-0698M; Own Motion Order dated February 5, 1987. The Referee was asked to determine whether claimant's then current condition was related to his 1972 injury and whether the condition had materially worsened so as to justify the reopening of his claim.

The litigation proceeded to hearing. On May 15, 1987, Referee Fink found that claimant's condition was related to his 1972 injury and that his condition had worsened. Consequently, the Referee recommended that claimant's request for Own Motion relief be granted.

Following our review of this record, we agree with the Referee that claimant's condition resulting from his 1972 compensable injury had worsened. However, our inquiry does not end there.

Pursuant to the provision of ORS 656.278(1)(a), claimant is entitled to receive temporary disability compensation only if his worsened condition requires inpatient or outpatient surgery or other treatment requiring hospitalization. The record does not support a finding that claimant underwent either inpatient or outpatient surgery or hospitalization.

We note further that claimant had not been gainfully employed since 1980 and had effectively removed himself from the work force. A claimant who has voluntarily removed himself from the labor market is not entitled to compensation for temporary disability. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985).

We conclude that claimant is not entitled to have his claim reopened. Accordingly, the request for own motion relief is denied.

IT IS SO ORDERED.

PATRICIA A. WASHBISH, Claimant
Black, et al., Claimant's Attorneys
Art Stevens (SAIF), Defense Attorneys

WCB 87-18851
December 14, 1988
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Mirassou's order which concluded that the SAIF Corporation did not pay temporary disability benefits at an incorrect rate.

ISSUES

Claimant contends that her time loss rate should have been based on her compensation for work at both the Union Club where her injury occurred and the adjacent business, Sally's Place. Claimant contends that the two businesses are, in fact one. SAIF contends that the two businesses are separate and that the rate of time loss was properly based only on claimant's compensation at the Union Club.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact.

CONCLUSIONS

The Board adopts the Referee's opinion.

ORDER

The Referee's order dated March 17, 1988 is affirmed.

Board Member Crider, dissenting:

I agree with the Referee and the Board majority that Union Club (the Clearwaters) and Sally's Place (the Thomas') are separate businesses; but I do not think that that separateness disposes of this case. For if Union Club and Sally's Place are joint employers for purposes of employing claimant or, alternatively, if claimant is really only an employee of Union Club although a part of her salary is paid by Sally's Place by virtue of an agreement between Union Club and Sally's Place, then claimant's temporary total disability benefits should be based on the total of the wages she was paid by the two business entities.

This record is sketchier than it ought to be; nevertheless, I believe it is incumbent on the Board to focus on the nature of the employment relationship between claimant and Union Club and Sally's rather than on the nature of the business relationship between the two businesses.

Claimant testified, without contradiction, that she was hired by Clearwater and advised by Clearwater regarding what her salary would be from each entity. She engaged in no negotiations with Thomas regarding her terms and conditions of employment. Tr. 8, 10. She worked at both places of business each time she came in to work; she did not keep track of her hours. The only evidence of any relationship between Sally's (the Thomas') and claimant is the evidence that, on a regular basis, claimant received cash directly from Sally's in addition to her check from Union Club.

The evidence that the two businesses desired to define and separate their financial affairs and that claimant received two simultaneous separate payments is insufficient to outweigh the evidence that claimant's work for the businesses was performed at the behest of Clearwater alone and was essentially inseparable. This is particularly so since the lease agreement between the Clearwaters and Thomas' seems to indicate that the Clearwaters as lessors would be responsible for handling utilities and janitorial while the Thomas' would share in the cost.

Therefore, claimant's temporary total disability benefit should be calculated based on the total of her regular payments from each business.

ANNA LEIN, Claimant
Robert Webber, Claimant's Attorney
Cowling & Heyse, Defense Attorneys

WCB 86-16887
December 15, 1988
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of Referee Brown's order that upheld the insurer's denial of the claimant's occupational disease claim for her shoulder and neck condition. We affirm.

ISSUE

Whether claimant's work activities were the major contributing cause of her shoulder and neck condition.

FINDINGS OF FACT

Claimant began working for her employer, an electronics firm, in March 1985. She worked in the finishing department until July 1986, at which time she transferred to the screen department. In the screen department, one of her job duties involved assembling radio antennas. This was accomplished by drilling holes in the ends of the antenna and pounding drive screws into the holes. Two of the holes were drilled while the antenna was fully supported; drilling the third hole required her to swing the long end of the antenna up behind her and hold it vertically under the drill press. She held the upper part of the antenna with her left hand elevated above her shoulders; her right hand positioned the antenna against the fence on the drill press. After drilling the hole, she turned and carried the antenna about two feet to a block where she inserted a drive pin and pounded it home. Each antenna is made up of two "U" shaped sections. Three holes are drilled in each leg of the "U", the two sections are joined together to form an oval, and the remaining six holes are drilled and screws driven. The completed antenna weighs 9.7 pounds; the one half that is drilled first weighs less than half as much.

In summary, for each antenna assembled, claimant drilled and drove 12 screws; two were drilled while she lifted and supported less than five pounds with her left hand; two were drilled and driven while lifting and supporting 9.7 pounds. Although employees worked at their own pace, on a good day, claimant assembled 40 antennas. Due to the nature of the work and the small work force, antennas were produced in batches of 40 to 60 rather than at one at a time.

Claimant also lifted 7 to 10 pound screens with her left hand while she drilled holes in them with her right hand. About 150 screens were assembled every four to six weeks, depending on the market and the personnel demands elsewhere in the plant.

There were many other drilling, bending and assembly functions involved in the screen department. The above-described activities were the only overhead left-handed activities.

In December 1984, prior to claimant's employment, she developed pain in her fingers, hands and left shoulder while feeding a dryer at a plywood mill. In March 1985 Dr. Worland, surgeon, diagnosed bilateral tenovaginitis, worse on the right than the left, and recommended a bilateral tenovagiotomy of the thumbs.

On May 17, 1985, Dr. Peterson, surgeon, performed a bilateral trigger thumb release. Post-operatively, claimant's right hand pain was relieved while she continued to exhibit minimal triggering of the left thumb. Claimant had pain in the right thumb when she began to work for the employer.

In August 1986, approximately three weeks after claimant began work in the screen department, she began to notice bilateral shoulder and neck pain. No specific incident caused the occurrence of this pain.

On October 24, 1986, claimant sought medical treatment from Dr. Peterson, who had been treating her for the unrelated trigger thumb condition. Her symptoms included ongoing numbness in both thumbs and the recent development of numbness involving both upper extremities, including hands, forearms and arms. Dr. Peterson referred her to Dr. Melson, a neurologist, who diagnosed: (1) cervical cephalgia; and (2) anxiety-tension state.

Around the time that claimant's neck and shoulder problems developed in 1986, her husband had been off work for approximately two years following surgery for a herniated disc. They had two children and were experiencing severe financial hardship. They were also experiencing marital problems at the time. By transferring to the screen department, claimant had hoped to increase her salary.

As claimant's condition gradually worsened, she became less proficient at work. On October 28, 1986, she was transferred from the screen department back to the finishing department due to the poor quality of her work. Three days later, she was admitted to the hospital by Dr. Maukonen, a neurologist, for severe neck and left arm pain and headaches. Dr. Maukonen diagnosed an overuse syndrome, or more specifically: (1) cervical strain; and (2) thoracic outlet syndrome on the left.

On November 14, 1986, claimant filed an injury report with her employer, stating that on August 5, 1986 she strained her neck and shoulder while lifting heavy screens and pounding drive screws into metal.

The evidence does not indicate that claimant's work activities were the major contributing cause of her neck and shoulder problems in the summer and fall of 1986.

CONCLUSIONS OF LAW

The Referee concluded that Dr. Maukonen did not have an accurate understanding of claimant's work activity when he opined that her neck and shoulder problems were work-related. We agree.

To establish a compensable occupational disease, claimant

has the burden of proving that the work activities were the major contributing cause of either the onset or worsening of her disease. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., supra, 295 Or at 309-10; Clark v. Erdman Meat Packing, 88 Or App 1, 5 (1987).

Compensability must be proven by a preponderance of the evidence. Summitt v. Weyerhaeuser Co., 25 Or App 851, 856 (1976). Contrary to claimant's assertion, it is a fundamental principle of the Workers' Compensation Law that the burden of proof rests with the claimant. Id. Lay testimony concerning causation is probative evidence. Garbutt v. SAIF, 297 Or 148 (1984). However, it may not be persuasive when the claim involves a complex medical question. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The present claim involves a complex medical question. Therefore, although we do not disregard claimant's testimony at hearing, we rely more heavily upon the medical opinions regarding causation.

In a March 30, 1987 deposition taken on behalf of claimant, Dr. Maukonen offered the only opinion regarding the causation of claimant's neck and shoulder pain. Dr. Maukonen saw claimant for the first time on October 31, 1986 in the emergency room. According to Dr. Maukonen, her symptoms at that time included pain in the neck and left arm, numbness and tingling in her hands and headaches.

Claimant provided Dr. Maukonen with the following information. She stated that she had recently changed jobs and was putting together antennas, holding the antenna with the left arm and pounding the hammer with the right arm. Based on that history and the erroneous belief that claimant did not experience bilateral shoulder pain, Dr. Maukonen diagnosed an overuse syndrome (characterized by holding an object in a fixed position for a long period of time) and thought that the work activity was the cause of her problem.

On cross examination, however, Dr. Maukonen admitted that: (1) he did not know the extent of the repetitive nature of the antenna assembly; (2) he did not know how much overhead work was involved; (3) he did not know how much weight claimant lifted; (4) he was under the impression that prior to claimant's work in the screen department she had never experienced neck, shoulder or arm problems; (5) when claimant initially developed the neck and shoulder problems it was not bilateral in nature; and (6) if claimant had experienced bilateral neck, shoulder and arm pain, then another possible etiology was a mental tension state.

Mr. Matsen, claimant's supervisor and only co-worker in the screen department, demonstrated the work activity at hearing. He estimated that it took him 20 seconds to drill three holes and drive three screws; claimant was not as fast. Assuming that it took claimant one minute to accomplish what Mr. Matsen accomplished in 40 seconds, each antenna would take her four minutes to drill and drive 12 screws. She had to lift and hold less than 5 pounds with her left hand for two of those screws and 9.7 pounds for two other screws, an average of 80 seconds for each antenna. At 40 antennas per day, she

would raise her arm for a total of 53 1/3 minutes, 20 seconds at a time. In a 4 week period, she would raise her arms 600 times for a total of three hours and 20 minutes.

A doctor's opinion is persuasive only to the extent that the history relied upon is accurate. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Dr. Maukonen explained that an overuse syndrome was caused by holding an object in a single fixed position for a long period of time which in turn caused muscle tightening and, ultimately, muscle spasm. It is clear from claimant's testimony at hearing and Dr. Maukonen's deposition testimony that he had little idea of what claimant was actually holding, where she was holding it and for how long. We conclude that holding between 5 and 10 pounds overhead for a total of less than 3 and a half hours during a month's time does not constitute what Dr. Maukonen characterized as a single fixed position for a long period of time. Therefore, Dr. Maukonen's opinion that claimant's work activities caused her neck and shoulder problems was not based on a complete or accurate history and is not persuasive. We agree with the Referee that claimant has not carried her burden of proof.

ORDER

The Referee's order dated May 29, 1987 is affirmed. The Board approves a client-paid fee, not to exceed \$504.

Board Member Crider dissenting.

There is no doubt that claimant suffered from a neck and left shoulder condition. The question is whether claimant's condition was work-related. I believe it was and would set aside the denial.

Claimant's treating physician, Dr. Maukonen, who offered the only medical opinion in the record, testified that claimant's condition was an overuse syndrome caused by her activity at work. The Referee declined to rely on it on the ground that the doctor did not understand the nature of claimant's work. The Board majority rejects it for that reason and also because, in their view, the doctor's opinion was based on the erroneous belief that claimant suffered unilateral rather than bilateral arm pain and that claimant had not suffered neck and shoulder difficulties before beginning work in the screen department.

The majority's criticisms of the doctor's opinion are without merit.

Although the doctor, in deposition, could not describe the work claimant did in the same detail that claimant and her supervisor did at hearing, he was able to describe it generally. Contrary to the Referee's contention, the doctor did not state that claimant held her left arm overhead constantly. In fact, he simply stated that she held her left arm overhead as long as it took to drive the screw. Ex. 6-11 and -12. He did not purport to estimate how long that process took. Claimant described her work honestly and accurately at hearing; I see no basis for an assumption that she did not describe it so to her own physician. The doctor's opinion cannot properly be attacked on the ground that he misunderstood claimant's work activities.

The majority correctly observes that the doctor concluded that claimant's problem was caused by overuse at work rather than to stress in part because her symptoms were unilateral. Ex. 6-14 and -15. The majority errs, however, in suggesting that the symptoms were bilateral. While she reported bilateral thumb numbness radiating into the forearms on October 24, 1986, these symptoms were reported on follow-up of bilateral thumb surgery resulting from a prior injury. Ex. O-L-1, O-I-4. Claimant's unrefuted testimony at hearing was that it was left shoulder pain that she suffered after working in the screen department. Tr. 7, 17. That is entirely consistent with the medical record. When she went to a hospital emergency room with severe pain and when she was hospitalized on October 31, 1986, she reported "severe neck, left arm pain and headache." Ex. 2-1, 5-1. Her November 24, 1986 801 form reports neck and left shoulder pain. Ex. 1. Dr. Melson reported, on November 5, 1986, an absence of reflex on the left. Ex. 2-4. There is simply no mention of bilateral shoulder or arm pain. Thus, there is no reason to doubt Dr. Maukonen's reasoning based on the unilateral nature of claimant's shoulder symptoms.

The majority's criticism of the doctor's assumption that claimant had no preexisting shoulder difficulties is also misplaced. There is no evidence claimant had any kind of shoulder problem when she commenced work for the insured. There is a December 19, 1984, note in the record to the effect that claimant's shoulder (unspecified) hurt immediately after the industrial injury that caused the enduring thumb problem (Ex. OA) and that her arm was put in a sling at that time (Ex. OC-1). However, the shoulder problem was never again mentioned in the medicals and apparently receded. This history in no way undercuts the doctor's opinion regarding causation.

The sole medical opinion is persuasive; it supports a finding of compensability. I would reverse.

ROGER G. PRUSAK, Claimant
MacMurray & Emerson, Claimant's Attorneys
Beers, et al., Defense Attorneys
Meyers & Terrall, Defense Attorneys

WCB 86-11067 & 87-02027
December 15, 1988
Order on Review

Reviewed by Board Members Johnson & Crider.

It has come to our attention that a typographical error appears in our Order on Review dated December 14, 1988. Specifically, approximately four lines on page 3 of our decision have been omitted. In order to correct this error, our December 14, 1988 order is withdrawn and replaced by the following order.

Claimant requests review of that portion of Referee Gruber's order that dismissed his requests for hearing on EBI Companies' denial of an aggravation claim relating to his upper back, neck and right shoulder. In its respondent's brief, EBI contends that the Referee erred in ordering it to pay: (1) interim compensation for the period from June 19 through October 7, 1986; (2) an associated penalty and attorney fee; and (3) another penalty and attorney fee for late denial of claimant's aggravation claim. We reverse in part and modify in part.

ISSUES

1. The timeliness of claimant's aggravation claim against EBI.

2. Aggravation of claimant's upper back, neck and right shoulder conditions.

3. Interim compensation for the period from June 19 through October 7, 1986.

4. Penalty and attorney fee for late payment of interim compensation.

5. Penalty and attorney fee for late denial of claimant's aggravation claim.

FINDINGS OF FACT

Claimant originally injured his upper back, neck and right shoulder in May 1983 in the course of his employment as a garbage collector for EBI's insured. Later, he also experienced headaches. He sought treatment from Dr. Williams, a chiropractor, and the claim was closed by Determination Order in April 1984 with no award of permanent partial disability. Claimant did not appeal the Determination Order. After claim closure, claimant continued to experience periodic flareups of upper back, neck and shoulder pain and headaches. He sought treatment for one such flareup in 1984.

In March 1985, claimant began working as a punch press operator for a company insured by Fireman's Fund Insurance Company. A year later, in March 1986, he began treating with Dr. Spady, a chiropractor, for complaints of increased upper back, neck and right shoulder pain and headaches. Dr. Spady completed an 829 form addressed to EBI on April 1, 1986. The form was received by EBI as evidenced by a perforation-type date stamp at the bottom of the form. The date is very difficult to read on the copy of the form included in the record, but we find the date to be April 4, 1986. The form indicated that claimant had experienced an "acute exacerbation" of his May 1983 industrial injury, that he was not medically stationary and that about three months of chiropractic manipulation and physiotherapy would be required.

Dr. Spady left his practice in April 1986 and Dr. Zurflu, an associate of Dr. Spady, assumed claimant's treatment. By letter to EBI dated June 19, 1986, Dr. Zurflu stated that he had taken claimant off work for one week beginning June 16 due to his upper back and neck pain. This letter was received by EBI on June 26. Dr. Zurflu released claimant for limited work on June 23. The employer was unable to employ claimant within the restrictions stated by Dr. Zurflu and terminated his employment.

On August 11, 1986, claimant's attorney mailed to the Board a request for hearing and application to schedule which raised issues of temporary total disability compensation, medical services, aggravation, penalties and attorney fees. EBI issued a formal denial of claimant's aggravation claim on September 8, 1986. Claimant then filed a new injury claim against his most recent employer, which was denied by Fireman's Fund on November 4, 1986. Claimant did not file a request for hearing on the Fireman's Fund claim until February 5, 1987 (93 days after the denial). On the same day (150 days after EBI's formal denial), he also filed

an amended application to schedule on the EBI claim which marked aggravation as one of the issues. On February 20, claimant filed a request for hearing which specifically mentioned EBI's formal aggravation denial (165 days after the denial).

FINDINGS OF ULTIMATE FACT

1. Dr. Spady's April 1, 1986 report indicated that claimant's condition had worsened and that claimant was in need of additional medical treatment. Claimant filed his initial request for hearing on the EBI aggravation claim more than 60 days after EBI received Dr. Spady's report.

2. Claimant's compensable upper back, neck and right shoulder condition worsened in March 1986.

3. Claimant was unable to perform his regular work from June 16 through at least September 8, 1986.

4. EBI unreasonably failed to pay interim compensation in timely fashion.

5. EBI unreasonably failed to deny claimant's aggravation claim in timely fashion.

CONCLUSIONS OF LAW

Timeliness

At the hearing, both EBI and Fireman's Fund moved to dismiss claimant's requests for hearing on timeliness grounds. The Referee took the motions under advisement and developed the record on the merits of the aggravation and new injury issues as well as the other procedural issues raised by claimant.

In his order, the Referee granted the insurers' motions to dismiss. Regarding the EBI claim, he concluded that claimant had filed an aggravation claim against EBI on June 19, 1986, the date of Dr. Zurflu's letter to EBI which indicated that claimant was unable to work. Because claimant had filed his request for hearing less than 60 days later, the Referee concluded that the request was premature and thus void on the aggravation issue. See ORS 656.262(6); Syphers v. K-W Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981). The Referee noted that claimant had filed another request for hearing on EBI's denial more than 60 but less than 180 days after the denial. He held, however, that claimant had failed to show good cause for failing to file the request within 60 days. See ORS 656.319(1)(b). Regarding the Fireman's Fund claim, the Referee found that claimant had filed his request for hearing more than 60 but less than 180 days after the denial, but, as with the EBI claim, held that claimant had failed to show good cause for the late request.

On Board review, claimant appeals only the Referee's ruling on the EBI claim. He makes two arguments. First, he contends that because his initial request for hearing was valid with regard to the interim compensation, penalty and attorney fee issues, it also gave the Hearings Division jurisdiction on the aggravation claim. Second, he contends that he was justifiably confused about the need for a request for hearing after EBI issued its formal denial and that this justifiable confusion was "good cause" for his tardy second hearing request.

We need not address claimant's arguments because our review of the record leads us to conclude that the Referee incorrectly set the date of the aggravation claim. According to ORS 656.273(3): "A physician's report indicating a need for medical services or additional compensation is a claim for aggravation." The report, by itself, need not be sufficient to establish a compensable aggravation; it need only indicate a change in the claimant's condition and a need for medical services. Krajacic v. Blazing Orchards, 84 Or App 127, 130, modified, 85 Or App 477, remanded for reconsideration on other grounds, 304 Or 436 (1987), former opinion adhered to, 90 Or App 593 (1988); Haret v. SAIF, 72 Or App 668, 671-72, rev den 299 Or 313 (1985). The report need not indicate that the claimant is unable to work. See Smith v. SAIF, 302 Or 396, 401 (1986).

The "829" form completed by Dr. Spady on April 1, 1986 satisfied these requirements. The report stated that claimant had experienced an "acute exacerbation" of his compensable condition and that medical treatment was required. EBI received this report on April 4. As of that date, therefore, EBI had a duty to process the report as a claim for aggravation. Barr v. EBI Companies, 88 Or App 132, 136 (1987). Claimant filed his initial request for hearing 129 days later on August 11, 1986. There is no time limit for the filing of a request for hearing on a "de facto" denial. Claimant's initial request for hearing, therefore, was neither premature nor late and vested jurisdiction in the Hearings Division on his aggravation claim.

Aggravation

It is undisputed that claimant's worsened symptoms after March 1986 related to his compensable May 1983 industrial injury. Claimant had received no award of permanent partial disability for this injury. Any period of total disability, therefore, represents a compensable aggravation. See Gwynn v. SAIF, 304 Or 345, 352 (1987); Smith v. SAIF, *supra*, 302 Or at 400-01. Claimant's worsened symptoms resulted in a period of total disability beginning June 16, 1986 and continuing through at least September 8, 1986. We, conclude, therefore, that claimant's condition worsened within the meaning of ORS 656.273(1) and that EBI's aggravation denial should be set aside.

Interim Compensation

The Referee ordered EBI to pay interim compensation from June 19 through October 7, 1986. EBI makes two arguments regarding the latter of these dates. First, it contends that the Referee should not have ordered payment of interim compensation past the date of its formal denial on September 8, 1986. This argument is well taken. See ORS 656.262(2). Second, it contends that the Referee should not have ordered it to pay interim compensation past August 11, 1986, the date when claimant requested a hearing on a "de facto" denial theory. In support of this argument, EBI cites our decision in Joyce A. Morgan, 36 Van Natta 114, 118, *aff'd mem.*, 70 Or App 616 (1984). We take this opportunity to reexamine that decision.

In Morgan, the claimant filed a request for hearing on a "de facto" denial theory a few days after the expiration of the 60-day deadline for acceptance or denial imposed by ORS 656.262(6). The insurer did not issue a formal denial between

that date and the date of the hearing some nine months later. The Referee assessed a penalty against the insurer for its failure to issue a formal denial. The Board reversed.

In reversing the Referee, the Board reviewed several prior cases in which it held that the carrier's failure to issue a formal denial did not warrant a penalty for compensation due after the claimant learned of the denial through informal channels. In Terry Dorsey, 31 Van Natta 14 (1981), the carrier issued a timely written denial, but failed to include the required notice of appeal rights. The claimant nonetheless timely requested a hearing. The Board concluded that no penalty was warranted for the carrier's failure to include the notice of appeal rights because the claimant had not been prejudiced. In Angela V. Clow, 34 Van Natta 1632 (1982), the carrier issued no formal denial but orally informed the claimant's attorney that the claimant's claim was denied. The attorney then requested a hearing. The Board concluded that no penalty was warranted for the carrier's failure to issue a formal denial because the claimant had not been harmed. In Martha A Baustain, 35 Van Natta 1287 (1983), the carrier failed to issue a formal denial and the claimant requested a hearing on a "de facto" denial theory. In a response to the request for hearing, the carrier alleged that the claimant's claim was not compensable. The Board concluded that a penalty was warranted for the carrier's failure to issue a formal denial, but limited the penalty period to the date of the carrier's response to the claimant's request for hearing.

After reviewing these cases, the Board in Morgan commented:

"The only apparent difference between the current case and those cited above is that in all of the prior cases there was some form of notification received by the claimant or the claimant's attorney which was understood to be, or reasonably should have been understood to be, the equivalent of a denial. In this case, there was no similar notification. However, claimant's attorney was familiar with the 'de facto' denial concept and filed a request for hearing on that basis almost immediately after expiration of the 60 day period. If a 'de facto' denial is sufficient to invoke the jurisdiction of this agency, cf Syphers v. K-W Logging, Inc., 51 Or App 769 (1981), we think that a claimant who elects to request a hearing on a 'de facto' denial must be deemed to have received at least some form of notification of the position of the employer/insurer. We think it follows that requiring an employer/insurer to issue a formal denial with notice of hearing rights or face penalties even after a request for hearing on a 'de facto' denial has been filed would be . . . an elevation of form over substance." 36 Van Natta at 117-18.

The Board thus ruled that a request for hearing on a "de

facto" denial is the equivalent of a formal denial and terminates the period for which a penalty may be imposed. Later cases employed Morgan to rule that a hearing request on a "de facto" denial also terminates a claimant's entitlement to interim compensation. William W. Soderwall, 38 Van Natta 544, 546 (1986); James E. Nelson, 37 Van Natta 645, 647 (1985). But see Daniel L. Jordan, 37 Van Natta 1600, 1601 (1985) (Morgan limits a carriers liability for penalties but not for interim compensation).

The underlying premises of Morgan and the decisions upon which it relied are that a claimant is not entitled to a penalty for a claims processing violation unless the claimant is somehow harmed or prejudiced by it and that a claimant is not prejudiced by a carrier's failure to issue a formal denial if he receives actual notice of denial. We disagree with both premises.

First, prejudice apparently was an element of a claims processing violation at one time. See Newman v. Murphy Pacific Corp., 20 Or App 17, 23 (1975). That rule, however, has since been expressly repudiated. Lester v. Weyerhaeuser Co., 70 Or App 307, 311, rev den 298 Or 427 (1984). Second, a claimant is prejudiced by a carrier's failure to issue a formal denial; for, by statute, a formal denial not only registers the carrier's unwillingness to pay but also must state the factual and legal bases for that unwillingness. ORS 656.262(6); see also Runft v. SAIF, 303 Or 493, 496 n.1 (1987). The formal denial equips the claimant to decide whether or not it should be contested. Having failed to issue such a denial, the carrier's duty to pay compensation is not extinguished.

In light of the above discussion, we conclude that the theoretical basis of Morgan is gone and that it is no longer the law. We hereby expressly disavow it. A carrier is required to pay interim compensation until it actually fulfills its duty to issue a formal denial. In the present case, this means that EBI is liable for interim compensation through September 8, 1986, the date of its formal denial.

Penalty and Attorney Fee for Late Payment of Interim Compensation

A penalty and attorney fee may be assessed under ORS 656.262(10) and 656.382(1) against a carrier which unreasonably delays payment of compensation. In this case, EBI failed to timely pay interim compensation for the period from June 19 through September 8, 1986. It offers no excuse for the interim compensation due between June 19 and August 11. Its failure to pay that compensation timely, therefore, was unreasonable. Although interim compensation was in fact due between August 11 and September 8, the Board's decisions in Joyce A. Morgan and subsequent cases provided a reasonable basis for EBI to conclude that compensation was not due for that period. EBI's failure to pay compensation for that period, therefore, while incorrect, was not unreasonable. See Forney v. Western States Plywood, 297 Or 628, 633 (1984). We thus conclude that a penalty is appropriate only on the interim compensation due from June 19 to August 11, 1986. We otherwise affirm the 15 percent penalty and \$200 attorney fee assessed by the Referee.

Penalty and Attorney Fee for Late Denial

A penalty and attorney fee may also be assessed under ORS 656.262(10) and 656.382(1) against a carrier which unreasonably delays acceptance or denial of a claim. Under ORS 656.262(6), a carrier has 60 days within which to accept or deny a claim. EBI received claimant's aggravation claim on April 4, 1986. Claimant requested a

hearing on a "de facto" denial theory on August 11, 1986 (129 days after EBI received his claim). EBI did not issue its formal denial until September 8, 1986. EBI offers no excuse for its tardiness other than the Board's decision in Joyce A. Morgan. Even applying the rule of that case, however, EBI offers no excuse for the 69 days prior to August 11. We conclude that its failure to issue a timely denial was unreasonable. We affirm the 10 percent penalty and \$200 attorney fee assessed by the Referee, except that once again we limit the calculation of the penalty to the period from June 19 through August 11, 1986.

ORDER

The Referee's order dated March 19, 1987 is reversed in part and modified in part. That portion of the order that dismissed claimant's requests for hearing on EBI Companies' aggravation denial is reversed. The denial is set aside and the claim is remanded to EBI for processing according to law. Claimant's attorney is awarded \$1,200 as an attorney fee for services through the hearing level, to be paid by EBI. Those portions of the Referee's order requiring EBI to pay interim compensation for the period from June 19 through October 7, 1986 and assessing penalties based upon this compensation period are modified. EBI shall pay claimant interim compensation for the period from June 19 through September 8, 1986. The penalties for late payment of interim compensation and late denial shall be based upon the compensation period from June 19 through August 11, 1986. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by EBI. Counsel for Fireman's Fund Insurance Company is authorized to charge a client-paid fee of up to \$176 for services on Board review.

RICARDO C. RAMIREZ, Claimant
Welch, et al., Claimant's Attorneys
David Smith (SAIF), Defense Attorneys

WCB 86-16529
December 15, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Peterson's order that affirmed a Determination Order granting claimant 55 percent (176 degrees) unscheduled permanent disability for a low back injury and 5 percent (7.5 degrees) scheduled permanent disability for loss of use of his right leg. We affirm.

ISSUE

Whether claimant is entitled to increased awards for permanent disability, both scheduled and unscheduled.

FINDINGS OF FACT

Claimant is a 42 year old sheet metal machine operator and welder who suddenly experienced back pain on December 2, 1980, when he turned to look back while operating a forklift truck. Dr. Peters, M.D., diagnosed back strain and treated claimant conservatively.

On June 2, 1981, claimant's claim was closed by Determination Order without an award of permanent disability.

On July 10, 1981, claimant returned to see Dr. Finley, M.D. He recommended trigger point therapy and ultrasound. On August 20, 1981, at the request of Dr. Finley, claimant saw Dr. Cottrell, M.D.

He diagnosed traumatic neuralgia and a sciatic nerve injury on the right but indicated that no treatment was necessary. Claimant continued to work for the employer until the company closed in 1982. In early 1982 claimant began to experience increased right leg pain. Therefore, on April 27, 1982, he was seen by Dr. Parsons, neurosurgeon, who recommended a myelogram. Claimant, however, refused to undergo the procedure and returned to the care of Dr. Finley. On December 20, 1983, Dr. Finley diagnosed L5, S1 radiculitis with right leg extension neuralgia grade III, paresthesia, hyperthesia anesthesia.

On June 27, 1984, a second Determination Order awarded claimant 40 percent unscheduled disability for injury to his low back.

On September 17, 1984, claimant began working at the position of traffic signal control assembly but was discharged on September 26, 1984 due to job interference from his continuing low back and right leg pain.

On November 5, 1984, Dr. Jones, M.D., reviewed a lumbar CT scan and reported abnormal findings at both L4-5 and L5-S1. On November 12, 1984, Dr. Parsons reviewed the CT scan and diagnosed a large bilateral defect secondary to a protruded lumbar disc at L4-5. He recommended a lumbar laminectomy at L4-5 bilaterally, which was performed on February 15, 1985.

On April 10, 1985, the June 27, 1984 Determination Order was set aside by stipulation and claimant's claim was reopened.

On April 23, 1985, claimant was incarcerated and, at the time of hearing, remained in the penitentiary. At the penitentiary, claimant came under the care of Dr. Becker, orthopedic surgeon, who diagnosed lumbosacral sprain with significant functional overlay.

During May 1985 claimant was seen by Dr. Collada, neurosurgeon, who diagnosed right sciatica with muscle spasms and recommended traction, muscle relaxants and anti-inflammatory medication.

On November 14, 1986, a Determination Order awarded claimant 55 percent (176 degrees) unscheduled permanent disability for injury to his low back and 5 percent (7.5 degrees) permanent disability for loss of use of his right leg.

On June 18, 1987, Dr. Becker diagnosed a chronic lumbar sacral strain with radicular complaints into the right lower extremity without hard or definite nerve root compression, status post lumbar laminectomy.

Claimant has no formal education except for two classes he took in English after moving to the United States from Mexico. He has worked as a farm laborer, nurseryman, road construction laborer, sugar mill worker, mobile home assemblyman, forklift operator, welder, sheet metal machine operator, furniture upholsterer, sawmill worker, and a computer parts assemblyman. He is able to read some limited Spanish and English. He is able to speak only limited English. During the eight months prior to hearing, he had worked 42 hours a week in the prison cafeteria. Claimant could return to his prior jobs of computer assemblyman or welding.

As a result of claimant's compensable back injury, he is limited to light or sedentary work. He is restricted from stooping or repetitive lifting with twisting. He has continuous low back pain

which increases if he bends, twists, stoops, sits for more than 30 minutes, climbs stairs, stands for more than one hour, or is too active. His right leg is weak and he favors it because it is painful when he puts weight on it; he often uses crutches to assist his right leg but not when he works in the prison cafeteria. He wears a back corset every day but takes no medication except Tylenol. He exercises daily and uses a hot towel on his low back every other day for reduction of pain. He has difficulty sleeping as a result of the pain.

CONCLUSIONS OF LAW

The Referee declined to award claimant any permanent disability, either scheduled or unscheduled, in excess of that awarded by Determination Order of November 14, 1986. Concluding that claimant had exaggerated the severity of his symptoms, the Referee based his decision primarily upon the opinion of Dr. Becker, who had treated claimant at the penitentiary for approximately two years. We agree and adopt the Referee's conclusions with the following comments.

Claimant contends that we should give no deference to Dr. Becker's opinions inasmuch as claimant had no choice in selecting him. He cites 656.245(3) in support of his contention. We agree with SAIF's counsel that claimant has misinterpreted the purpose of the statute. ORS 656.245(3) was designed to supplement the intent of 656.245(1) which requires insurers to provide medical services for compensable injuries. 656.245(3) guarantees that the insurer cannot circumvent its statutory duties via a favored selection of claimant's doctor. 656.245(3) gives claimant the right to choose his own doctor. See Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985). In other words, the provisions of 656.245(3) relate to the issue of compensable medical expenses and not to administrative deference to medical opinions.

The fact that claimant's incarceration limited his choice of an attending physician to Dr. Becker does not mean that Dr. Becker was not claimant's primary treating physician for more than two years prior to hearing. Therefore, the Referee was correct to defer to his opinions absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983).

In June 1987 Dr. Becker examined claimant and found continued hysterical features but would not "go so far as to say [claimant was] malingering." He concluded that beneath the exaggerated symptoms claimant did actually have some low back impairment and recommended he be limited to sedentary and light work, not involving prolonged stooping or repetitious lifting with twisting. There were no other medical opinions that attempted to measure the extent of claimant's physical impairment.

Claimant also argues that if we accept Dr. Becker's diagnosis of significant functional overlay, we must find that condition compensable since it developed as a result of his compensable back injury. We disagree.

Functional overlay is "an ailment in addition to an already existing condition which is not caused by a structural defect." Barrett v. Coast Range Plywood, 294 Or 641, 644 (1983). The specific cause of that ailment, however, is a factual question to be determined by each individual record. The present case lacks any medical evidence establishing a causal relationship between claimant's compensable back injury and the functional overlay. Dr. Becker provided the only clue as to its origin when he stated that claimant

was not malingering. The record, however, is unclear whether claimant's exaggerated symptomology is the result of a preexisting psychological condition, the compensable injury, or some other unrelated cause. Therefore, in rating the extent of claimant's permanent disability, we decline to consider those symptoms which were not corroborated by objective neurological findings.

ORDER

The Referee's order dated July 20, 1987 is affirmed.

BRIAN C. ROLL, Claimant
Horton & Koenig, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney

WCB 86-17840
December 15, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Peterson's order that upheld the SAIF Corporation's partial denial of claimant's preexisting osteomyelitis condition. We reverse.

ISSUE

Whether the symptoms of claimant's preexisting osteomyelitis condition were precipitated by his compensable right shoulder injury.

FINDINGS OF FACT

Claimant is a 17 year old scouting aide. In the fall of 1985 he fell off his skateboard and suffered an abrasion to his right shoulder. This noncompensable injury caused the development of an osteomyelitis condition in his right shoulder. The osteomyelitis remained asymptomatic until July 13, 1986, when claimant reinjured his right shoulder while instructing Boy Scouts in throwing life bouys. On July 17, 1986, he was examined by Dr. Larsen, M.D., who diagnosed right rotator cuff injury and put his arm in a sling.

For approximately one week following claimant's shoulder injury, his pain gradually decreased. Thereafter, it gradually increased again. When the shoulder pain began to worsen, he sought treatment from Dr. Matthews who prescribed medication. From September to November 1986, claimant's level of pain remained unchanged.

Dr. Matthews then diagnosed osteomyelitis and referred claimant to Dr. Cronk, an orthopedic surgeon, who examined him on November 3, 1986. Dr. Cronk also diagnosed osteomyelitis of the right acromion process. Dr. Cronk continued claimant on antibiotic medication.

On December 8, 1986, SAIF denied responsibility for claimant's osteomyelitis condition.

Claimant's right shoulder symptoms continued and on May 4, 1987, Dr. Cronk debrided the right acromion process. Thereafter, claimant's right shoulder condition began to improve.

Claimant's July 13, 1986 right rotator cuff injury caused the preexisting osteomyelitis condition to become symptomatic to the extent that medical services were required.

CONCLUSIONS OF LAW

The Referee found that claimant's osteomyelitis condition was not compensable because: (1) the shoulder injury did not worsen the underlying disease; and (2) the osteomyelitis would have become symptomatic within days of the injury if the injury had not occurred. We disagree with the Referee's reasoning on both accounts and reverse.

First, claimant's disability is the result of an accident and not an occupational disease. Therefore, claimant need not prove that the injury caused a worsening of the preexisting condition in order to establish a compensable claim. See Jameson v. SAIF, 63 Or App 553, 555 (1983), citing Weller v. Union Carbide, 288 Or 27 (1979). In order to establish the compensability of the osteomyelitis condition, claimant need only show that the compensable right shoulder injury caused the osteomyelitis to become symptomatic. Grace v. SAIF, 76 Or App 511, 517 (1985).

Second, it is irrelevant that the osteomyelitis condition might have become symptomatic, in the absence of the compensable injury, at some speculative future date. We are only concerned with answering the question: Did claimant's right shoulder injury cause the preexisting osteomyelitis condition to become symptomatic?

Dr. Matthews did not answer the question. On November 13, 1986, he merely stated that claimant was suffering from an osteomyelitis most likely caused by an abrasion occurring about one year before the shoulder injury. He did not discuss what impact, if any, the shoulder injury had on the symptoms of that condition.

Dr. Cronk, an orthopedic surgeon and claimant's treating physician, followed claimant's lack of progress for many months before recommending a debridement of the right acromion process. In May 1987 Dr. Cronk performed that surgery. In June 1987 he opined that:

"it [was] clear that [claimant] had developed a low-grade infection in his right shoulder prior to the July, 1986 throwing incident. It is likely that the throwing incident exacerbated the underlying infection to the point that it became obviously symptomatic to the patient. It is likely that this symptomatology would develop at some time."

Dr. Girod, an expert in infectious diseases, performed a file review on SAIF's behalf to determine the relationship between claimant's osteomyelitis and his occupational injury. He authored two reports. In his first report, dated February 27, 1987, Dr. Girod opined that:

"it [was] likely that the claimant had a smoldering, chronic bone infection which probably antedated the incident at work by many weeks or months. His first symptoms referable to this infection occurred while throwing the buoy at work. However, that throwing event in no way caused nor did it worsen the infection. The throwing event only precipitated transient symptoms which subsequently resolved. The return of his symptoms one week later were due to the

underlying osteomyelitis. Those symptoms would have become apparent had the incident at work not occurred."

We understand this opinion to mean that Dr. Girod believed that claimant's shoulder injury neither worsened the underlying osteomyelitis condition nor did it cause the condition to become symptomatic. Instead, Dr. Girod believed that claimant's initial right shoulder pain was caused entirely by the throwing incident. Further, he believed that while the injury-related pain was resolving, the osteomyelitis condition, although completely unaffected by the injury, was becoming progressively symptomatic.

On August 3, 1987, Dr. Girod offered a second opinion after reviewing Dr. Cronk's June 8, 1987 report. In that report, Dr. Girod stated that he did "not believe that the incident at work made the symptoms of infection worse, but could have prompted them to appear a few days earlier." Later in the same report, he again pointed out that "the incident at work may have resulted in the development of symptoms of the unrelated infection a few hours to a few days prior to the time that they otherwise would have occurred."

We find no persuasive reasons in the record why we should not defer to the opinion of claimant's treating physician, Dr. Cronk. Dr. Matthews referred claimant to Dr. Cronk in November 1986 and he has remained claimant's attending physician throughout the course of treatment. Dr. Girod, although an expert in infectious diseases, never examined claimant and offered two opinions at variance with each other that, when read together, also support the compensability of claimant's osteomyelitis condition.

Based on the record as a whole, we find that claimant has proven by a preponderance of the evidence that his July 1986 right shoulder injury caused his previously asymptomatic osteomyelitis condition to become symptomatic. Therefore, that condition is compensable.

ORDER

The Referee's order dated October 2, 1987 is reversed. The SAIF Corporation's partial denial is set aside and the osteomyelitis claim is remanded to SAIF for processing according to law. For services at the hearing level and on Board review, claimant's attorney is awarded a reasonable assessed fee of \$1,500, to be paid by SAIF.

MARK L. ELLINGSEN, Claimant
Malagon & Moore, Claimant's Attorneys
Pamela Schultz (SAIF), Defense Attorney

WCB 86-08119
December 20, 1988
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of Referee Gruber's order that: (1) upheld the SAIF Corporation's partial denial relating to his neck and low back; (2) rejected his contention that his claim was prematurely closed; (3) upheld SAIF's denial of his aggravation claim relating to his neck and low back; (4) increased his award of unscheduled permanent partial disability for an injury to his pelvis from 5 percent (16 degrees) to 10 percent (32 degrees); and (5) rejected his request for penalties and attorney fees for SAIF's allegedly unreasonable compensability and aggravation denials.

ISSUES

1. Compensability of claimant's neck and low back conditions.
2. Premature closure of claimant's claim.
3. Aggravation of claimant's neck and low back conditions.
4. Extent of disability relating to claimant's pelvis.
5. Penalties and attorney fees for unreasonable compensability and aggravation denials.

FINDINGS OF FACT

Claimant injured his pelvis, low back and neck on January 13, 1986 in the course of his employment as a roofer when he slid off a roof and fell approximately 20 feet to the ground. He landed mainly on his right hip and back and also bumped the back of his head on the ground. He was taken to the hospital where he was attended by Dr. Schroeder, an orthopedic surgeon. X-rays revealed two or three nondisplaced fractures in the lower right portion of the pelvis. Dr. Schroeder hospitalized claimant for observation and then prescribed conservative follow-up care, including pain medication. Claimant's condition improved steadily and Dr. Schroeder released him to return to his regular work in March 1986, two months after the accident. During the period prior to his return to work, claimant's neck and low back symptoms were masked by pelvic pain, pain medication and inactivity.

After returning to work, claimant noticed pain in his neck and low back. In July 1986, he visited Dr. Davis, an orthopedic surgeon. Dr. Davis noted full range of motion in claimant's neck, although he also noted discomfort with rotation of the head to the left. He also noted discomfort at the lumbosacral interspace. With respect to the neck complaints, Dr. Davis opined that claimant had probably sustained a C5-6 disc injury "at some point in his life" and that the symptoms of this condition were being aggravated by the posture he was required to assume in his work as a roofer. Regarding the low back discomfort, Dr. Davis stated that claimant probably had a mild strain, "possibly as a result of his fall."

In August 1986, Dr. Schroeder declared claimant's pelvis injury medically stationary and rated his impairment as minimal. He noted complaints of neck pain and commented that claimant had never voiced such complaints previously. He also reported that claimant's lumbosacral spine was normal. The claim was closed by Determination Order dated October 21, 1986 with a 5 percent unscheduled permanent partial disability award.

About a month before claim closure, claimant began treating with Dr. Watts, a chiropractor. Dr. Watts diagnosed cervical and lumbosacral strains and sprains and indicated that these strains were related to claimant's industrial fall. We accept Dr. Watts' opinion on these points. SAIF issued an aggravation denial on October 31, 1986 which was orally amended at the time of the hearing to include a denial of the compensability of claimant's neck and low back complaints. When the Determination Order issued on October 21, 1986, further material improvement was reasonably expected in claimant's neck and low back conditions from chiropractic treatment.

CONCLUSIONS OF LAW

Compensability of Claimant's Neck and Low Back Conditions

To establish the compensability of his neck and low back conditions on an accidental injury theory, claimant must prove that his industrial fall was a material contributing cause of disability or a need for medical services associated with the conditions. See former ORS 656.005(8); Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). "Material contributing cause" means a substantial cause, but not necessarily the sole or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697 (1987); Lobato v. SAIF, 75 Or App 488, 492 (1985).

In our findings of fact, we found that claimant's industrial fall had caused his neck and low back symptoms and that those symptoms required medical treatment. We based our findings primarily on the opinions of Drs. Davis and Watts. Both doctors indicated that claimant's neck and low back symptoms were related to the industrial fall. Dr. Davis thought that claimant's neck condition may have existed before the fall. Even assuming the correctness of that conclusion, however, there is no indication in the record that the condition was symptomatic until the fall. That being the case, the symptoms of the condition are compensable even if the condition preexisted the fall. See Barrett v. D & H Drywall, 300 Or 553, 555-56 (1986).

Dr. Schroeder expressed skepticism regarding the relation of claimant's neck and low back symptoms to the industrial fall because of claimant's delay in reporting his symptoms. We find a logical explanation for this delay, however, in the pain medication prescribed for claimant's pelvic fractures and his inactivity following that injury. We thus conclude that claimant has proven the compensability of his neck and low back conditions.

Premature Closure

ORS 656.268 provides in pertinent part that "[c]laims shall not be closed . . . if the worker's condition has not become medically stationary." A worker's condition is "medically stationary" when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). If a claim involves more than one compensable medical condition, the claim may not be closed until all such medical conditions are medically stationary. See Utrera v. Department of General Services, 89 Or App 114, 116 (1987); Rogers v. Tri-Met, 75 Or App 470, 473 (1985).

In our findings of fact, we found that further material improvement in claimant's neck and low back conditions was expected at the time of claim closure. By definition, therefore, the conditions were not medically stationary. In light of our conclusions that claimant's neck and low back conditions are compensable and were not medically stationary at the time of claim closure, it follows that claim closure was premature.

Aggravation

Aggravation can only become an issue once a valid claim closure has been accomplished. See ORS 656.273. In light of our decisions on the compensability and premature closure issues, the aggravation issue in this case is moot.

Extent of Disability

Extent of disability, like aggravation, can only become an issue once a valid initial claim closure has been accomplished. See ORS 656.268. As no valid initial claim closure has been accomplished in this case, the extent of disability issue also is moot.

Penalties and Attorney Fees

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Price v. SAIF, 73 Or App 123, 126 n.3 (1985); Mt. Mazama Plywood Co. v. Beattie, 62 Or App 355, 358 (1983).

When SAIF issued its aggravation and compensability denials, it possessed a report from Dr. Schroeder which questioned the causal relation between claimant's industrial fall and his neck and low back complaints. This report and the fact that claimant's neck and low back complaints were not documented for six months after the industrial fall provided a reasonable basis for SAIF's denials. No penalties or attorney fees, therefore, are warranted.

ORDER

The Referee's order dated February 24, 1987, as republished by the order dated April 6, 1987, is reversed in part. Those portions of the Referee's order that upheld the SAIF Corporation's partial denial relating to claimant's neck and low back conditions, rejected claimant's contention that his claim was prematurely closed and increased the award of unscheduled permanent partial disability for claimant's pelvis are reversed. The claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorneys are awarded \$2,000 for services rendered at the hearing level and on Board review concerning the compensability issues, to be paid by the SAIF Corporation.

Board member Ferris, dissenting.

I respectfully dissent. The majority finds support for claimant's claim in the opinions of Drs. Davis and Watts. Dr. Davis's report contains unexplained and obviously speculative statements that have little probative value. Dr. Watts opinion, when viewed as a whole, is simply not credible. Dr. Watts opined that a great number of complaints were related to claimant's industrial injury including headaches, neck pain, neck stiffness, sleeping problems, back pain, tension, irritability, pins and needles in the arms, numbness in the fingers, depression, constipation and numbness in the arms and back. Dr. Watts rendered this opinion before he had even reviewed claimant's medical records. The Referee rejected Dr. Watts' opinion with the following words:

"As the reliability of Chiropractor Watts' opinions is critical to resolving all of the issues of this case, I am compelled to clearly state that I find his reports to be unreliable. The fact that his November 17, 1986 letter, which attributes almost every conceivable physical ailment to the January 13, 1986 injury, was issued without

review of the records of the previous treating physicians causes me to have serious concerns as to whether he was acting as a medical practitioner or as an advocate. His opinion is particularly questionable given that he decided the cervical and lumbosacral conditions were materially caused by the January 1986 injury after he had seen the claimant on only a single occasion. For these reasons, I find that Dr. Watts' unsupported conclusions warrant little, if any, weight when compared with the more comprehensive treatment and reports of Drs. Schroeder and Davis." (O & O at 3).

I find the Referee's reasoning compelling and accordingly would discount the opinion of Dr. Watts. Without that opinion, there is no probative support for claimant's claim. SAIF's denial should be upheld.

FRANKLIN W. GOUGE, Claimant
Malco & Glode, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 86-01015
December 20, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee McCullough's order that: (1) upheld the insurer's denial of chiropractic treatment for his knee condition; (2) declined to assess penalties and attorney fees for an alleged unreasonable denial; (3) declined to assess penalties and attorney fees for the insurer's alleged unreasonable closure of his claim; and (4) awarded no scheduled permanent disability for loss of use or function of the right leg, in lieu of a Determination Order which awarded claimant 5 percent (7.5 degrees) scheduled permanent disability. We affirm.

ISSUES

- (1) Existence and extent of permanent right knee disability;
- (2) Whether the insurer's closure of the claim by Notice of Closure was unreasonable;
- (3) Denial of medical services as not reasonable and necessary; and
- (4) Penalties and attorney fees for the closure and medical services denial.

FINDINGS OF FACT

Claimant, 26 at hearing, compensably injured his right knee on April 24, 1984 when his leg was caught between two vehicles, one stationary and one moving. He sought treatment at the local hospital emergency room, and was taken off work. The knee was contused and scraped, but not swollen. An x-ray was taken, which showed both the soft tissue and bones were intact. The claim was accepted as disabling by the insurer.

Claimant received conservative care from Dr. Oksenholt, osteopath. He was off work for approximately one month, and continued to experience knee discomfort when he returned to work.

Dr. Oksenholt documented a click in the knee, both medial and lateral. An arthrogram performed on May 18, 1984, revealed no meniscal damage.

Claimant changed treating physicians in November 1984, and began seeing Dr. Scheinberg, orthopedist. He received an injection, which temporarily relieved his symptoms. When he returned two weeks later, Dr. Scheinberg prescribed no further treatment, but indicated he would see claimant again if the pain continued.

On May 21, 1985, the insurer sent claimant a Notice of Closure. The insurer determined that claimant was entitled to temporary disability from April 25, 1984 to May 28, 1984. It found that claimant had suffered no permanent disability as a result of the injury.

Claimant received no further medical treatment for his knee until June 1985, when he began seeing Dr. Ray, chiropractor. Dr. Ray attributed his pain and popping to his slight bowleggedness, visible only on x-rays. He placed claimant on a regular regimen of knee adjustments, which gave claimant relief ranging from 5 minutes to two weeks.

On October 7, 1985, Dr. Abrams of Independent Chiropractic Consultants examined claimant, and reviewed x-rays taken earlier. He found no objective indication of a continuing knee condition, and no impairment. Claimant did not limp during the examination, and was able to hop on his right leg without difficulty or complaint of pain.

Claimant was examined by Dr. Puziss, orthopedist, on March 20, 1986. At that time, his patellar tendon and midpopliteal region were tender, but there was no crepitus in the knee. Dr. Puziss did observe on the x-ray that claimant had very slight bowleggedness.

On June 6, 1986, claimant was referred by Dr. Ray to Dr. Bolin, chiropractor, for evaluation. Dr. Bolin found minimal impairment from claimant's inability to fully extend his knee. He also noted claimant's bowleggedness.

In February 1986, claimant left the employer at injury for reasons unrelated to the injury. He subsequently worked at a gas station for four months, and then quit to enroll in a pre-chiropractic program at a community college.

Claimant's current knee condition and chiropractic treatments are not related to his compensable injury.

CONCLUSIONS OF LAW AND OPINION

Extent of disability

To prevail on the issue of scheduled permanent disability, claimant must prove by a preponderance of the evidence that, as a result of his industrial injury, he has sustained permanent loss of use or function of his right knee. ORS 656.214. Claimant's treating chiropractor says that he is limited in weight bearing, climbing, heavy carrying and twisting the knee, all as a result of his injury. Dr. Ray's diagnoses are a "rotational malposition" of the right tibia, and possible chronic medial meniscal derangement.

Dr. Bolin, an examining chiropractor, diagnosed possible

torn meniscus and rotational subluxation of the tibia. He characterized claimant's permanent impairment as minimal, based on claimant's inability to fully extend his leg during a "bounce home test." He admitted, however, that this test creates only a suspicion of a meniscal problem, not a probability of one.

On the other hand, neither Dr. Abrams nor Dr. Puziss found abnormalities in claimant's knee. Dr. Abrams performed a detailed examination, and reviewed x-rays and the arthrogram. They concluded that claimant had no injury-related impairment and that no restrictions were appropriate.

Dr. Puziss noted one snap in claimant's knee during his examination, but no general crepitus. He opined that a snap, in and of itself, is not necessarily pathological, and he found no abnormality to support the conclusion that claimant has an on-going difficulty with his knee. He found there was no permanent impairment, and that no further treatment was warranted.

Most tellingly, the medical evidence immediately following claimant's injury does not support a finding of injury-related permanent disability. X-rays and an arthrogram were normal, showing no tissue damage, meniscal tears or bone problems. Dr. Scheinberg felt that there was no further treatment to offer claimant, and for seven months after that opinion, he received none.

We conclude that claimant has failed to meet his burden of proving that he has sustained a loss of use or function of his right knee from his 1984 injury.

Notice of Closure

Claimant contends that the insurer's self-closure of his claim was unreasonable, and requests penalties and attorney fees. The Referee found that the insurer's action was reasonable, based upon the information available to it at the time. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987). We agree, and affirm the Referee's order on this issue.

Chiropractic treatment

Claimant contends that his chiropractic treatments are related to his compensable injury, and that they are reasonable and necessary. We conclude otherwise. Claimant suffered a relatively minor injury to his knee, which caused no damage beyond bruises and scrapes. Within a few months, most of his symptoms had abated, and he was suffering only intermittent, vague pain. He then sought no treatment at all for another seven months. A lengthy gap in treatment does not necessarily mean that the injury has resolved and that current treatment is not compensable. Jordan v. SAIF, 86 Or App 29 (1987). However, given the slight damage to his knee, as well as the gap in treatment, we find that the injury had resolved. Current chiropractic treatment is therefore not compensable.

ORDER

The Referee's order dated June 15, 1987 is affirmed. The Board approves a client-paid fee, not to exceed \$1,802.

DUANE H. HIGH, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 86-16051
December 20, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Thye's order that upheld the insurer's denial of compensability of his October 2, 1986 myocardial infarction. We affirm.

ISSUE

Compensability of claimant's myocardial infarction.

FINDINGS OF FACT

Claimant, 56, is employed as a maintenance engineer for the employer, a hospital. He has a history of heart problems dating at least to March 1983, when he suffered a myocardial infarction. Heart disease was diagnosed, and he had triple bypass surgery in April 1983. Six weeks later, he had further surgery when he developed an aneurism in his abdominal aorta.

Claimant returned to work, and there is no record of problems until April 1984, when he had another myocardial infarction. No surgery was performed, and he again returned to work. He continued to experience angina. A number of tests showed functional limitations but no acute problems.

Then, on October 2, 1986, claimant was admitted into the employer-hospital for sudden onset of severe chest pain which occurred at work. He had been exerting himself in the process of installing a computer into a reception desk. This required that he use substantial pressure to remove a false wall from the desk, and then work under the desk with his arms extended in front of him. At the time he felt the severe pain, he was lying on his back under the desk, pulling wires overhead from right to left.

When claimant was admitted, a myocardial infarction was found to have occurred. An EKG taken that day indicated that the infarction was a "non-Q-wave" infarction. EKGs taken on October 3 and 4, however, indicated that the infarction had become a "Q-wave" infarction. It was diagnosed to have occurred when claimant's left anterior descending artery became completely occluded.

Claimant was released from the hospital after eight days of conservative treatment under the supervision of Dr. Crislip, cardiologist.

Claimant was not physically examined by cardiologists Drs. Kloster and Toren. However, they examined his medical records and history. Each testified at hearing regarding the cause of claimant's myocardial infarction.

Claimant's work activities were not a material cause of his myocardial infarction.

CONCLUSIONS OF LAW AND OPINION

To establish that his myocardial infarction is compensable, claimant must prove by a preponderance of the evidence that work

activity was both its legal and its medical cause. Legal causation can be established by showing chronic stress or an episode of acute stress at work. Medical causation requires expert medical evidence that the stress was, within reasonable medical probability, a material contributing cause of the condition. Somers v. SAIF, 77 Or App 259 (1986).

Claimant has established legal causation. His myocardial infarction occurred while he was exerting himself installing a computer in a reception desk. This involved working under the desk with his arms outstretched, and lying on his back pulling wires. He also had to exert a substantial amount of pressure to dismantle part of the desk.

The issue of medical causation is a close one. Three cardiologists rendered opinions on the question. Claimant's treating physician, Dr. Crislip, was equivocal. He said only that he thought the stress of claimant's job may have played a role in his infarction, but that "the role of stress in coronary disease is not a clear one and it's impossible to be certain."

Dr. Kloster testified that claimant's work stress was a material contributing factor in his infarction. He based this conclusion on an examination of all of claimant's medical records except for the EKGs taken on October 2, 3, and 4, 1986. He assumed from the evidence that claimant had suffered a "non-Q-wave" infarction. Noting that a December 1986 angiogram showed that claimant's left anterior descending artery was completely occluded, he considered it reasonable that the occlusion had begun within three to four days prior to October 2, 1986. Claimant had reported having angina pains during those preceding days. Dr. Kloster then calculated that, given claimant's exertion at the time and the fact that it was shortly after lunch, when he would require extra blood to the gastrointestinal tract, claimant's needs exceeded his restricted blood flow. This stress and blood supply conflict caused the infarction.

When he was shown the EKGs at hearing, Dr. Kloster corrected his assumption regarding the type of infarction claimant had suffered. He read the first day's printout to show that claimant was having a "non-Q-wave" infarction, but that on the second and third days it had become a "Q-wave" infarction. Dr. Kloster testified that this did not alter his conclusion, because the professional understanding of the distinction between the two is in flux. He believes it is at least agreed that stress correlates to occurrence of "non-Q-wave" infarctions.

Dr. Toren testified that he did not believe claimant's work activities were a material contributing factor in his infarction. It is his opinion that exertion plays no role in "Q-wave" infarctions. Rather, they arise because of blood clots which develop around tears in the plaque lining the artery walls. He believed that the angina claimant suffered just prior to October 2, 1986 was caused by the narrowing of the artery as the clot formed. However, the severe pain which developed occurred when the clot completely occluded the artery. That it also occurred while claimant was exerting himself is a coincidence under Dr. Toren's theory.

We are persuaded by Dr. Toren's opinion that claimant's heart attack was not the result of his work activities. Both doctors agree that claimant suffered a "Q-wave" attack. Dr. Kloster believes

that the role of stress in such infarctions is not clearly understood. Dr. Toren believes stress plays no role in them. We note that claimant appears to have had a "non-Q-wave" infarction at the outset, which progressed over the next 24 hours to a "Q-wave" infarction. Neither doctor discussed whether stress might play a role by triggering the former type, which could progress to the latter type.

We therefore assume that did not happen in this case. We conclude that claimant has not proven that his work activities were the medical cause of his myocardial infarction.

ORDER

The Referee's order dated June 23, 1987 is affirmed.

P.D. HILDEBRANDT, Claimant	WCB 86-14277
Brothers, Drew, et al., Claimant's Attorneys	December 20, 1988
Cummins, et al., Defense Attorneys	Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Emerson's order that: (1) upheld the insurer's denials of chiropractic treatment; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. We affirm.

ISSUES

- (1) Compensability of current chiropractic treatments; and
- (2) Penalties and attorney fees for alleged unreasonable denial of medical services.

FINDINGS OF FACT

Claimant was compensably injured on May 26, 1983, when she slipped on a stairway and caught herself with her left arm to avoid falling. She sought treatment at a hospital emergency room later that day for pain in her left shoulder area. A claim for injury to her left shoulder was accepted as disabling.

Claimant sought treatment a few days following her injury from her family physician, Dr. Gleason. He released her to work on June 8, 1983, and her claim was closed by the insurer on June 16, 1983 without permanent disability. She continued to see Dr. Gleason for pain in her shoulder until November, 1983.

On November 9, 1983, Dr. Cohen examined claimant on referral from Dr. Gleason. He recommended an arthrogram to rule out a tear in her rotator cuff. The arthrogram, performed on December 9, 1983, was normal.

On February 28, 1984, claimant changed treating physicians, and began seeing Dr. Walker, a chiropractor, for pain in her neck and left shoulder. Dr. Walker treated her regularly until April 20, 1984, when he found her asymptomatic and medically stationary.

Claimant and her husband separated during the summer of 1984. They were divorced in 1987. The separation caused claimant a great deal of stress.

Claimant returned to Dr. Walker in October 1984 with

increased pain. He referred her to Dr. Smith, neurologist, for evaluation to determine whether she was having a cervical disc problem. Dr. Smith found no evidence of a cervical disc problem, no atrophy, and good range of motion in the affected shoulder.

In November 1984, claimant was involved in an automobile accident. She was injured, and lost time from work as a result of the accident. However, it did not increase her left shoulder or neck pain. On March 15, 1985, the insurer issued a partial denial for cervical muscle strain resulting from the automobile accident. That denial was not appealed.

Claimant began treating with Dr. Villnave, chiropractor, on November 6, 1984. He treated her until April 10, 1986, when he reported that she was medically stationary.

Claimant was examined by Dr. Duff, orthopedist, on November 20, 1984. At that time, claimant reported that her shoulder was "a little tight", but that she had pain only with repetitive motion. She had some limited range of motion in her left shoulder.

Claimant moved to Bend, and began treating with Dr. Silva, a chiropractor, on April 14, 1986.

On August 16, 1986, claimant was examined by a panel from Independent Chiropractic Consultants. She was examined by Dr. Howell, osteopath, on January 27, 1987. Cybex testing suggested that claimant had no shoulder pain, and had exerted inconsistent and submaximal effort during the tests. An EMG of the shoulder was normal. She had almost full range of motion in her shoulder, with some loss of left shoulder adduction. She also had a muscle spasm in the neck.

Dr. Silva referred claimant to Dr. Christensen, chiropractor, for evaluation in April 1987. Cybex testing there suggested severe impairment of the shoulder, with limited range of motion.

Claimant began treating with Dr. Rockwell in June 1987, when Dr. Silva moved his practice out of the area.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that only one of the 39 exhibits was formally received into evidence. From the conduct of the Referee and of the parties, it is apparent that all of the exhibits were intended to be received. We therefore overlook the technical deficiency, and consider all of the evidence in the record.

Chiropractic treatments

An injured worker is entitled to all medical services reasonably required by the nature of an injury and necessary to the process of recovery. ORS 656.245(1). Claimant has the burden of establishing by a preponderance of the evidence that medical services are reasonable and necessary.

The denials at issue are for chiropractic treatments provided by Drs. Silva and Rockwell. The record contains no evidence from either physician regarding the treatment, beyond the fact that it was given. Claimant contends that this evidence alone is "de facto" proof of its reasonableness and necessity, as no physician

would provide unreasonable or unnecessary treatments. The argument is unpersuasive. Evidence of reasonableness and necessity must include evidence of the nature and purpose of the treatment, and of its link to the compensable injury.

The Independent Chiropractic Consultants, and Dr. Duff diagnose claimant's condition as chronic subacromial bursitis/tendonitis, and opine that there is no manipulative therapy which would be helpful. Dr. Howell questions the diagnosis because of the paucity of objective findings, and agrees that manipulation is not indicated. All of these physicians reach their conclusions after thorough examinations, and in persuasively reasoned reports.

Dr. Christensen conducted many of the same tests that Dr. Howell did, and reaches the conclusion that claimant would benefit from further treatment. We are not persuaded by his conclusions, which are somewhat conclusory and irreconcilable with the results of the others. We therefore affirm the Referee.

ORDER

The Referee's order dated August 19, 1987 is affirmed. The Board approves a client-paid fee, not to exceed \$319.

RICHARD L. HILL, Claimant
Coons & Cole, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-16327
December 20, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Howell's order that dismissed his hearing request concerning the self-insured employer's denial of his injury claim on the grounds that it was not timely filed. On review, the issue is jurisdiction.

We affirm and adopt the order of the Referee with the following comment.

The Referee applied former OAR 438-05-040(4) in this situation which involves an initial hearing request that was mailed within 60 days of the employer's denial, but had been mistakenly addressed to the employer. Yet, the aforementioned rule pertains to "filing" documents with the Board by means of actual receipt or by date of mailing. Inasmuch as a request for hearing is filed only when it is actually received, that portion of the rule dealing with filing by mailing does not apply.

Claimant asserts that, because the original of the request for hearing was inadvertently mailed to the employer, it had a duty to forward the request to the Board. Claimant relies on OAR 438-06-015. We disagree.

We have previously held that a letter to an insurer regarding representation on the claim, and indicating that a request for hearing has been filed, is not, in and of itself, a request for hearing which the insurer must forward to the Board. Vernon L. Wellington, 37 Van Natta 183 (1985). By the same token, we conclude that a letter indicating that a request for hearing has been filed, with the original attached, need not be forwarded to the Board.

In the past, informal references to a request for hearing have been accepted as a valid request. See Burkholder v. SAIF, 11 Or App 334 (1972). Given this precedent, a copy of a formal request for hearing would have been acceptable, had one been timely received. However, we find that the employer could reasonably have assumed from the letter it received that such a copy had already been sent to the Board, and, further, that it was not necessary to submit the original.

Accordingly, we agree with the Referee that the record neither establishes that the request for hearing was timely filed nor that the employer was obligated to forward to the Board the misaddressed original request.

ORDER

The Referee's order dated June 10, 1987 is affirmed. A client-paid fee, not to exceed \$400, is approved.

GARY R. LAKE, Claimant
Robert Chapman, Claimant's Attorney
Stoel, Rives, et al., Defense Attorneys

WCB 86-16600
December 20, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Mongrain's order that upheld the self-insured employer's "backup" denial of claimant's previously accepted right knee injury claim. We affirm.

ISSUES

1. Propriety of "backup" denial.

a. Whether claim acceptance was based upon fraud, misrepresentation or other illegal activity.

b. Whether the self-insured employer's decision to accept claimant's claim could reasonably have been affected by knowledge of claimant's alleged fraud or misrepresentation.

2. Whether remand is warranted for the further taking of evidence on the issue of compensability.

3. If remand is not warranted, whether the alleged on-the-job injury was a material cause of his right knee condition.

FINDINGS OF FACT

Claimant, 24 years old at the time of hearing, had increasing right knee discomfort for several years prior to 1983. In March 1983, Dr. James, orthopedist, performed an arthroscopic partial lateral meniscectomy and partial shaving of the right lateral compartment of claimant's right knee. Subsequent to this surgery, claimant did not seek medical treatment for his right knee until December 11, 1985.

In the late summer of 1985 claimant joined Triple Nickle, a city league football team. There were 18 to 22 members on the team, but only 7 were allowed to play at any given time. Games were played every Sunday. Terence Burns was the player/coach of the football

team; Galen Hockman was the assistant coach in charge of the linemen. Claimant began the season on September 8, 1985 at defensive cornerback, but it soon became apparent that he did not have the speed to stay with the offensive receivers. Therefore, Mr. Burns switched claimant to the position of inside linebacker but soon discovered that claimant did not have the speed, strength or size to play that position either.

During the third or fourth game of the season (no later than September 29, 1985) claimant was playing defense and dove to touch a receiver who had caught the football. Although claimant always wore his right knee brace during these games, this particular fall caused pain and swelling in his right knee. The swelling did not subside for at least three days following the game.

Three days after the injury, claimant rode his motorcycle to the home of Charles Sampson, a friend and teammate. He asked Mr. Sampson's wife, Regina, who was a nurse, to look at his swollen right knee. She complied and recommended that he seek treatment from an orthopedic surgeon. Claimant told the Sampsons that he would get his employer, a tire centers, to pay for any medical treatment on his knee by saying that he hurt it at work. The Sampsons told claimant not to get caught. Claimant also had a group health insurance plan through the employer.

Following the third or fourth game, Mr. Burns and Mr. Hockman sat down with claimant and explained that there were better players than him on the team and that claimant would no longer be starting at his former defensive position. Claimant became angry at this demotion, but continued to practice with the team for a couple of weeks before quitting. By the end of October 1985, however, claimant's anger had resolved and he agreed to return to the team, but only to videotape the remaining games from the sidelines.

On December 10, 1985, claimant filed an 801 injury form with his employer. It alleged that he twisted his right knee slightly at work about a month before November 29, 1985, and then twisted his knee severely on November 29, when he went into a crouched position to remove a tire and slipped on the ice. Prior to November 29, claimant had not exhibited any right knee discomfort or unusual gait at work. Although the alleged incident occurred during a "snow rush" by customers and in an area of the shop that was open and offered unobstructed views, there were no witnesses.

On December 11, 1985, claimant sought medical treatment from Dr. Baskin, orthopedic surgeon, who diagnosed a torn right medial meniscus. On December 25, 1985, Dr. Baskin performed an arthroscopy with removal of the torn portion of the lateral meniscus and shaved the chondromalacia, tibial plateau and femoral condyle, laterally. Claimant also sought treatment from Dr. Gilsdorf, who recommended that claimant not perform work requiring repetitive squatting, kneeling or carrying and lifting. Vocational rehabilitation efforts were initiated at that time.

On December 26, 1985, the employer accepted claimant's right knee claim.

Bob Horton, the employer's manager, was aware when he hired claimant that he had experienced previous knee problems. Around the middle of 1986, Mr. Horton began to hear rumors from a number of employees that a customer, Charles Sampson, had indicated that

claimant hurt his knee playing football. Mr. Horton spoke with Mr. Sampson and surreptitiously obtained statements that claimant hurt his knee playing football. Mr. Horton then called Ms. Stigall, the employer's risk and claims manager, who proceeded to initiate an investigation. Mr. Horton spoke with Mr. Sampson on two additional occasions to confirm his information.

On July 14, 1986, a Determination Order awarded claimant approximately 6 months of temporary disability benefits and 15 percent scheduled permanent disability for loss of use of his right knee.

Claimant's knee pain continued and on July 15, 1986, Dr. Gilsdorf, orthopedic surgeon, performed a diagnostic arthroscopy and found post traumatic chondromalacia of the right knee.

On August 21, 1986, a second Determination Order set aside the prior Determination Order, awarded increased temporary disability benefits and again awarded claimant 15 percent scheduled permanent disability for loss of use of his right knee.

On February 3, 1987, Ms. Stigall prepared a retroactive denial of the claim based upon new evidence demonstrating the injury did not arise out of or in the course and scope of employment.

Claimant did assert to the Sampsons that he would file a fraudulent claim with his employer to cover the medical costs of the football injury to his right knee. However, claimant quit playing football for Triple Nickle after the third or fourth game of the 1985 season because he was demoted from the starting unit, not because of the right knee injury.

We find that the record does not establish by a preponderance of the evidence that claimant's work activities in November 1985 were a material cause of his right knee condition.

CONCLUSIONS OF LAW

The Referee concluded that Mr. and Mrs. Sampson were credible witnesses while claimant was evasive and not credible. Accordingly, he believed that a preponderance of the evidence established that claimant injured his knee playing football and intended to file a fraudulent claim. The Referee found that this information could reasonably have affected the employer's decision to accept the claim. Having found that the retroactive denial was proper, the Referee continued his analysis by finding that claimant had not shown that he had sustained a compensable injury in late November 1985. We agree.

Propriety of "backup" denial

In order to support a "backup" denial, the employer or insurer must show that there was fraud or misrepresentation and that the acceptance decision could reasonably have been affected if the true facts had been known. Ebbtide Enterprises v. Tucker, 303 Or 459 (1987). The employer is not required to show that it in fact would have denied the claim with the correct information. Newport Elks Club v. Hays, 92 Or App 604, 607 (1988).

To determine whether claimant filed a fraudulent claim or misrepresented material facts that could reasonably have affected the employer's decision to accept the claim, we must establish the parties' credibility or lack thereof.

Claimant testified that: (1) he did not injure his right knee playing football for Triple Nickle; (2) he never asked Regina Sampson to examine his knee; and (3) he never told the Sampsons that he was going to file a workers' compensation claim for the football injury to his right knee. Although Terence Burns testified that he never knew that claimant had been hurt playing football and claimant had shown no physical signs of injury while videotaping the games, he also testified that he did not always pay attention to what was happening on the playing field. Therefore, we give little weight to his testimony.

Claimant's testimony was effectively rebutted by the testimony of Charles and Regina Sampson. Mr. Sampson actually saw claimant hurt his knee during the third or fourth game of the 1985 season. He saw claimant walk off the field limping and joked with him about it. Three days after this incident, claimant went to the Sampsons' house and asked Mrs. Sampson to examine his knee. Mrs. Sampson complied, observed the swelling in the knee and even remembered the name of the orthopedic surgeon whom she recommended claimant see. Both Mr. and Mrs. Sampson recalled claimant asserting that he would file a workers' compensation claim to get medical coverage for his knee. Mr. Sampson testified in a very credible manner, although he was confused regarding dates and appeared to the Referee to be upset about testifying against a person he considered to be his friend. He stated that had he known about claimant's workers' compensation claim he would not have originally talked to Mr. Horton. We also refuse to disturb the Referee's finding that Mrs. Sampson's demeanor as a witness was extremely credible.

Based on the nature of the Sampsons' testimony, there is no doubt that claimant did injure his knee playing football during the warm fall weather of late September 1985. Claimant's failure to inform his employer of this injury was at best a material misrepresentation of a fact that could reasonably have affected its decision to accept his claim. Therefore, the "backup" denial was properly issued.

Remand

Claimant argues that, should we find that the "backup" denial was properly issued, we must remand the case to the Referee to take further evidence on the merits of the compensability issue. Claimant refers us to a preliminary discussion held at hearing in which claimant's attorney expressed his concern to the Referee that he was not prepared to prove medical causation if the Referee should find that fraud or misrepresentation had not been shown. The record further indicates that the parties agreed that if fraud or misrepresentation were not shown, claimant would retain his accepted claim and would not have to prove that the work activities were a material cause of his right knee condition. Since we agree with the Referee that the employer has successfully shown fraud or misrepresentation, that stipulation is moot. Nonetheless, claimant requests that we remand his case to the Hearings Division for the further taking of evidence concerning the compensability of his claim.

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 for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing.

Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

The employer's February 3, 1987 denial asserted that new evidence demonstrated that claimant's injury did not arise out of or was in the course and scope of his employment. That denial put the compensability of the claim squarely at issue.

Although medical reports from claimant's treating physicians were needed to help support the compensability of his claim, they were not obtained. Regardless of whether claimant's counsel was under the mistaken assumption that compensability would not be at issue if fraud or misrepresentation were shown by the employer, the medical evidence to rebut that challenge to the claim was obtainable with due diligence at the time of the hearing.

After de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we find that the evidence claimant desires to obtain on remand was obtainable with due diligence at the time of hearing. Accordingly, we conclude that remand is not warranted. We now proceed to address the compensability issue on the merits.

Compensability

The litigation of a "backup" denial does not end with the employer proving fraud, misrepresentation or other illegal activity by a preponderance of the evidence. Claimant is allowed to rebut that evidence by showing that, notwithstanding the fraud or misrepresentation, the alleged industrial injury was still a material cause of his previously accepted condition. Parker v. D.R. Johnson Lumber Co., 70 Or App 683, 687 (1984). In the present case, claimant has failed in carrying that burden.

We have already found claimant not to be a credible witness. This fact, coupled with his expressed intention to file a fraudulent workers' compensation claim and the lack of witnesses to the alleged work-related injury, leads us to the conclusion that claimant probably did not injure his right knee at work. At best, he injured his knee playing football and subsequently experienced another incident at work, in which case there would be no persuasive medical opinion of causal relationship because no such history has been presented to any of the doctors who have treated claimant. In either case, claimant has not carried his burden of proof.

ORDER

The Referee's order dated September 24, 1987 is affirmed. The Board approves a client-paid fee, not to exceed \$3,154.

HERSCHEL E. SNYDER, Claimant
Gary L. Susak, Claimant's Attorney
Wendell Gronso, Defense Attorney

WCB 86-00540
December 20, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Wasley's order which upheld the self-insured employer's denial of compensability of an injury in January 1987. We affirm.

ISSUES

The issue is whether claimant's compensable injury in 1982 is a material cause of his injury in 1987 and if so whether the consequences of the 1987 fall are compensable.

FINDINGS OF FACT

Claimant compensably injured his low back on January 2, 1982. He has received awards for unscheduled disability totalling 55 percent. He has had two surgeries as a result of the compensable injury. These surgeries were to remove disc fragments at L4-5. The L4 nerve was not affected by this disc. The only problem claimant has which may affect the L4 nerve is a preexisting spinal stenosis.

Claimant first complained to doctors of problems with his legs buckling in July 1985. On July 18, 1985, claimant's legs buckled and he fell into farm machinery he was working around. He broke his right leg and bruised his ribs.

The compensable injury was not a material cause of claimant's fall in July 1987.

CONCLUSIONS

In order to establish that the consequences of the fall in 1987 are compensable, claimant must prove by a preponderance of the evidence that his compensable injury is a material cause of that fall. Grable v. Weyerhaeuser Company, 291 Or 387 (1981).

The Referee concluded that the compensable injury was a material cause of the fall; he concluded for other reasons that the fall was not material. The Referee found Dr. Maloney more persuasive than Dr. O'Brien. We disagree.

Dr. O'Brien is a neurologist. He reviewed the surgical records and concluded that the disc problem could not have impinged on the L4 nerve; rather, it impinged on the L5 nerve root. The L5 nerve root problems could not cause claimant's legs to buckle. L4 nerve root problems could cause claimant's legs to buckle.

Dr. Maloney is a physical medicine and rehabilitation specialist. She believed that somehow the disc problems at L4-5 could impinge on the L4 nerve root and that that impingement caused claimant's legs to buckle.

We find Dr. O'Brien's explanation more persuasive than Dr. Maloney's.

Accordingly, claimant has failed to prove the compensability of the consequences of his fall in July 1987.

ORDER

The Referee's order of September 14, 1987 is affirmed.

ROBERT D. BASEL, Claimant
Rosenthal & Greene, Claimant's Attorneys
James C. Purcella, Defense Attorney
Carl M. Davis, Assistant Attorney General

WCB 86-13677
December 21, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Hoguet's order which upheld the SAIF Corporation's denial of his bodily injuries sustained in an automobile accident.

The Board affirms the order of the Referee.

ISSUES

1. Whether claimant was an independent contractor or an employee at the time he sustained his bodily injuries.
2. Whether claimant's bodily injuries arose out of and in the course of his employment.

FINDINGS OF FACT

Claimant, a painter, was hired by the employer, Frank Saniti, Jr., ("Saniti"), in the early 1980's. Shortly thereafter, he was provided with a business card and painting shirts emblazoned with the Saniti logo. He painted at locations and times directed by Saniti. Other painters usually worked with him. The paint brushes and paint used at each job site, were owned by Saniti. In 1984 and 1985, he regularly worked four-to-five days a week. Saniti paid him by the hour or day.

On the morning of February 4, 1985, claimant parked his van near Saniti's boathouse. Saniti then drove him to a job site in Beaverton, Oregon. After the two completed their work, Saniti drove claimant back to Saniti's boathouse.

After arriving at Saniti's boathouse, Saniti asked claimant to run an errand for him. Claimant did so and returned to Saniti's boathouse a short time later.

Saniti then asked claimant to drive him to Vancouver, Washington, to size up a painting job at a pharmacy. Saniti's wife was an employee at the pharmacy. They traveled to the pharmacy in claimant's van and arrived at approximately 5:00 p.m. After viewing the job, they decided that it would be necessary to hire an additional painter.

At approximately 7:00 p.m., claimant and Saniti departed from the pharmacy in Saniti's wife's car. They traveled to a restaurant apparently hoping to locate a certain individual to help them with the pharmacy painting job. The individual was not there.

Thereafter, claimant and Saniti left the restaurant and traveled to a cocktail lounge, arriving at approximately 8:30 p.m. While there, they talked and drank several alcoholic beverages. Claimant does not recall the topic of conversation.

Claimant and Saniti then traveled to another cocktail lounge on Hayden Island. They continued drinking for approximately one hour and may have subsequently traveled to other

cocktail lounges. At some point in the evening, claimant became intoxicated and Saniti left with a woman friend.

Claimant does not remember how he finished up the night or how he got back to his van, which was apparently parked at Saniti's boathouse. On February 5, 1985, at approximately 4:00 a.m., claimant, intoxicated and alone, was seriously injured when he crashed his van into a light pole.

On July 7, 1986, claimant filed a workers' compensation claim for his bodily injuries sustained in the crash. SAIF denied his claim on September 26, 1986.

CONCLUSIONS OF LAW

The Board adopts the "opinion" of the Referee.

ORDER

The Referee's order dated January 12, 1988, is affirmed.

ROBERT D. HANKS, Claimant
Pozzi, et al., Claimant's Attorneys
Randolph Harris (SAIF), Defense Attorney

WCB 87-06694
December 21, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of Referee Leahy's order that granted claimant permanent total disability. Claimant cross-requests review to assert that the Referee's award of permanent total disability should have been effective as of an earlier date. The issues are extent of permanent disability, we affirm, as modified, including permanent total disability and the effective date of the disability award.

FINDINGS OF FACT

We adopt the Referee's statement of the facts, with the following additions. Claimant's attending physician took claimant off work as of April 30, 1986. At that time, claimant was incapable of performing his regular work or the modified work he was performing for the employer and was incapable of performing any other work in which he had skills, experience or training. Claimant's vocational assistance program was terminated due to a misunderstanding between claimant and his vocational counselor over what selected occupations claimant was familiar with. Claimant has looked for work in occupations he understands and has been unsuccessful in obtaining employment. Claimant was medically stationary as of April 8, 1987.

CONCLUSIONS AND OPINION

We adopt the Referee's opinion as to the extent of claimant's disability. We agree that claimant has established by a preponderance of the evidence that he is permanently and totally disabled.

The Referee stated that the effective date of the permanent total disability award was not raised by the parties. He made the award effective as of the date of his order, February 16, 1988. Claimant cross-requested review, stating that

the order was erroneous as to the effective date of permanent total disability. SAIF contends that we do not have jurisdiction to consider this issue. We find SAIF's argument unpersuasive. We conclude that it is implicit in every case involving permanent total disability that the award, if granted, should be made effective as of the date the evidence establishes the disability status. See Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988); Morris v. Denny's, 50 Or App 533, modified, 53 Or App 863, (1981).

Claimant urges that the appropriate date is April 16, 1986. On that date, Dr. Steinmann suggested that claimant take two weeks off work. We conclude that, while Dr. Steinmann's report established the aggravation, it was not until Dr. Fagan's April 30, 1986 note that claimant's total disability status became established. However, claimant was at that time temporarily totally disabled. He became medically stationary on April 8, 1987. We conclude that the award of compensation for permanent total disability shall commence as of April 8, 1987. The SAIF Corporation is authorized to offset any permanent partial disability compensation paid after April 8, 1987 as a prepayment of claimant's permanent total disability compensation. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983).

ORDER

The Referee's order dated February 16, 1988 is modified to grant compensation for permanent total disability effective April 8, 1987 and to authorize the SAIF Corporation to offset compensation for permanent partial disability, if any, paid after that date against compensation for permanent total disability. The Referee's order is otherwise affirmed. Claimant's attorney is awarded a reasonable assessed attorney fee of \$1,875 for services on Board review, to be paid by the SAIF Corporation.

SHELLEY F. HEMPEL, Claimant
Coons & Cole, Claimant's Attorneys
Joseph McNaught (SAIF), Defense Attorney

WCB 86-15537
December 21, 1988
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of Referee Gruber's order that dismissed her request for hearing as untimely filed without good cause. We affirm.

ISSUE

Whether claimant had good cause for failing to timely file her Request for Hearing within 60 days following the SAIF Corporation's denial of compensability.

FINDINGS OF FACT

Claimant was employed as a lumber grader for the employer during 1985-6. In 1985, she noticed pain in her right wrist. In January 1986, the work load increased and with it she noticed a sharp increase in her wrist pain. She reported the problem to the plant nurse and obtained a wrist brace and daily wrapping of the wrist in order to continue performing her job. She missed no time from work due to the condition. On or about May 30, 1986, she was discharged for reasons unrelated to her wrist condition.

Claimant's wrist pain did not improve after her discharge, and she sought medical treatment from Dr. Carroll, M.D., on June 17, 1986. She had tenosynovitis.

SAIF received Dr. Carroll's chart note on July 3, 1986, and began paying interim compensation. On September 4, 1986, it sent claimant notification that it was denying compensability of the claim. She received the letter on or about September 5, 1986.

On October 30, 1986, claimant wrote to the Workers' Compensation Board requesting a hearing on the denial. She was aware that the appeal had to be filed with the Board no later than the sixtieth day following the date of the denial letter. She gave the letter to a friend to personally deliver to the Board by November 4, 1986. The friend mailed the letter on November 5, 1986. It was received by the Board on November 7, 1986. Claimant has not shown good cause for failing to file the request with the Board by November 3, 1986.

CONCLUSIONS OF LAW AND OPINION

A hearing on a denial of a claim for compensation shall not be granted and the claim shall not be enforceable unless a request for hearing is filed within 60 days after the claimant is notified of the denial. ORS 656.319(1)(a). This is not an absolute time limit. If claimant files a request for hearing within 180 days, she may establish that there was good cause for failure to file by the 60th day. ORS 656.319(1)(b). "Good cause" has been defined as "mistake, inadvertence, surprise or excusable neglect" as those terms have been employed under ORCP 71B and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513 (1986).

Claimant contends first that she inadvertently miscalculated the date on which she had to file, and that the Board should forgive that inadvertence in addressing the issue of good cause. The 60th day following the date of the denial was November 3, 1986. Claimant believed that it was November 4, 1986, and instructed her friend to deliver the request to the Board by November 4. If the request had reached the Board on November 4, 1986, claimant's mistake might be relevant to our deliberations. However, it did not.

Claimant next contends that the fact that the request arrived at the Board on November 7, 1986, was due to excusable neglect. Claimant's friend was waylaid on a personal mission of her own, and did not deliver the letter at all. Instead, on November 5, 1986, she deposited it in a mail box in another city. It was received by the Board on November 7, 1986.

Claimant's crucial mistake was not in her calculation of dates, but in choosing her method of delivering the request for hearing to the Board. She knew from the day she got the denial that she had to respond to it within 60 days. She waited until the 56th day to write the request for hearing. Even then, she had time to mail it. Instead of doing so, she chose to entrust the request to another individual. The Supreme Court has held that a claimant is bound by the negligence of her attorney in failing to timely file a request for hearing. Sekermestrovich v. SAIF, 280 Or 723 (1980). We see no reason to distinguish between the acts of an attorney on behalf of claimant, and the acts of another agent on her behalf. We conclude that the friend's failure to deliver the request timely does not constitute good cause, and therefore affirm the dismissal.

ORDER

The Referee's order dated September 1, 1987 is affirmed.

Board Member Crider, dissenting:

The Referee dismissed claimant's request for hearing, concluding that claimant's miscalculation of the date upon which the time for filing ended by a single day was not good cause for failure to timely file her request for hearing. He, therefore, did not decide whether claimant's friend's failure to hand deliver the request to the Board on the miscalculated date amounted to good cause. The majority affirms, deciding the question the Referee declined to address and declining to decide the question the Referee did address. I disagree with both grounds of decision and would decide the compensability dispute on the merits.

"Good cause" as used in ORS 656.319 means the same thing as "mistake, inadvertance, surprise or excusable neglect" as found in former ORS 18.160 or ORCP 71B(1). Sekermestrovich v. SAIF, 280 Or 723 (1977); Anderson v. Publishers Paper Co., 78 Or App 513 (1986). In deciding good cause, we have an obligation to consider former ORS 18.160 and ORCP 71B(1) and the cases construing them. Anderson, supra at 517.

ORS 18.160 (and presumably ORCP 71B(1)) should be construed to the end that every litigant will have an opportunity to have a day in court; however, it should not be construed in a way which would defeat the ends of substantial justice. Coleman v. Meyer, 261 Or 129, 134 (1972).

The majority notes that the court has held that negligence of an attorney in failing to timely request a hearing is not good cause. Sekermestrovich v. SAIF, supra. About that proposition, there can be no quarrel. However, the majority goes on to say, "We see no reason to distinguish between the acts of an attorney on behalf of claimant, and the acts of another agent on her behalf." The courts have been able to see a reason where the Board does not. The Supreme Court explicitly held that the negligence of a non-lawyer may be excusable neglect where the negligence of a lawyer would not be. Brown v. EBI Companies, 289 Or 455 (1980). Moreover, in an array of civil cases, the Court of Appeals has held that failure of a corporation's employee to follow through on instructions from the responsible officer and agent for service of the corporation, resulting in a failure to appear to defend a lawsuit, is good cause. See e.g., Reitz v. Coca-Cola, 36 Or App 487 (1978). In short, reliance on a non-lawyer who fails to follow through on instructions may be excusable and thus good cause although reliance on a lawyer who negligently fails to follow through on instructions will not be good cause.

Thus, the majority's assumption that negligence of a non-lawyer "agent" of a party cannot be excusable neglect is wrong.

In this case, claimant's reliance on her friend to deliver the request for hearing on November 4, 1986, as she had promised, although in retrospect misplaced, constitutes excusable neglect. Claimant knew and trusted her friend who had proved reliable before. The friend intended to deliver the request for hearing and did not do so only because she discovered en route that her grandfather was sick.

The question then becomes whether claimant's erroneous belief that the 60th day was November 4, 1986 rather than November 3, 1986 is the type of mistake which constitutes good cause. Claimant was aware that she had 60 days in which to request a hearing. She prepared a request for hearing and attempted to have it delivered on the 60th day. Claimant's miscalculation does not reflect a lack of diligence such that good cause should not be found. Compare Cogswell v. SAIF, 74 Or App 234 (1985). Rather, it reflects a failure to accurately compute the time period. While such a fault on the part of a lawyer would not be excusable, it is an entirely understandable failure of a lay person unaccustomed to dealing with limitations periods. It is the type of mistake which constitutes good cause.

Accordingly, the Board should have decided this case on the merits.

JANE KELLEY, Claimant
Ralph M. Yenne, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney

WCB 87-13880
December 21, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee McMurdo's order that upheld the SAIF Corporation's partial denial of her cervical radiculopathy condition.

The Board affirms the order of the Referee.

ISSUE

Whether claimant's compensable left foot injury of December 26, 1986, was a material contributing cause of her cervical radiculopathy condition.

FINDINGS OF FACT

The Board adopts the Referee's facts.

CONCLUSIONS OF LAW

The Board adopts the Referee's opinion with the following supplementation.

The Referee found that claimant intentionally concealed her slip-and-fall injury of January 14, 1987. After our de novo review, we agree. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). First, when questioned by a SAIF investigator, claimant denied any other injuries, accidents, or falls. Second, absent from the medical reports and notes are any indications that claimant's examining physicians were aware of the January 1987 injury. Last, Dr. Neller testified that he was not aware of the January 1987 injury at the time he authored his report of August 8, 1987.

Aside from claimant's reliability, the issue of whether her cervical radiculopathy condition was materially caused by the December 1986 left foot injury, is a complex medical question. Uris v. Compensation Dept., 247 Or 420, 424-25 (1967). Dr. Neller is the only medical expert who rendered an opinion with a complete and accurate history of both the December 1986 and January 1987 incidents. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977). Neller testified, inter alia:

"Q. [SAIF's Counsel] . . . [I]s it probable, then, that the December of '86 fall resulted in the June and July '87 complaints? Or is [it] merely possible? Is it medically probable?

"A. It's -- it's -- in my opinion, it's possible. But the probability would be that it would have become apparent considerably earlier than, say, a six-month interval."

"* * * * *"

"Q. [SAIF's Counsel] [I]s it medically probable that her fall in December of '86 resulted in her -- no complaints of pain until July -- June/July of '87 . . . ?

"A. . . . I would think that the probability would be pretty skimp. I would think that a person would -- would have some evidence of radiculopathy a lot earlier than that." [Emphasis added].

We are not persuaded by Dr. Neller's testimony. He merely stated that there was a "possibility" that the December 1986 left foot injury contributed to claimant's cervical radiculopathy condition. See Paige v. SAIF, 75 Or App 160, 163 (1985). On this record, we agree with the Referee that claimant has not met her burden of proof.

ORDER

The Referee's order dated March 1, 1988, as reconsidered on March 10, 1988, is affirmed.

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

WCB 87-03095, 87-03096 & 87-03097
December 21, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Blevins' order that denied his request for a penalty. The only issue on review is a penalty. We modify the Referee's order.

FINDINGS OF FACT

The relevant fact are not disputed. On April 28, 1986, Referee Myers issued a decision that resulted in the self-insured employer being ordered to pay claimant compensation for temporary total disability during the period April 1, 1985 to January 29, 1986. Referee Myers acknowledged that this compensation resulted in an overpayment and authorized offset against future awards of permanent disability compensation. That order was abated for reconsideration and republished effective May 20, 1986. The employer requested Board review and immediately requested the Board's authorization to stay payment of a lump sum of compensation ordered paid by Referee Myers' order during the Board review proceeding. The Board denied the motion for a stay in payment.

The employer did not pay the compensation. Claimant requested a hearing to compel the employer to pay the compensation as ordered by Referee Myers. On November 26, 1986, Referee Leahy issued a decision that ordered the employer to "pay all of the compensation" ordered by Referee Myers, together with a 25 percent penalty and an employer-paid attorney fee. (Ex. 5-3.) Within 14 days of Referee Leahy's order, the employer began paying claimant the compensation due under Referee Myers' order in bi-weekly installments of approximately \$650 each. Under this method of payment, the last installment was paid on August 25, 1987. We affirmed Referee Myers' order on December 18, 1986. We affirmed Referee Leahy's order on March 10, 1987.

CONCLUSIONS AND OPINION

We note that our orders affirming Referee Myers' and Referee Leahy's orders were both affirmed by the Court of Appeals on June 22, 1988. Weyerhaeuser Co. v. Rencehausen, 91 Or App 717 (1988) (Referee Leahy); Weyerhaeuser Co. v. Rencehausen, 91 Or App 719 (1988) (Referee Myers). The question in this case is whether the employer's payment of the temporary total disability compensation ordered by Referee Myers in installments, rather than in a lump sum, was in reasonable compliance with Referee Leahy's order, and, if not, whether a second penalty may be imposed.

The employer relies upon OAR 436-60-150 to support its position. OAR 436-60-150(3)(e) provides that compensation for temporary disability is timely if paid within 14 days after the date of a litigation order that orders payment of temporary disability compensation. OAR 436-60-150(4) requires that "continued" temporary disability compensation must be paid at 14 day intervals. We conclude that the employer's reliance upon these rules is misplaced and that its actions were an unreasonable delay in payment of compensation due.

Referee Leahy's order specifically ordered the employer to pay "all of the compensation" awarded by Referee Myers. (Ex. 5-3, emphasis supplied.) We conclude that "all" of the compensation was that due between April 1, 1985 and January 29, 1986 and we interpret OAR 436-60-150(3)(e) to require that the payment be made in a lump sum. We conclude that OAR 436-60-150(4) does not apply in this case because the compensation due was entirely liquidated and there was no "continued" compensation because claimant's claim had long been closed.

The Referee did not specifically state whether he viewed the employer's payment in installments as unreasonable delay in compensation. He declined to award a penalty because Referee Leahy had imposed a maximum penalty in his order and because "no additional compensation is now due and unpaid." The Referee's award of an assessed attorney fee leads us to believe that he found the employer's conduct unreasonable, but believed he could not assess a penalty, either because Referee Leahy had already done so or because he believed there were no amounts upon which to base a penalty.

On de novo review, we conclude that the employer's interpretation of the rules was unreasonable and resulted in increased delay in compensation due claimant. Penalties may be assessed on unpaid "amounts then due." ORS 656.262(10). In Harold A. Lester, 37 Van Natta 745, 747 (1985), we held that the word "then" in the phrase "amounts then due" refers to the time when refusal or delay in payment of compensation occurred. We conclude that in this case a second period of delay in compensation began 14 days after Referee Leahy's order for all of the compensation ordered by Referee Myers except the first installment of \$644.24, which was paid December 9, 1986. We

conclude that all but the first installment of \$644.24 is subject to another penalty, see Georgia-Pacific v. Piowar, 305 Or 494, 506-07 (1988), and that the penalty should be 25 percent of the untimely-paid compensation.

ORDER

The Referee's order dated August 10, 1987 is modified. The self-insured employer shall pay to claimant as a penalty for unreasonable delay in payment of compensation a sum equal to 25 percent of the compensation due for temporary total disability between April 1, 1985 and January 29, 1986 less \$644.24. As modified, the Referee's order is affirmed. A client paid attorney fee for counsel for the self-insured employer is approved, not to exceed \$300.

ROBERT L. RODRIGUEZ, Claimant
Carney, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-10928
December 21, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of that portion of Referee Sorensen-Jolink's order that awarded claimant temporary disability compensation for the period from June 3, 1987 through November 24, 1987. Claimant cross-requests review of that portion of the Referee's order that declined to assess penalties and an associated attorney fee for the employer's alleged unreasonable failure to pay temporary disability during this period of time. We reverse on the temporary disability issue and affirm with regard to penalties and attorney fees.

ISSUES

1. Temporary Disability. Whether the employer should have resumed payment of temporary disability benefits when claimant was forced to leave a modified job due to an off-work injury?

2. Penalties and Attorney Fees.

FINDINGS OF FACT

Claimant injured his left wrist on May 19, 1987 while working as a warehouseman. He filed an injury claim which was accepted by the employer. Claimant was subsequently off work for approximately one week, during which time he received temporary total disability benefits.

On May 28, 1987, claimant returned to light work at a reduced wage for several days. The employer paid him temporary partial disability benefits during this time.

On June 1, 1987, claimant was assigned to modified job duties which were similar to his prior duties but without requiring heavy lifting. He worked his regular pre-injury hours and received his pre-injury wages for the next two days. The employer discontinued time loss payments.

On the morning of June 3, 1987, claimant separated his left shoulder in a nonwork-related incident. Because of that injury, he was totally disabled from even the modified work he had been performing.

The employer did not resume payment of temporary benefits until claimant underwent left wrist surgery on November 25, 1987. In the interim, claimant was released to, and requested, light-duty work several times. The employer denied the request on the basis of a lack of available light work.

At no time since his compensable injury has claimant been released to return to his pre-injury job.

CONCLUSIONS OF LAW AND OPINION

Entitlement To Temporary Disability Benefits

Citing Jackson v. SAIF, 7 Or App 109 (1971), the Referee concluded that an employer may terminate temporary disability compensation in just three situations: (1) when there has been a determination that the worker's condition has become medically stationary; (2) when the worker has been released by his physician to return to his regular work; or (3) when the worker has returned to his regular work. But see Fazzolari v. United Beer Distributors, 91 Or App 592, 595 (1988). The Referee first noted that claimant had not been determined to be medically stationary. The Referee went on to find that claimant's release and return to a modified job on June 1, 1987, even though at the same wages and hours as his at-injury job, did not constitute a release or return to "regular work" within the meaning of Jackson, *supra*. The Referee concluded that the employer was required to resume payment of temporary total disability benefits commencing June 3, 1987, the date claimant left work due to his off-work shoulder injury.

Subsequent to issuance of the Referee's order, the Court of Appeals decided Safeway Stores v. Owsley, 91 Or App 475 (1988). In Owsley, following a compensable injury and a period of time loss, claimant had returned to modified work without any reduction in wages. In fact, claimant's weekly earnings exceeded her weekly wage at the time of injury. Claimant was subsequently fired "for reasons unrelated to her claim." The employer terminated payment of temporary benefits. A Referee concluded that claimant was entitled to benefits for temporary total disability subsequent to being fired. The Referee reasoned that the employer was not authorized to terminate benefits unilaterally when claimant was fired. We affirmed and adopted the Referee's opinion and order.

On review, the court reversed. Relying upon its prior analysis in Fink v. Metropolitan Defender, 67 Or App 79, *rev den* 296 Or 829 (1984), the court first concluded that because claimant's weekly wages were more during the period for which she sought compensation than at the time of injury, she was not entitled to benefits for temporary partial disability. *Id.* at 479. Citing Noffsinger v. Yoncalla Timber Products, 88 Or App 118, *rev den* 305 Or 102 (1988) and Nix v. SAIF, 80 Or App 656, *rev den* 302 Or 158 (1986), the court rejected claimant's contention that the employer was required to begin paying temporary partial disability benefits after she was fired. The court concluded:

"Even assuming that claimant's termination did not preclude recovery of benefits for temporary partial disability, she would have been entitled only to the amount that

she could have received on account of her disability had she not been fired. In this case, that is nothing." Id. at 480 (emphasis added).

Similarly here, claimant returned to modified work with no reduction in wages following a compensable injury and a period of time loss. Claimant subsequently left work for reasons unrelated to his compensable injury. The employer then unilaterally terminated payment of temporary benefits. Under these circumstances, we conclude that the court's decision in Owsley, supra, is controlling. Accordingly, even assuming that claimant's off-work injury did not preclude recovery of benefits for temporary partial disability, he would have been entitled only to the amount that he could have received had he not become disabled as a result of an off-work injury. In this case, as in Owsley, that is nothing.

Penalties and Attorney Fees

In light of our decision on the merits of the claim, we conclude that assessment of a penalty and award of associated attorney fees is not appropriate.

ORDER

The Referee's order dated December 31, 1987 is reversed in part and affirmed in part. That portion of the Referee's order that awarded claimant temporary total disability benefits from June 3, 1987 until November 25, 1987 is reversed. That portion of the Referee's order that awarded an attorney fee payable from this increased compensation is also reversed. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed \$852, is approved.

WILFRED L. SPECKMAN, Claimant
William G. Whitney, Claimant's Attorney
Steven Maher (SAIF), Defense Attorney
Scheminske & Lyons, Defense Attorneys
Carl M. Davis, Assistant Attorney General

WCB 85-05088, 85-02030 & 86-10233
December 21, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Argonaut Insurance Company requests review of Referee Pferdner's order that: (1) set aside its "de facto" denial of claimant's accidental injury claim relating to his left foot; (2) assessed a penalty and associated attorney fee on the ground that the denial was unreasonable; and (3) awarded claimant's attorney an attorney fee of \$2,000 for prevailing against the denial. We reverse the penalty and associated attorney fee assessed by the Referee, but otherwise affirm.

ISSUES

1. Whether Argonaut provided coverage for claimant's employer at the time of claimant's injury.

2. Whether the Referee erred in assessing a penalty and associated attorney fee against Argonaut for unreasonable denial of claimant's claim.

3. Whether the Referee erred in ordering Argonaut to pay claimant's attorney a fee of \$2,000 for prevailing against its denial.

FINDINGS OF FACT

Claimant fractured his left foot in the course of his employment with Dan Shebley Construction (Shebley) on October 15, 1984. Shebley was a subcontractor of Westwood Construction Company (Westwood), which at the time of claimant's injury was insured by the SAIF Corporation.

On October 1, 1984, about two weeks before claimant's injury, Kenneth D. Shebley, the owner of Dan Shebley Construction, submitted an application for workers' compensation insurance and a check for \$350 made out to Argonaut to an insurance agent named Ken McMantis. McMantis forwarded the application and the check to another insurance agent, Michael Patrick. Patrick had an agency agreement with Argonaut which authorized him to bind coverage with that company. Patrick's office received Shebley's application and check on October 2, 1984. The check was deposited in Patrick's agency account later that day. Patrick reviewed the application during the next few days and bound coverage with Argonaut on October 5, 1984. He forwarded the application to Argonaut at some point between that date and October 22, 1984, the date that Argonaut actually received the application.

On October 22, 1984, Bruce Hoffman, an underwriter at Argonaut, returned the Shebley application to Patrick. In a note, Hoffman told Patrick that Argonaut refused to recognize the binder because Patrick had not complied with a clause in the agency agreement which required Patrick to notify Argonaut within one business day of binding coverage.

In December 1984, a field investigator from the Compliance Division investigated the complying status of Shebley and tentatively came to the conclusion that it was subject and noncomplying for the period from October 1, 1984 through the date of the investigation. The Compliance Division supervisor decided not to issue a proposed order of noncompliance; however, on the theory that claimant was an employee of Westwood rather than Shebley by virtue of former ORS 656.029. (See Ex. 14). The supervisor then referred two claims to SAIF on claimant's behalf. The first was a claim against Westwood and SAIF as its insurer. The second was a claim against Shebley and SAIF as statutory insurer for noncomplying employers pursuant to ORS 656.054. The supervisor recommended that SAIF deny the second claim on the ground that claimant was not a "subject employee" of Shebley. SAIF issued a denial to that effect on January 29, 1985. SAIF denied the first claim on February 15, 1985 on the ground that Argonaut had provided coverage for Shebley on the date of claimant's injury. Claimant requested a hearing on both denials.

A hearing was scheduled for January 2, 1986 before Referee Shebley. On November 15, 1985, SAIF filed a motion to join Argonaut as a party. Referee Shebley denied this motion and the hearing was held as scheduled. Claimant and Patrick were the only two witnesses. After hearing Patrick's testimony, Referee Shebley concluded that he had erred in denying SAIF's motion to join Argonaut. On January 6, 1986, he issued an order making Argonaut a party to the proceeding and a second hearing was

scheduled, this time before Referee Pferdner. Argonaut issued no formal denial before the second hearing, but made it clear in a letter to Referee Shebley dated January 7, 1986 and in a subsequent motion to dismiss that it would deny claimant's claim on coverage grounds.

The second hearing was held on July 9, 1986. A transcript of the first hearing, with the exception of Patrick's testimony, was admitted as an exhibit. The sole witness at the second hearing was Patrick. In his Opinion and Order, Referee Pferdner denied Argonaut's motion to dismiss, held that Shebley had coverage through Argonaut on the date of claimant's injury and set aside Argonaut's "de facto" denial. The Referee ordered Argonaut to pay claimant's attorney a fee of \$2,000 for prevailing against the denial and also imposed a penalty and attorney fee on the ground that the denial was unreasonable.

FINDINGS OF ULTIMATE FACT

1. Dan Shebley Construction had coverage through Argonaut on the date of claimant's injury.
2. Argonaut's denial of coverage was not unreasonable.

CONCLUSIONS OF LAW

Coverage

Argonaut makes two basic arguments on the coverage issue. First, it contends that the Referee did not have jurisdiction to determine that it provided coverage for Shebley. Second, it contends that the Referee erred in concluding that Patrick's binder was effective.

Argonaut's jurisdictional argument finds support in the Board's decision in Gary A. Lafarge, 38 Van Natta 901 (1986). In that case, the claimant sustained an accidental injury while working on a farm owned by a couple named the Wards. The Wards also owned a grocery store for which they had obtained workers' compensation insurance. The claimant filed a claim against the Wards and a coverage investigation ensued. After completing its investigation, the Compliance Division did not issue a proposed order of noncompliance. The insurer nonetheless denied the claimant's claim on coverage grounds. The Referee considered the coverage issue on the merits and concluded that the guaranty contract filed in connection with the grocery store extended coverage to the farm.

On review, we affirmed the Referee but held that she had erred in addressing the merits of the coverage question. We cited an earlier case, Susan K. Bell, 38 Van Natta 252 (1986), for the proposition that questions of compliance are not within the general jurisdiction of the Hearings Division for "questions concerning a claim" and found no other provision of law which expressly authorized the Hearings Division to address the coverage question under the facts presented. We then concluded that coverage had to be presumed from the Compliance Division's failure to issue a proposed order of noncompliance.

Application of Lafarge in the present case is problematic. In Lafarge, there was only one potential insurer. It was thus a simple matter to determine which insurer should be

presumed to provide coverage. In the present case, there are two potential insurers, Argonaut as insurer of Shebley and SAIF as insurer of Westwood. The Compliance Division did not issue a proposed order of noncompliance against Shebley because even if Shebley did not have coverage through Argonaut, coverage would be provided by Westwood and SAIF pursuant to former ORS 656.029. Ultimately, therefore, the Compliance Division made no determination regarding whether Argonaut provided coverage for Shebley and the Lafarge presumption cannot be invoked to decide that question.

The problem we faced in Lafarge and which we again face in the present case arises because of ambiguities in the statutes defining the respective jurisdiction of the Board and the Director in coverage disputes which arise in association with claims for compensation. ORS 656.017 and ORS 656.052(1) require every employer subject to the chapter to provide workers' compensation coverage for subject workers in its employ. ORS 656.052(2) gives the Director the responsibility of enforcing this requirement. It provides:

"(2) Whenever the director has reason to believe that any person has violated subsection (1) of this section, the director shall serve upon the person a proposed order declaring the person to be a noncomplying employer and containing the amount, if any, of civil penalty to be assessed pursuant to ORS 656.735(1)."

ORS 656.735(1) authorizes the Director to assess a penalty of up to \$1,000 for violations of ORS 656.052(1). Subsections (2) and (3) of ORS 656.735 authorize the Director to assess additional penalties under certain circumstances. Once a proposed order of noncompliance has become final by operation of law or on appeal, Subsection (3) of ORS 656.052 authorizes the Director to file suit to enjoin an employer from employing subject workers until it complies with ORS 656.017.

Review of proposed orders of noncompliance is provided for in ORS 656.740. Subsection (1) of that section authorizes the alleged noncomplying employer to request a hearing on the proposed order. Subsection (2) provides for joinder of insurers with which the employer alleges coverage. Subsection (3) provides that the hearing on the proposed order is to be conducted by a referee of the Board's Hearings Division. Subsection (4) provides that appeal of the referee's order is to be to the Court of Appeals under the Administrative Procedures Act, with one exception. That exception is: "When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim." ORS 656.740(4)(c). In such cases, therefore, review of the Referee's determination of both the coverage dispute and the matter concerning a claim is through the Board. See ORS 656.289 to 656.298.

The problem with this scheme in the present context is that it does not expressly anticipate the situation in which a coverage dispute arises in connection with a claim for compensation and the Director, for whatever reason, does not issue

a proposed order of noncompliance. In such situations, the Director's silence leaves the coverage dispute officially unresolved. If an insurer nonetheless denies the claimant's claim for compensation on coverage grounds and the claimant requests a hearing under ORS 656.283, the Hearings Division and the Board are thrust into something of a jurisdictional quagmire. In Lafarge, the only route we could find out of this quagmire was to construe the Director's silence as conclusive proof of coverage. As the present case demonstrates, however, silence is not always conclusive. After considering the matter again, we conclude that there is another way out of this quagmire and that we can no longer adhere to our Lafarge decision.

The Hearings Division has general jurisdiction of "all cases, disputes and controversies regarding matters concerning a claim . . . and for conducting such other hearings and proceedings as may be prescribed by law." Former ORS 656.708(3). "Matters concerning a claim" are "those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3).

In Amos v. SAIF, 72 Or App 145 (1985), a mother and her son claimed death benefits by virtue of the fact that the mother had at one time cohabited with the deceased worker. One defense raised by SAIF concerned the son's paternity. It contended that paternity could only be established by a circuit court under the provisions of ORS chapter 109 and thus that the Hearings Division was without jurisdiction to decide that issue. In holding that former ORS 656.708(3) did provide jurisdiction for the Hearings Division to decide paternity, the court adopted the following language from the Referee's opinion:

"SAIF contends that only the circuit court has jurisdiction to determine paternity. That may very well be in order to establish responsibility for support of the child or similar liability considerations, but such an issue is not presented here. The issue presented in this case deals only with a claim for compensation and a Referee has jurisdiction to decide any question concerning a claim. Consequently, I conclude that I do have jurisdiction to decide all questions pertaining to this minor child's claim for the sole purpose of determining whether he is entitled to workers' compensation." 72 Or App at 149.

We conclude that similar reasoning should apply to coverage disputes.

A coverage dispute between an employer and an insurer which is not associated with a claim for compensation is not a matter concerning a claim and the Hearings Division has no jurisdiction to resolve it except as provided in ORS 656.740. See SAIF v. Broadway Cab Co., 52 Or App 689 (1981). When coverage is raised as a defense to a claim for compensation, however, that issue must be resolved to determine the worker's right to receive compensation. In such situations, therefore, the coverage issue is a dispute or controversy "regarding" a matter concerning a claim, former ORS 656.708(3), and the Hearings Division has

jurisdiction to decide it for purposes of determining the claimant's right to receive compensation.

This construction of former ORS 656.708(3) is supported by a careful reading of the provisions of ORS 656.740. The joinder and hearing procedures prescribed by ORS 656.740(2) and (3) reflect a legislative intent to permit full and fair litigation of coverage disputes, including the right of appeal. In view of this obvious legislative purpose, it was anomalous to rule, as we did in Lafarge, that no hearing or appeal of any kind is permitted in coverage disputes in which the Director has not issued a proposed order of noncompliance. It is much more reasonable to conclude that the legislature intended coverage disputes which are associated with matters concerning a claim to be litigated along with such matters except as expressly limited by the provisions of ORS 656.740.

This conclusion is further reinforced by ORS 656.740(4)(c). That provision states that when an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim, review of the referee's order on both issues shall be as prescribed for matters concerning a claim. This reflects a legislative intent that coverage disputes associated with claims for compensation be litigated along with matters concerning a claim and at least implies that the Hearings Division and the Board have jurisdiction to resolve such disputes independent of the provisions of ORS 656.740. We can discern no reason why the Legislature would have prescribed different rules for coverage disputes associated with claims for compensation depending upon whether or not the Director had issued a proposed order of noncompliance.

Further support for the above conclusions is found in the Court of Appeals decision in SAIF v. Harrington, 63 Or App 696 (1983). In that case, the court decided on the merits a coverage dispute in which the Director had refused to issue a proposed order of noncompliance. Id. at 699. As is clear from the caption of the case and the text of the opinion itself, the coverage dispute in Harrington arose in connection with a claim for compensation. Although the issue of the court's jurisdiction apparently was never raised, a court has a duty on its own motion to determine whether it has jurisdiction of the subject matter of a controversy brought before it and to refuse to proceed further if it does not. See In re Oregon Mass Transportation Financing Authority, 284 Or 241, 248 (1978). We conclude, therefore, that Harrington does provide some authority for the proposition that a coverage dispute which was never the subject of a proposed order of noncompliance may be resolved by the Hearings Division in connection with a matter concerning a claim. The Board did not discuss the Harrington case when it rendered its Lafarge decision.

For all of the above reasons, we conclude that the Hearings Division and the Board do have jurisdiction to ascertain the presence or absence of coverage in a proceeding on a matter concerning a claim except as expressly limited by ORS 656.740. We disavow our prior decision in Lafarge. ORS 656.740 does not limit the jurisdiction of the Hearings Division under the facts of the present case and hence we conclude that the Referee properly decided the coverage issue in his order and that we have jurisdiction to review that decision.

On the merits, Argonaut was a "guaranty contract insurer" as that phrase is used in the Workers' Compensation Law. See former ORS 656.005(15). ORS 656.419 regulates the issuance and cancellation of guaranty contracts. Of particular interest in the present case is ORS 656.419(3). It provides:

"(3) Workers' compensation coverage is effective when the application of the subject employer for coverage together with any required fees or premium are received and accepted by an authorized representative of an insurer."

Patrick was an "authorized representative" of Argonaut by virtue of his agency agreement with the company which authorized him to bind coverage. He received Shebley's application for workers' compensation insurance and premium check on October 2, 1984 and "accepted" the application on October 5, 1984 when he bound coverage. We conclude, therefore, that as of the latter date, Shebley had coverage with Argonaut.

ORS 656.419(5) provides: "Coverage of an employer under a guaranty contract continues until cancelled or terminated as provided by ORS 656.423 or 656.427." Cancellation of coverage in the present case is governed by ORS 656.427. Subsection (1) of that section requires the insurer to give the employer and the Director written notice of termination. Subsection (2) provides: "A termination under this section is effective at 12 midnight not less than 30 days after the date the notice is received by the director." Subsection (4) adds: "Termination shall in no way limit liability that was incurred under the guaranty contract . . . prior to the effective date of the termination."

Claimant was injured on October 15, 1984. Argonaut had issued no notice of termination by that date and, in any event, under ORS 656.427(2) the termination would not have been effective until 30 days after the Director received it. We conclude, therefore, that Shebley was insured by Argonaut on the date of claimant's injury. The fact that Patrick did not inform Argonaut within one business day that he had extended coverage to Shebley and thus failed to comply with his agency agreement with Argonaut does not alter this conclusion. The requirements and effective dates for cancellation of coverage are set by statute. To the extent that the agency agreement purported to modify those requirements or the effective dates of coverage, it is invalid. See SAIF v. Harrington, supra, 63 Or App at 699-700.

Penalty and Attorney Fee for Unreasonable Denial

An insurer which unreasonably delays or refuses to pay compensation is subject to penalties and attorney fees. ORS 656.262(10); 656.382(1). The Referee concluded that Argonaut's denial of coverage was unreasonable. We disagree. In light of the jurisdictional problems which we discussed earlier, as well as a number of ambiguous terms in ORS 656.419, we conclude that the denial, although incorrect, was not unreasonable.

Attorney Fee for Prevailing Against the Denial

The Referee ordered Argonaut to pay claimant's attorney a fee of \$2,000 for setting aside its denial. Argonaut contends

that this fee is too high because it was only joined as a party to the proceeding after the first hearing and "claimant's attorney spent most of his time pursuing SAIF."

Although Argonaut was not a party to the proceeding until after the first hearing, the transcript of the first hearing, with the exception of Patrick's testimony, was introduced as an exhibit at the second hearing. Duplication of effort by claimant's attorney, therefore, was minimized. Argonaut's denial of coverage ultimately was overturned. Under these circumstances, we find no error in the attorney fee awarded by the Referee.

Claimant's counsel is entitled to an insurer-paid attorney fee for services rendered on review concerning the coverage issue. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated July 18, 1986, as supplemented by the orders dated August 4, 1986 and September 2, 1986, is reversed in part. That portion of the order which ordered Argonaut to pay a 25 percent penalty and associated attorney fee of \$500 is reversed. The remainder of the order is affirmed.

LESLIE A. WHALEY, Claimant
Horne & Meserow, Attorneys

WCB 87-07340
December 21, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Leahy's order that upheld the insurer's denial of a low back injury claim. We affirm.

ISSUE

The issue on review is compensability.

FINDINGS OF FACT

At hearing, claimant was 33 years old. He had been employed in the construction and building trades as a laborer and materials handler for about 10 years. At the time he was hired by this employer, claimant was incarcerated in a work release center on an assault conviction.

The employer, operator of a lumber and materials yard, needed a forklift operator and driver to deliver materials to customers. The job required the driver to be "on call" at home so that a delivery could be made at any time if the customer needed materials. The position also required a bond.

When claimant applied, he did not tell the employer that he was then employed at a warehouse. He told the employer that he had been bonded previously and that there would be no problem in being bonded now. He did not tell employer of his conviction and restricted living arrangement. He applied for a bond and falsely stated on the application that he had not been convicted of a crime.

He worked for employer about 11 days. On his first day, he delivered lumber to a job site and insisted on rolling the lumber off the truck onto the parking lot of the customer. The customer wanted to offload the truck with a forklift. An argument followed and the customer complained to claimant's supervisor. Claimant lied to the supervisor about this incident.

The employer found out that claimant was in a work release center and could not be bonded. Claimant was fired when he arrived for work on March 31, 1987. The next day, claimant went to the emergency room of a hospital complaining of low back pain. He was released for work that day after an examination. He told the emergency room doctor that he had injured his back on Friday, March 27, 1987, while lifting bags of cement at work.

On April 8, 1987 claimant was examined by Dr. Utterback, M.D. He diagnosed probable lumbar strain. One week later, claimant told Dr. Utterback he was somewhat improved. On April 23, 1987, Utterback released claimant for work with a weight restriction on lifting for three days. Claimant did not have a job and was still in the work release center. On May 7, 1987, claimant told Dr. Utterback his back was not bothering him, but he was now experiencing cramping pain in his thighs and legs. He did not appear for a scheduled May 14, 1987 appointment with Utterback.

The insurer paid temporary disability benefits from March 31 to April 28, and denied the claim on April 29, 1987.

The only other medical evidence is an examination by the Orthopaedic Consultants. They examined claimant on June 24, 1987. They noted inconsistencies between their findings, which failed to show any injury, and claimant's complaints.

Claimant is not a credible witness. None of the witnesses called by claimant are reliable.

ULTIMATE FINDINGS OF FACT

Claimant has failed to prove by a preponderance of the evidence that he has suffered a work related injury.

CONCLUSIONS

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). We are not convinced that any injury occurred, and if one did, we are not convinced that it was related to claimant's work activities.

It is possible to prove a compensable injury without medical evidence. The lay testimony of a claimant or others can be accepted, even over contrary medical testimony, to establish a compensable condition. Here, claimant was found to be not credible by the Referee. After reviewing claimant's testimony, we agree and give no weight to his testimony. Claimant's wife's testimony is not convincing. The other witnesses were all inmates of the release center at the time of the alleged injury. We find their testimony to be unconvincing.

The medical evidence does not prove, or even tend to prove that claimant has suffered a work related injury. The remainder of claimant's testimony is not reliable. There is no evidence to support a finding favoring claimant.

ORDER

The Referee's order dated December 28, 1987 is affirmed.

MERRITT E. WILSON, Claimant
Royce, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-11217
December 21, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Galloway's order that awarded an additional 10 percent (32 degrees) unscheduled permanent disability for his respiratory condition, beyond a Determination Order that awarded 5 percent (16 degrees). Although the insurer has not formally cross-requested review, it argues in its brief that: (1) the Referee's award of unscheduled permanent disability should be reduced; and (2) the Referee's assessment of an attorney fee for allegedly unreasonable claims processing should be reversed.

The Board affirms the order of the Referee.

ISSUES

1. The extent of claimant's unscheduled permanent disability.
2. Whether the insurer acted unreasonably in delaying acceptance beyond the 60-day period of ORS 656.262(6).

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

Claimant has minimal physical impairment as a result of his work exposure to isocyanate-based paint. He has transferable skills and training as a salesman and stock broker.

The insurer unreasonably delayed accepting claimant's claim for a respiratory condition.

CONCLUSIONS OF LAW

The Board adopts the Referee's opinion with the following supplementation.

ORS 656.262(6) allows an insurer 60 days to accept or deny a claim. If an insurer does not do so within the 60-day period, it risks the assessment of penalties and/or attorney fees. ORS 656.262(10).

Here, there is no dispute that the insurer accepted claimant's claim nearly two months after the 60-day period. Its only explanation is that it desired claimant to undergo an independent medical examination. During the 60-day period it had a right to defer acting on the claim and to await the results of

an independent medical examination without risking the assessment of a penalty or attorney fee. Thereafter, it did not.

At the expiration of the 60-day period, the insurer delayed acting on the claim pending the results of an independent medical examination that had not yet taken place and that did not take place until approximately six weeks later. Under such circumstances, we agree with the Referee's assessment of an attorney fee. Mischel v. Portland General Electric, 89 Or App 140, 143 (1987); Spivey v. SAIF, 79 Or App 568, 572 (1986).

ORDER

The Referee's order dated January 26, 1988 is affirmed. The Board approves a client-paid fee not to exceed \$1,193.

JACK CORWIN, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 85-0635M
December 22, 1988
Own Motion Order

SAIF Corporation has voluntarily reopened the above claim commencing temporary disability benefits as of October 26, 1988, the date claimant was hospitalized for surgery. SAIF asks the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625. Claimant asks that the Board allow temporary disability from September 29, 1988, the date he was hospitalized for a myelogram.

ORS 656.278 provides for the payment of temporary disability benefits from the date the worker is hospitalized for treatment or from the date of outpatient surgery. There is no indication in the record that claimant's hospitalization on September 29, 1988 was for anything more than a diagnostic procedure accomplished during a single day. We do not feel that a brief stay in the hospital for the purpose of diagnostic testing satisfies the requirements set forth in ORS 656.278. Claimant's request for benefits to commence September 29, 1988 is denied.

SAIF's voluntary reopening as of October 26, 1988 was appropriate. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

MICHELLE GRIFFITH, Claimant
Doblie & Associates, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 88-12832
December 22, 1988
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of Referee Podnar's order that affirmed the Determination Order that awarded 29 percent (92.8 degrees) unscheduled permanent partial disability. The only issue on review is extent of unscheduled permanent partial disability. We reverse and modify the Determination Order.

FINDINGS OF FACT

Claimant is a 29 year old sales promotion representative. She was injured on October 2, 1986, when she fell from a milk carton while constructing a product display in a grocery store. Initially her treatment was conservative chiropractic treatment for a thoracic

strain. The claim was first closed by a June 30, 1987 Determination Order that awarded no compensation for permanent disability. Claimant requested a hearing from the June 30, 1987 Determination Order.

Claimant continued to experience symptoms in her cervical and thoracic spine. She was referred to Dr. Parsons, neurosurgeon, who diagnosed possible protruded thoracic discs. Magnetic resonance imaging, myelography and a CT scan confirmed herniated discs at T6-7 and T8-9. Claimant submitted to thoracic spinal surgery on December 9, 1987. The surgery consisted of the following procedures: T6-7 laminectomy and discectomy; total removal of the spinous process and lamina of T6; total removal of the spinous process and lamina of T7; and facetectomy on the right of T6-7. No surgery was performed on the herniated T8-9 disc. On February 18, 1988 claimant's request for hearing from the June 30, 1987 Determination Order was dismissed by stipulation of the parties, with claimant retaining the right to relitigate the extent of her disability upon reclosure of the claim.

Claimant was medically stationary following the surgery as of June 7, 1988. She has not been released to perform her at injury occupation. She may perform any work that does not involve lifting more than 25 pounds frequently. Claimant's claim was closed by a Determination Order issued July 20, 1988. She was awarded compensation of 92.8 degrees for 29 percent unscheduled permanent partial disability. At the time of claim closure, claimant was not working.

Claimant is a high school graduate with some community college course work. She has received no specific vocational training. The jobs held by claimant in the past ten years have been as a sales promotion representative, merchandising survey worker, cake decorator, delicatessen assistant manager, administrative assistant and photofinisher. The highest specific vocational preparation value in these jobs was six (cake decorator, delicatessen assistant manager and administrative assistant). Before her injury, claimant performed medium level work. Since her surgery, she is able to perform only light level work.

At the time of the hearing claimant was released to, and was performing, modified work as a pasta processor, which is light work. She continues to experience some occasional tightness in her lumbar spine which translates to pain and tightness in the thoracic spine and stiffness with pain in the cervical spine. She experiences reduced ability in forward flexion and right and left rotation of the cervical spine.

CONCLUSION AND OPINION

Applicable Law

Claimant became medically stationary after January 1, 1988 and her claim was rated by the Evaluation Section, Workers' Compensation Division, Department of Insurance and Finance ("Evaluation") after July 1, 1988. We conclude that claimant's disability must be rated in accordance with the standards for rating of permanent disability adopted by the Director of Department of Insurance and Finance pursuant to ORS 656.726(3)(f). ORS 656.283(7); 656.295(5). See OAR 438-10-005 (Temp.) (WCB Admin. Order 2-1988). These standards are found at OAR Chapter 436, Division 35, and were effective as of July 1, 1988. (WCD Admin. Order 3-1988).

Claimant has advanced two reasons why we should rate her disability under the law in effect prior to January 1, 1988. First, claimant argues that her disability, at least of the lumbar and cervical spine, should be rated under the old law because she was never afforded the opportunity to litigate extent of permanent disability under the June 30, 1987 Determination Order. We disagree. The request for hearing on the 1987 Determination Order was dismissed. Claimant was afforded the right to raise issues of disability of all body parts upon reclosure of the claim after the thoracic surgery. This she has done. The fact that the law under which claimant's disability is to be rated has changed was a risk both parties faced in dismissing the previous request for hearing.

The second reason is that claimant alleges that rating her disability under the Director's standards is a denial of her rights to due process and equal protection of law. She does not specify whether she alleges a denial of federal or Oregon constitutional rights. The basis of claimant's argument is that, because the Director is authorized to increase the money value of a degree of unscheduled permanent disability for more seriously injured workers injured after July 1, 1988 if cost savings result from implementation of the disability rating standards, ORS 656.215, benefits will be withheld from claimant and similarly situated workers injured before July 1, 1988 and redistributed to workers injured after July 1, 1988.

We reject claimant's argument, for three reasons. First, the value of a degree of unscheduled disability has not been increased; claimant has shown no wrong deserving of a remedy and we believe there is no justiciable controversy. Second, the entire workers' compensation system is a creature of the legislature, and the legislature alone is the arbiter of what process is "due." Finally, claimant has not advanced any argument that she is a member of a "suspect" class and we find no rational basis upon which to believe she is a member of a "suspect" class. All that we need find to sustain the law is that there is a rational relationship between the legislation and claimant and other members of her class, i.e. workers injured before July 1, 1988. We conclude, in the absence of any showing to the contrary, that the relationship between the legislation and claimant's class is rational.

Basis of the Referee's Decision and Scope of Review

The Referee concluded in whole:

"There [has] been no persuasive evidence presented in this matter which would indicate that there were areas of claimant's anatomy affected by this injury which were not rated, that the standards were misapplied or that there were factors outside the standards which could have been but were not taken into consideration.

"The Determination Order will be affirmed."

It is not clear to us whether the Referee perceived his role as one of reviewing the decision of Evaluation for sufficiency and correctness or whether he independently undertook to find facts and rate claimant's disability under OAR 436-35. We conclude that the role of the Referee in an extent of unscheduled disability case under the current law is to find facts based upon the entire hearing record and to rate claimant's disability on the basis of the facts found. We conclude that our role is the same: To review the record

de novo, find facts and rate claimant's disability on the basis of the facts found. The record of this case and the positions taken by the parties at the hearing and on review do not suggest that claimant's disability should be rated using any method other than a strict application of the standards.

Indispensable Facts in Rating Extent
of Disability Under OAR 436-35

ORS 656.726(3)(f)(A) provides that the Director shall create standards for evaluation of unscheduled disability. With respect to that standard, it further states that:

"The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job. The term 'education' shall include the development of an objective standard for evaluating a worker's skills, training and formal education."

OAR 436-35-270(2) provides: "The criteria for rating of [unscheduled permanent partial] disability shall be impairment as modified by age, education (including formal education, training and skills), and adaptability to perform a given job."

We conclude that to apply OAR 436-35 to unscheduled disability, at a minimum, the finder of fact must find: (1) the level of the claimant's impairment due to the industrial injury; (2) the claimant's work status -- specifically, whether the claimant is working at his or her regular work, has refused an offer of employment at his or her regular work, is working at modified work or is not working at all; (3) the claimant's age; (4) the claimant's education, including years of formal education, the highest occupational skill level attained in the previous ten years and training, if any, supported by documented competence in a specific vocational pursuit; and (5) adaptability to perform a given job, based upon the claimant's physical capacity before the injury compared to his or her physical capacity after the injury. Each of these facts must be proven by a preponderance of the evidence presented at the hearing.

Rating this Claimant's Disability

1. Impairment. We conclude from the record, as we have found above, that claimant has had a laminectomy and single discectomy of T6-7, total removal of the spinous process and lamina of T6 and T7, facetectomy of the right T6-7 and that claimant has an unoperated disc herniation at T8-9, which is symptomatic, and reduction of cervical ranges of flexion and rotation. We conclude that the total removal of the spinous process and lamina of T6 and T7 are each entitled to a separate value in impairment rating under OAR 436-35-350(2). Applying the disability rating standards, we find the following numerical values for the intervertebral disc findings (OAR 436-35-350(2)):

T6-7 laminectomy and single discectomy	+5
Removal of spinous process and lamina T6	+5

Removal of spinous process and lamina T7	+5
Unoperated T8-9 disc herniation, symptomatic	+4
Facetectomy, right T6-7	+3.

These values are combined (not added), see OAR 436-35-360(11), for a value of +19.

Applying the disability rating standards, we find the following numerical values for the cervical spine range of motion findings (OAR 436-35-350(2), (5)):

Approximately 50 percent loss of cervical flexion	+1
Approximately 30 percent loss of cervical rotation	+1

These values are added, see OAR 436-35-360(10), for a total of +2.

The total value for the intervertebral disc findings and the total value for the cervical range of motions findings are combined (not added, however in this case the same value is reached whether the values are added or combined), for a total impairment value of +21.

2. Age. No value is assigned for workers who have returned to their regular work, refused their regular work after release to regular work by the attending physician or who are 39 years old or younger no matter what their work status. OAR 436-35-290. It is not disputed that claimant is age 29. Claimant's age value is therefore zero.

3. Education.

a. Formal education. No value is assigned for workers who have returned to their regular work, refused their regular work after release to regular work by the attending physician or who have a high school education or general educational development certificate or more education, no matter what their work status. OAR 436-35-300(2), (3). It is not disputed that claimant is a high school graduate. Claimant's formal education value is therefore zero.

b. Skills. No value is assigned for workers who have returned to their regular work or refused their regular work after release to regular work by the attending physician. OAR 436-35-300(2). Claimant has not been released to her regular work nor has she returned to her regular work. OAR 436-35-300(4) provides the values assigned to the various specific vocational preparation (SVP) levels, obtained with reference to the Dictionary of Occupational Titles and applicable supplements. Claimant's highest SVP in the past ten years is 6, which is assigned a value of +2.

c. Training. No value is assigned for workers who have returned to their regular work or refused their regular work after release to regular work by the attending physician. OAR 436-35-300(2). Claimant has not been released to her regular work nor has she returned to her regular work. OAR 436-35-300(5) provides that if there is no documentation of training in a specific vocational pursuit, a value of +1 is assigned. There is no evidence of any such documentation in this case. Claimant's training value is therefore +1.

All of the education factors are added for a total education value of +3.

4. Adaptability to perform a given job. No value is assigned for workers who have returned to their regular work or refused their regular work after release to regular work by the attending physician. OAR 436-35-310(1). Values are determined by comparing the claimant's physical capacity before and after the injury. The values are different depending upon whether claimant is not working at all, or is working at modified work, at the time of the disability rating. At the time of claimant's rating by Evaluation, claimant was not working and her physical capacity had been reduced from medium to light. Evaluation assigned a value of +4 under OAR 436-35-310(4). At the time of the hearing, claimant was working at modified work. We rate claimant's disability as of the hearing. Because she was working, we assign the value under OAR 436-35-310(3), which is +2.

5. Assembling the Factors. The value for age is added to the total value for education. (Zero + 3 = 3.) The sum of the values for age and education are multiplied by the value for adaptability. (3 x 2 = 6.) The product of the values for age/education and adaptability are added to the total impairment value to reach extent of disability. (6 + 21 = 27.)

We conclude that claimant is entitled to compensation of 86.4 degrees for 27 percent unscheduled permanent partial disability for the cervical and thoracic spine.

ORDER

The Referee's order dated September 22, 1988 is reversed. The Determination Order dated July 20, 1988 is modified. Claimant is awarded compensation of 86.4 degrees for 27 percent unscheduled permanent partial disability for the cervical and thoracic spine. A client-paid fee, not to exceed \$984.50, is approved.

LEONARD L. OSBORNE, Claimant
Wade P. Bettis, Claimant's Attorney
Davis & Bostwick, Defense Attorneys

Own Motion 88-0487M
December 22, 1988
Order Denying Attorney Fee

The Board issued an Own Motion Order on September 22, 1988 whereby the insurer's request for own motion relief was denied. The insurer had specifically requested that the Board exercise its own motion authority to reconsider a Referee's order. The Board declined to use the own motion statute for this purpose.

Claimant's attorney has now requested that the Board grant him a fee equal to \$275.80 as an "extraordinary approved fee (a fee paid out of compensation). As there is no compensation due claimant from the Board's September 22 order which was not already due him from the Referee's March 1988 order, we conclude there is no provision for a fee in this matter. See OAR 438-15-080 and 438-15-020. The request for an attorney fee for the attorney's services on claimant's behalf is hereby denied.

IT IS SO ORDERED.

DANIEL F. PRICE, Claimant
Royce, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-10520 & 86-16390
December 22, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of those portions of Referee Fink's order that: (1) awarded temporary disability compensation for the period of August 27, 1986 to March 26, 1987; (2) set aside the insurer's denial of claimant's claim for certain diagnostic medical services; and (3) set aside the insurer's denial of chiropractic treatment. Claimant asks for penalties and attorney fees for the insurer's alleged unreasonable termination of temporary disability benefits. He also requests an attorney fee stemming from the rescission of a portion of the insurer's July 16, 1987 denial. We reverse in part and affirm in part.

ISSUES

1. Entitlement to temporary disability benefits for the period of August 27, 1986 to March 26, 1987.
2. The compensability of diagnostic services.
3. The compensability of chiropractic services.
4. Penalties and attorney fees for an alleged unreasonable termination of temporary disability benefits.
5. Attorney fees in connection with the insurer's July 16, 1987 denial.

FINDINGS OF FACT

Claimant compensably injured his left shoulder and trapezius muscle in July 1986 while tightening down a truck load. He visited Dr. Smith, who released him to return to work with no use of the left upper extremity. Although claimant did not inform the employer of his release, an employer representative became aware of it on or about August 14, 1986 through a conversation with Dr. Smith. The employer then offered claimant a light-duty job within the restrictions outlined by claimant's physician. The job consisted of general clean-up and other light tasks. Claimant was to be paid the salary he was earning at the time of his injury. He was given a copy of company rules and regulations regarding light-duty assignments.

On or about August 20, 1986, claimant was assigned the light-duty task of hosing off the employer's loading dock, using an inch-and-three-quarter diameter hose. The job could be performed with one hand. Claimant performed the job without complaint. He was then assigned to police the employer's parking lot and instructed to not use his left arm or hand. Claimant performed the job until the end of the first workday, although he complained of left arm and shoulder pain.

Claimant did not report for work the following day. He called the employer and advised that the work he had been assigned was too strenuous. He was advised that he was to be placed in the office, manning telephones, but claimant stated that he wanted to remain home and relax. He further indicated that he would contact

his doctor and have the physician contact the employer. The employer never received word from a physician. The employer hand delivered a letter to claimant on August 21, 1986, advising him to report for work the following workday or risk termination. Claimant did not report for work.

Claimant was terminated from his employment on August 28, 1986 for failing to report for work, insubordination and misrepresenting his work release. Claimant's temporary disability payments were terminated as of August 27, 1986.

Claimant began receiving chiropractic adjustments from Dr. Strom in October 1986. The adjustments helped to relieve claimant's minor neck pain, but did not alleviate his more problematic left-side complaints. On July 16, 1987, the employer denied that claimant's continuing condition was related to his compensable injury. It also denied responsibility for further chiropractic treatment. On September 14, 1987, the insurer rescinded its previous denial to the extent that it denied that claimant's symptoms were related to his injury. The employer continued to deny further chiropractic treatment, however.

In mid-1987, claimant underwent a battery of tests to determine the etiology of various upper gastric complaints. A gall bladder screening and other tests were performed, during which a sliding hiatal hernia was discovered. The hernia is unrelated to claimant's industrial injury. Claimant also suffers from minimal to mild obstructive pulmonary disease, which is also unrelated to industrial exposure.

Claimant was not a credible witness.

Claimant violated established company policies when he refused to report for light-duty employment on August 21, 1986. He is not entitled to temporary disability compensation for the period of August 28, 1986 through March 26, 1987.

Claimant's ongoing chiropractic treatment is neither the reasonable nor necessary result of his compensable injury.

Claimant's diagnostic treatments are reasonable and necessary.

CONCLUSIONS OF LAW

1. Entitlement to additional temporary disability

Claimant asserts entitlement to temporary disability compensation for the period of August 27, 1986 through March 26, 1987. It is his burden to prove entitlement to the compensation he seeks. The employer argues that it was justified in terminating claimant's compensation when he violated various company policies by refusing to report for work.

OAR 436-60-030(3) provides that an insurer shall cease paying temporary total disability compensation and commence paying such temporary partial disability compensation as is due from the date the injured worker accepts and commences any wage earning employment prior to claim determination. Temporary partial disability compensation is to be continuous thereafter until the duration of the offered job has expired or that the offer of such employment is withdrawn. An employer discharging the worker

because of a violation of normal employment standards shall not be considered a withdrawal of offered employment.

In Donald W. Courtier, 39 Van Natta 705 (1987), the claimant sustained a compensable injury and thereafter was released to return to modified employment. He did so and was paid his regular wage for modified work. He was ultimately terminated for violating a company employment standard. He sought additional temporary disability compensation after his termination. The Referee denied claimant's request and the Board affirmed, holding that where the claimant had returned to modified work, his entitlement to temporary total disability ceased and the insurer was obligated to pay temporary partial disability only. Because claimant had returned to work at his regular wage, the rate of temporary partial disability was zero. Following claimant's justifiable termination, he was entitled to temporary partial disability only. The insurer paid none because none was due. Id. at 708. See also Safeway Stores v. Owsley, 91 Or App 478 (1988).

The present case is similar to Courtier. Claimant returned to modified light work at his regular wage. He ceased to be entitled to temporary total disability as of the date he returned to work. He became entitled to temporary partial disability compensation, but the rate was zero because of his receipt of regular wages. We find that he was insubordinate to his supervisor, Ms. Hill, upon returning to work, and that he misrepresented his work release. These were violations of normal employment standards, see Courtier, supra. Therefore, subsequent to his termination, claimant was entitled to temporary partial disability compensation only. There was none due, and the insurer was justified in not paying further disability compensation. Claimant is not entitled to additional compensation.

2. Penalties and attorney fees for the insurer's alleged unreasonable termination of temporary of temporary disability compensation

Our finding with regard to the propriety of the insurer's termination of temporary disability compensation moots the issue of penalties and attorney fees.

3. Compensability of diagnostic services

Claimant asserts that the diagnostic procedures performed on him in mid-1987 are compensable. It is his burden to so prove.

Diagnostic services are compensable to the extent that they are reasonable and necessary to determine whether there is a causal relationship between a worker's injury and his condition. Clifford Howerton, 38 Van Natta 1425 (1986); Tonya Reidhead, 37 Van Natta 1078 (1985). At the time of claimant's diagnostic tests, his treating physician was attempting to determine the cause of his ongoing left side complaints. He questioned whether claimant's soft tissue injury remained the cause and recommended diagnostic procedures as an aid in determining causation. Under these conditions, we find that claimant's diagnostic procedures were reasonable and necessary to determine whether the compensable injury remained the cause of his complaints. Howerton and Reidhead, supra.

Johnsen v. Hamilton Electric, Inc., 90 Or App 161 (1988), cited by the insurer as authority for finding claimant's diagnostic procedures noncompensable, does not control. In Johnson, the issue was whether the claimant had a compensable condition from the outset. By contrast, the present case involves an accepted compensable condition and the issue is whether the diagnostic tests performed on claimant are the necessary result of that accepted injury.

4. The compensability of chiropractic treatment

Claimant asserts entitlement to continuing chiropractic treatment. It is his burden to prove that such treatment continues to be both reasonable and necessary as a result of his injury. McGarry v. SAIF, 24 Or App 883 (1976). After reviewing this record, we find that it is not.

The Referee questioned the credibility of both claimant and Dr. Trapp, the most recent treating chiropractor. We, therefore, place less weight on the opinion of Dr. Trapp, which was dependent, at least in part, on claimant's history.

As early as October 1986, Dr. Wilson stated his preference that claimant receive physical therapy over continuing chiropractic care. The Western Medical Consultants opined that ongoing manipulative treatment was unnecessary. Dr. Burke, an independent examining chiropractor, stated that continuing chiropractic treatment should be discontinued as having been ineffectual. Claimant himself reported that he had received relief for minor neck pain, but that chiropractic treatment had failed to lessen his primary left side complaints. In October 1987, Dr. Trapp reported that claimant's primary complaints were probably related to his noncompensable hiatal hernia.

From the aforementioned evidence, we conclude that ongoing chiropractic treatment is not the reasonable and necessary result of claimant's 1986 compensable injury. The preponderance of medical evidence does not support claimant's claim, and his statements to the contrary are of questionable value because of the uncertainty surrounding his credibility.

5. Attorney fees regarding the July 16, 1987 denial

Claimant asserts entitlement to an attorney fee in connection with the insurer's rescission of a portion of its July 16, 1987 denial. The original denial denied that claimant's symptoms were related to his compensable injury. It also denied further chiropractic treatment. Claimant requested a hearing from the denial. On September 14, 1987, the insurer rescinded the portion of the original denial that denied responsibility for claimant's symptoms. The insurer continued to deny chiropractic treatment.

We are unable to determine from this record whether the insurer rescinded a portion of its July 16, 1987 denial as a result of claimant's request for hearing, or whether the rescission was the result of the insurer's own initiative. We find, therefore, that claimant has failed to prove entitlement to a separate attorney fee. In any event, it appears that the Referee included claimant's request for a separate fee in his award of a \$1,400 attorney fee for services at hearing.

ORDER

The Referee's order dated February 2, 1988 is reversed in part and affirmed in part. Those portions of the order that awarded temporary disability compensation for the period of August 27, 1986 through March 26, 1987 and set aside the insurer's denial of further chiropractic treatment are reversed. The insurer's denial is reinstated and upheld. The remainder of the Referee's order is affirmed. Claimant's requests for penalties and attorney fees and for a separate attorney fee in connection with the insurer's July 16, 1987 denial are denied. For services on Board review, claimant's attorney is awarded a reasonable attorney fee of \$400, to be paid by the insurer. A client-paid fee not to exceed \$1,570 is approved.

CURTIS P. SMITH, Claimant
Francesconi & Cash, Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 85-11983
December 22, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Neal's order which: (1) found that the claim was not prematurely closed; (2) affirmed a Determination Order that did not award permanent disability for a low back and right leg injury; (3) upheld a partial denial of chiropractic treatments in excess of the administrative guidelines; (4) reduced a Determination Order's award of temporary disability; and (5) declined to award a penalty and associated attorney's fee for the allegedly unreasonable unilateral termination of time loss benefits. We affirm.

ISSUES

The first issue is whether claimant is entitled to an award for permanent partial disability.

The second issue is whether chiropractic treatment in excess of the administrative guidelines is reasonable and necessary.

The third issue is whether claimant is entitled to any time loss benefits from June 27, 1985 through March 18, 1986.

Finally, claimant urges that the Board repudiate the Referee's holding that claimant was fired for good cause.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following supplementation: Following a compensable injury, claimant returned to modified work with a rate of pay equal to his pay at the time of injury. Consequently, the self-insured had properly reduced claimant's rate of temporary partial disability to zero. The employer fired claimant for reasons unrelated to his compensable injury on June 27, 1985. We also find that claimant was not released to regular work. The employer did not reinstate claimant to any temporary disability benefits.

CONCLUSIONS

The Board adopts all portions of the Referee's opinion

except those relating to the issues of whether claimant was entitled to temporary disability benefits after June 27, 1985, penalties and fees for unilateral termination of benefits and whether claimant was fired for good cause.

The question of whether claimant was fired for good cause is irrelevant under Safeway Stores v. Owsley, 91 Or App 478 (1988). Owsley holds that once a claimant has demonstrated by a return to modified work at a wage equal to his wage at injury that he is no longer losing wages due to the compensable injury, and is then fired for reasons unrelated to the compensable injury, he is not entitled to have temporary disability benefits reinstated. Accordingly, claimant was not entitled to additional temporary disability benefits after his firing.

Because claimant was no longer entitled to temporary disability benefits after his firing and because the employer had properly reduced temporary partial benefits to zero prior to the firing, it was not unreasonable in refusing to reinstate claimant to temporary disability benefits. Accordingly, no penalty is due.

ORDER

The Referee's order of December 31, 1986 is affirmed. A client-paid fee, not to exceed \$120, is approved.

BRENDA M. BROOKS, Claimant
DONALD L. & LEAH L. KIMBERLING, dba,
THE COACH HOUSE RESTAURANT, dba,
THE COLONIAL TIMBER INN, Employer
Ackerman, et al., Claimant's Attorneys
E. Jay Perry, Attorney
SAIF Corp, Insurance Carrier
Carl M. Davis, Assistant Attorney General

WCB 86-15811, 87-02076, 86-09009
& 86-12401
November 30, 1988
Order of Abatement

The SAIF Corporation has requested reconsideration of the Board's Order on Review dated October 31, 1988. In order to allow sufficient time for the employer to respond and for the Board to consider the request, our Order on Review is abated and withdrawn, effective this date. The employer is allowed 14 days from the date of this order in which to file a response. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED

BRENDA HINKLE, Claimant
Patrick K. Mackin, Claimant's Attorney
Chelsea Mohnike (SAIF), Defense Attorney

WCB 86-08581, 87-01428 & 87-01429
October 21, 1988
Order of Abatement

On our own motion, we hereby abate and withdraw our Order on Review dated October 19, 1988. We take this action to further consider our analysis concerning the aggravation issue, particularly our application of Gwynn v. SAIF, 304 Or 345, 352-53 (1987). Following our further consideration, an order on reconsideration will soon be forthcoming.

THERESA L. HOWARD, Claimant
Malagon & Moore, Claimant's Attorneys
Nelson, et al., Defense Attorneys
Fenner, et al., Attorneys
H. Tom Andersen (SAIF), Defense Attorney

WCB 87-06763, 86-15767 & 86-15861
November 29, 1988
Order of Abatement

The Board has received claimant's motion for reconsideration of our Order on Review dated November 3, 1988.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. The SAIF Corporation and Liberty Northwest Insurance Corporation are requested to file a response to the motion within ten days from the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

WOODIE R. STRIPLIN, Claimant
Vick & Gutzler, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-12406
October 20, 1988
Order of Abatement

The Board has received the insurer's motion for reconsideration of our Order on Review dated September 30, 1988.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. Claimant is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

JACKLYN WILSON, Claimant
Malagon & Moore, Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 88-00086
December 15, 1988
Order on Abatement

Claimant has requested reconsideration of that portion of our November 15, 1988 Order on Review that awarded a \$750 insurer-paid attorney fee for her counsel's services at hearing and on Board review, in prevailing against the SAIF Corporation's denial of payment for an MMPI.

In order to fully consider claimant's request, our prior order is abated and withdrawn. SAIF is granted an opportunity to respond to the request. The response should be submitted within 10 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Everett S. Standley, Claimant.

PACIFIC MOTOR TRUCKING COMPANY,
Petitioner,

v.

STANDLEY,
Respondent.

(WCB 85-13382, 86-02530; CA A45029)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 29, 1988.

Thomas W. Sondag, Portland, argued the cause for petitioner. With him on the brief was Spears, Lubersky, Campbell, Bledsoe, Anderson & Young, Portland.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Malagon & Moore, Eugene, and Karen M. Werner, Eugene.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

VAN HOOMISSEN, J.

Affirmed.

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Pacific Motor Trucking v. Standley

VAN HOOMISSEN, J.

Employer seeks review of a Workers' Compensation Board order which affirmed the referee's order increasing claimant's award of unscheduled permanent partial disability from 40 percent to 65 percent and awarding attorney fees. We affirm.

Claimant was compensably injured in April, 1980. He suffered shoulder and neck injuries, fractured two fingers on his left hand and received a concussion. He was released to return to work in May, 1980. He received temporary total disability (TTD) for the time he missed, and 10 percent permanent partial disability (PPD) for loss of the use of his left hand. He continued to work for employer until May, 1983, when he retired.

On December 7, 1983, claimant returned to his treating physician, complaining of increasing problems with neck pain radiating into the right arm and constant headaches. Employer reopened the claim and agreed to pay for medical services but refused to pay time loss, because claimant had retired. Claimant requested vocational assistance. The Director determined that he was ineligible, because he had retired. Claimant requested a hearing on that decision and on employer's denial of TTD. The referee concluded that claimant had retired and upheld the denial of vocational assistance and TTD. We affirmed. *Standley v. Pacific Motor Trucking*, 80 Or App 791, 722 P2d 1294, rev den 302 Or 194 (1986).

In November, 1985, while claimant's TTD claim was pending, he was found to be medically stationary, and a determination order was issued awarding him 40 percent PPD. He requested a hearing, seeking additional PPD. Employer argued that claimant was not entitled to any PPD, because he had retired before the aggravation claim giving rise to the November, 1985, determination order. The referee concluded that claimant was disabled more than 40 percent and granted an additional 25 percent PPD. The Board affirmed.

Employer does not challenge the extent of claimant's disability. However, it contends that claimant is not entitled to PPD benefits, because he is not a "worker" within the meaning of the Workers' Compensation statutes, relying on *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 702 P2d 403 (1985).

Cite as 93 Or App 204 (1988)

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Employer's reliance on *Cutright* is misplaced. That case held that retired persons are not entitled to TTD payments, because TTD payments are based on lost wages, ORS 656.210, and retired persons have no wages. PPD payments, on the other hand, compensate for loss, or loss of use, of body parts or loss of earning capacity. ORS 656.214. A person who suffers an increase in permanent disability due to aggravation of a compensable injury is entitled to increased compensation if the injury is a material cause of the increased disability, whether or not the aggravation occurs on the job. ORS 656.273; see *Grable v. Weyerhaeuser Company*, 291 Or 387, 631 P2d 768 (1981); *Crumley v. Combustion Engineering*, 92 Or App 439, ___ P2d ___ (1988). We conclude that the same rule applies to persons who are retired at the time of the aggravation.¹

Affirmed.

¹ Implicit in our opinion is our conclusion that a person is a "worker" for purposes of increased disability benefits for aggravation if he or she was a "worker" at the time of the original compensable injury, whether or not he or she is retired at the time of the aggravation. See ORS 656.005(27); ORS 656.003.

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October 5, 1988

No. 550

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Richard G. Kasper, Claimant.

KASPER,
Petitioner,

v.

STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Respondents.

(WCB 84-08210; CA A44502)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 19, 1988.

Edward J. Harri, Salem, argued the cause for petitioner. On the brief were J. David Kryger and Emmons, Kyle, Kropp, Kryger & Alexander, P.C., Albany.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayr, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order upholding the validity of a disputed settlement agreement and denying his aggravation claim. We conclude that the agreement is valid under ORS 656.236 and that the Board did not err in denying claimant's aggravation claim.

Claimant has a long history of back ailments; however, we recite only those conditions pertinent to the issues on review. In 1974, he was involved in a work related car accident which resulted in acute lumbar and cervical strains. Spinal x-rays taken in conjunction with treatment showed degenerative osteoarthritis and spondylosis. In October, 1976, he was awarded 15 percent permanent partial disability for back strain.

In 1977, claimant began work as a truck driver for North Santiam Paving Co., which was insured by SAIF. He filed an aggravation claim on December 3, 1980, complaining that his back condition had worsened from driving over rough roads. SAIF denied that claim, as well as a second claim filed by his treating physician in March, 1981. Both denials were consolidated for hearing, and the referee concluded that claimant's back complaints were caused by work conditions and that he had an occupational disease. The resulting 1982 order was not appealed.

Claimant's back pains increased, prompting him to file two aggravation claims, which were denied. The parties executed a disputed claim settlement on March 16, 1984:

"The parties DO HEREBY STIPULATE AND AGREE that their [*sic*] exists between them a bona fide dispute as to the compensability of the osteoarthritis and they do hereby desire to settle their differences and do hereby agree that SAIF will pay unto the claimant the sum of \$7,720 in full and final settlement of claimant's request for hearing concerning the partial denial of October 12, 1983, * * * and that SAIF will have no further responsibility for any medical treatment or compensation resulting from osteoarthritis to the claimant's back; and

"IT IS FURTHER HEREBY STIPULATED AND AGREED that the claimant shall hold SAIF harmless for any responsibility for any past medical treatment for claimant's

osteoarthritis and further agreed that claimant will be responsible for the cost of said medical treatment for the osteoarthritic condition, both in the past and in the future."

In April, 1984, claimant filed another aggravation

claim. SAIF rejected it, because it concluded that the 1984 agreement settled all claims arising from claimant's osteoarthritic condition.¹ Claimant did not contest the validity of the agreement, but contended that the condition for which he received compensation in 1982 had worsened. The referee, on his own, raised the issue of the validity of the agreement and then ruled that the agreement was invalid under ORS 656.236 and that the condition had worsened. On appeal, the Board reversed the referee on two bases: first, the agreement was a valid disputed claim settlement which precluded claims based on the osteoarthritic condition; and, second, claimant had failed to prove any worsening of a compensable injury.

Claimant first contends that the Board's reinstatement of the 1984 agreement and SAIF's reliance on it to deny his claim was error. ORS 656.236(1) provides:

"No release by a worker or beneficiary of any rights under ORS 656.001 to 656.794 is valid."

That provision is intended to protect injured workers and the public at large. *Schulz v. Compensation Department*, 252 Or 211, 216-17, 448 P2d 551 (1968). However, ORS 656.289(4) allows settlement of claims:

"Notwithstanding ORS 656.236, in any case *where there is a bona fide dispute over compensability of a claim*, the parties may, with the approval of a referee, the board or the court, by agreement make such disposition of the claim as is considered reasonable." (Emphasis supplied.)

See Greenwade v. SAIF, 41 Or App 697, 701, 598 P2d 1265, *reversed* 288 Or 173 (1979).

Claimant suggests that there was no *bona fide* dispute as to the compensability of his osteoarthritis, because that

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condition was determined to be compensable in the 1982 order which was not appealed. Consequently, he contends that the settlement was invalid. SAIF argues that the 1982 order and 1984 agreement cover different issues regarding petitioner's osteoarthritic condition. The order, it argues, concerns only job related acceleration of the arthritic condition, while the agreement covers preexisting osteoarthritis and any natural progression. After reviewing the 1982 order and agreement, we conclude that, under the circumstances in 1984, a *bona fide* dispute as to SAIF's responsibility for claimant's osteoarthritic condition existed.

The legislature has specifically authorized certain types of settlements under ORS 656.289(4). Settlements are to be encouraged within the limits of the statute and should be set aside only if they clearly violate the statute. As required by ORS 656.289, the referee authorized the settlement agreement here after determining that a *bona fide* dispute existed and that the settlement was reasonable. The 1982 referee's order concluded:

¹ Doctors differed as to the cause of claimant's April, 1984, back problems. One attributed the condition to a "biomechanical imbalance" rather than degenerative changes. On the other hand, SAIF's examining physician concluded that the natural progression of the osteoarthritis caused the current disability. That conclusion led to SAIF's denial.

"Degenerative arthritic changes appear in the medical records as far back as September 1975. Nor do I understand the reasons for Dr. Degge's conclusion that the osteoarthritis is not related to the claimant's work.

"I am persuaded * * * that the degeneration in the claimant's back * * * was accelerated by the claimant's work for Santiam in 1980 and March 1981."

It is not quite clear what the referee found to be compensable. He noted that there was little doubt that claimant's multiple back injuries had caused or accelerated the spondylosis, osteoarthritis and degenerative disc disease. He did not find that the symptoms of the accelerated osteoarthritis was a permanent condition. No party appealed the order, and it became final. ORS 656.289(3). The order determined the relationship between claimant's preexisting arthritis and his employment in 1980 and 1981. It did not, however, determine SAIF's responsibility for the natural progression of the preexisting osteoarthritis. That was the issue disputed in 1984.

Cite as 93 Or App 246 (1988)

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Because that was a *bona fide* dispute, the settlement was valid under ORS 656.289(4).²

Claimant next contends that the Board erred in denying his aggravation claim. The 1984 settlement only forecloses aggravation claims arising from osteoarthritis. The petition for review was filed before July 20, 1987; therefore, we review *de novo*. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 202, 752 P2d 312 (1988).

Claimant asserts a worsening of his condition under ORS 656.273(1).³ He, therefore, must demonstrate that there has been worsening and that it makes him less able to work, either temporarily or permanently. *DeMarco v. Johnson Acoustical*, 88 Or App 439, 441, 745 P2d 815 (1987). We agree with the Board that the medical evidence does not show an aggravation.

Affirmed.

² Claimant has been represented by the same law firm in 1982, 1984 and now. According to the attorney who represented him in 1984, he intended to settle all disputes concerning osteoarthritis, when he drafted the settlement agreement. Claimant did not raise the validity of the settlement initially and only argued that there was no *bona fide* dispute after the referee raised the issue and SAIF appealed.

³ ORS 656.273(1) states:

"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."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Norma J. Bolton, Claimant.

BOLTON,
Petitioner,

v.

OREGONIAN PUBLISHING CO. et al,
Respondents.

(WCB 86-03073; CA A45216)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 14, 1988.

Peter W. McSwain, Portland, argued the cause for petitioner. With him on the brief was Francesconi & Associates, P.C., Portland.

Allan M. Muir, Portland, argued the cause for respondents. With him on the brief were Charles A. Shea, III and Schwabe, Williamson & Wyatt, Portland.

Before Buttler, Presiding Judge and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed.

Cite as 93 Or App 289 (1988)

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ROSSMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's determination of the rate of temporary partial disability compensation. The only question is the method to be used in calculating benefits for time loss when the claimant is injured while holding employment for two different employers and is unable to return to the work where the injury occurred, but is able to return to the other job.

ORS 656.212 is the general provision concerning the calculation of temporary partial disability benefits:

"When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power bears to the earning power existing at the time of the occurrence of the injury."

OAR 436-60-030 describes in greater detail the calculation of benefits for temporary partial disability. It provides, in part:

"(1) The rate of temporary partial disability due a worker shall be determined by:

"(a) Subtracting the post injury wage earnings available from any kind of work; from

"(b) The wage earnings from the employment at the time of, and giving rise to, the injury; then

“(c) Dividing the difference by the wage earnings in sub-section (b) to arrive at the percentage of loss of earning power; then

“(d) Multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.”

OAR 436-60-020 deals generally with the calculation of benefits for temporary total disability. It also describes the calculation of compensation in special employment situations. OAR 436-60-020(7)(f) deals with the rate of compensation for a worker who has two jobs. It provides:

“(7) The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section * * *.

“* * * * *

“(f) Employed two jobs, two employers: Use only wage of job on which injury occurred if worker unable to work either job. If able to return to job where injury occurred, no benefit is due. *If able to return to the job other than the one where injury occurred, temporary partial disability is due based on the combined earning power of both jobs.*” (Emphasis supplied.)

Employer contends that the Board's method of calculating claimant's benefits properly considers claimant's *total* pre-injury wages only in determining the percentage loss of earning power.¹ Employer asserts that claimant's method, which would require that claimant's wage rate be based on her total pre-injury wages, cannot be what was intended, because it would result in one who has returned only to the non-injury job recovering the same benefits as or greater benefits than one who has not returned to either job.² Additionally, by claimant's calculation, had she been partially disabled from her bus driving job as well as totally disabled from her paper route job, employer would have had to pay greater disability benefits than would have been due had claimant been totally disabled from both jobs.

We agree with employer that that is not a result which the Workers' Compensation Division could have intended or which is permissible under the statutes. At the pertinent time, ORS 656.005(26) provided, in part:

¹ Claimant's weekly wage at the time of the injury from the "at injury" paper route job was \$77.97. Her weekly wage from her bus driving job was \$288.46. Her total weekly wages were \$366.43. Claimant has returned to bus driving. She is unable to return to her paper route. The parties agree that claimant's loss of earning power equals 21.28%. The Board then multiplied claimant's pre-injury wages from her paper route job only (\$77.97) by 66.66% (ORS 656.210), for a current temporary total disability compensation rate of \$51.98. It multiplied that figure by claimant's percentage loss of earning power (21.28%), to reach a figure of \$11.06 per week temporary partial disability compensation due.

Claimant contends that OAR 436-60-020(7)(f) requires that the temporary total disability compensation rate be calculated by multiplying by 66.66% her wages from both jobs at the time of the injury (\$366.43), not just the job at which she was injured. In that case, claimant's temporary total disability compensation rate would be \$244.26, which, in turn, would be multiplied by the percentage loss of earning power (21.28%), for temporary partial disability benefits of \$51.98 per week.

² Assuming that claimant had not returned to either job, OAR 436-60-020(7)(f) provides that only the wage of the job on which the injury occurred is to be considered in determining the rate of compensation. In that case, claimant's rate of compensation would be her pre-injury wage at that job (\$77.97) multiplied by 66.66%, or \$51.98.

“‘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* * * *.” (Emphasis supplied.)

Employers do not have to bear more than the “cost” of the injuries sustained in their service. *Reed v. SAIF*, 63 Or App 1, 662 P2d 776 (1983). They cannot be required to pay greater benefits for temporary disability than the maximum benefits that would be due on the basis of wages that the claimant was receiving in their employ. The fact that a claimant had other employment cannot enhance an employer’s liability.

The emphasized portion of OAR 436-60-020(7)(f) states that, when the employe returns to the non-injury job only, benefits are due based on the combined *earning power* of both jobs. It does not direct that the *wage rate* be based on the wages of both jobs. We conclude that the emphasized portion of OAR 436-60-020(7)(f) merely requires that, in the case of dual employment, wages of both jobs, including the job not giving rise to the injury, be considered for the purpose of calculating a claimant’s percentage loss of earning power. The Board correctly held, however, that the temporary total disability rate must be based only on the wages of the job where the injury occurred.

Affirmed.

No. 560

October 5, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

METCO MANUFACTURING, INC.,
Petitioner,

v.

BUREAU OF LABOR AND INDUSTRIES,
Respondent.

(50-86; CA A47312)

Judicial review from the Bureau of Labor and Industries.

Argued and submitted July 1, 1988.

Lee A. Hansen, Portland, argued the cause for petitioner. With him on the brief was Brown & Hansen, Portland.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Graber, Judge, and Riggs, Judge pro tempore.

RIGGS, J. pro tempore.

Affirmed.

RIGGS, J. pro tempore.

Petitioner seeks review of an order of the Bureau of Labor and Industries (Bureau), which ordered petitioner to pay a former employe approximately \$8,500 in lost wages and \$2,500 as mental stress damages. We affirm.

The employe filed an unlawful employment practice complaint with Bureau alleging that petitioner fired him because of his use of the workers' compensation system. Bureau attempted, without success, to conciliate the dispute. On June 29, 1987, Bureau sent petitioner a "Notice of Hearing and Specific Charges." Appended to that notice was a copy of pertinent agency rules, one of which expressly required petitioner to respond to the charges within 20 days, or face default. OAR 839-30-060; OAR 839-30-185(1)(a). Petitioner failed to respond within 20 days. On July 24, 1987, petitioner, through its president, filed a request for relief from default and a document titled "Pleading Response," which responded to the charges filed by Bureau. The hearings referee denied the request. On August 7, 1987, petitioner, through its attorney, moved for reconsideration of the denial. The referee denied the motion.

At the hearing, Bureau presented evidence through exhibits and witnesses. The referee denied petitioner the right to cross-examine, explaining that that right had been defaulted. Petitioner's attorney and its president left the hearing. The referee filed a proposed order, petitioner filed exceptions to that order, and the Commissioner then entered a final order.

Petitioner's first assignment of error raises two issues. The first is whether the referee had authority to rule on petitioner's request for relief from default. Petitioner argues that only the Commissioner may rule on such a motion. OAR 839-30-190¹ provides:

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Metco Mfg. v. Bureau of Labor and Industries

"(1) The Commissioner may, in the Commissioner's discretion and upon such terms as may be just, at any time within ten (10) days after Charging Document becomes final by reason of default, or a Final Order has been issued, or a Notice of Default has been issued to a Charged Party, relieve a party from a default taken against that party where the party establishes that the default was the result of an excusable mistake or circumstances beyond the control of the party.

"(2) The request for relief shall be in writing directed to the Commissioner and shall be accompanied by a written statement or statements, together with appropriate documentation, setting forth the facts supporting the alleged excusable mistake or the circumstances beyond the control of the party."

Petitioner directed his request for relief from the

¹ Petitioner also relies on OAR 839-30-025(11), which provides:

"'Good Cause' means, unless otherwise specifically stated, that a party failed to perform a required act due to an excusable mistake or circumstances over which the party had no control. Good Cause does not include a lack of knowledge of the law including these rules. The hearings referee will, except in the case of a request for relief from a default, determine what constitutes good cause."

The definition parallels the grounds for relief from default in OAR 839-30-190. However, the latter rule does not use the term "good cause," and 839-30-025(11) does not address who may rule on motions for relief from default. Accordingly, OAR 839-30-025(11) does not prohibit the hearings officer from making a recommendation to the Commissioner on a request for relief from default.

default to Bureau, not directly to the Commissioner. We need not decide whether the referee properly ruled on petitioner's request for relief from default. The final order "ratified" the referee's denial of the motion. Because the Commissioner ratified the referee's denial, petitioner suffered no prejudice from the referee's preliminary ruling recommending² that relief be denied. Thus, petitioner received exactly what it argues it was entitled to: a ruling on its request by the Commissioner.

The second issue raised by petitioner's first assignment of error is whether the referee erred in failing to allow petitioner to cross-examine Bureau's witnesses at the hearing. OAR 839-30-060 provides, in part:

"(1) A party filing a written request for a hearing, or a party served with Specific Charges, must file, within twenty (20) days of the date of issuance of the Charging Documents, a written response, referred to as an 'Answer' to the allegations in the Charging Document. This Answer must include an admission or denial of each factual matter alleged in the Charging Document and a statement of each relevant defense to the allegations.

"(2) Except for good cause shown to the Hearings Referee, factual matters alleged in the Charging Document, and not denied in the Answer, shall be deemed admitted by the

Cite as 93 Or App 317 (1988)

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party. The failure of the party to raise an affirmative defense in the Answer shall be deemed a waiver of such defense. Any new facts or defenses alleged in the Answer shall be deemed denied by the Agency, and except for good cause shown to the Hearings Referee, evidence shall not be taken at the contested case hearing on any factual or legal issue not raised in the Charging Document or the Answer."³

Failure to respond timely to a charging instrument results in the admission of any factual matters alleged and the waiver of any affirmative defenses.⁴ By failing to respond, petitioner lost its right to address by any means, including cross-examination, issues raised in that instrument.

Petitioner's third assignment of error⁵ claims that the Commissioner erred in not deducting claimant's unemployment compensation from his award for lost wages. Petitioner raised that affirmative defense for the first time in its exceptions to the proposed order. Petitioner also waived its right to raise that issue when it defaulted:

"The failure of [a] party to raise an affirmative defense in the answer shall be deemed a waiver of such defense." OAR 839-30-060(2.)

Affirmed.

² Except for procedural matters, all of the hearings referee's rulings are recommendations to the Commissioner, OAR 839-30-100(1)(i), who has the final word. See OAR 839-30-180.

³ Petitioner has not challenged the validity of the rule.

⁴ OAR 839-30-185(1) states that a default occurs:

"(a) Where a party has been served with a Charging Document and fails to file a required response, including an Answer, within the stated time limitation * * *."

Petitioner defaulted when it failed to answer timely.

⁵ Petitioner's second assignment lacks merit and requires no discussion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Roland L. Dawkins, Claimant.

DAWKINS,
Petitioner,

v.

PACIFIC MOTOR TRUCKING,
Respondent.

(WCB 85-11265; CA A43907)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 15, 1988.

On petitioner's petition for reconsideration filed July 27, 1988. Former opinion filed June 22, 1988, 91 Or App 562, 756 P2d 60.

Randy M. Elmer and Vick & Gutzler, Salem, for petition.

Thomas W. Sondag, and Spears, Lubersky, Bledsoe, Anderson, Young & Hilliard, Portland, for response.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reconsideration allowed; former opinion adhered to.

Cite as 93 Or App 349 (1988)

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BUTTLER, P. J.

Claimant petitions for review of our decision affirming the Workers' Compensation Board's determination that he was not entitled to benefits for temporary total disability because he had withdrawn from the work force. 91 Or App 562, 756 P2d 60 (1988). We treat the petition as one for reconsideration, ORAP 10.10, and allow it for the purpose of addressing claimant's argument that the decision is inconsistent with *Chapel of Memories v. Davis*, 91 Or App 232, 754 P2d 913, *rev den* 306 Or 413 (1988).

The distinction between the two cases is factual. Here, claimant testified that he would like to work but that, on the advice of his doctor, he had withdrawn from the work force and would not be seeking employment in the future. Our opinion notes, mistakenly, that claimant had not sought retirement benefits. In fact, the record shows that he was receiving a union disability *pension*. The facts in *Chapel of Memories* were similar. The distinguishing point, however, is that, although the claimant in that case had not looked for work after the injury, he testified that he had not retired and that he would be willing to take a suitable job. *See Sykes v. Weyerhaeuser Co.*, 90 Or App 41, 750 P2d 1171 (1988). As the dissent in *Chapel of Memories* noted, a person may have withdrawn from the work force in fact even though he does not consider himself retired. The majority in that case found, however, that the claimant's uncontroverted testimony that

he had not retired and that he was willing to seek work was sufficient to show that he had not withdrawn from the work force. Here, in contrast, we found that claimant had withdrawn completely from the work force. That distinction explains the different results in the two cases.

Reconsideration allowed; former opinion adhered to.

No. 569

October 12, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

BROWN,
Appellant,

v.

INSURANCE COMPANY OF NORTH AMERICA,
Respondent.

(A8610-06409; CA A45088)

In Banc

Appeal from Circuit Court, Multnomah County.

Charles S. Crookham, Judge.

Argued and submitted May 2, 1988.

Margaret E. Rabin, Assistant Attorney General, Salem, argued the cause for appellant. With her on the briefs were Dave Frohnmyer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Mildred J. Carmack, Portland, argued the cause for respondent. With her on the brief was Schwabe, Williamson & Wyatt, Portland.

WARDEN, J.

Reversed and remanded for further proceedings not inconsistent with this opinion.

Cite as 93 Or App 355 (1988)

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WARDEN, J.

In this action, the Director of the Workers' Compensation Department (Director) seeks reimbursement of workers' compensation benefits paid on the compensable claim of a worker employed by an employer who was noncomplying because defendant, his insurer, denied coverage. *See* ORS 656.054(3). The trial court granted defendant's motion for judgment on the pleadings, and the Director appeals. We reverse.

We take the facts from plaintiff's complaint, because defendant admitted most of them in its answer and because, on a motion for judgment on the pleadings, we assume that the allegations in the pleadings of the party moved against are true. *See Straub v. Oregon Electric Ry. Co.*, 163 Or 93, 96, 94 P2d 681 (1939). On August 13, 1979, Michael Weber suffered a compensable injury while employed by Dwayne Vandagriff, dba Astrocopters, Ltd. Weber filed a claim for workers' compensation benefits, and defendant, Vandagriff's insurer,

denied coverage for the claim. Vandagriff was declared not to have complied with ORS 656.017.¹ The State Accident Insurance Fund Corporation (SAIF) paid over \$17,000 on the claim, and the Director assessed a civil penalty of \$2,000 against Vandagriff for his failure to comply with the workers' compensation laws.

On October 25, 1982, Astrocopters, Ltd., filed a petition under chapter 11 of the Bankruptcy Code. Vandagriff filed an individual chapter 11 petition on February 14, 1983. In April, 1983, the Director filed proofs of claim in both bankruptcy cases, seeking recovery of both the money that SAIF had paid on the workers' compensation claim and the civil penalty. Thereafter, Vandagriff filed an action against defendant for wrongful failure to provide workers' compensation

insurance. The complaint recited that the Department of Revenue had made a claim in the bankruptcy proceeding. Vandagriff obtained a judgment against defendant on October 22, 1984. Defendant paid the judgment to Vandagriff and refused to reimburse the state for the money that it had expended.

After defendant's payment of the judgment, the Director commenced this action, contending that defendant remained liable under ORS 656.054(3),² because that statute, by operation of law, makes the Director the employer's "assignee" or "subrogee" and defendant had notice of the state's rights. The issue on appeal is whether the complaint states a claim.

A right to subrogation exists in "every instance in which one party is required to pay a debt for which another is primarily answerable * * *." *United States F. & G. Co. v. Bramwell*, 108 Or 261, 277, 217 P 332 (1923). If the person primarily responsible has notice of the subrogation and nevertheless pays the subrogor, that person continues to be liable to the subrogee and is required to pay again. See *State Farm Ins. v. Pohl*, 255 Or 46, 50, 464 P2d 321 (1970).

The complaint states, in relevant part:

"[T]he State Accident Insurance Fund Corporation has expended to date the sum of \$17,845.38 [and a civil penalty of \$2,000 has been assessed against employer]. ORS 656.054

¹ ORS 656.017(1) provides:

"Every employer subject to this chapter shall maintain assurance with the director that subject workers of the employer and their beneficiaries will receive compensation for compensable injuries as provided by this chapter and that the employer will perform all duties and pay other obligations required under this chapter, by qualifying:

"(a) As a carrier-insured employer; or

"(b) As a self-insured employer as provided by ORS 656.407."

² ORS 656.054(3) provides:

"In addition to, and not in lieu of, any civil penalties assessed pursuant to ORS 656.735, all costs to the Industrial Accident Fund of a claim processed under subsection (1) of this section shall be a liability of the noncomplying employer. Such costs include compensation, reasonable administrative costs and any attorney fees awarded to the claimant, but do not include assessments for reserves in the Insurance and Finance Fund. The director shall recover such costs from the employer. The director shall provide by regulation for the Insurance and Finance Fund to reimburse, on a periodic basis, the Industrial Accident Fund for any costs it incurs under this section. When the director prevails in any action brought pursuant to this subsection, the director is entitled to recover from the non-complying employer court costs and attorney fees incurred by the director."

directs the plaintiff to recover from the employer the total paid out to or in behalf of the worker. Employer has failed and refused to reimburse the Workers' Compensation Department or the State Accident Insurance Fund Corporation said sum except for none.

Cite as 93 Or App 355 (1988)

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"That employer obtained a judgment against Insurance Company of North America in the amount of \$22,558.78 for damages and \$4,811 for costs, disbursements and attorneys' fees [for wrongful failure to provide worker's compensation insurance]. This judgment was docketed in Coos County Circuit Court on October 22, 1984.

"That a satisfaction of judgment was filed by employer and entered on the court records.

"That pursuant to ORS 656.054 plaintiff paid all claim costs in full for which defendant is primarily responsible as previously determined in the case of *Vandagriff v. Insurance Company of North America, et al, supra*."

Exhibit G to the complaint, which is the employer's complaint against defendant, states, in part:

"On or about April 19, 1983, the Oregon Department of Revenue filed a claim in the Astrocopters, Ltd. bankruptcy proceeding in the amount of \$17,845.38 as a cost of a claim for compensable injury to Michael J. Webber [sic].

"On or about April 19, 1983, the Department of Revenue filed a claim in the amount of \$2,000 based on an assessment of civil penalties pursuant to ORS 656.735."

The complaint in this case sufficiently alleges facts that give rise to the state's subrogation rights.

The remaining question is whether defendant, when it paid the judgment, had notice that the state was subrogated to Vandagriff's rights. See *State Farm Ins. v. Pohl, supra*, 255 Or at 50. Vandagriff's complaint against defendant alleged that the state had paid the workers' compensation claim for the employer and had filed a claim for the funds expended on behalf of the employer. It follows, not only that defendant could be charged with actual notice of the state's claim, but that defendant also knew that the only basis for Vandagriff's claim against it was the state's claim against Vandagriff. Vandagriff had never paid anything on Weber's workers' compensation claim; SAIF had. There was no reasonable basis for defendant to believe that Vandagriff was ultimately entitled to the money. It satisfied the judgment with full notice.

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Brown v. Insurance Company of North America

Reversed and remanded for further proceedings not inconsistent with this opinion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James G. Heiden, Claimant.

HEIDEN,
Petitioner,

v.

DON POLLOCK INVESTMENTS et al,
Respondents.

(WCB 86-01669; CA A45336)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 21, 1988.

Emerson G. Fisher, Portland, argued the cause for petitioner. With him on the brief was Garry L. Kahn, P.C., Portland.

Mildren J. Carmack, Portland, argued the cause for respondents. With her on the brief was Schwabe, Williamson & Wyatt, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Remanded for reconsideration.

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Heiden v. Don Pollock Investments

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board that reduced the permanent partial disability awarded by the referee. The petition for review was filed after July 20, 1987, and our review is as specified in ORS 656.298. See *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

The Board's order is insufficient for effective review. It contains no explanation or reasoning about why the referee's decision was altered. The order does not satisfy the standards for review set out in *Armstrong v. Asten-Hill Co.*, *supra*.

Remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Alvin L. Dick, Claimant.

DICK,
Petitioner,

v.

SPAUR et al,
Respondents.

(WCB 85-13494; CA A45720)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 4, 1988.

Linda C. Love, Portland, argued the cause for petitioner. With her on the brief was Francesconi & Associates, P.C., Portland.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayr, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded for reconsideration.

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Dick v. Spaur

RICHARDSON, P. J.

Claimant seeks review of an order of the Workers' Compensation Board affirming, without discussion, the order of the referee, which denied an increase in the award of permanent disability. We reverse and remand.

In August, 1984, claimant simultaneously suffered a myocardial infarction and a left shoulder injury while operating a front-end loader at work. He filed claims for both conditions, which were denied by SAIF, employer's insurance carrier. Compensability of the myocardial infarction was resolved by a settlement, and the shoulder injury claim was litigated at a hearing. The referee concluded that the shoulder injury was separately compensable and reversed SAIF's denial. SAIF did not appeal. The resulting determination order awarded claimant permanent partial disability.

Claimant appealed the determination order, seeking permanent total disability or an increase in the permanent partial disability award for his shoulder. The referee affirmed the determination order. He found that claimant's left shoulder symptoms were related to the myocardial infarction and not to any traumatic incident. Consequently, he concluded that the settlement encompassed the shoulder condition as well as the heart condition.

SAIF concedes, and we agree, that the final order of the first referee determined that the shoulder injury was sepa-

rately compensable and that that determination is effectively the law of the case. The referee and the Board erred in reconsidering the compensability of the shoulder condition.

Claimant suggests that we can determine the extent of his disability. Our review is not *de novo*. ORS 183.482; *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

Reversed and remanded for reconsideration.

No. 588

October 19, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Bert E. Miltenberger, Claimant.

MILTENBERGER,
Petitioner,

v.

HOWARD'S PLUMBING et al,
Respondents.

(WCB 86-0564M; CA A43602)

Judicial review from Workers' Compensation Board.

Argued and submitted January 13, 1988.

Jay W. Beattie, Portland, argued the cause for petitioner. On the brief were Catherine Riffe and Lindsay, Hart, Neil & Weigler, Portland.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayr, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

Cite as 93 Or App 475 (1988)

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NEWMAN, J.

Claimant seeks review of the Workers' Compensation Board's own motion order on reconsideration that held that, because claimant's aggravation rights had expired, it had own motion jurisdiction. *Former* ORS 656.278.¹ We affirm.

If claimant's aggravation rights under ORS 656.273 had expired, the Board had own motion jurisdiction. *Former* ORS 656.278. Although, in that event, ORS 656.278(3) limits claimants' appeal rights to cases where "the [own motion] order diminishes or terminates a former award," claimant may seek review of the Board's determination that, because aggravation rights had expired, it had own motion jurisdiction. ORS 656.298(1).

On January 29, 1979, claimant suffered a compensable injury to his lower back. The Workers' Compensation

Department initially did not issue a Determination Order. At first, the injury was nondisabling, but in November, 1980, it became disabling. Insurer reopened the claim. On November 17, 1981, the Department issued a determination order that awarded compensation for temporary total disability from December 8, 1980, through April 13, 1981, and five percent unscheduled permanent partial disability.² The order advised claimant:

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Miltenerberger v. Howard's Plumbing

"If your condition as a result of this injury or disease gets worse, you may apply to the insurer named on this order for additional compensation. You must file your claim for additional compensation within five years from * * * November 17, 1981."

In August, 1985, claimant's condition worsened. Insurer reopened the claim and submitted it to the Evaluation Division for closure. The Division forwarded it to the Board, because the Division believed that claimant's aggravation rights had expired. In October, 1986, the Board issued an own motion determination that claimant receive TTD from August 19, 1985, through May 13, 1986. On claimant's request, the Board abated the order. Thereafter, it issued an own motion determination on reconsideration and ruled that it had jurisdiction to issue an own motion order. It stated:

"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 the injury, [insurer] correctly processed the claim as one for aggravation. [ORS 656.262(12), formerly ORS 656.262(11).] Once claimant's condition stabilized, [insurer] 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 [17], 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 [insurer] vol-

¹ Former ORS 656.278 provided:

"(1) Except as provided in subsection (5) of this section, the power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified."

"(2) An order or award made by the board during the time within which the claimant has the right to request a hearing on aggravation under ORS 656.273 is not an order or award, as the case may be, made by the board on its own motion.

"(3) The claimant has no right to appeal any order or award made by the board on its own motion, except when the order diminishes or terminates a former award. The employer may appeal from an order which increases the award.

"(4) The insurer or self-insured employer may voluntarily reopen any claim to provide benefits or grant additional medical or hospital care to the claimant.

"(5) The provisions of this section do not authorize the board, on its own motion, to modify, change or terminate former findings or orders:

"(a) That a claimant incurred no injury or incurred a noncompensable injury; or

"(b) Approving disposition of a claim under ORS 656.289(4)."

² In 1982, the Board increased the award to 15 percent.

untarily reopened his claim. Since claimant's aggravation rights had expired, we had jurisdiction to issue our own motion determination pursuant to ORS 656.278."

ORS 656.273(4)(b), on which the Board relies, states:

"If the injury was nondisabling and no determination was made, the claim for aggravation must be filed within five years after the date of injury."

If that section applies, claimant's aggravation rights had

Cite as 93 Or App 475 (1988)

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expired, and the Board had jurisdiction to issue its own motion determination. Claimant asserts, however, that under the law in effect on the date he was injured, he had five years from the date of the determination order of November 17, 1981, to file an aggravation claim. At the time of claimant's injury, *former* ORS 656.273(4) read:

"(a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the first determination made under (3) of ORS 656.268.

"(b) If no determination was made, the claim for aggravation must be filed within five years after the date of injury.

"(c) If a nondisabling injury did not become disabling within at least one year from the termination of medical services, the claim for aggravation must be filed within five years from the date of injury rather than the date of any determination issued in the claim."

Even if *former* ORS 656.273(4) applies, however, claimant's aggravation rights expired before he filed his aggravation claim. The five-year period runs from the date of the nondisabling injury and not from the date of a determination order, if the period between "the termination of medical services" and the date that the injury became disabling is not less than one year. *Former* ORS 656.273(4)(c). The statutory language "termination of medical services" means termination of medical services for the nondisabling injury.

The record, which we review *de novo*, does not show that claimant's injury became disabling less than one year after the termination of medical services for the nondisabling injury. It was claimant's burden to show that.³ At most, the record only shows that claimant received medical services for "several months" after that injury. Accordingly, even if *former* ORS 656.273(4)(c) applies, the Board did not err when it decided that it had own motion jurisdiction.

Claimant also asserts that the Board is estopped from exercising its own motion jurisdiction, because the November

17, 1981, determination order expressly stated that he had five years from that date to file an aggravation claim. The Board conceded that the information contained in the order was misleading. Claimant, however, does not argue that he was, in fact, misled and did not show that he relied on that informa-

³ At oral argument, claimant argued that we should, at a minimum, remand the case to the Board to take evidence on when medical services terminated after his January, 1979, injury. Claimant, however, had the opportunity to submit his evidence to the Board when it reconsidered its own motion determination.

tion to his detriment. See *Employment Div. v. Western Graphics Corp.*, 76 Or App 608, 612, 710 P2d 788 (1985). Claimant's condition worsened in August, 1985, over six years after the date of the nondisabling injury. He could not have filed an aggravation claim before his condition worsened. Accordingly, he could not have delayed filing an aggravation claim in reliance on the Department's misleading communication. The Board was not estopped from exercising its own motion jurisdiction.

Affirmed.

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October 26, 1988

No. 595

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
William J. Anderson, Claimant.

ANDERSON,
Petitioner,

v.

PUBLISHERS PAPER CO.,
Respondent.

(WCB No. 82-07774; CA A42755)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 5, 1988.

Robert Udziela, Portland, argued the cause for petitioner. On the brief were Diana Craine, Daniel C. Dziuba, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Jerald P. Keene, Portland, argued the cause for respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge pro tempore.

JOSEPH, C. J.

Affirmed.

Van Hoomissen, J., pro tempore, dissenting.

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Anderson v. Publishers Paper Co.

JOSEPH, C. J.

Claimant seeks review of a Workers' Compensation Board order dismissing his claim. On remand from this court, the Board ruled that he had not established good cause for failing to request a hearing within 60 days after the denial of his claim.¹ We affirm.

¹ ORS 656.319(1) provides:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial."

The background facts are in *Anderson v. Publishers Paper Co.*, 78 Or App 513, 515, 717 P2d 635, *rev den* 301 Or 666 (1986), and we will not repeat them here. We remanded for the Board to determine whether claimant's failure to request a hearing on the denial in a timely manner was due to his "mistake, inadvertence, surprise or excusable neglect," as those terms were used in *former* ORS 18.160, now ORCP 71B(1).² The Board held that claimant had not sufficiently shown any of the four factors to prove good cause.

The burden of establishing good cause for failure to file a request for a hearing in a timely manner is on the claimant. *Naught v. Gamble*, *supra* n 2; *Cogswell v. SAIF*, 74 Or App 234, 237, 702 P2d 81 (1985). Here, claimant contends that he did not make a timely request for a hearing because employer's physician told him that his condition was unrelated to his compensable injury. He argues that that constitutes good cause.

On *de novo* review, we hold that claimant has not met his burden. After working in Wyoming for a different employer, he went to employer's physician, Dr. Button, rather than to Dr. Lawton, who had performed the surgery on his hand and forearm. Button told him that his condition was due to overuse and was related more to his recent employment in the Wyoming oil fields than to his past work at employer. Cite as 93 Or App 516 (1988) 519

Claimant said that he went to Button because his physical problems had persisted when he returned to work. We infer from that that he went to employer's doctor because he was dissatisfied with what Lawton had been able to do for him. Button sent a report to employer. On April 30, 1982, claimant signed a certified mail receipt for employer's denial letter and notice of right to request a hearing. He testified that he did not then file a request for a hearing, because "he didn't think he could do anything about it."

Claimant then returned to Lawton, who noted, on May 17, 1982, that the symptoms were related to his original injury. On June 14 and 24, 1982, Lawton reported to employer that claimant's condition was an aggravation of his original compensable injury. The record does not clearly show whether or to what extent Lawton discussed his diagnosis with claimant. However, his chart note of May 17, 1982, combined with the May 26, 1982, notation that claimant had talked with a representative of the carrier, was aware that his claim had been denied and was continuing to have problems, persuades us that claimant knew, or should have known, that his condition was related to his previous injury before 60 days had passed and intentionally did nothing.

On August 24, 1982, claimant contacted an attorney. He filed a request for a hearing three days later, after the 60-day period had expired, but within the 180 days allowed under ORS 656.319. The Board found, and we agree, that claimant received the denial letter, read it, understood it and chose not to act within the 60 days, but not because of Button's advice or because Lawton was involved. His explanations for lack of diligence do not constitute good cause for failure to file a timely claim.

² See *Brown v. EBI Companies*, 289 Or 455, 457, 616 P2d 457 (1980); *Naught v. Gamble, Inc.*, 87 Or App 145, 150, 741 P2d 901 (1987).

Affirmed.

VAN HOOMISSEN, J., pro tempore, dissenting.

On *de novo* review, I would hold that claimant has shown good cause for failure to file a request for a hearing in a timely manner.

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October 26, 1988

No. 600

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Keith W. Summey, Claimant.

SUMMEY,
Petitioner,

v.

AUTO BODY SPECIALIST et al,
Respondents.

(WCB 86-09560; CA A46065)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 9, 1988.

Thomas Cary, Eugene, argued the cause for petitioner. With him on the brief was Coons & Cole, P.C., Eugene.

Mildred J. Carmack, Portland, argued the cause for respondents. On the brief were Allan M. Muir, Roger A. Luedtke and Schwabe, Williamson & Wyatt, Portland.

Before Warren, Presiding Judge, and Joseph, Chief Judge, and Rossman, Judge.

WARREN, P. J.

Affirmed.

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Summey v. Auto Body Specialist

WARREN, J.

Claimant seeks review of a Workers' Compensation Board order affirming the referee's determination that he did not have good cause for filing an untimely request for hearing on Safeco's denial of his claim. Claimant contends that there is evidence from which it must be found that, in not filing his request for hearing on Safeco's denial, he was relying on a representation by a SAIF employee that SAIF would accept the claim and that that reliance constitutes good cause. Without deciding whether reliance on a representation by SAIF could, as a matter of law, constitute good cause for not filing a request for hearing on Safeco's denial, we hold that there is substantial evidence on the whole record to support the Board's finding that claimant did not, in fact, rely on that representation. We affirm. ORS 183.482.

Claimant injured his back in December, 1985, when he was working for Safeco's insured. He filed the claim in early January, 1986, and Safeco denied responsibility on February 28, 1986:

"In summary, from the medical information we received,

your present condition is due to an accident on the job with Auto Body Specialist on or about September 20, 1984, and your alleged reinjury of December 30, 1985, is merely an aggravation of your preexisting condition. Therefore, on behalf of your employer * * * your claim is respectfully denied. I will forward the medical information we have on file to SAIF Corporation to put them on notice, which may constitute a claim for benefits with them. However, you may wish to contact them."

Safeco forwarded the medical records to SAIF on March 3, 1986, and SAIF denied the claim on May 28, 1986.

Claimant testified that the alleged conversation on which he relied took place in June, 1986, and, he thought, before SAIF had denied the claim. Lundeen, a SAIF claims examiner, allegedly told claimant that he would not need to appeal the Safeco denial, because SAIF would probably accept the claim. The record shows that claimant received SAIF's denial on May 30, 1986. Even if, as claimant testified, the conversation with Lundeen took place before SAIF's denial, and not, as claimant also testified, in June, 1986, that evidence

Cite as 93 Or App 544 (1988)

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still does not place the conversation before April 29, the 60th day after Safeco's denial.

The record shows that, on March 24, 1986, Lundeen spoke with claimant's treating chiropractor, who told him that claimant's present condition was the result of a new injury. Claimant contends that the only possible finding, therefore, is that Lundeen would have told claimant after March, 1986, that SAIF would accept the claim and that it, therefore, must be found that the representation by Lundeen took place before that date. Although the evidence shows that Lundeen had information on March 24, 1986, that the claim was not SAIF's responsibility, it does not require the finding that claimant's conversation with Lundeen took place before that date.

Without deciding whether representations by SAIF could constitute good cause for failing to seek a hearing on Safeco's denial, we hold that there is substantial evidence on the whole record to support the Board's finding that the conversation with Lundeen took place more than 60 days after Safeco's denial and that claimant could not have relied on it in failing to file a request for hearing.

Claimant contends that he relied on representations made by *Safeco* in its denial that the claim would be compensable by SAIF. Safeco's denial did not represent that the claim would be compensable by SAIF. We hold, as a matter of law, that claimant could not have relied on it in filing a late request for hearing.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Barbara P. Brown, Claimant.

BROWN,
Petitioner,

v.

ARGONAUT INSURANCE COMPANY et al,
Respondents.

(WCB 86-03915; CA A46551)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 18, 1988.

Kenneth D. Peterson, Jr., Hermiston, argued the cause for petitioner.

Michael G. Bostwick, Portland, argued the cause for respondents. With him on the brief was Davis and Bostwick, Portland.

Before Warden, Presiding Judge, Graber, Judge, and Van Hoomissen, Judge pro tempore.

GRABER, J.

Remanded for reconsideration.

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Brown v. Argonaut Insurance Company

GRABER, J.

Claimant seeks review of an order of the Workers' Compensation Board (Board) that reversed the referee's assessment of a penalty and attorney fees against Argonaut. We review for substantial evidence and errors of law, ORS 656.298(6), and remand for reconsideration.

In 1983, claimant suffered a compensable injury to her left elbow, which was diagnosed as tennis elbow.¹ In January, 1986, claimant returned to her treating physician, Dr. Carpenter, complaining of pain in her left arm. Carpenter referred claimant to Dr. Eisler. Both Eisler and Carpenter wrote reports about their examinations. At Carpenter's request, Eisler examined claimant again on February 18, 1986. In a letter to Carpenter, he concluded that claimant's "symptoms are more likely to be the so-called resistant tennis elbow syndrome" than any alternative diagnosis. The Board found that Argonaut received Eisler's February 18 letter on April 7.

Carpenter sent claimant a bill dated February 6, 1986. Claimant received it and, she testified, shortly thereafter sent it to Argonaut. On February 20, 1986, Argonaut issued a timely partial denial, which said:

"The medical reports we have received indicate you are suffering from conditions described as Reynaud's Phenomena and ulnar nerve irritation. We are unable to accept responsi-

¹ Several months after surgery for that injury, claimant developed a small lipoma near her left elbow. She filed a claim, which was resolved by a disputed claim settlement. The settlement provided that it "does not affect claimant's right under the compensable accepted claim for the left tennis elbow condition."

bility for these conditions, as they appear to be unrelated to your accepted claim for left tennis elbow. * * * However, we wish to reaffirm our acceptance of responsibility for your industrial injury of April 1, 1983, which resulted in left tennis elbow."

Claimant requested a hearing on whether her new condition related to the compensable injury.

On June 7, 1986, Eisler wrote to Argonaut, repeating his conclusion that claimant's "diagnosis is a resistant tennis elbow syndrome." On July 11, 1986, shortly before the hearing, Argonaut changed its position and agreed that claimant's new symptoms stemmed from her compensable tennis elbow.
Cite as 93 Or App 588 (1988) 591

Accordingly, Argonaut agreed to pay claimant's medical expenses but continued its denial of Reynaud's Phenomenon and ulnar nerve irritation "to the extent they exist."

Because Argonaut agreed that claimant's new symptoms resulted from her compensable injury, there was no issue of compensability or payment for medical services at the hearing. However, the referee assessed a penalty and attorney fees against Argonaut for unreasonable delay and resistance to paying claimant's medical expenses. See ORS 656.262(10); ORS 656.382(1). The Board reversed.²

We first address the applicable standard of review. Whether a denial or delay is unreasonable involves both legal and factual questions. We review for errors of law in examining whether the Board applied the correct legal standard. ORS 183.482(8)(a). That standard is whether, from a legal standpoint, Argonaut had a legitimate doubt as to its liability. If so, the denial was not unreasonable. *Norgard v. Rawlinsons*, 30 Or App 999, 1003, 569 P2d 49 (1977). "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the insurer. See *Ginter v. Woodburn United Methodist Church*, 62 Or App 118, 122, 659 P2d 434 (1983).

Using the legal standard, the Board makes a factual finding about reasonableness. See *Lester v. Weyerhaeuser Co.*, 70 Or App 307, 311, 689 P2d 342, rev den 298 Or 427 (1984). We review that finding for substantial evidence. ORS 183.482(8)(c); see also *Williams v. SAIF*, 31 Or App 1301, 1305, 572 P2d 658 (1977).

In this case, the Board found that Argonaut reasonably denied the claim, because it had a legitimate doubt as to its liability, on February 20. The Board then reasoned:

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"[T]he insurer's February 20, 1986, denial was issued within the 60 days period for notice of acceptance or denial provided by statute. ORS 656.262(6). Furthermore, since it

² The referee affirmed Argonaut's partial denial of Reynaud's Phenomenon and ulnar nerve irritation. Claimant did not make a contrary argument to the Board, no doubt because Argonaut had denied conditions that were not at issue. Argonaut agreed to pay all of claimant's medical bills on the basis that they were related to the compensable tennis elbow injury. Consequently, the Board's order addressed only those issues that the parties argued before the Board and this court: the penalty and attorney fees. The Board's order concluded, "The referee's order dated July 29, 1986, is reversed." On these facts, we construe the Board's order to reverse only as to those issues that it addressed, namely, the penalty and attorney fees award. On remand, the Board should correct the oversight.

had already denied responsibility for claimant's current problems, it was not necessary for the insurer to issue another denial for the same problems after it received Dr. Eisler's February 18, 1986 report. Consequently, we do not find the insurer's failure to respond to Dr. Eisler's February 1986 report unreasonable."

It is unclear whether the Board meant that, as a matter of law, an insurer that timely and properly denies a claim has no duty to reevaluate the denial when it receives a later medical report or that, as a matter of fact, Argonaut had a legitimate doubt about its liability even after it received Eisler's report.

If the Board meant the former, then it applied the wrong standard. After an insurer reasonably denies a claim for medical services on the basis that they were unrelated to the compensable condition, continuation of that denial in the light of new medical evidence becomes unreasonable if, but only if, the new evidence destroys any legitimate doubt about liability. See *Price v. SAIF*, 73 Or App 123, 126, 698 P2d 54 (1985); *Norgard v. Rawlinsons*, *supra*, 30 Or App at 1003.³

Even if the Board applied the correct legal standard, its order is not sufficient to permit our review for substantial evidence. See *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). First, the Board made insufficient findings about the February 20 denial, which it concluded was reasonable. Because reasonableness depends upon an evaluation of all the evidence available to the insurer when it acted, a necessary first step is to determine what evidence Argonaut had when it denied the claim. The record is unclear on that point, and the various medical reports are inconsistent, but neither the referee nor the Board made the required findings. Second, the Board did not make *any* findings to support its conclusion that the February 20 denial, if reasonable, did not become unreasonable in the light of later medical reports.

Remanded for reconsideration.

³ No statute or previous case addresses this issue directly.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Betty L. Vessey, Claimant.

VESSEY,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 85-06062; CA A43063)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 13, 1988.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were Donald R. Wilson and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmyer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Reversed; referee's order reinstated.

618

Vessey v. SAIF

PER CURIAM

Claimant appeals an order of the Workers' Compensation Board which reversed the decision of the referee that claimant was entitled to an award of permanent total disability. The Board awarded her 60 percent permanent partial disability. The petition for review was filed February 10, 1987. We review *de novo*, *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

There are no issues of law involved; only issues of fact. The principal difference between the decision of the referee and that of the Board was whether claimant had satisfied the requirements of ORS 656.206(3) that she "is willing to seek regular gainful employment and that [she] has made reasonable efforts to obtain such employment." We conclude that the referee correctly analyzed the evidence and we agree with his findings and conclusions. It would serve no purpose to recite the findings of the referee in this opinion.

Reversed; referee's order reinstated.

No. 619

November 2, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Rene Van Woesik, Claimant.

VAN WOESIK,
Petitioner,

v.

PACIFIC COCA-COLA CO. et al,
Respondents.

(WCB 84-09431; CA A36863)

On remand from the Oregon Supreme Court, *Van Woesik v. Pacific Coca-Cola Co.*, 304 Or 436, 746 P2d 219 (1987).

Judicial Review from Workers' Compensation Board.

Submitted on remand January 11, 1988.

James L. Edmunson and Malagon & Associates, Eugene, for petitioner. Peter O. Hansen, Portland, filed an association of counsel.

Craig A. Staples and Roberts, Reinisch & Klor, P.C., Portland, for respondents.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded to the Board with instructions to accept the claim.

Cite as 93 Or App 627 (1988)

629

RICHARDSON, P. J.

This case is on remand from the Supreme Court for reconsideration in the light of *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987). Claimant had been awarded benefits totaling 30 percent unscheduled permanent partial disability for a back injury. In our previous opinion, *Van Woelik v. Pacific Coca-Cola Co.*, 85 Or App 9, 735 P2d 1232 (1987), we affirmed the Board's determination that claimant had not suffered an aggravation sufficient to qualify for additional benefits under ORS 656.273.

The first issue on remand is whether the last arrangement of compensation, a stipulated agreement dated February 3, 1983, contemplated that claimant would have periodic symptomatic flareups of his underlying condition. See *Gwynn v. SAIF, supra*. The language of the agreement is silent on that question. We recently addressed a similar issue in *Mathis v. Modoc Lumber Company*, 91 Or App 67, 754 P2d 590, *rev den* 306 Or 195 (1988), and determined that, on the basis of medical evidence existing at the time of the stipulation, the permanent nature of the claimant's injury created a probability that disabling symptoms would come and go and that the stipulation contemplated future flareups. Similar reasoning is applicable here. Claimant's back condition is permanent, and the medical evidence at the time of the stipulation showed that it was likely that claimant would continue to experience a waxing and waning of his pain symptoms. In October, 1982, for example, Dr. Renholds examined claimant and predicted that he would have episodes of increased symptoms requiring periods of physical therapy. We conclude that the parties contemplated periodic flareups at the time of the stipulation.

We turn to the question of whether claimant has proved an aggravation of his low back condition since the last arrangement of compensation. When an initial award of permanent partial disability is predicated on an anticipation of some short periods of waxing and waning, there is no legal reason to order payment of additional compensation for those periods. Nevertheless, if a claimant's physical condition worsens or the symptoms of his injury produce disability for more than the short period contemplated at the time of the stipulation, then additional benefits may be justified. *Gwynn v. SAIF, supra*.

Employer agrees that claimant has experienced periodic flareups of pain. It is difficult to determine from the record how long each episode lasted but it is clear that they have increased in frequency and that some lasted for at least the 14-day period identified in *Gwynn* as the appropriate guideline. Accordingly, we conclude that claimant has established a worsening since the 1983 stipulated settlement.

Reversed and remanded to the Board with instructions to accept the claim.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Cleo F. Perry, Claimant.

PERRY,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 85-07195; CA A44205)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 13, 1988.

Leo R. Probst, Portland, argued the cause for petitioner. With him on the brief was Leo R. Probst & Associates, Portland.

Darrell E. Bewley, 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 Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded to the Board for acceptance of the claim.

Cite as 93 Or App 631 (1988)

633

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order which affirmed the referee's decision upholding SAIF's denial of his aggravation claim.

Claimant injured his back on the job in November, 1979. The first determination order respecting the injury was May 14, 1980. After several subsequent reopenings, the claim was finally closed on July 2, 1984, by a stipulated award of 30 percent permanent partial disability.¹ The parties also agreed, as part of the written stipulation, that claimant was not permanently and totally disabled at that time.

In April, 1985, he was admitted to the hospital for treatment of his low back. His right to file an aggravation claim for the 1979 injury would expire May 14, 1985, and to establish an aggravation, he would have to show a worsening subsequent to the last arrangement of compensation on July 2, 1984. He consistently has refused surgery. On that occasion, he was put in traction, which relieved the pain, and spent about six days in the hospital. He filed a claim for aggravation on May 6, 1985, eight days before his aggravation rights expired. SAIF denied the claim.

¹ Claimant had already received permanent partial disability awards for other compensable injuries. The cumulative total of all of the awards was in excess of 100 percent of the degrees allowed by ORS 656.214.

SAIF argues that claimant has not proved a worsening of his back condition before the expiration of his aggravation rights. Claimant counters that the statutory limitation is for the filing of a claim for aggravation and that he must prove only that a worsening occurred before the hearing. In essence, he contends that he could file a timely claim for aggravation and then establish it by showing that his condition worsened *after* the claim was filed and *after* his rights to aggravation have expired. We disagree. A claim for aggravation is essentially a notification to the employer or carrier that a compensable condition has become worse. Under claimant's theory, he could file a precautionary aggravation claim just before expiration of the limitation period simply to preserve a claim which did not then exist. If his condition worsened later, he would have preserved a timely request for compensation.

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Perry v. SAIF

There has to be a worsening before expiration of the aggravation rights.

The referee found that claimant had experienced episodes of pain since the last arrangement of compensation but that his underlying *condition* had not worsened before May 14, 1985. We agree. His treating physician indicates that, although he had flare-ups of pain requiring treatment, his condition did not change until late 1985, after the aggravation period had expired.

After this case was submitted, the Supreme Court decided *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987). There the court said:

"Compensation is not payable under the Workers' Compensation Law for symptoms alone, but to the extent that symptoms, such as pain, dizziness, nervousness, etc., cause loss of function of the body or its parts and, in the case of unscheduled disability, resulting loss of earning capacity, the disabling effects of the symptoms are to be considered in fixing awards for disability." 304 Or at 352.

In a situation where there is a waxing and waning of symptoms of a compensable condition which may have been contemplated in the last award of compensation, the court devised a bright line to determine when the resulting incapacity becomes an aggravation under ORS 656.273:

"If the worker, as a result of worsening of the worker's condition from the original injury, becomes totally disabled for more than 14 consecutive days or becomes an inpatient at a hospital for treatment of that condition, the worker is at least entitled to compensation for temporary total disability." 304 Or at 353.

The worker may also be entitled to some degree of permanent disability to be fixed after becoming medically stationary.

Claimant received inpatient hospital treatment for his back condition before expiration of his aggravation rights. The referee and the Board upheld the denial on the basis that there was no worsening of his underlying *condition*. That analysis is no longer controlling in a case of this sort.

Reversed and remanded to the Board for acceptance of the claim.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Irene Jensen, Claimant.

JENSEN,
Petitioner,

v.

EMPLOYMENT DIVISION MANAGEMENT et al,
Respondents.

(WCB 86-03379; CA A44025)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 13, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. On the brief were Karen M. Werner and Malagon & Moore, Eugene.

Darrell E. Bewley, 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 Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

Cite as 93 Or App 635 (1988)

637

RICHARDSON, P. J.

Claimant seeks review of an order of the Workers' Compensation Board which reversed the referee and upheld SAIF's denial of her occupational disease claim. On *de novo* review, we affirm.

Claimant, who is now 55 years old, worked for the State Employment Division. In 1980, she was transferred to the claims department, which involved some standing, more activity and stressful contact with sometimes hostile claimants. After several months in that department, she developed severe back pain and was hospitalized. The diagnosis was a marked narrowing of the space between two discs resulting from a degenerative disc disease. She returned to work but quit in 1981 because of back pain and then worked with her husband in a plant nursery business. Her back pain abated during that time.

In early 1983, she returned to the claims department of the Employment Division. Her back pain returned within a few months, and she again sought treatment. The diagnosis and treatment were the same as in 1981. After returning to work with a reduced work load, she quit in August, 1984, and filed an occupational disease claim in December, 1985.

The medical evidence, in addition to the diagnosis of

disc disease, consists of reports by Dr. Lahti, claimant's treating physician, and Dr. Langston, who examined claimant at the request of SAIF. Both physicians agreed with the earlier diagnosis and concluded that the disc disease was not caused by claimant's work. They also stated that she had a strain superimposed on the degenerative condition that was produced by the work which she described.

The referee held that the strain was a separate condition from the disc disease and was compensable, because the major contributing cause of it was the stress at her employment. The Board, in reversing the referee, concluded that the two doctors were merely describing symptoms of the degenerative disease and not a separate condition. We agree with the Board essentially. Neither physician described a work-caused strain that was separate from the symptoms that the stress produced on the disc disease. There was no worsening of the

638 *Jensen v. Employment Division*

underlying condition. *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979).

Affirmed.

No. 627

November 2, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Robert S. Littleton, Claimant.

LITTLETON,
Petitioner,

v.

WEYERHAEUSER CO.,
Respondent.

(WCB 85-04258; CA A45147)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 14, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Allan M. Muir, Portland, argued the cause for respondent. With him on the brief were Roger A. Luedtke and Schwabe, Williamson & Wyatt, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLE, P. J.

Reversed; remanded for award of attorney fees.

Cite as 93 Or App 659 (1988)

661

BUTTLE, P. J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's determination that certain medical services are not compensable, because

they are not reasonable and necessary. Additionally, he seeks attorney fees for having prevailed before the Board on employer's cross-appeal concerning the compensability of certain other medical bills which the Board held were related to diagnostic procedures.

We review pursuant to ORS 656.298(6) and conclude that the Board's decision concerning the compensability of the medical services is supported by substantial evidence.

The remaining question is whether claimant is entitled to attorney fees for having prevailed on employer's cross-appeal to the Board. The present statutory provision is ORS 656.382(2):

"If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

Claimant contends that, as we have interpreted that provision in *Travis v. Liberty Mutual Ins.*, 79 Or App 126, 717 P2d 1269, *rev den* 301 Or 445 (1986), it requires that claimant be awarded attorney fees. In *Travis*, we held that a claimant can recover insurer-paid attorney fees under ORS 656.382(2) for prevailing on an employer's cross-appeal to the Board.

As employer notes, OAR 438-47-075 provides:

"In the event of a cross-appeal by either party [the administrative provisions relating to attorney fees] 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."

Read in the context of the other administrative rules, OAR 662 Littleton v. Weyerhaeuser Co.

438-47-075 would appear to preclude an award of insurer-paid attorney fees to a claimant for having prevailed on an employer's cross-appeal to the Board or cross-petition to the Court of Appeals, unless the cross-appeal or cross-petition is the only matter which proceeds to disposition by the Board or court. Only in that circumstance is the cross-appeal or cross-petition considered to have been "initiated" by the employer, as required by ORS 656.382(2). Claimant contends that the rule is inconsistent with our opinion in *Travis*. Although we agree that it is, the parties in *Travis* did not raise, and we did not address the application of, the administrative rule; therefore, that case is not dispositive.¹ The question, therefore, is not whether the rule is inconsistent with *Travis*, but whether it is inconsistent with the statute.

The rule was adopted in 1974. In *Teel v. Weyerhaeuser*, *supra*, n 1, decided in 1983, the Supreme Court

¹ The application of the administrative rule has not been raised or addressed in any case decided under ORS 656.382(2). See *Teel v. Weyerhaeuser Co.*, 294 Or 588, 660 P2d 155 (1983); *Saiville v. EBI Companies*, 81 Or App 469, 726 P2d 394, *rev den* 302 Or 461 (1986).

held that the term "initiated" as used in an earlier version of ORS 656.382(2), encompassed "cross-appeals" to the Court of Appeals of issues that would otherwise not have been dealt with by that court, even though the statute at that time did not refer to "cross-appeals" to the Court of Appeals.² The court held that the party responsible for bringing an issue before the reviewing body, whether by appeal or cross-appeal, "initiates" the appeal within the meaning of the statute. Shortly after *Teel* was decided, the statute was amended to refer specifically to cross-appeals, consistent with *Teel*. Or Laws 1983, ch 568, § 1. Although *Teel* involved a cross-appeal to the Court of Appeals, the same reasoning applies to initiating review by the Board. In fact, we have read the present statute to encompass cross-appeals to the Board, although it is not clear that it expressly includes them. *Travis v. Liberty Mutual Ins.*, *supra*.

We understand the legislature to have adopted the Supreme Court's rationale that the term "initiated," as used in the statute, encompasses the raising of issues that would

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not otherwise have been dealt with by the reviewing body, and we have applied that rationale, under the present statute, to cross-appeals at the Board level. *Travis v. Liberty Mutual Ins.*, *supra*. The Board is not authorized to interpret the statute more narrowly; OAR 438-47-075 has been superseded by both the courts and the legislature. Here, employer raised an issue in its cross-appeal that the Board would not otherwise have considered. Claimant is entitled to attorney fees for having prevailed on that issue.

Reversed; remanded to the Board for an award of attorney fees.

² The Supreme Court, the statute and OAR use the terms "appeal" and "cross-appeal" to describe what we generally refer to as a petition or cross-petition for review. In our discussion of *Teel*, we also use the statutory language.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Carol J. Knapp, Claimant.

KNAPP,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 86-02762; CA A45202)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 6, 1988.

Michael R. Stebbins, North Bend, argued the cause for petitioner. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Jon Littlefield, Coos Bay, argued the cause for respondent. On the brief were Daniel M. Spencer and Foss, Whitty, Littlefield & McDaniel, Coos Bay.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded.

BUTTLER, P. J.

In this workers' compensation case, claimant seeks review of the Board's order affirming the referee's determination that employer's letter to claimant dated November 22, 1985, was a permissible "back-up denial" of compensation, see *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), and that claimant did not have good cause for failing to request a hearing within 60 days of that denial.

From January to September, 1983, while working for employer, claimant experienced back pain and saw Dr. Bert for treatment and medication. In September, she was laid off from her job for reasons unrelated to her back. She continued to receive treatment and, in August, 1984, underwent back surgery. On October 4, 1984, employer denied a claim for an occupational disease. Claimant sought a hearing, at which she testified that, because of her back problem, she had not worked for wages after September, 1983. In an order dated June 20, 1985, the referee determined that the claim, including the back surgery of August 23, 1984, was compensable. He reversed employer's denial but did not remand the case to employer for payment of compensation. The Board affirmed. Employer did not pay benefits for temporary total disability, apparently reasoning, in reliance on *Cutwright v. Weyerhaeuser Co.*, 299 Or 290, 702 P2d 403 (1985), that, because claimant had been laid off since September, 1983, she was not entitled to any benefits for time loss.

Claimant sought another hearing. The evidence showed that, after she was laid off, she looked for work and drew unemployment compensation from September, 1983, until July, 1984, and that her doctor had authorized time loss from June 22, 1984. On October 11, 1985, another referee ordered employer to pay temporary total disability benefits, offset by any unemployment compensation that claimant had received, from June 22, 1984, "until termination * * * is appropriate." The Board affirmed that order on June 17, 1986.

In the meantime, on November 22, 1985, employer wrote to claimant, advising her that it had just learned that she had reported to the Employment Division that she had earnings of \$785 for the period from April 29, 1984, through July 22, 1984. The letter went on to state that claimant's treating physician apparently had had no knowledge of the

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work resulting in those earnings and that the clinical evidence showed that claimant experienced a worsening of her back condition during the same period. Because claimant's treating physician had testified that claimant's worsened back condi-

tion was the result, in part, of off-the-job activity, employer reasoned that work claimant may have performed from April 29, 1984, to July 22, 1984, contributed to the condition for which surgery was performed in August, 1984. Accordingly, employer denied responsibility for the condition it had been ordered by the first referee to accept in 1984.

Claimant received the denial on November 23, 1985. Her attorney received a copy on November 25, 1985. He read it on December 2, 1985, and understood it to be a denial, but did not file a request for hearing until February 24, 1986. The Board, affirming the second referee, dismissed the request for hearing as untimely, because claimant had not established good cause.

Claimant contends that her request for hearing should not be subject to or limited by the time restrictions applicable to hearing requests on denials, because there is no legal basis for employer's denial and, therefore, it should be treated as a nullity. She asserts, in essence, that employer, having once denied the claim and having been ordered to accept it, could not again deny it, even if, as employer contends, claimant testified untruthfully at the hearing. We agree that there was no circumstance that permitted a denial. There must be some finality to the process of claims adjudication. It would not be furthered by a policy permitting readjudication each time that a party discovers a nondisclosure or misrepresentation by the other party. For that reason, issue preclusion applies to workers' compensation cases, including this case. *North Clackamas School Dist. v. White*, 305 Or 48, 750 P2d 485, on reconsideration, 305 Or 468, 752 P2d 1210 (1988).

Contrary to employer's contention, *Bauman v. SAIF*, *supra*, is inapplicable. It permits an employer to deny a claim that it has accepted if the *acceptance* was made under circumstances of fraud or misrepresentations. It does not permit a collateral challenge to a final order of the Board on the same grounds. Employer had once denied this claim and had had the opportunity to litigate the denial on its merits. It may not do so again.

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Knapp v. Weyerhaeuser Co.

Employer's denial, having no basis in law, did not require a response within the period of limitation of ORS 656.319(1)(a). Claimant's request for hearing is, therefore, not subject to dismissal on the ground that it was not filed within 60 days of the denial and should be treated as a challenge to employer's refusal to pay benefits pursuant to the prior orders.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Benny G. Parker, Claimant:

PARKER,
Petitioner,

v.

D. R. JOHNSON LUMBER CO.,
Respondent.

(WCB 85-10591; CA A45598)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 1, 1988.

Dean Heiling, Roseburg, argued the cause for petitioner. With him on the brief was Heiling & Morrison, P.C., Roseburg.

E. Jay Perry, Eugene, argued the cause for respondent. With him on the brief was Employers Defense Counsel, Eugene.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded to referee for determination of benefits, penalties and attorney fees.

Cite as 93 Or App 675 (1988)

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WARREN, J.

Claimant seeks review of a Workers' Compensation Board order affirming the referee's decision that he is not entitled to penalties and attorney fees. We review pursuant to ORS 183.482(7) and (8) and reverse and remand.

There are four Board orders. We review only the last one, Order IV. On January 15, 1985, pursuant to our decision in *Parker v. D. R. Johnson Lumber Co.*, 70 Or App 683, 690 P2d 1087 (1984), the Board issued an order on remand (Order I), ordering employer to accept claimant's back claim. Employer did not seek review of that order, and it became final. On January 22, 1985, it filed a Board motion seeking another hearing on the question decided in our opinion on the ground that we had changed the burden of proof. The Board issued an order on reconsideration (Order II) on January 30, 1985, denying a new hearing. It did not abate Order I. Employer sought review, and we affirmed Order II without opinion on October 23, 1985. *D. R. Johnson Lumber Co. v. Parker*, 76 Or App 212, 707 P2d 643, *rev den* 300 Or 470 (1985).

In the meantime, on February 12, 1985, claimant had filed a request for hearing, alleging that employer's motion for rehearing had been filed for the purpose of delay and without reasonable grounds. ORS 656.382(2). Claimant also sought payment of temporary total disability and medical benefits and requested a penalty and attorney fees for employer's continued nonpayment.

On March 22, 1985, employer paid claimant \$25,884.88 for temporary total disability from September 13, 1982, through April 17, 1984. Claimant had not been released for work, and employer had not sought claim closure. Employer explains that its decision not to pay disability benefits for the period after April 17, 1984, was based on a medical report of May 18, 1984, from which it determined that claimant had become medically stationary on April 17, 1984.

A referee issued an order dismissing claimant's request for hearing on the ground that it had been prematurely filed, because the benefits under Order I did not become due until 14 days after Order II, on February 14, 1985. Claimant requested Board review. On July 17, 1986, in Order III, the Board affirmed the referee as to the medical benefits,

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Parker v. D. R. Johnson Lumber Co.

on the grounds that employer's obligation to pay those benefits was stayed pursuant to ORS 656.313(4) pending employer's petition for review of Order I or, in the alternative, that the petition was premature as to medical benefits, because they did not become due until 90 days after Order I. It correctly reasoned, however, that Order II did not extend the deadline for the payment of benefits for disability, because it neither abated nor withdrew Order I. It determined that payment of those benefits was not stayed pending review and became due 14 days after Order I. On the merits, Order III awarded claimant penalties and attorney fees on "amounts due under [Order I]."

Employer did not seek review of Order III. However, it did not pay penalties and attorney fees or temporary total disability due after April 17, 1984, and claimant again sought a hearing. The Board issued the order on review here (Order IV), affirming without opinion the referee's determination that the issue of claimant's entitlement to benefits for temporary total disability for the period after April 17, 1984, and related penalties, either should have been raised before or had been decided adversely to claimant in Order III. It determined that Order III awarded penalties and attorney fees only with respect to the amount of temporary disability that had been paid by employer on March 22, 1985, and said nothing about whether claimant was entitled to benefits after April 17, 1984.

Reading Order III as a whole, we disagree with Order IV and conclude that, although Order III did not expressly discuss the question of claimant's entitlement to disability benefits after April 17, 1984, it implicitly decided that question *favorably* to claimant. The first paragraph of the referee's order in that proceeding indicates that claimant raised the question of employer's continued failure to pay temporary total disability. It can be inferred from Order III that the Board assumed that employer had a continuing obligation to pay benefits after April 17, 1984, because, although there was evidence that he was medically stationary, he had not been released for work and employer had not sought claim closure. The order recites that, on March 22, 1985, employer "paid a *portion* of the temporary disability benefits" due (emphasis supplied), thereby suggesting that additional benefits for disability were due. It requires employer to pay a penalty on "the amount due under [Order I]," again suggesting that there was

still an amount due. Implicit in Order III is the conclusion that the duration of claimant's temporary disability was then undetermined but that it extended beyond April 17, 1984. The penalty assessed by Order III applies to whatever benefits ultimately are determined to be due under Order I. Employer did not seek review of Order III, and it became final.

Claimant is entitled to penalties and attorney fees for late payment of temporary total disability benefits now due. Because of our disposition of the petition for review, we do not reach claimant's remaining assignments.

Reversed and remanded to the referee for a determination of benefits, penalties and attorney fees.

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November 2, 1988

No. 634

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Annette K. Mageske, Claimant.
ARGONAUT INSURANCE COMPANY et al,
Petitioners,
v.
MAGESKE,
Respondent.

(WCB 84-13399; CA A44265)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 8, 1988.

Allen W. Lyons, Portland, argued the cause for petitioners. With him on the brief was Davis, Bostwick, Scheminske & Lyons, Portland.

Robert Wollheim, Portland, argued the cause for respondent. With him on the brief was Welch, Bruun & Green, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

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Argonaut Insurance Company v. Mageske

DEITS, J.

Employer seeks review of a Workers' Compensation Board order affirming the referee and holding that claimant's left thoracic outlet syndrome is compensable. On *de novo* review, we affirm.¹

Claimant was employed by Ruth Ashbrook Bakery as a wrapping machine operator. On August 21 and 27, 1984, she sought treatment from Dr. Stiger for pain in her chest and arm. Stiger noted that she was experiencing "another episode

¹ The petition for review in this case was filed on May 20, 1987, before the effective date of Or Laws 1987, ch 884, § 12a.

of chest pain [and] pain down (L) arm." He also noted that this was a "work associated and aggravated condition." On August 28, 1984, claimant filed a claim with employer, reporting that sometime during the past week she had injured her neck and back while lifting 30 to 40 pound rolls of cellophane and placing them on a wrapping machine. Subsequently, her condition was diagnosed as bilateral carpal tunnel syndrome and left thoracic outlet syndrome (TOS).

Employer accepted coverage of the carpal tunnel syndrome claim but denied the TOS claim, asserting that it was not the result of a work-related injury. Claimant sought a hearing. She testified that, on August 18 or 19, 1984, she had dropped a roll of cellophane on her shoulder while placing it on a wrapping machine and that the pain associated with her condition arose after that incident. Dr. Silver, a neurosurgeon and claimant's treating physician, concluded that the TOS could have resulted from claimant's work if she had suffered a traumatic blow to her shoulder. His opinion was generally supported by Dr. Baum, an orthopedic surgeon, who also evaluated claimant in April, 1985. Four other physicians who examined claimant testified that her TOS was not the result of a work-related injury. The referee determined that claimant's TOS claim is compensable, and the Board affirmed. Employer seeks review, contending that claimant did not prove that her condition was caused by her employment.

In order to establish that her TOS is compensable, claimant must prove by a preponderance of the evidence that a work-related injury was a material contributing factor in producing her TOS. *Olson v. State Ind. Acc. Com.*, 222 Or 407, 352 Cite as 93 Or App 698 (1988) 701

P2d 1096 (1960).² Claimant's case is largely dependent on the testimony of Silver. Employer asserts that the referee and Board should have rejected his opinion because it was based on an inaccurate medical history. It argues that the medical history was inaccurate because there was no reliable evidence that claimant suffered a blow to her shoulder in August, 1984.

We conclude that Silver's diagnosis was not based on an inaccurate medical history. Claimant established by a preponderance of the evidence that an injury occurred in August, 1984. Although Stiger, who treated her soon after the alleged injury, do not specifically indicate that she dropped a roll of cellophane on her shoulder, he noted in his reports that she was required to lift such rolls and that she was suffering a "work associated and aggravated condition." On the 801 form filed with employer on August 28, she indicated that she was injured while "lifting [a] paper roll up to machine * * *." Further, in February, 1985, when she first saw Silver, she told him that she had been injured in an incident in August. Employer asserts that there were inconsistencies in her indication of the exact date of the alleged injury and that these inconsistencies result in a failure of proof. We do not agree. Claimant's contradictory statements were made months after the alleged injury and are just as likely attributable to her inability to remember the exact date as to an intent to fabricate the inci-

² Employer asserts that claimant must prove that her work activities were the major contributing cause of her TOS. However, that burden applies only to occupational diseases, as opposed to work-related injuries. ORS 656.802(1)(a). Although it may not have been clear from claimant's initial filing whether she was proceeding on a theory of injury or occupational disease, she has taken the position before the referee, the Board and this court that she suffered an injury.

dent. In view of the referee's finding her credible and the fact that on her 801 form she did report an incident, we conclude that she has proved by a preponderance of the evidence that an incident occurred in which she suffered a blow to her shoulder.

Employer also argues that, even if claimant did suffer an injury to her shoulder, Silver's explanation of the cause of TOS should be rejected because it is based on a causation theory of TOS that has not been proven and because there is substantial medical opinion in the record concluding that her condition was not work related. Silver said that the TOS was caused by a nerve irritation or spasm that resulted from a blow

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to her shoulder. Although Baum agreed with Silver's nerve irritation theory, physicians called by employer disagreed. They testified that TOS is most often the result of a congenital abnormality or a compressed artery.

We conclude that Silver's testimony established that claimant's injury was compensable. Although there was contradictory medical evidence, even the physicians who did not agree with Silver's theory testified that he is a qualified physician held in high regard in the medical community. They also conceded that TOS is an area of medical science where there is considerable controversy among experts. Silver was claimant's treating physician for a substantial time and, as the treating physician, was able to observe claimant's shoulder during surgery. Significantly, he indicated that he saw no evidence that her TOS was the result of a congenital defect or a compressed artery. Because of his first-hand exposure to and knowledge of claimant's condition, we give his opinion great weight. *See Givens v. SAIF*, 61 Or App 490, 494, 658 P2d 526 (1983).

Affirmed.

No. 635

November 2, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Rozalia Mal, Claimant.

MAL,
Petitioner - Cross-Respondent,
v.

UNIQUE BUILDING MAINTENANCE CO. et al,
Respondents - Cross-Petitioners.

(WCB 84-06350, 85-09396; CA A44114)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 4, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. With him on the briefs were Karen M. Werner, and Malagon & Moore, Eugene.

Jerry K. Brown, McMinnville, argued the cause for respondents - cross-petitioners. With him on the brief was Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed on petition and on cross-petition.

Cite as 93 Or App 703 (1988)

705

DEITS, J.

Claimant seeks review of a Worker's Compensation Board order reversing the referee and holding that claimant failed to prove that her carpal tunnel syndrome is compensable. Employer cross-petitions from the portion of the Board's order holding that claimant's psychiatric disorder is compensable. On *de novo* review,¹ we affirm.

Claimant, 51 years old at the time of the hearing, began working for employer as a janitress in 1982. In June 1983, she suffered a compensable low back injury. Several doctors treated her in 1983 for that injury. The claim was closed by a determination order on February 9, 1984, with an award of temporary total disability. On March 2, 1984, she began treatment for her back with Dr. Eric Long. He also referred her to a psychiatrist, Dr. Deale. On August 7, 1984, she complained to Long of upper back and shoulder pain, as well as coldness in her hands. Long diagnosed bilateral carpal tunnel syndrome and concluded that the condition was unrelated to her 1983 injury. In January, 1985, Long performed nerve conduction studies which revealed deficits in claimant's median nerves bilaterally and in her upper right ulnar nerve. That confirmed his diagnosis of the syndrome. At that time, claimant indicated to him that her upper extremity problems first began while working for employer. Long concluded that claimant's carpal tunnel symptoms "appear to relate to work activity while employed by [employer] though not clearly to the low back incident." On January 14, 1985, claimant filed a claim for bilateral carpal tunnel syndrome, which was denied by employer.

In February, 1985, Dr. Wilson examined claimant at the request of employer and performed nerve conduction studies. On the basis of those studies, he concluded that her symptoms were unrelated to carpal tunnel syndrome and to her work activities with employer. Dr. David Long also examined claimant. He reported that he had first examined her in late 1984 and that, at that time, she had not mentioned any problems with her upper extremities. After his examination, he concluded that there was no relationship between claimant's

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upper extremity complaints and her work activities or her back injury. Dr. Nathan testified that he did not believe that claimant's condition was causally related to her work but concluded that it was idiopathic in origin.

In order to establish that her condition is compensable, claimant must prove by a preponderance of the evidence that her work activities were the major contributing cause of

¹ The petition for review in this case was filed before the effective date of Or Laws 1987, Or 884, § 12.

her condition. *Dethlefs v. Hyster Co.*, 295 Or 298, 667 P2d 487 (1983); *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1980).

We conclude that claimant has failed to meet that burden. She offered the testimony of Dr. Eric Long, the only doctor to find that the carpal tunnel syndrome was work-related. We find that that testimony is insufficient to sustain claimant's burden of proof. His opinion was dependent on claimant having experienced upper extremity symptoms before her 1983 back injury and her departure from work.² However, claimant did not establish that. She saw several doctors during 1983 and 1984, but she never expressed any complaints regarding her upper extremities until August, 1984. Although she testified at the hearing that she first experienced pain while working for employer, that testimony was inconsistent with her failure to mention it to the physicians who treated her for her 1983 injury and with other statements that she had previously made. During a 1983 back examination, she specifically denied having aches or pains in any other joints in her body. On August 28, 1984, when asked by Long, she clearly stated that she had not experienced pain while working for employer.³

An additional problem with Long's opinion is that, although he was aware of claimant's work-related activities,
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he testified that he was not aware of her non-work-related activities, and there is no evidence that he was aware of her general activities after she stopped working for employer. See *Blakely v. SAIF*, 89 Or App 653, 656, 750 P2d 528, *rev den* 305 Or 672 (1988). Without some knowledge of a claimant's other activities or an explanation of why, in a particular case, the knowledge is unnecessary, a conclusion that a claimant's work-related activities are the *major* contributing cause is not persuasive.

The other medical evidence in this case also does not support the claim. All of the other doctors who rendered opinions either found that claimant was not suffering from carpal tunnel syndrome or that her condition was not work-related. In view of the inconsistencies in claimant's evidence and the substantial contrary evidence, we conclude that she has not sustained her burden of establishing that her work-related activities were the major contributing cause of her condition.

Employer cross-petitions from the Board's order affirming the compensability of claimant's psychiatric condition. It contends that claimant did not sustain her burden of establishing, by a preponderance of the evidence, that her work-related injury was a material cause of her psychiatric

² Although at one point Long stated that his opinion would not change if she had first experienced symptoms two months after she left her employment, he later stated that, if she did not experience symptoms until that time, it was improbable that her condition was work-related.

³ Claimant contends that Long's opinion is entitled to more weight, because he was her treating physician. Although he worked with her for a substantial period of time, he first examined her over nine months after she stopped working for employer. Consequently, he has no greater insight as to when and if she experienced upper extremity pain during her employment with employer, or the particulars of that pain, than any other physician in this case might have. See *Kienow's Food Stores v. Lyster*, 79 Or App 416, 421, 719 P2d 890 (1986).

disorder. *Jeld-Wen, Inc. v. Page*, 73 Or App 136, 139, 698 P2d 61 (1985).

Deale, who treated claimant for her psychiatric problems, concluded that a material cause of claimant's condition was the long term pain which she had suffered as a result of her back injury. Employer contends, however, that we should not give Deale's opinion much weight, because there was no indication in her reports that she was aware of claimant's complete medical history. Specifically, employer contends that she was not aware that claimant suffered a non-industrial back injury in November, 1983, and that all of her treating doctors for the June, 1983, injury agreed that her back problems resulting from that injury had completely resolved before the November, 1983, injury. However, not all of claimant's treating doctors found that claimant's June injury had completely resolved by November, 1983. In addition, although it is unclear whether Deale was aware of claimant's second injury, we do not believe that that fact is decisive. Deale's opinion was based on at least five visits with claimant over a three month

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period and an extensive review of her medical history. In the light of her extended consultation with claimant and her review of her medical history, Deale's opinion that the June injury was a material cause of her psychiatric disorder is persuasive.

Employer argues that the opinion of Dr. Parvaresh, who also examined claimant, is more persuasive. He concluded that "her back problem is not a *major contributing factor* to her depression" and that, in comparison, claimant's cultural and social problems had contributed more to her condition.⁴ Parvaresh's opinion is not determinative, however, because it addressed the occupational disease standard, whether the condition was the major contributing cause of her condition, but he did not address the question of whether the work injury was a *material* cause, which is the correct standard. See *Jeld-Wen, Inc. v. Page*, *supra* 73 Or App at 140. The Board did not err in holding claimant's psychiatric disorder compensable.

Affirmed on petition and on cross-petition.

⁴ She emigrated from Russia in 1976 and has some cultural and language difficulties.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Carl L. Bohrer, Claimant.

BOHRER,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 85-13672; CA A43588)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 21, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner, and Malagon & Moore, Eugene.

Allan M. Muir, Portland, argued the cause for respondent. With him on the brief were William H. Replogle, and Schwabe, Williamson & Wyatt, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

Cite as 93 Or App 751 (1988)

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DEITS, J.

Claimant seeks review of a Workers' Compensation Board order awarding him 75 percent permanent partial disability. Claimant contends that he is permanently and totally disabled under the odd-lot doctrine. We affirm.

Claimant was 55 years old at the time of the hearing and has an eighth-grade education. Most of his work experience has involved manual labor, and he has worked for 24 years for employer, most recently as a sander. In 1984, he sustained a compensable low back injury. Dr. Hockey performed a laminectomy, which gave him only partial relief. In January, 1985, Orthopaedic Consultants evaluated claimant's condition and concluded that he could return to work if he avoided lifting and bending. In August, 1985, Hockey reported that claimant could sit, stand, and walk for a period of three to four hours and could lift and carry 36 to 50 pounds. After reviewing a video tape of claimant's position as a sanding operator, Hockey concluded that claimant could perform the job if he started on a part-time basis. He returned to work but soon reported to Hockey and his family doctor, Thompson, that he was suffering from increased pain. Although neither doctor noted any objective change in his condition, they concluded that he could not return to work at that time.

An evaluation of claimant by the Northwest Pain Center stated that he could perform sedentary work. Dr. Corrigan, of the Center, concurred that claimant was capable of

performing the sanding operator position if he did not have to change belts, use wrenches, open gates, reach or stoop. He thought that claimant could perform the sander position part time at first and eventually, full time. Employer's personnel director stated that she was familiar with the sanding operator position, that it had been modified to primarily a button-pushing activity and that claimant had been offered the position. Shortly before the hearing, claimant tried to perform the job, but he was only able to work five hours, three hours and five hours on three successive days.

Permanent and total disability exists when a disability renders a claimant unemployable. ORS 656.206. The proper inquiry is not whether the claimant has earning capacity, "but rather * * * whether the claimant is currently employable or able to sell his services on a regular basis in a

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hypothetically normal labor market." *Harris v. SAIF*, 292 Or 683, 695, 642 P2d 1147 (1982). There is no medical evidence in the record that directly states that claimant is permanently and totally disabled. All of his doctors, as well as his vocational counselors, agree that he is capable of performing some work. At the time of the hearing, he had worked for three days in the modified sander position. Claimant has not shown that he is permanently and totally disabled.¹

In the alternative, claimant contends that, if he is not permanently and totally disabled, his claim was prematurely closed. In order to show that his claim was prematurely closed, claimant must prove by a preponderance of the evidence that he was not medically stationary at the time of closure. *Austin v. SAIF*, 48 Or App 7, 615 P2d 1188 (1980). In August, 1985, Hockey wrote to employer, stating that claimant was medically stationary. Claimant argues, however, that an October, 1985 letter from Hockey shows that the August letter was misconstrued, and that he was, in fact, not stationary. We do not agree. There is nothing in the October letter that contradicted Hockey's earlier unequivocal statement that claimant was medically stationary.² Although the October letter noted that claimant should continue to receive time loss payments, it did not state that further improvement was to be expected.

Claimant also assigns as error the Board's denial of his request for attorney fees. The governing statute is ORS 656.382(2), which provides:

"If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or

¹ Claimant moved to supplement the record with deposition testimony of Hockey, which was taken more than a year after the hearing in preparation for an aggravation claim. He also seeks to submit additional evidence of a psychological evaluation by Dr. Radman who did not begin treatment of claimant until July, 1987. The motion is denied. See *Compton v. Weyerhaeuser Co.*, 301 Or 641, 724 P2d 814 (1986).

² Claimant's post-operative medical examinations have noted that he has been depressed and has significant functional overlay. Claimant argues that his psychological condition was not stationary at the time of closure. However, he has never undergone psychiatric treatment, and the medical reports do not indicate that his condition would improve with treatment.

the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

In this case, claimant challenged his medically stationary date, arguing that it was later than the date established in the determination order. Employer did not file a cross-request for review, but argued orally at the hearing that claimant became medically stationary before the date in the order.³ The referee found that the date in the determination order was proper and awarded claimant attorney fees. The Board reversed the referee on the attorney fees' issue, holding that, because the issue raised by the employer at the hearing was the same as that raised by claimant, he was not entitled to attorney fees.

ORS 656.382(2) provides that a claimant is entitled to attorney fees if a request for hearing or request for review is initiated by an employer or insurer. Here, claimant filed the request for hearing before the referee and the request for review before the Board. Employer filed neither a request for hearing nor review, nor any cross-request. Accordingly, under the terms of the statute, claimant is not entitled to attorney fees.⁴

The question remains whether an employer or insurer could be said to "initiate" a request for review in a situation when it argues an issue orally without formally filing a request, as in this case. In *Teel v. Weyerhaeuser Co.*, 294 Or 588, 660 P2d 155 (1983), the Supreme Court held that an issue that was raised by a procedure not specifically mentioned in ORS 656.382(2) would be deemed to "initiate" an issue for purposes of the statute. In that case, the employer had filed a cross-appeal to this court which, at that time, was not mentioned in the statute.⁵ The court held that:

"[T]he word 'initiated' encompasses raising issues that would otherwise not be dealt with by the reviewing body, and thus an initiation may take the form of a cross-appeal."

Assuming, without deciding, that an employer or insurer could "initiate" a request for review under the terms of the statute without formally filing a request or cross-request for review, employer did not do so here. The issue raised by claimant was when he became medically stationary. Employer's contentions were made in defense of the issue raised by claimant.

Affirmed.

³ The applicable statutes and administrative rules do not require the Board to limit its review to issues raised by the parties in their requests for review or cross-review. On *de novo* review, the Board may make such disposition of the case as it determines to be appropriate. *Neely v. SAIF*, 43 Or App 319, 602 P2d 1101 (1979), *rev den* 288 Or 493 (1980).

⁴ This is in contrast to *Travis v. Liberty Mutual Ins.*, 79 Or App 126, 717 P2d 1269, *rev den* 301 Or 445 (1986), where the insurer filed a cross-appeal to the Board. We held that the cross-appeal constituted a cross-request to the Board under the terms of the statute and that, because the insurer lost before the Board, claimant was entitled to attorney fees.

⁵ After the *Teel* decision, the statute was amended specifically to include cross-appeals.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Clay E. Hughes, Claimant.

HUGHES,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 86-00869; CA A46549)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 16, 1988.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were Lawrence Baron and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Jerry K. Brown, McMinnville, argued the cause for respondent. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board which reversed the referee's decision and upheld employer's denial. We affirm.

Claimant sought compensation for a low back condition which he asserted was an occupational disease. The issues raised by claimant are purely issues of fact. The petition for review was filed on November 18, 1987, consequently, our review is for substantial evidence. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). Claimant contends on appeal that our review is *de novo* and, consequently, has not pointed out any fact finding of the Board which he contends is not supported by substantial evidence in the record. We decline to search the record to determine if the facts recited by the Board are supported in the record. The Board adequately explains the reasoning from the facts it found to the conclusion it reached.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

HENDRICKSON,

Appellant,

v.

LEWIS et al,

Respondents.

(A8510-06526; CA A42747)

Appeal from Circuit Court, Multnomah County.

Robert L. Burns, Judge Pro Tempore.

Argued and submitted November 30, 1987.

John Wittrock, Portland, argued the cause for appellant.
On the brief was Kathleen O'Brien, Portland.

Harry Auerbach, Deputy City Attorney, Portland, argued
the cause for respondents. With him on the brief was Beth R.
Skillern, Associate Deputy City Attorney, Portland.

Before Richardson, Presiding Judge, and Newman and
Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded.

Cite as 94 Or App 5 (1988)

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RICHARDSON, P. J.

Plaintiff appeals a summary judgment for defendants on a claim for personal injuries and property damage as a result of an automobile accident with defendant Lewis, an employe of defendant city. Defendants pleaded immunity under ORS 30.265(3)(a), which shields municipalities and their employes from liability for injuries covered by the Worker's Compensation Act. At issue is plaintiff's contention that he was not in the course and scope of his employment at the time of the accident and, consequently, that his injuries are not covered under the act. We reverse.

Defendants submitted, with the motion for summary judgment, plaintiff's deposition and a copy of a claim form which he filled out and submitted to the city. Plaintiff did not file any contrary evidence and does not argue that there is an issue of fact. We summarize the undisputed facts. Plaintiff was employed in his family's business of selling and installing whirlpool bathtubs and was classified as a "sales and field engineer." His principal function was to demonstrate and sell the tubs; he testified in his deposition that he spent very little time driving for the company. On the day of the accident, he stopped on his way home at a lumber yard and picked up some lumber which he was going to use to build a display for his employer's use at home shows. He intended to take the lumber to his home and either work on the display there or store it for a period of time and build the display later at the company warehouse. He stated that, ordinarily, the warehousemen would pick up the lumber, but he did so because the lumber

yard was on his way home. The accident occurred after he had purchased the lumber and was enroute to his residence. He filed a claim with the city for his injuries using a printed form supplied by the city. He answered "yes" to the question on the form, "Were you on the job at the time of the accident?"

In a single claim, plaintiff sought damages for his personal injuries and for property damages to his truck. Although defendants' motion for summary judgment was imprecise, it was litigated by the parties as a motion for summary judgment on defendants' immunity defense.

Defendants' liability is governed by ORS 30.265(3)(a):

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"Every public body and its officers, employes and agents acting within the scope of their employment or duties * * * are immune from liability for:

"(a) Any claim for injury to or death of any person covered by any workers' compensation law."

Injuries covered by workers' compensation include accidental injuries "arising out of and in the course of employment." ORS 656.005(7)(a). In granting defendants' motion for summary judgment, the trial court determined that plaintiff was operating within the scope of his employment when he was injured.

Whether an injury has occurred in the course of employment depends on the particular facts of each case. *Wallace v. Green Thumb, Inc.*, 296 Or 79, 81, 672 P2d 344 (1983). An employee's injuries are generally not covered by workers' compensation if they are sustained while going to or coming from work. *Heide/Parker v. T.C.I. Incorporated*, 264 Or 535, 539, 506 P2d 486 (1973); *Walker v. SAIF*, 28 Or App 127, 129, 558 P2d 1270 (1977). The general principle, however, is subject to a number of exceptions. When a trip to or from work is combined with a business-related purpose, an injury incurred during the trip may be compensable. We discussed the exception to the general rule of noncompensability of injuries incurred on a trip to or from work in *Gumbrecht v. SAIF*, 21 Or App 389, 534 P2d 1189 (1975). In that case, the claimant, who travelled to and from work by bus, stopped at a shopping center on her way home to make a purchase on behalf of her employer. After the purchase, she continued her bus ride home, where she arrived about 30 minutes later than usual. While crossing the road from the bus stop to her residence, she slipped and was injured. She claimed that the work related aspects of the trip made her injuries compensable, because they arose out of and were sustained in the course of her employment. We concluded, after analyzing the "dual purpose" exception, that the business purpose had been accomplished when the claimant completed the purchase and continued her journey home. We said:

"The fact that at some earlier time in her journey claimant may have been performing a task for her employer did not change the nature of her journey home after the task was accomplished." 21 Or App at 395.

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basis for the summary judgment and plaintiff cannot contradict it by testimony in his deposition. Plaintiff testified on deposition:

Defendants argue that *Gumbrecht* is distinguishable or inapplicable for a variety of reasons. They first contend that plaintiff not only picked up the lumber but also intended to transport it to his home to build a display for his employer. The apparent argument is that the work errand would continue as long as the lumber was at plaintiff's residence. His testimony in the deposition was to the effect that the material was usually picked up by the warehousemen and that he typically built displays at the warehouse. His counsel indicated at argument on the motion that he intended either to work on the display at his home or to take the material to the warehouse and to build the display. An important part of the inquiry is whether he was benefitting the employer as opposed to completing a personal purpose at the time of the injury. In *Gumbrecht*, we held that the work relatedness of the errand had terminated even though the claimant was carrying the package she purchased for the employer and would have had to transport it to the work place on the next day. Here, plaintiff had completed the errand for his employer and was simply on his way home. The fact that he would later have to transport the materials to his place of work or to use the materials at his home did not convert the commuting trip to a business trip for the benefit of his employer. See *Johnson v. Emp. Benefits Ins. Co.*, 25 Or App 215, 548 P2d 519, *rev den* (1976).

Defendants also argue that plaintiff was required to use his own vehicle at work and thus was required by his employer to drive his car to the work place. Citing *Jenkins v. Tandy Corp.*, 86 Or App 133, 738 P2d 985, *rev den* 304 Or 279 (1987), they contend that the trip home was for his employer's benefit and that, therefore, he was in the course and scope of his employment. Plaintiff testified that his job required very little driving and that the only required driving in his employment was to home shows. There is no indication that he was required by his employer to drive his vehicle to work so that it could be used in his employment as a general matter or particularly on the day of the accident. There is no basis in the evidence to support the summary judgment on the theory propounded in *Jenkins*.

Another argument defendants make is that plaintiff admitted on the claim form that he was "on the job at the time of the accident." That admission, they argue, is a sufficient

"Q And on this claim form you indicated that you were on the job at the time of the accident.

"A Yes, I did say that.

"Q And are you now contending that you weren't on the job at the time of the accident?

"A Well, I feel that I'm on the job, because it's a family thing, all the time. Even when I'm on my way home, like they could have called me back if they wanted to, but I would have gone back and worked for nothing, it's just one of those things.

"Q Just because it's a family-owned-business?

"A Yes, ma'am."

Whether a person is injured in the course and scope of his employment is a legal conclusion based on particular facts. Plaintiff's assertion by his affirmative answer to the question on the claim form is a legal conclusion. He did not

contradict any fact contained in the claim form when he gave a deposition. The testimony in the deposition does not support the legal conclusion that plaintiff was in the course and scope of his employment at the time of the injury. We conclude that the court erred in granting defendants' motion for summary judgment.

Reversed and remanded.

No. 647

November 23, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Robert H. Anderson, Claimant.
STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Petitioners,

v.

ANDERSON,
Respondent.

(WCB 85-15825; CA A42722)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 21, 1987.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Karen M. Werner, and Malagon & Moore, Eugene.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

Cite as 94 Or App 11 (1988)

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RICHARDSON, P. J.

SAIF seeks review of a decision by the Workers' Compensation Board that claimant's stress-related psychological condition is compensable.

Claimant is a 38-year-old policeman employed by the city of Lebanon since 1978. Throughout his employment, he has been the subject of poor performance evaluations and disciplinary measures. The incidents are too numerous to recite here. They run from citizen complaints regarding claimant's lack of tact to an off-duty appearance at a New Year's Eve Party where minors were served alcohol. In addition, he has been the target of numerous allegations that he has misused sick time and conducted personal errands during times when he was on patrol.

Dr. Holland, a psychologist, conducted an evaluation of claimant's employment record. He reported that the files

included reports of 33 off-the-job injuries and non-job related illnesses, 13 on-the-job injuries and attendant compensation claims, at least 17 written notifications of unacceptable job performance, four special investigations into his conduct and at least 12 incidents of significant discrepancies between his description of events and the descriptions of others. The referee provided a summary of claimant's work performance and consequent relationship with employer:

"Claimant has been reprimanded or written up about 30 times. He denies the legitimacy of any complaint which was not fully documented to *his* satisfaction. On several occasions he has compounded the initial problem by 'asserting his rights' and filing a union grievance. Between claimant's conduct, the efforts at supervision, the union grievances, and claimant's numerous on and off job injuries, claimant can hardly be said to be a model officer. It is surprising under these circumstances that the department was able to get any work out of claimant at all."

The most recent disciplinary incident occurred on December 2, 1985. Claimant, his wife and his 22-year-old girlfriend were involved in a violent domestic fight in front of claimant's home. A neighbor observed the incident and reported that the two women began fighting and that claimant struck his wife several times in the face and stomach while trying to separate them. Claimant's wife subsequently denied

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being assaulted by him. He was suspended with pay pending an investigation of the incident. He filed this stress-related disability claim shortly thereafter. Insurer denied the claim, but the referee held the claim compensable and the Board affirmed. Claimant was eventually terminated. Our review is *de novo*, and we affirm.

SAIF did not assign as error the finding by the Board that claimant's disability is stress-related and that the work environment was the major contributing cause of the stress. SAIF does argue that stress caused by ordinary and justified disciplinary actions is not the type of work activity which produces a compensable result. A similar argument was advanced and rejected in *SAIF v. Varner*, 89 Or App 421, 749 P2d 606 (1988), where we concluded that if the discipline was objectively stressful, it would support a claim for a stress-related occupational disease. In this case, the disciplinary actions, even though justified, were objectively stressful. SAIF admits that, "[i]f the legislature intended that the type of stress contended in this case does form such a basis, then this claim is compensable, because it was job related."¹ Although we have some hesitancy in concluding that the work-related discipline, although a cause of stress, was the major contributing cause when compared with the events of claimant's personal life, we accept SAIF's concession.

Affirmed.

¹ The definition of "occupational disease" was changed in 1987. We apply the prior law to this claim, which arose before the amendment became effective. See ORS 656.802(2)(b).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Sandra L. Berkey, Claimant.

BERKEY,
Petitioner,

v.

FAIRVIEW HOSPITAL et al,
Respondents.

(WCB 86-00608; CA A45337)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 4, 1988.

Donald O. Tarlow, Newberg, argued the cause for petitioner. With him on the brief was Brown & Tarlow, P.C., Newberg.

Darrell E. Bewley, 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 Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order which affirmed the referee's decision denying temporary total disability benefits. Claimant contends that she was entitled to them after she filed an aggravation claim because employer had knowledge of medical verification of her inability to work. ORS 656.273(6). We agree and reverse.

Claimant suffered a compensable injury to her left shoulder while working for Fairview Hospital on December 8, 1984. She was awarded 15 percent unscheduled permanent partial disability and did not return to work at Fairview or find other employment. She continued to receive treatment for her injury and obtained vocational counseling. On March 13, 1986, her treating physician, Dr. Winkler, wrote to SAIF and requested that her claim be reopened due to marked tenderness and pain in her left shoulder. On March 18, 1986, her vocational counselor made a report to SAIF which stated, in part:

"In February, [claimant], after missing a fourth appointment, indicated to me that Dr. Winkler had told her that he did not want her to participate in further vocational rehabilitation, as her back and shoulders were deteriorating and that she did not have the physical ability to return to work or to even participate in looking for work.

"I contacted Dr. Winkler by letter and in a statement from him, he verified this recommendation. On March 17th, I notified Ms. Wilch at SAIF about this development and she recommended case closure." (Emphasis supplied.)

SAIF denied claimant's aggravation claim on July 22, 1986, but made no temporary disability payments during the interim. Claimant requested a hearing and the referee upheld SAIF's denial. The referee also denied her claim for temporary total disability, because SAIF had not received medical verification of her inability to work before July 22, 1986, when it denied her aggravation claim. In affirming the referee's order, the Board explained:

"The physician's only direct communication with SAIF referred only to the need for additional medical services. The remaining pertinent information came from a vocational provider who, because he or she was presumably not a physician, necessarily interpreted the doctor's report as a layperson."

Cite as 94 Or App 28 (1988)

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Claimant does not dispute SAIF's denial of her aggravation claim. She contends only that the Board erred in concluding that SAIF did not receive medical verification of her inability to work. SAIF argues that medical verification of claimant's inability to work must come *directly* from Dr. Winkler. See *Crooke v. Gresham Transfer*, 88 Or App 246, 744 P2d 1316 (1987).

Entitlement to interim compensation in the form of temporary total disability depends on whether, before denial of an aggravation claim, there was medical verification of a claimant's inability to work. ORS 656.273(6);¹ *Silsby v. SAIF*, 39 Or App 555, 561, 592 P2d 1074 (1979). If the employer has notice or knowledge of verification, temporary total disability payments must begin within 14 days. ORS 656.273(6). The notification is not intended to establish a substantive right to compensability but is intended to ensure prompt payment of interim support to a worker who has filed an aggravation claim. *Silsby v. SAIF*, *supra*, 39 Or App at 562.

Under the circumstances of this case, we conclude that SAIF received adequate notice of medical verification by a physician of claimant's inability to work. Dr. Winkler notified SAIF that claimant's compensable injury had worsened. Five days later, her vocational counselor reported to SAIF that Dr. Winkler informed her that claimant could not work due to a worsening of her compensable injury. This was sufficient medical verification to trigger SAIF's duty to pay temporary total disability.

Claimant next contends that she is entitled to penalties and attorney fees under ORS 656.262(10) because SAIF unreasonably failed to make the interim payments. Neither the referee nor the Board considered whether penalties and attorney fees were warranted. We therefore remand to the Board for a determination of the amount of temporary total

¹ ORS 656.273(6) provides:

"A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first instalment of compensation due under ORS 656.262(4) shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition."

disability and to determine whether SAIF's failure to pay interim compensation justifies penalties and attorney fees.

Reversed and remanded.

No. 659

November 23, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Ronald D. Chaffee, Claimant.

CHAFFEE,
Petitioner,

v.

NOLT et al,
Respondents.

(WCB 85-03983; CA A46200)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 1, 1988.

David J. Hollander, Portland, argued the cause for petitioner. With him on the brief was David J. Hollander & Associates, Portland.

Jerry K. Brown, McMinnville, argued the cause for respondents. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.

Before Buttler, Presiding Judge, and Graber and Riggs, Judges.

BUTTLER, P. J.

Affirmed.

Cite as 94 Or App 83 (1988)

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BUTTLER, P. J.

Claimant seeks review of an order of the Workers' Compensation Board. We conclude that substantial evidence supports the Board's findings that claimant was medically stationary without permanent disability at the time employer issued its notice of closure, that his compensable back injury did not contribute to the onset or worsening of his psychological condition and that chiropractic treatments in excess of two per month are not reasonable and necessary. We affirm the Board on all of those issues without discussion, and write only to address one procedural question raised by claimant.

Three days before it issued its notice of closure, employer determined that it would pay no further benefits for claimant's back problem and sent him a letter stating:

"Our on-going medical investigation shows that you are experiencing symptoms related to a psychological condition. We are hereby denying any psychological condition as not related to your condition."

At the hearing, employer's counsel stated that the letter was intended to indicate that all of claimant's back symptoms were related to the noncompensable psychological condition

and to deny all future benefits for the back condition. Although characterized as a "partial denial" of the psychological condition, *see Georgia Pacific v. Piowar*, 305 Or 494, 501, 753 P2d 948 (1988); *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987), given counsel's interpretation of the letter, it was not a denial of a separate condition from the one that had been accepted originally. It was, in effect, a prospective denial of the back condition for which employer had been paying benefits all along, and, as such, was improper. *See Roller v. Weyerhaeuser*, 67 Or App 583, 679 P2d 341, *on reconsideration* 68 Or App 743, 683 P2d 554, *rev den* 297 Or 601 (1984); *Safstrom v. Riedel International, Inc.*, 65 Or App 728, 672 P2d 392 (1983), *rev den* 297 Or 124 (1984); *Aquillon v. CNA Insurance*, 60 Or App 231, 235, 653 P2d 264 (1982), *rev den* 294 Or 460 (1983).

However, we agree with the Board that, in view of employer's prompt closure of the claim immediately after the issuance of the denial, it does not appear that its conduct was intended to shortcut the ordinary process of claim closure or was otherwise unreasonable. The Board, therefore, did not err in deciding the compensability of claimant's psychological condition.

Affirmed.

No. 662

November 23, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

JUNGEN et al,
Appellants,

v.

STATE OF OREGON,
Respondent.

(L86-2634; CA A45994)

Appeal from Circuit Court, Douglas County.

Joan G. Seitz, Judge.

Argued and submitted September 28, 1988.

G. Dennis Halkides, Redding, California, argued the cause for appellants. With him on the briefs was Halkides & Morgan, Redding, California.

Margaret E. Rabin, Assistant Attorney General, Salem, argued the cause for respondent. 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.

Affirmed.

Cite as 94 Or App 101 (1988)

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WARREN, J.

Plaintiffs appeal from an ORCP 67B judgment granting the state's motion to dismiss a claim on the ground that the state is immune from liability under ORS 30.265(3)(a).

Alfred Jungen, an employee of a California corporation, was fatally injured when the tractor he was driving overturned on an Oregon state highway. His employer's workers' compensation carrier paid benefits to his surviving spouse, who, as administratrix of his estate, brings this wrongful death action against the state, alleging that it negligently constructed and repaired the road. Fremont Indemnity Company, claiming that it is subrogated to the administratrix's rights, seeks reimbursement for the workers' compensation benefits it paid to the deceased's spouse.

ORS 30.265, a section of the Oregon Tort Claims Act, provides, in relevant part:

"(1) Subject to the limitations of ORS 30.260 to 30.300, every public body is subject to action or suit for its torts and those of its officers, employees and agents acting within the scope of their employment or duties ***.

"* * * * *

"(3) Every public body *** [is] immune from liability for:

"(a) Any claim for injury to or death of any person covered by any workers' compensation law."

Plaintiffs contend that subsection (3)(a) violates both Article I, section 20, of the Oregon Constitution and the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution by discriminating against persons receiving workers' compensation benefits. They argue that it precludes them from suing the state for pain, suffering, emotional injuries and loss of consortium, which are not recoverable under the Workers' Compensation Law, but are recoverable by persons who are not covered by workers' compensation and who are allowed to sue the state. See ORS 30.020.

Plaintiffs make the same arguments in support of both their state and federal claims. They argue, first, that

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Article I, sections 1 and 10,¹ of the Oregon Constitution create an "important" or a "fundamental" right guaranteeing to each person "the right to sue for all compensable components of personal injury." They urge us to apply strict judicial scrutiny to determine if subsection (3)(a) narrowly accomplishes a compelling state purpose. Plaintiffs acknowledge that we rejected an Article I, section 20, constitutional challenge of an earlier version of that subsection in *Edwards v. State Military Dept.*, 8 Or App 620, 494 P2d 891, *rev den* (1972), where we held that the classification was reasonable and did not offend the equal protection guarantees of the Oregon or United States Constitutions. 8 Or App at 626; *see also Millsbaugh v. Port of Portland*, 65 Or App 389, 394, 671 P2d 743 (1983), *rev den* 296 Or 411 (1984). They argue, however, that *Edwards* is not dispositive in this case, because there we applied the rational basis standard of review and not strict judicial scrutiny, which they contend is warranted here because a "fundamental right" is involved. They also contend that the statute

¹ Article I, section 1, provides, in part, that "[w]e declare that all men, when they form a social compact are equal in right * * *." Article I, section 10, provides, in relevant part, that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation."

does not satisfy the rational basis standard of review. Alternatively, they argue that under the "balancing test" of *Olsen v. State ex rel Johnson*, 276 Or 9, 20, 554 P2d 139 (1976), the detriment caused to them by subsection (3)(a) outweighs the state's justification.

We address plaintiffs' state constitutional claim first. We consider plaintiffs Article I, section 20,² challenge, despite our earlier decision in *Edwards v. State Military Dept.*, *supra*, because the Oregon Supreme Court has altered its Article I, section 20, analysis since we issued that decision. The court in *Olsen v. State ex rel Johnson*, *supra*, announced a "balancing test" approach in place of the federal "fundamental rights" analysis. Although the court has not explicitly rejected the *Olsen* test, it has not in recent years applied it to an Article I, section 20, challenge. See Schuman, "The Right to Equal Cite as 94 Or App 101 (1988) 105

Privileges and Immunities: A State's Version of 'Equal Protection,' " 13 Vt L Rev 221, 228 n 43 (1988).³ Therefore, we turn to its current analysis, as articulated, in part, in *State v. Clark*, *supra* n 3, 291 Or at 240. In order to succeed, plaintiffs must show, (1) that another group has been granted a "privilege" or "immunity" which their group has not been granted, (2) that subsection (3)(a) discriminates against a "true class" on the basis of characteristics which they have apart from that statute, *Hunter v. State of Oregon*, *supra* n 3, 306 Or at 533; *State v. Clark*, *supra* n 3, 291 Or at 240, and (3) that the distinction between the classes is either impermissibly based on persons' immutable characteristics, which reflect "invidious" social or political premises, or has no rational foundation in light of the state's purpose. *Van Daam v. Hegstrom*, 88 Or App 40, 43-44, 744 P2d 269 (1987), *rev den* 305 Or 433 (1988).

The opportunity to sue the state is a "privilege" which subsection (3)(a) denies to persons who have recovered workers' compensation benefits. By doing so, it discriminates against a "true class" and therefore, is subject to Article I, section 20, scrutiny. The distinction drawn between persons receiving workers' compensation benefits and those not receiving benefits is established by workers' compensation laws, *see* ORS 656.001 *et seq.*, and exists independently of subsection (3)(a). *Van Daam v. Hegstrom*, *supra*, 88 Or App at 45. That distinction is not based on immutable personal characteristics, such as race or gender. Accordingly, plaintiffs must show that subsection (3)(a) is not rationally related to a legitimate state purpose. Plaintiffs have failed to do so. We conclude, for the reasons we discussed to in *Edwards*, that there is

² Article I, section 20, provides:

"No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

³ The author points out on page 228, n 43, that "*Olsen* predated the court's rejection of judicial balancing, and has not been followed. In *Hunter v. State*, 84 Or App 698, 735 P2d 1225 (1987), the Oregon Court of Appeals decided a criminal procedure case using the *Olsen* balancing test. The Supreme Court of Oregon allowed review and requested counsel to brief the question of *Olsen*'s continuing validity." In *Hunter v. State of Oregon*, 306 Or 529, 533, 761 P2d 502 (1988), the Supreme Court applied the *Clark* analysis, *see State v. Clark*, 291 Or 231, 240, 630 P2d 810, *cert den sub nom Clark v. Oregon* 454 US 1084 (1981), and did not discuss *Olsen*.

a rational basis for retaining governmental immunity as to those persons receiving workers' compensation benefits.

We turn to plaintiffs' argument that the statute violates the Equal Protection Clause of the Fourteenth Amendment.⁴ The right to sue the state is not a "fundamental right" requiring strict judicial scrutiny under a federal analysis, because it is not a right that is "explicitly or implicitly protected by the [United States] Constitution." *San Antonio School District v. Rodriguez*, 411 US 1, 16-17, 93 S Ct 1278, 36 L Ed 2d 17 (1973); see also *State v. Wagner*, 305 Or 115, 139, 752 P2d 1136 (1988). Our conclusion that there is a rational basis for the statute under plaintiffs' state claim is equally applicable to their federal claim.

Affirmed.

⁴ The Equal Protection Clause of the Fourteenth Amendment provides that "[n]o state shall . . . deny to any person within its jurisdiction the equal protection of the laws."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Felix A. Mershon, Claimant.

MERSHON,
Petitioner,

v.

OREGONIAN PUBLISHING et al,
Respondents.

(85-11970; CA A42850)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 23, 1988.

Robert K. Udziela, Portland, argued the cause for petitioner. On the brief were Christopher G. Cournoyer, and Pozzi, Wilson, Atchison, O'Leary and Conboy, Portland.

Ridgway K. Foley, Jr., Portland, argued the cause for respondents. On the brief were Allan M. Muir, Christopher B. Rounds, Delbert J. Brenneman, and Schwabe, Williamson and Wyatt, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded.

Cite as 94 Or App 127 (1988)

ROSSMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's dismissal of his claim for failure to comply with a prehearing order requiring discovery.

Claimant sought a hearing on employer's denial of the claim. Before the hearing, employer sought a private meeting with claimant's physician. Claimant instructed his physician to refuse to meet with employer unless claimant's attorney was also present. The referee, relying on a Board opinion, held that employer was entitled to "full, complete and private access" to claimant's physician. The referee issued orders to that effect on December 31, 1985, February 19, 1986, and March 31, 1986. Claimant refused to comply. Finally, on May 28, 1986, the referee dismissed the claim for "want of prosecution," and the Board affirmed without opinion.

The first question is whether the referee had authority to dismiss the claim. OAR 438-06-085, the administrative rule on which the referee relied, provides:

"A request for hearing may be dismissed for want of prosecution where the party requesting the hearing occasions a delay of more than ninety (90) days without good cause. Prior to dismissal an order may be entered allowing a specific time within which the party requesting the hearing will have the opportunity to show cause why the case should not be dismissed. The filing of an application for a hearing date without explanation for the prior delay does not constitute a showing of good cause."

The referee apparently concluded that the "delay" occasioned by claimant's continued refusal to comply with the order allowing discovery justified dismissal. As we understand the rule, however, it is intended to apply to delays occasioned by a party's refusal to allow a case to come to hearing. It is not a sanction for a failure to comply with discovery. See OAR 438-07-015(3);¹ OAR 438-07-005(5), (6) and (8).² The referee dismissed this matter even before the originally scheduled hearing date. Claimant had not requested a postponement or otherwise insisted on a delay of the hearing date. The claim should not have been dismissed for want of prosecution.

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¹ OAR 438-07-015(3) provides:

"Upon written demand by the insurer, the claimant shall within fifteen (15) days of the mailing of said demand, furnish to the insurer, without cost, copies of all medical and vocational reports and other documents pertaining to the claim which are then or come to be in the possession of the claimant and which the insurer would not reasonably be expected to receive through claims processing, except that evidence offered solely for impeachment need not be so disclosed. Failure to comply with this section may be considered grounds for postponement of the hearing or dismissal of the request for hearing."

² OAR 438-07-005 provides, in part:

"(5) The insurer may subpoena the claimant's doctor or vocational expert for cross-examination. Medical, surgical, hospital or 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 herself or himself available for cross-examination shall be excluded from the record unless good cause is shown to receive such evidence.* The cost of 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.

"*****"

"(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 or the referee.*" (Emphasis supplied.)

We address the merits of the petition, because the question will arise again on remand. Employer asserts that, by virtue of OAR 436-10-030, it is entitled to full and unrestricted access to claimant's physician for the purpose of discovery. That rule provides, in part:

"The act of the worker in applying for workers' compensation benefits constitutes authorization for any physician, hospital, or other medical vendor to supply relevant information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, or the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. No person who reports to these persons in accordance with department rules shall bear any legal liability for disclosure of such (ORS 656.252). The physician may require evidence from the representative of his or her representative capacity. The authorization is valid for the duration of the work-related injury or illness."

Cite as 94 Or App 127 (1988)

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The rule implements the requirements of ORS 656.252 regarding the filing of reports by attending and consulting physicians. It is not a discovery provision through which employer could obtain the information it seeks. Although there is no doubt that the rule *authorizes* physicians to release information relevant to the claim, and protects them if they do so in accordance with the department's rules, the rule does not itself *require* the disclosure of information or indicate how that information must be disclosed.

The Board has provided for discovery elsewhere in its rules. OAR 438-06-055;³ OAR 438-07-005(5) and (6); OAR 438-07-015(3). It expressly encourages the use of conventional discovery tools, including depositions and interrogatories, and provides for sanctions against a party who refuses to make medical reports available. OAR 438-07-005(6) and (8); OAR 438-07-015(3). Employer was entitled to seek the information it wants through those provisions, but it apparently chose not to do so. In view of the availability of conventional methods of discovery, the referee should not have ordered that claimant make his physician available for a private conference and should not have dismissed the request for hearing when claimant refused to comply. Claimant's motion to remand for further evidence taking is moot.

Reversed and remanded.

³ OAR 438-06-055 provides:

"Depositions are permitted by agreement of the parties, or by approval of a referee subject to the provisions of ORS 656.285."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Thomas R. Lucas, Claimant.
STATE ACCIDENT INSURANCE FUND
CORPORATION et al,
Petitioners,
v.
LUCAS,
Respondent.

(WCB 85-04275; CA A44281)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 8, 1988.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmeier, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James O. Marsh, Portland, argued the cause for respondent. With him on the brief was Carney, Buckley, Kasameyer & Hayes, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Insurer seeks review of the Workers' Compensation Board's order that determined that claimant sustained a compensable worsening of a preexisting personality disorder.

Our review is *de novo*. Except for a 21 month period, claimant worked for the Josephine County Sheriff's Department from February, 1974, until March 15, 1985. He had a good work record until August, 1984, when his supervisor disciplined him for an incident involving a struggle with a suspect. In the succeeding months, his superiors subjected him to a series of disciplinary actions that culminated in his discharge on March 15, 1985. Insurer denied the stress claim that claimant filed.

The referee found that claimant had good performance evaluations every six months through June, 1984. The parties stipulated, and the referee found, that the disciplinary actions involving claimant were real events that occurred during the course and scope of his employment and were capable of causing stress. The referee also found that the employment conditions, when compared to "the off the job and non-course and scope factors," were "the major contributing cause" of claimant's symptoms. Based on the medical testimony, however, the referee concluded that claimant was suffering from a noncompensable preexisting personality disorder and that the claim was not compensable.

On review, the Board reversed the referee. It stated that

"the symptoms of a preexisting personality disorder and the disorder itself are one and the same; if the symptoms worsen, the underlying condition has worsened. Our decision was dictated by the Court of Appeals' holding to that effect in *Adsitt v. Clairmont Water District*, 79 Or App 1, 6, 717 P2d 1231, *rev den* 301 Or 338, 301 Or 666 (1986). We reaffirm that rule in this case. Claimant, therefore, sustained a compensable worsening of his preexisting personality disorder and [insurer's] denial must be set aside."

We affirm, but on other grounds.

We have reviewed the extensive medical evidence. We find that claimant was suffering from an occupational

Cite as 94 Or App 132 (1988)

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stress disorder, and not from a preexisting personality disorder. We also find that stressful conditions objectively existed on the job and that the employment conditions, when compared to non-employment conditions, were the "major contributing cause" of claimant's disease. See *McGarrah v. SAIF*, 296 Or 145, 166, 675 P2d 159 (1983). Claimant suffered from an occupational disease which is compensable. *Former* ORS 656.802¹.

Affirmed.

¹ *Former* ORS 656.802(1)(a) provided that an occupational disease is:

"Any disease or infection which arises out of and in the scope of the employment, and to which the employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

Oregon Laws 1987, chapter 713, section 4, amending *former* ORS 656.802, does not apply.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Barbara June Meherin, Claimant.

MEHERIN,
Petitioner - Cross-Respondent,
v.

STAYTON CANNING CO.,
Respondent - Cross-Petitioner.
(86-00160; CA A45922)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 9, 1988.

Bruce D. Smith, Salem, argued the cause for petitioner - cross-respondent. With him on the briefs was Michael B. Dye, Salem.

Craig A. Staples, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

On petition, remanded to the Board to determine the compensability of claimant's scoliosis and otherwise affirmed; affirmed on cross-petition.

PER CURIAM

In this workers' compensation case, claimant experienced a compensable back injury, which employer accepted. Employer subsequently issued a "partial denial" of claimant's scoliosis. Claimant properly challenged the denial by requesting a hearing. The referee determined that the scoliosis was compensable, and that, in addition, employer's denial of the condition was precluded by *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983). The Board correctly reversed the referee on the *Bauman* question, noting that *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987), permits the partial denial of a condition that has not, as here, been formally accepted. However, it erred in remanding the matter to the Evaluation Division to determine the compensability of the scoliosis. The parties agree that the Board should have determined that question.

On petition, remanded to the Board to determine the compensability of claimant's scoliosis and otherwise affirmed; affirmed on cross-petition.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James G. Adams, Claimant.

GIUSTI WINE CO. et al,
Petitioners,

v.

ADAMS et al,
Respondents.

(86-08747, 85-15626, 86-01876, 86-08746;
CA A46450)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 9, 1988.

Patric J. Doherty, Portland, argued the cause for petitioners. With him on the brief were Karli L. Olson and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

James L. Edmunson, Eugene, argued the cause for respondent James G. Adams. With him on the brief were A. Sue Guthrie and Malagon & Moore, Eugene.

Otto R. Skopil, III, Portland, argued the cause for respondent United Pacific Insurance. With him on the brief were Bruce L. Byerly and Moscato & Byerly, Portland.

Craig A. Staples, Portland, argued the cause for respondent Western Employers Insurance. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Christopher P. Thomas, Portland, argued the cause for respondent Royal Insurance. On the brief was Daryll E. Klein, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Reversed and remanded.

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Giusti Wine Co. v. Adams

PER CURIAM

In this workers' compensation case, EBI seeks review of a decision of the Board determining that claimant's request for hearing was not untimely.

On August 19, 1985, EBI issued a denial of responsibility for claimant's aggravation claim. It sent the letter by certified mail, return receipt requested, to claimant's correct address. Claimant did not claim the letter, despite notices left by the post office on August 21 and 27. On October 29, 1985, employer sent a copy of the notice of denial through the regular mail. Claimant received it on November 4, 1985. He filed a request for hearing on December 18, 1985.

The Board held that the request for hearing was not untimely, because the time for filing the request did not begin to run until claimant actually received notice of the denial. As

we held in *Cowart v. SAIF*, 86 Or App 748, 740 P2d 249 (1987), the date of mailing, not receipt, starts the running of the 60 days under ORS 656.319. Because the notice was mailed August 19, 1985, claimant's request for hearing was not timely, and we reverse and remand for a determination of whether claimant had good cause for filing a late request for hearing.

Reversed and remanded.

No. 677

November 23, 1988

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Delores A. Martin, Claimant.

AMFAC, INC., et al,
Petitioners,

v.

MARTIN,
Respondent.

(WCB 86-01972; CA A47324)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 3, 1988.

Janet M. Schroer, Portland, argued the cause for petitioner. With her on the brief were William H. Replogle and Schwabe, Williamson & Wyatt, Portland.

Kenneth D. Peterson, Jr., Hermiston, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

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AMFAC, Inc. v. Martin

PER CURIAM

Employer seeks review of a decision of the Workers' Compensation Board affirming without opinion the referee's determination that claimant's carpal tunnel syndrome is compensable. The referee reviewed the conflicting medical evidence and concluded that, because claimant had had no prior wrist symptoms and her treating physician believed that the present symptoms constituted a worsening of carpal tunnel syndrome, the syndrome was compensable. The referee made no findings as to whether the syndrome is compensable as an occupational disease or as an injury or, if a disease, whether it was a preexisting condition. Without findings on those questions, it is impossible for us to determine whether the referee applied the correct legal standard for compensability. Therefore, the findings and opinion are not adequate for judicial review. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).¹

Reversed and remanded for reconsideration.

¹ In its brief, employer asserted that the petition for review was not timely or properly perfected because the original certificate of service did not list the Workers' Compensation Board. The amended certificate of service shows that the Board was properly served. The petition was timely.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Harold D. Tallent, Claimant.

METRO MACHINERY RIGGING et al,
Petitioners,

v.

TALLENT,
Respondent.

(WCB 85-09741; CA A47908)

Judicial Review from Workers' Compensation Board.

Submitted on record and brief October 10, 1988.

Priscilla M. Taylor and Davis and Bostwick, Portland,
filed the brief for petitioners.

No appearance for respondent.

Before Warden, Presiding Judge, and Graber and Riggs,
Judges.

GRABER, J.

Affirmed.

Cite as 94 Or App 245 (1988)

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GRABER, J.

Metro Machinery Rigging and EBI Companies (EBI) seek review of an order of the Workers' Compensation Board that denied EBI's request to offset an alleged overpayment of compensation against any future benefits paid to claimant. The referee found, and the Board agreed, that there was no evidence to support the amount of overpayment claimed by EBI or to explain how that amount was calculated. EBI argues that there was not substantial evidence to support the Board's finding (in other words, that it is entitled to the overpayment as claimed) or, at a minimum, that we should remand the case to the referee for a determination of the amount of offset. On review for substantial evidence and errors of law, ORS 656.298(6), we affirm.

Claimant injured his head and wrist on June 29, 1984, when he fell from a roof. On September 10, 1984, the Evaluation Division issued a determination order awarding him 10% unscheduled permanent partial disability (PPD) and 30% scheduled PPD. He requested a hearing. Later he entered an authorized training program and, as a result, the hearing was postponed until he completed the program.

On January 8, 1987, the Division issued a second determination order, which noted claimant's completion of the training program but made no change in the disability award. The new determination order also awarded claimant temporary total disability (TTD) benefits from March 10, 1986, to October 10, 1986, and found him to have been medically stationary since June 21, 1985. On February 17, 1987, EBI sent claimant a letter advising him that

"[a]n audit of the Determination Order has now been completed. As you know, the Determination Order terminated your benefits effective October 10, 1986 and we continued to pay you benefits through January 9, 1987.

"Therefore, this has created an overpayment in the amount of \$3,949.46. We will be requesting authorization to recover this from any future benefits."

On February 18, 1987, EBI filed a response to the request for hearing, raising the issue of overpayment.

248 A hearing took place on March 2, 1987. The only Metro Machinery Rigging v. Tallent

evidence on the overpayment was EBI's letter of February 17 and claimant's statement at the beginning of the hearing:¹

"MR. TALLENT: There's one thing I wanted to ask and, you know, I'm not familiar with any of this. The last checks that I got, they mailed me two checks on—it was on January—it was either the 8th—it was on a Saturday. I think it was either on the 8th or the 9th. One check was mine, because it was my last check, and I took that check back, and I can't figure out how it could be almost \$4,000 when I was only out of school for three months, and I wasn't even hardly getting \$1,000 a month.

"REFEREE: Well, that's something that [EBI's representative is] going to have to prove, how they came up with that amount."

In his opinion and order, the referee found that EBI had followed the proper procedure in notifying claimant of the alleged overpayment, *see* OAR 436-60-170,² but had failed to present sufficient evidence at the hearing to prove the amount of the overpayment alleged and how it was calculated.³

EBI "is entitled to an offset of benefits that have been paid only if the evidence shows that the claimant was not entitled to the benefits." *Fazzolari v. United Beer Distributors*, 91 Or App 592, 595, 757 P2d 857, 93 Or App 103, 761 P2d 6 (1988). EBI's letter fulfills the procedural requirement of notification but, without more, is insufficient to prove EBI's entitlement to a particular amount of overpayment by a preponderance of the evidence.

EBI relies in its brief on an audit sheet, dated February 12, 1987, which details the method of calculating the
Cite as 94 Or App 245 (1988) 249

claimed overpayment. The audit sheet was not introduced at the hearing, however. EBI moved to reconsider, seeking to add the audit sheet to the record. The referee denied the motion on the basis that

¹ Claimant was unrepresented at the hearing and is unrepresented on appeal.

² OAR 436-60-170 provides the following requirements for notifying a claimant of an overpayment and the intent to offset it against future benefits:

"(1) Insurers may recover overpayment of benefits paid to a worker through the procedure specified by ORS 656.268(10).

"(2) Recovery of overpayment by the insurer shall be explained in written form to the worker, and the worker's attorney if represented, or to the dependent(s) of the worker if a fatality, and include:

"(a) An explanation for the reason of overpayment;

"(b) The amount of the overpayment; and

"(c) The method of recovery of the overpayment."

³ The opinion and order also increased claimant's award of unscheduled PPD to 30 percent.

"the argument presented, carried to its logical conclusion, denies the need for evidence to prevail on an issue, as well as concepts of finality and *res judicata*."

In affirming the referee, the Board rejected EBI's entreaty to remand to the referee for consideration of the audit sheet.

"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 for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. *Kienow's Food Stores v. Lyster*, 79 Or App 416, [719 P2d 890] (1986); *Delfina P. Lopez*, 37 Van Natta 164, 170 (1985).

"After de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we find that the additional evidence regarding the amount of the overpayment was obtainable with due diligence at the time of the hearing. Accordingly, we conclude that remand is not warranted and affirm the order of the Referee."

The Board applied the correct legal standard to EBI's request to supplement the record. See *Compton v. Weyerhaeuser Co.*, 301 Or 641, 647-48, 724 P2d 814 (1986). There is substantial evidence to support the Board's finding that the audit sheet was obtainable at the time of the hearing, because it was EBI's own document and was prepared well before the hearing. Consequently, there also is substantial evidence to support the Board's finding that the hearing record failed to establish EBI's entitlement to the overpayment.

Affirmed.

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November 30, 1988

No. 697

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Edward O. Miller, Claimant.

MILLER,
Petitioner,

v.

GLEN FALLS INSURANCE et al,
Respondents.

(WCB 82-0210M; CA A45745)

Judicial Review from Workers' Compensation Board.

Submitted on record and briefs October 13, 1988.

Millard M. Becker, Portland, filed the brief for petitioner. With him on the brief was Becker & Hunt, Portland.

Patric J. Doherty, Portland, filed the brief for respondents Brander Meat Company and Glen Falls Insurance. With him on the brief were Ronald W. Atwood, and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Respondent Coast Packing Company waived appearance.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

Cite as 94 Or App 264 (1988)

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PER CURIAM

In this workers' compensation case, claimant seeks review of the Board's "Own Motion Order on Remand"¹—dated August 21, 1987, in which the Board ruled that claimant was not entitled to an award of permanent disability for "either his compensable 1970 head injury or his complex partial seizure disorder." Employer agrees with claimant that the Board's findings are insufficient for judicial review under ORS 656.298(6) and *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).²

Reversed and remanded for reconsideration.

¹ We had remanded this case to the Board in *Miller v. Coast Packing Company*, 84 Or App 83, 733 P2d 97 (1987).

² Claimant's other assignment of error is rendered moot by the Order of Remand.

No. 702

December 7, 1988

283

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
James W. Howard, Claimant.

HOWARD,
Petitioner,

v.

LIBERTY NORTHWEST INS. et al,
Respondents.

(WCB 86-11692; CA A46394)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 6, 1988.

Michael G. Erwert, Wilsonville, argued the cause and filed the brief for petitioner.

Kay E. Kinsley, Salem, argued the cause for respondents. With her on the brief was Kevin L. Mannix, P. C., Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLE, P. J.

Affirmed.

Warren, J., dissenting.

Cite as 94 Or App 283 (1988)

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BUTTLE, P. J.

In this workers' compensation case, claimant seeks review of a Board order affirming the referee's determination

that he is not entitled to a penalty for employer's delay in paying him the amount agreed upon in a disputed claim settlement agreement. ORS 656.289(4).

The threshold question is whether the Board has jurisdiction to enforce the agreement. In *EBI Companies v. Moore*, 90 Or App 99, 750 P2d 1194 (1988), we held that the Board had jurisdiction over a dispute between the claimant and the insurer where the claimant asserted that the insurer had violated the terms of a disputed claim settlement by not paying all outstanding medical bills in full, as it had allegedly agreed to do. Employer's argument here raises questions regarding the Board's jurisdiction that were not considered in *Moore* and require further consideration. We conclude, however, that the Board has jurisdiction to enforce such agreements.

The Hearings Division of the Board has jurisdiction over all "disputes and controversies *regarding matters concerning a claim* under ORS 656.001 to 656.794, and for conducting such other hearings and proceedings as may be prescribed by law." ORS 656.708. (Emphasis supplied.) ORS 656.283(1) provides that "any party * * * may at any time request a hearing *on any question concerning a claim.*" (Emphasis supplied.) ORS 656.704 provides, in part:

"(1) Actions and orders of the director, and administrative and judicial review thereof, *regarding matters concerning a claim* under ORS 656.001 to ORS 656.794[,] are subject to the procedural provisions of ORS 656.001 to ORS 656.794 and such procedural rules as the board may prescribe.

"(2) Actions and orders of the director and the conduct of hearings and other proceedings pursuant to ORS 656.001 to ORS 656.794, and judicial review thereof, *regarding all matters other than those concerning a claim* under ORS 656.001 to 656.794, are subject only to ORS 183.310 to 183.550 and such procedural rules as the director may prescribe. * * *

"(3) For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under ORS 656.001 to 656.794, and for determining the procedure for the conduct

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Howard v. Liberty Northwest Ins.

and review thereof, *matters concerning a claim* under ORS 656.001 to 656.794 are those matters under which a worker's right to receive compensation, or the amount thereof, are directly in issue." (Emphasis supplied.)

Matters directly concerning a worker's right to receive compensation come before the Board and its appointed agents and are subject to review pursuant to ORS chapter 656. Matters other than those in which the worker's right to compensation is directly in issue come before the director and his appointed agents and are subject to review pursuant to ORS 183.310 to ORS 183.550. "Compensation" is defined as "all benefits, including medical services, *provided for a compensable injury* to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." ORS 656.005(8). (Emphasis supplied.)

When claimant filed his claim, which employer denied, there is no question but that the dispute directly involved "a worker's right to receive compensation." Because

it did, it could be resolved only within the workers' compensation system, either by order or, if there were a *bona fide* dispute over the compensability of the claim, by agreement, with the approval of the referee, the Board or the court. ORS 656.289(4).

The agreement here provides that "[t]his claim shall remain denied and that no legal rights related to this claim, either present or future, express or implied, shall survive the settlement of this claim, and none shall arise after the settlement of this claim." The amount agreed upon was to be paid "in lieu of any and all compensation claimed by Claimant." Employer contends that, because it did not agree that the claim was compensable, and it has never been determined to be, the payment to which claimant is entitled under the agreement is not "compensation" as defined in ORS 656.005(9). Accordingly, it concludes that a proceeding brought to enforce the agreement does not involve the worker's right to compensation, and is not, therefore, a "matter concerning a claim" over which the Board has jurisdiction.

Although the solution is not free from doubt, we conclude that, because the agreement resolved a dispute involving a worker's right to receive compensation, which was resolved,
Cite as 94 Or App 283 (1988) 287

as it must have been, within the workers' compensation system by an agreement which the Board had jurisdiction to approve or disapprove, the Board has jurisdiction to supervise its enforcement. Accordingly, claimant is entitled to a hearing on any question concerning it. ORS 656.283.

On the merits, as we have stated, the payment to which claimant was entitled under the agreement is not "compensation." We are not aware of any statutory provision that would authorize the assessment of a penalty under these circumstances.

Affirmed.

WARREN, J., dissenting.

In *EBI Companies v. Moore*, 90 Or App 99, 750 P2d 1194 (1988), we held that the Board had jurisdiction to decide a dispute between the claimant and the insurer concerning the terms of a disputed claim settlement. After further consideration of that question, I would reach the opposite conclusion. The Board has jurisdiction only over matters concerning a claim. ORS 656.704(1). A "matter concerning a claim" is defined as a matter "under which a worker's right to receive compensation, or the amount thereof [is] directly in issue." As the majority states, the amount agreed to be paid under the disputed claim settlement is expressly agreed to be "in lieu of any and all compensation claimed by Claimant." Accordingly, the settlement payment is not compensation. I would hold, therefore, that a proceeding brought to enforce the agreement does not involve the worker's right to compensation and is not, therefore, a "matter concerning a claim" over which the Board has jurisdiction. I therefore conclude that we should remand to the Board for dismissal of the appeal for lack of jurisdiction and therefore disagree with the majority's affirmation on the merits.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Leon E. Cowart, Claimant.

COWART,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-02070; CA A47227)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 25, 1988.

Willard E. Merkel, Portland, argued the cause for petitioner. With him on the brief were Mary F. O'Donnell and Galton, Popick & Scott, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Assistant Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded.

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Cowart v. SAIF

WARREN, J.

Claimant seeks review of an order of the Workers' Compensation Board on our remand. In *Cowart v. SAIF*, 86 Or App 748, 740 P2d 249 (1987), we remanded the case to the Board for a determination of whether claimant's failure to request a hearing was due to good cause, ORS 656.319(1)(b), under the standard applicable to relief from default judgments under ORCP 71B(1).

In his second and third assignments of error, claimant contends that he need not have sought a hearing within the time required by ORS 656.319, because SAIF's partial denial was void, either because it was an improper back-up denial under *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), or an improper attempt to terminate responsibility for an accepted claim before claim closure. See *Roller v. Weyerhaeuser Company*, 67 Or App 583, 679 P2d 341, on reconsideration 68 Or App 743, 683 P2d 554 (1984). Assuming, without deciding, the correctness of claimant's legal argument regarding the effect of an allegedly "void" order, see *Knapp v. Weyerhaeuser Company*, 93 Or App 670, ____ P2d ____ (1988), claimant's factual premise is incorrect. The condition which SAIF originally accepted was for left shoulder and neck pain. Although it had paid benefits for a low back condition, it did not thereby waive its right to deny the claim later. See ORS 656.262(9).

Claimant contends in his first assignment that the Board erred in deciding that he did not have good cause for not seeking a hearing within 60 days of SAIF'S denial. We do not review *de novo*.¹ Our review is limited to the question whether the Board's conclusion is supported by its findings. The Board incorporated our statement of the facts as its findings. According to those findings, claimant's attorney had been in contact with SAIF and had asked it to mail all documents related to the claim to him. Additionally, claimant had left instructions with his attorney to challenge all denials. Claimant assumed, therefore, when he received SAIF's partial denial, that his attorney had received a copy and had taken action as instructed. In fact, SAIF did not mail a copy of the

Cite as 94 Or App 288 (1988)

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denial to claimant's attorney, although it had been in regular correspondence with him for approximately two years.

Although it is true that SAIF was not required by statute to serve a copy of the denial on claimant's attorney, in view of its regular correspondence with him, claimant had reason to expect that SAIF would notify his attorney if there was any significant action taken on the claim. See OAR 436-60-015.² He failed to seek a hearing on the partial denial because he believed that he had already acted to protect himself by advising his attorney to act on his behalf. We hold that the Board's findings support only the conclusion that claimant's failure to seek a hearing was excusable neglect and that claimant therefore had good cause under ORS 656.319(1)(b).

Reversed and remanded.

¹ The petition for review in this case was filed on January 19, 1988. See *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988).

² OAR 436-60-015 provides:

"(1) When an injured worker is represented by an attorney and the attorney has given written notice of such representation:

"(a) The Director or insurer shall not request the worker to submit to an independent medical examination without giving prior or simultaneous written notice to the worker's attorney.

"(b) The insurer shall not request suspension of compensation pursuant to ORS 656.325 without giving prior or simultaneous written notice to the worker's attorney.

"(c) An insurer shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits.

"(2) An insurer who intentionally or repeatedly fails to give prior or simultaneous written notice to the worker's attorney as required by section (1) may receive a penalty assessed by the Director."

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Cherryl Ann Fromme, Claimant.

FROMME,
Petitioner on Review,

v.

FRED MEYER, INC., et al,
Respondents on Review.

(WCB 85-10042; CA A42360; SC S34944)

In Banc

On review from the Court of Appeals.*

Argued and submitted May 3, 1988.

David C. Force, Eugene, argued the cause and filed the petition for review.

Deborah L. Sather, Portland, argued the cause and filed a response to petitioner's petition for review. With her on the response was Moscato & Byerly, Portland.

CAMPBELL, J.

The order of the Court of Appeals allowing costs is reversed.

* Judicial review of an order of the Workers' Compensation Board. 88 Or App 306, 744 P2d 1336 (1987); 89 Or App 397, 749 P2d 590 (1988).

CAMPBELL, J.

In 1987, the legislature amended ORS 656.236(2) to prohibit charging workers' compensation claimants with costs on judicial review. The law in effect before the 1987 amendment allowed employers to recover court costs from claimants. The principal issue is which law applies in this case, where judicial review was pending on the effective date of the 1987 amendment. We hold that the 1987 amendment applies and that the Court of Appeals erred in charging costs to the claimant.

The claimant petitioned for judicial review of an order of the Workers' Compensation Board on December 5, 1986. At that time, employers could recover court costs from workers who were unsuccessful on judicial review. ORS 20.120;¹ *Compton v. Weyerhaeuser*, 302 Or 366, 730 P2d 540 (1986). While the Court of Appeals' decision in this case was pending, the legislature amended ORS 656.236(2) to overrule *Compton* and prohibit assessing court costs against workers. Or Laws 1987, ch 250, § 4 (the 1987 amendment). ORS 656.236(2) now provides:

¹ ORS 20.120 provides:

"When the decision of an officer, tribunal, or court of inferior jurisdiction is brought before a court for review, such review shall, for all the purposes of costs or disbursements, be deemed an appeal to such court upon errors in law, and costs therein shall be allowed and recovered accordingly."

"Except as provided in ORS 656.506 [Assessments for retroactive reserve and workers' reemployment reserve] and ORS 656.538 [Assessment for handicapped workers reserve and workers' reemployment reserve], none of the cost of workers' compensation to employers under ORS 656.001 to 656.794 [the Workers' Compensation Law], or in the court review of any claim therefor, shall be charged to a subject worker." (Emphasis added.)

The 1987 amendment added the italicized portion of the statute. Its effective date is September 27, 1987. See Or Const, Art IV, § 28.

On November 12, 1987, the Court of Appeals affirmed the board's decision and ordered the claimant to pay her employer's court costs on appeal. *Fromme v. Fred Meyer, Inc.*, 88 Or App 306, 744 P2d 1336 (1987). The claimant objected to

Cite as 306 Or 558 (1988)

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the cost bill on the ground that it violated ORS 656.236(2) as amended in 1987. She also raised a constitutional claim which we do not reach. The Court of Appeals concluded that the 1987 amendment did not apply because this appeal was pending when the 1987 amendment became law. Accordingly, the court applied the law in effect before the 1987 amendment and overruled the claimant's objection to the cost bill. *Fromme v. Fred Meyer, Inc.*, 89 Or App 397, 749 P2d 590 (1988). The claimant seeks review of the order overruling her objection to the cost bill and allowing costs. She does not contest the Court of Appeals' decision on the merits of her claim.

Whether new law applies to pending cases is a question of legislative intent. *E.g., Whipple v. Howser*, 291 Or 475, 480, 632 P2d 782 (1981). The 1987 legislature was silent on which cases it intended the 1987 amendment to govern. Rules of statutory construction led the Court of Appeals to conclude that the 1987 amendment should not be applied retroactively. The court then held that applying the 1987 amendment to this case would amount to retroactive application of the 1987 amendment. *Fromme v. Fred Meyer, Inc.*, *supra*, 89 Or App at 400.

Although the question has not been addressed in Oregon, the American Law Reports states:

"It is well settled that the question whether costs may be allowed in an action or suit * * * is governed by the law as it exists at the time of the judgment which terminates the action or suit, rather than by the law as it existed at the time when the action or suit was commenced." 96 ALR 1428 (1935); see also *id.* at 1434 (discussing court costs on appeal).

The American Law Reports rule is consistent with Oregon law regarding the application of new legislation.

As a general rule, the court construes legislation to operate prospectively unless it appears that the legislature intended to enact retroactive legislation. *E.g., Mahana v. Miller*, 281 Or 77, 80, 573 P2d 1238 (1978). The parties agree with the Court of Appeals that the legislature did not express an intent to have the legislation apply retroactively. We agree and hold that the 1987 amendment applies prospectively.

Retroactive legislation affects prior transactions or existing legal rights and obligations, not necessarily pending

actions. *See generally* 2 Singer, Sutherland Statutory Construction 337, § 41.01 (4th ed 1986). Therefore, when a prospective application is called for, the court applies the legislation in a manner which does not affect legal rights and obligations arising out of past actions or occurrences. *Joseph v. Lowery*, 261 Or 545, 549, 495 P2d 273 (1972); *Kempf v. Carpenters and Joiners Union*, 229 Or 337, 343, 367 P2d 436 (1961). *Cf. Mahana v. Miller, supra*, 281 Or at 80-81 (defining prospective application of "remedial" statutes).

The narrow issue in this case is whether the action or occurrence that would trigger the right to recover costs is commencing an appeal or prevailing on appeal. No right to recover court costs can exist until the party prevails. ORS 20.310(1). Therefore the action or occurrence that would trigger the right to recover court costs is prevailing on appeal, not commencing the appeal as the Court of Appeals concluded.

Until the Court of Appeals issued its decision in this case on November 12, 1987, there was no prevailing party. Applying the 1987 amendment to this case will not affect legal rights and obligations arising out of actions which occurred before the effective date of the 1987 amendment. *See Joseph v. Lowery, supra*, 261 Or at 549; *see also Pearl v. Harrington, Brayt.* 48 (1820) ("a party has no vested right in the bill of costs until after recovery in the suit, so that this circumstance does not give the act a retroactive operation"). We hold that the 1987 amendment, applied prospectively, prohibits ordering the claimant in this case to pay her employer's court costs.

The order of the Court of Appeals awarding costs to the employer is reversed.

No. 100

September 20, 1988

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IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Richard C. Larsen, Claimant.

LARSEN,
Petitioner on Review,

v.

OSMOSE WOOD PRESERVING et al,
Respondents on Review.

(WCB 85-15043; CA A42397; SC S34792)

In Banc

On review from the Court of Appeals.*

Argued and submitted May 3, 1988.

James L. Edmunson, Eugene, argued the cause and filed the petition for review. With him on the petition were Karen M. Werner and Malagon & Moore, Eugene.

Ridgway K. Foley, Jr., P.C., Portland, argued the cause and filed a response to the petition for review. With him on the response was Schwabe, Williamson & Wyatt, Portland.

CAMPBELL, J.

The order of the Court of Appeals allowing costs is affirmed.

* Judicial review from an order of the Workers' Compensation Board. 87 Or App 552, 742 P2d 1202 (1987).

Cite as 306 Or 563 (1988)

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CAMPBELL, J.

A 1987 amendment to ORS 656.236(2) prohibits charging workers' compensation claimants with court costs on judicial review. The issue is whether the amendment applies in this case, where the Court of Appeals decided the merits of the claim before the effective date of the amendment. We hold that the amendment does not apply and affirm the Court of Appeals' order allowing costs.

Before the legislature amended ORS 656.236(2), the court had authority pursuant to ORS 20.120 to assess court costs against workers' compensation claimants who were unsuccessful on judicial review. *Compton v. Weyerhaeuser*, 302 Or 366, 730 P2d 540 (1986). The 1987 legislature amended ORS 656.236(2) to read:

"* * * none of the cost of workers' compensation to employers under ORS 656.001 to 656.794 [the Workers' Compensation Law], or in the court review of any claim therefor, shall be charged to a subject worker." (Emphasis added.)

The amendment added the italicized portion of the statute. Or Laws 1987, ch 250, § 4. The effective date of the amendment is September 27, 1987. See Or Const, Art IV, § 28.

In late 1986, the claimant petitioned for judicial review of an order of the Workers' Compensation Board. The Court of Appeals affirmed the board's decision on September 23, 1987, four days before the effective date of the amendment to ORS 656.236(2). *Larsen v. Osmose Wood Preserving*, 87 Or App 552, 742 P2d 1202 (1987). Osmose submitted its cost bill the next day. The claimant objected on the ground that an order awarding costs would violate ORS 656.236(2). On October 30, 1987, the Court of Appeals issued an order allowing the employer's cost bill. The claimant petitioned for judicial review of that order.¹ He does not seek review of the decision on the merits of his claim.

In *Fromme v. Fred Meyer, Inc.*, 306 Or 558, ____ P2d 566
Larsen v. Osmose Wood Preserving

____ (1988), also decided today, we held that the 1987 amendment to ORS 656.236(2) applies prospectively to forbid awarding court costs in that case because the right to recover court costs arose after the amendment's effective date of September 27, 1987. Applying the amendment to appeals which were still pending as of September 27, 1987, would not affect existing rights and obligations and therefore would not constitute a

¹ We initially denied the petition for review in this case. *Larsen v. Osmose Wood Preserving*, 305 Or 273, ____ P2d ____ (1988). In light of our decision to allow the petition for review in *Fromme v. Fred Meyer, Inc.*, 305 Or 467, ____ P2d ____ (1988), we allowed the claimant's petition for reconsideration on April 5, 1988.

retroactive application. We reversed the order allowing costs because the Court of Appeals did not determine the prevailing party, and therefore no right to recover court costs existed, until after the effective date of the amendment. *Fromme v. Fred Meyer, Inc.*, *supra*, 306 Or at ____.

The Court of Appeals determined the prevailing party in this case before the effective date of the amendment. Although the cost bill was allowed after the amendment became law, *Fromme v. Fred Meyer, Inc.*, *supra*, held that the application of the amendment depends on when the right to recover costs arises rather than the date the cost bill is allowed. The right to recover court costs in this case arose before the effective date of the amendment. Applying the amendment in this case would amount to a retroactive application. *Id.* at _____. Because the legislature did not express an intent to have the amendment operate retroactively, we apply the law which was in effect before ORS 656.236(2) was amended.

Compton v. Weyerhaeuser, *supra*, interpreted the law in effect prior to the amendment to ORS 656.236(2) and held that employers could recover court costs pursuant to ORS 20.120. 302 Or at 369. We hold that the *Compton* decision is controlling and the employer has the right to recover court costs from the claimant. ORS 20.120; *Compton v. Weyerhaeuser*, *supra*, 302 Or at 369.

The order of the Court of Appeals allowing costs is affirmed.

No. 101

September 20, 1988

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IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Sammy W. Barton, Claimant.

BARTON,
Petitioner on Review,

v.

SAIF CORPORATION et al,
Respondents on Review.

(WCB 85-06533, 85-06534; CA A42641; SC S34743)

In Banc

On review from the Court of Appeals.*

Argued and submitted May 3, 1988.

James L. Edmunson argued the cause and filed the petition for petitioner on review. With him on the petition was Karen M. Werner and Malagon & Moore, Eugene.

Michael Reynolds, Jr., Assistant Attorney General, Salem, argued the cause for respondents on review.

PER CURIAM

The decision of the Court of Appeals allowing costs is reversed.

* Judicial review from an order of the Workers' Compensation Board. 88 Or App 306, 744 P2d 1336 (1987).

PER CURIAM

The 1987 legislature enacted an amendment to ORS 656.236(2) that prohibits assessing court costs against workers' compensation claimants. This case was pending on the effective date of the amendment. The issue is whether the amendment applies. We hold that it does.

Before 1987, employers could recover court costs from workers who unsuccessfully appealed workers' compensation claims. ORS 20.120; *Compton v. Weyerhaeuser*, 302 Or 366, 730 P2d 540 (1986). In 1987, the legislature amended ORS 656.236(2) to prohibit charging workers with court costs on judicial review. ORS 656.236(2) now provides:

"Except as provided in ORS 656.506 [Assessments for retroactive reserve and workers' reemployment reserve] and ORS 656.538 [Assessment for handicapped workers reserve and workers' reemployment reserve], none of the cost of workers' compensation to employers under ORS 656.001 to 656.794 [the Workers' Compensation Law], or in the court review of any claim therefor, shall be charged to a subject worker." (Emphasis added.)

The 1987 amendment added the italicized portion of the statute. Or Laws 1987, ch 250, § 4. The effective date is September 27, 1987. See Or Const, Art IV, § 28.

On January 5, 1987, the claimant appealed from an order of the Workers' Compensation Board. On November 12, 1987, the Court of Appeals affirmed the decision of the Board and ordered the claimant to pay the employer's court costs. *Barton v. SAIF*, 88 Or App 306, 744 P2d 1336 (1987). The claimant objected on the ground that ORS 656.236(2) prohibits the cost award. The Court of Appeals overruled his objection.

Fromme v. Fred Meyer Inc., 306 Or 558, ___ P2d ___ (1988), also decided today, holds that the amendment to ORS 656.236(2) is to be given a prospective application, which means that it must be applied "in a manner which does not affect legal rights and obligations arising out of past actions or occurrences." 306 Or at 562. The "action or occurrence" that triggers the right to recover court costs is prevailing on appeal.

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Barton v. SAIF

Because the Court of Appeals in *Fromme* determined the prevailing party after the effective date of the amendment, applying the amendment did not affect pre-existing rights in that case. Accordingly, we applied the amendment and reversed the order allowing costs. *Id.* at ___.

Like *Fromme*, *supra*, this case was decided on the merits after the effective date of the 1987 amendment. The decision in *Fromme* is controlling and the 1987 amendment to ORS 656.236(2) applies to bar the cost award in this case.

The decision of the Court of Appeals awarding costs to the employer is reversed.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
James A. Evans, Claimant.

EVANS,
Petitioner on Review,

v.

GENERAL TRAILER COMPANY et al,
Respondents on Review.

(WCB 84-09673; CA A43860; SC S34922)

In Banc

On review from the Court of Appeals.*

Argued and submitted May 3, 1988.

James L. Edmunson of Malagon & Moore, Eugene, argued the cause for petitioner on review. Karen M. Werner filed the petition for review. With her on the petition was Malagon & Moore, Eugene.

Michael Reynolds, Jr., Assistant Attorney General, Salem, argued the cause for respondents on review.

PER CURIAM

The decision of the Court of Appeals allowing costs is reversed.

* Judicial review from an order of the Workers' Compensation Board, 89 Or App 178, 747 P2d 1018 (1988).

Cite as 306 Or 571 (1988)

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PER CURIAM

The issue is whether a 1987 amendment to ORS 656.236(2) applies to prohibit the award of court costs in this case. The claimant sought judicial review of an order of the Workers' Compensation Board on April 15, 1987. On January 6, 1988, the Court of Appeals decided in favor of the employer and ordered the claimant to pay his employer's court costs.

This case was decided after the effective date of the amendment. Therefore, the amendment applies and the Court of Appeals erred in assessing costs against the claimant. *Fromme v. Fred Meyer, Inc.*, 306 Or 558, ___ P2d ___ (1988); *Barton v. SAIF*, 306 Or 567, ___ P2d ___ (1988).

The decision of the Court of Appeals awarding costs to the employer is reversed.

IN THE SUPREME COURT OF THE
STATE OF OREGON

BLACKNALL,
Petitioner on Review,

v.

WESTWOOD CORPORATION,
DEVELOPERS and CONTRACTORS,
dba Westwood Construction Company,
Respondent on Review.

(TC A8607, 03986; CA A43239; SC S34871)

On review from the Court of Appeals.*

Argued and submitted May 4, 1988.

J. Randolph Pickett, P. C., Portland, argued the cause and filed the petition for petitioner on review.

Thomas W. Brown, Cosgrove, Kester, Crowe, Gidley & Lagesen, Portland, argued the cause and filed a brief for respondent on review.

Robert K. Udziela, Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, filed a brief amicus curiae on behalf of Oregon Trial Lawyers Association.

Before Peterson, Chief Justice, and Lent, Linde, Campbell, Carson and Gillette, Justices.**

PETERSON, C. J.

The decisions of the trial court and the Court of Appeals are affirmed.

* Appeal from Multnomah County Circuit Court, Richard Spier, Judge Pro Tempore, 89 Or App 145, 747 P2d 412 (1987).

** Lent, J., retired September 30, 1988.

Cite as 307 Or 113 (1988)

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PETERSON, C. J.

This is a tort action brought by a worker against an employer for damages for personal injuries. The plaintiff was employed by Adia Services, Inc. (Adia), a corporation that provided temporary workers to its clients. He was injured while working at defendant Westwood Corporation's construction site and brought this negligence action against the defendant.

ORS 656.020 states that damage actions may be brought "by an injured worker *** against any employer who has failed to comply with ORS 656.017 ***." ORS 656.017(1) requires subject employers to "maintain assurance *** that subject workers of the employer *** will receive compensation for compensable injuries" by either buying workers' compensation insurance coverage or by qualifying as a "self-insured employer." With exceptions not relevant here, the statute immunizes employers maintaining such assurance from tort claims arising from injury to their subject workers. ORS 656.018. The question in this case is whether the defendant, who had coverage for its "regular" hourly and salaried

workers, has complied with ORS 656.017. If it did, it is immune from tort liability to the plaintiff. If it did not, it is not immune. The trial court and Court of Appeals ruled in favor of the defendant. We affirm.

THE FACTS

This case was decided on the defendant's motion for summary judgment. The material facts set forth below are not in dispute.

Adia engages in the business of providing temporary workers — clerical, accounting, banking, word processing, secretarial, light industrial, factory and warehouse employees — to its customers. The defendant sent a work order to Adia requesting that Adia “[f]urnish labor as requested for clean up work, complete with employee insurance and workmen’s [sic] compensation as quoted in your hourly rate per man hour.” Adia sent the plaintiff. Adia’s hourly rate for the plaintiff’s services, paid by the defendant, included workers’ compensation insurance premiums which Adia paid on behalf of the plaintiff. The defendant directed the plaintiff when to come to and leave work, where to work, what work to do, and it could

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terminate the plaintiff’s services at any time. The agreement between Adia and the defendant provided that “the supervision of the assigned Adia Personnel Services employee for the agreed upon duties is [the defendant’s] responsibility.”

The agreement between Adia and the defendant also required that Adia provide workers’ compensation coverage in favor of persons such as the plaintiff. As stated above, the fee that Adia charged to the defendant included an amount for workers’ compensation premiums.

The defendant had procured workers’ compensation coverage from SAIF for its employees. Adia procured workers’ compensation coverage from CNA which extended to the plaintiff. After the plaintiff was injured, CNA provided workers’ compensation benefits to the plaintiff.

The plaintiff makes two assertions of error:

- “1. Did the trial court err in holding that as a matter of law plaintiff was an employee of defendant?
- “2. Did the trial court err in ruling that defendant was a complying employer for the purposes of ORS 656.018 and that defendant is immune from tort liability?”

The answers to these questions largely are determined by Oregon’s Workers’ Compensation Law, and we therefore turn to it.

THE WORKERS’ COMPENSATION STATUTES

ORS 656.005(27) defines a “worker” as

“*** any person *** who engages to furnish services for a remuneration, subject to the direction and control of an employer ***.”

There is no doubt that the plaintiff was a “worker.”

A “subject worker” is defined in ORS 656.005(25) as “a worker who is subject to this chapter ***.” There is no question but that the plaintiff was a “subject worker.”

An "employer" is defined in *former* ORS 656.005(14) (now ORS 656.005(13)) as

"* * * any person * * * who contracts to pay a remuneration for and secures the right to direct and control the services of any person."

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The defendant was an "employer."

A "subject employer" is defined in ORS 656.023 as follows:

"Every employer employing one or more subject workers in the state is subject to ORS 656.001 to 656.794."

The defendant was a "subject employer."

To this point there is little dispute. The plaintiff was a "worker" and a "subject worker." The defendant was an "employer" and a "subject employer."

The duties of a subject employer are set forth in ORS 656.017. It provides:

"(1) Every employer subject to this chapter shall maintain assurance with the director that *subject workers of the employer and their beneficiaries will receive compensation* for compensable injuries as provided by this chapter and that the employer will perform all duties and pay other obligations required under this chapter, by qualifying:

"(a) As a carrier-insured employer; or

"(b) As a self-insured employer as provided by ORS 656.407." (Emphasis added.)

ORS 656.018(1)(a) grants a *quid pro quo* to complying employers:

"The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in ORS 656.001 to 656.794."

Two other statutes merit mention. ORS 656.005(18) defines a "noncomplying employer" as "a subject employer who has failed to comply with ORS 656.017." ORS 656.020(1) provides for actions against noncomplying employers as follows:

"Actions for damages may be brought by an injured worker or the legal representative of the injured worker against any employer who has failed to comply with ORS 656.017 or is in

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default under ORS 656.560. Except for the provisions of ORS 656.578 to 656.593 and this section, such noncomplying employer is liable as the non-complying employer would have been if ORS 656.001 to 656.794 had never been enacted."

We turn then to consider these questions.

1. Was the plaintiff a "subject worker" of the defendant under ORS 656.017?

2. Was the defendant a noncomplying employer, i.e., had the defendant "failed to comply with ORS 656.017"?

DISCUSSION

In deciding whether the plaintiff was a "subject worker of the [defendant] employer," we first look to the definition of "worker" contained in ORS 656.005(27). Was the plaintiff furnishing services "for remuneration, subject to the direction and control of an employer"? Beyond any question, the plaintiff was "subject to the direction and control" of the defendant. He was furnishing "services for remuneration." That his remuneration came directly from Adia does not take him out of the definition of "worker." The plaintiff was a "subject worker" of the defendant because the plaintiff was not excluded from coverage under ORS 656.027.

Reciprocally, the defendant was the plaintiff's "employer" under ORS 656.017(1) because (in the words of ORS 656.005(13) quoted above) it contracted "to pay a remuneration for and secure[d] the right to direct and control the services of [the plaintiff]." Remuneration and the right to control are the two statutory elements of both ORS 656.005(13) and (27). Both exist here. The defendant is the plaintiff's "employer"; the plaintiff was a "subject worker" of the defendant. That Adia may also have been the plaintiff's employer, and the plaintiff a subject worker of Adia, makes no difference. As this court stated in *Brazeale v. State Ind. Acc. Comm.*, 190 Or 565, 576, 227 P2d 804 (1951), an employee can have more than one employer for workers' compensation purposes. See also *Oremus v. Oregonian Pub. Co.*, 3 Or App 92, 470 P2d 162 (1970).

We turn to the second issue: Did the defendant comply with ORS 656.017(1)? It requires that the employer "maintain assurance with the director that subject workers of

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employer * * * will receive compensation * * * and that the employer will [qualify] * * * (a) [a]s a carrier-insured employer * * * or (b) [a]s a self-insured employer * * *."

The defendant maintained assurance that its subject workers would receive compensation by (1) insuring with SAIF and (2) contracting with Adia to provide coverage for its workers obtained from Adia. Workers' compensation benefits were provided to the plaintiff pursuant to the defendant's contract with Adia. The defendant complied with ORS 656.017(1).

Any uncertainty is eliminated by ORS 656.407(1) and ORS 656.419(1)(a). ORS 656.407(1) requires every employer to

"establish proof with the director that the employer is qualified either: (a) As a carrier-insured employer by causing a guaranty contract issued by a guaranty contract insurer to be filed with the director; or (b) As a self-insured employer * * *."

The defendant was a "carrier-insured employer" with coverage from SAIF.

ORS 656.419(1) requires that every "guaranty contract issued by an insurer shall provide that the insurer agrees to assume, without monetary limit, the liability of the employer * * * for prompt payment of: (a) All compensation for compensable injuries that may become due under this chapter to subject workers * * *." Had the plaintiff made a workers' compensation claim against the defendant or its compensation carrier, the claim would have to be paid.¹ Though the SAIF insurance contract is not in evidence, ORS 656.407(1)(a) and ORS 656.419(1)(a) are mandatory provisions of the workers' compensation law, and would apply in this case.

The defendant had complied with ORS 656.017(1). It therefore is not subject to the plaintiff's damage claim under ORS 656.020.

The decisions of the trial court and the Court of Appeals are affirmed.

¹ We express no opinion as to the ultimate responsibility for payment as between SAIF and CNA. ORS 656.307.

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November 16, 1988

No. 123

IN THE SUPREME COURT OF THE
STATE OF OREGON

GIBSON,
Petitioner on Review,

v.

SAFEWAY STORES, INC.,
Respondent on Review.

(TC No. 85-4-113; CA A42800; SC S34752)

In Banc*

On review from the Court of Appeals**

Argued and submitted May 4, 1988.

Orrin Leigh Grover, Woodburn, argued the cause and filed the petition for petition on review.

Barry M. Mount, Portland, argued the cause for respondent on review.

PETERSON, C. J.

The decision of the Court of Appeals and the judgment of the trial court are affirmed.

* Lent, J., retired September 30, 1988.

** Appeal from Clackamas County Circuit Court, Howard J. Blanding, Judge. 305 Or App 331, 744 P2d 1336 (1987)

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Gibson v. Safeway Stores, Inc.

PETERSON, C. J.

This workers' compensation case involves issues similar to those in *Blacknall v. Westwood Corporation*, 307 Or 113, ___ P2d ___ (1988) also decided this day. As in *Blacknall*, the trial court granted the defendant Safeway's motion for sum-

mary judgment, and the Court of Appeals affirmed. *Gibson v. Safeway Stores, Inc.*, 88 Or App 306, 744 P2d 1336 (1987). We affirm as well.

The essential facts are without material dispute. The plaintiff was employed by Wallace Security Systems (Wallace) to work as a security guard at a Safeway warehouse in Clackamas, Oregon. Wallace was under contract with Safeway to provide security services as needed. The plaintiff allegedly fell and was injured while on routine patrol of the fenced perimeter of Safeway's property.

Although the plaintiff was employed by Wallace, Safeway, by virtue of its agreement with Wallace, had the right to and in fact did exercise control over the plaintiff in these respects:

1. Safeway determined the specific tasks to be performed by the plaintiff.

2. Safeway determined how many Wallace personnel would be needed to accomplish the security tasks.

3. Safeway set the specific hours and shifts the plaintiff would work.

4. Safeway directed the routes of travel that the plaintiff would follow within the Safeway Distribution Center.

5. Safeway determined the specific timing of the guard routes within the Center.

6. Safeway determined the specific security procedures to be used by the guards and promulgated these procedures in a securities manual which the Wallace personnel were required to follow.

7. Safeway had the right to dismiss or terminate any guard who was not performing his or her job in accordance with Safeway's procedures.

Cite as 307 Or 120 (1988)

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8. Safeway had the right to control the Wallace guards while they were on the Safeway premises.

At the time of the plaintiff's injury, Safeway was self-insured. Wallace was compensated by Safeway for the security guard services provided to Safeway. Wallace provided workers' compensation benefits to the plaintiff.

As in *Blacknall*, and for the reasons set forth in *Blacknall*, it is established that the plaintiff was a subject worker of the defendant, ORS 656.005(25), and that the defendant was the plaintiff's employer under ORS 656.017(1).

The remaining question is whether the defendant met the ORS 656.017(1) requirement that the employer "maintain assurance" that its subject workers "will receive compensation for compensable injuries *** by qualifying *** (a) [a]s a carrier-insured employer *** or (b) [a]s a self-insured employer ***." As stated, it is established that the defendant was a self-insured employer. It had complied with ORS 656.017(1). Because of ORS 656.403(1), it had "assumed[d] the responsibility for providing compensation

due subject workers * * *." As in *Blacknall*, had the plaintiff made a workers' compensation claim against Safeway, the claim would have to be paid.¹ Under the reasoning set forth in *Blacknall*, 307 Or at ___, the defendant is entitled to immunity under ORS 656.018(1)(a).

The plaintiff also asserts that the 1975 repeal of a statute then popularly referred to as the "joint premises" statute (*former* ORS 656.154(1)) was intended "to limit the workers' compensation immunity to the direct employer." That statute, ORS 656.154(1) (1973), read:

"If the injury to a workman is due to the negligence or wrong of a third person not in the same employ, the injured workman * * * may elect to seek a remedy against such third person. However, no action shall be brought against any such third person if he or his workman causing the injury was, at the time of the injury, on premises over which he had joint supervision and control with the employer of the injured workman * * *."

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Gibson v. Safeway Stores, Inc.

Oregon's joint supervision and control doctrine extended immunity to a third party who — along with the injured party's employer — had joint control over the *premises* where the claimant worked. This exemption from liability applied to employers involved in a common enterprise on the same premises and where each employer exercised supervisory power over the injured employee. The focus was *not* on the employer-employee relationship but on the *place* of the injury. In *Mason v. Sutherlin Machine Works*, 240 Or 51, 54, 399 P2d 1016 (1965), the court stated:

"It is clear that the express purpose of this provision of the act, *exempting employers in joint control of premises while engaged in a common enterprise*, was to spread the contractual provision of the act so that, while such an operation is in effect, the employees of each employer are to be considered in the same posture as if there was but a single employer." (Emphasis added.)

The repeal of ORS 656.154(1) in 1975 effectively withdrew the immunity of a second employer from the damage claim of a worker employed by another employer if the worker was injured on premises over which the second employer and the other employer had "joint supervision and control." ORS 656.154(1) did not concern the immunity of the injured person's employer provided by ORS 656.018(1). The repeal of ORS 656.154(1) did not reduce or otherwise affect the immunity of a worker's employer from a damage claim by a worker against his or her employer.

The decision of the Court of Appeals and the judgment of the trial court are affirmed.

¹ We express no opinion as to the ultimate responsibility for payment as between SAIF and Wallace's compensation carrier. ORS 656.307.

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Anderson, Merwin, 88-0580M (11/88)
Anderson, Steven L., 88-0552M (9/88)
Angulo, Marcelino T., 87-0599M (11/88)
Antilla, Henry O., 88-0023M (2/88)
Applegate, Larry J., 88-0627M (10/88)
Ariniello, Edward, 88-0480M (8/88)
Armon, Lowell, 88-0197M (5/88)
Armon, Lowell, 88-0504M (9/88)
Arndorfer, William, 88-0282M (5/88)
Arnold, Donovan L., 88-0149M (5/88)
Arvidson, George, 84-0581M (4,11/88)
Atkinson, Kevin, 88-0054M (5/88)
Atleson, Sherri, 87-0593M (2/88)
Bachand, John, 88-0546M (9/88)
Bailey, Claude, 88-0158M (9/88)
Baird, Ricky, 88-0393M (7/88)
Baldonado, Virginia, 88-0306M (7/88)
Baldridge, Danny M., 88-0044M (3,6/88)
Baldwin, Gene F., 88-0174M (4/88)
Baldwin, Raymond, 87-0034M (7/88)
Ball, Irene, 88-0190M (7,11/88)
Ballard, William R., 88-0485M (9/88)
Baller, Debra A., 86-0543M (8/88)
Baney, Ruby, 88-0220M (5/88)
Barber, Milton S., 84-0438M (1/88)
Barnes, Donald R., 88-0056M (2,12/88)
Barone, Phillip E., 88-0679M (10/88)
Barrera, David G., 87-0430M (11/88)
Barton, William, 88-0200M (5/88)
Bates, Victor, 88-0695M (12/88)
Bathke, John W., 87-0660M (1,2/88)
Baxter, Lyle, 88-0708M (12,12/88)
Beckstead, James K., 87-0580M (1/88)
Bedsaul, Michael, 88-0264M (5/88)
Beeler, James B., 87-0613M (7/88)
Bell, Allan, 88-0688M (11/88)
Benda, Elden, 88-0140M (4/88)
Bennett, Douglas F., 88-0700M (12/88)
Bennett, Joseph, 88-0019M (1/88)
Benson, Yvonne, 88-0734M (12/88)
Benton, James E., 87-0228M (4/88)
Berg, Alex M., 88-0005M (1/88)
Bergamo, Terry, 88-0261M (5/88)

Name, WCB Number (Month/Year)

Berline, Jackie Hoop, 88-0388M (12/88)
Best, Curtis, 87-0401M (6/88)
Bettin, Clifford A., 86-0257M (3/88)
Biddlecome, John, 88-0562M (10/88)
Bidney, Donald, 87-0721M (1/88)
Biggs, Gladys, 87-0368M (10/88)
Billups, Terry, 88-0055M (2/88)
Bilyeu, Patricia J., 87-0487M (1/88)
Bilyeu, Patricia J., 88-0609M (12/88)
Black, Thomas L., Sr., 88-0007M (1/88)
Blaikie, Harvey, 88-0481M (12/88)
Blair, Clarence, 88-0633M (10/88)
Blake, Pamela R., 87-0476M (1/88)
Blaser, Martin E., 88-0159M (5,7/88)
Blaylock-Love, Carolyn, 88-0759M (12/88)
Blodgett, Kathie R., 88-0665M (11/88)
Blum, Maynard, 88-0380M (12/88)
Bodda, Harvey, 87-0312M (5/88)
Boese, Henry, 88-0462M (8/88)
Boldman, John C., 88-0361M (9/88)
Borisoff, Henry T., 87-0404M (1,7/88)
Bostwick, Harry R., 87-0657M (2/88)
Bowen, Ronald, 88-0093M (7/88)
Bowen, Wayne, 88-0556M (11/88)
Bowser, Gail, 87-0280M (8/88)
Boyers, Bruce A., 88-0655M (11/88)
Bradford, Timothy J., 87-0467M (6/88)
Bradley, Mary C., 88-0527M (9/88)
Bradley, Richard Paul, 88-0419M (12/88)
Branca, Richard W., 87-0390M (10/88)
Brasmer, Silas F., 88-0115M (4/88)
Bratton, John, 88-0497M (8/88)
Brenner, John, 88-0165M (4/88)
Brewer, Norman P., 88-0027M (2/88)
Bronson, David N., 88-0369M (9/88)
Brookshire, Joy J., 86-0689M (1/88)
Brown, Charles E., 86-0637M (6/88)
Brown, Charles E., 88-0660M (11/88)
Brown, Donald M., 87-0718M (1/88)
Brown, Janice, 88-0592M (10/88)
Brown, Patrick B., 88-0016M (1/88)
Brown, R.W., 88-0712M (12/88)
Bruner, Michael, 88-0020M (1/88)
Buckman, Danny, 88-0353M (6/88)
Burgess, Paul H., 87-0351M (1/88)
Burkett, Ralph, 88-0539M (9/88)
Burrington, Kyle, 87-0711M (6/88)
Burris, Joann, 86-0382M (2,4/88)
Burt, William A., 87-0609M (1/88)
Burton, Jack, 87-0674M (1/88)
Burton, James, 88-0522M (9/88)
Bush, Ernest M., 87-0333M (5/88)
Bush, Shirley, 88-0109M (4,7/88)

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Name, WCB Number (Month/Year)

Butler-Reeves, Kathleen, 87-0432M (7/88)
 Byrd, Curtis, 87-0555M (7/88)
 Caccamise, Chris, 86-0680M (2/88)
 Cagle, Bruce, 88-0757M (12/88)
 Cambron, Connell R., 88-0034M (2/88)
 Cambron, Connell R., 88-0337M (7/88)
 Campbell, Jess P., 87-0700M (1/88)
 Campbell, John T., 88-0680M (11/88)
 Carlson, Orville, 88-0697M (12/88)
 Carlson, Rick, 88-0435M (7/88)
 Carlston, Lois O., 88-0342M (6/88)
 Carlton, Dennis L., 88-0212M (5/88)
 Carlton, Paul, 88-0014M (11/88)
 Carmien, James, 88-0333M (7/88)
 Carothers, Norman D., 88-0368M (7/88)
 Carr, Iola P., 86-0706M (8/88)
 Carrigan, Donald, 88-0667M (11/88)
 Carrington, Virginia M., 87-0610M (11/88)
 Carter, Donald, 88-0251M (5,7/88)
 Carter, Dorothy, 88-0476M (9/88)
 Carter, Ronald, 87-0294M (8/88)
 Casteel, Katherine, 88-0683M (12/88)
 Castoe, Ezra E., 87-0745M (2/88)
 Charlson, Lynn, 88-0278M (6/88)
 Charlson, Lynn, 88-0773M (12/88)
 Chastain, Ronald, 88-0235M (5/88)
 Cheatham, Verla, 87-0534M (5,9/88)
 Chew, Vernon, 88-0379M (7/88)
 Chilson, Bonnie D., 88-0120M (3/88)
 Chittick, Zedra P., 88-0358M (9/88)
 Chrestensen, Robert, 88-0119M (4/88)
 Christ, Leone Sue, 88-0735M (12/88)
 Christensen, Jesse D., 88-0081M (2/88)
 Christmas, Dorothy, 88-0391M (7/88)
 Christopher, Ohman E., 87-0746M (1/88)
 Christopher, Terry, 87-0712M (4/88)
 Christy, Patty D., 84-0254M (7/88)
 Clark, Kenneth, 88-0760M (12/88)
 Clark, Michael, 88-0414M (8/88)
 Clark, Virgil D., 88-0616M (10/88)
 Clark, William, 87-0760M (1/88)
 Clavette, Reno, 88-0438M (8/88)
 Clements, Thomas, 88-0257M (5/88)
 Clevenger, Shirley E., 88-0206M (5/88)
 Cochell, Richard W., 88-0801M (12/88)
 Cochran, Robert, 88-0313M (6/88)
 Coiteux, Linda M., 88-0755M (12/88)
 Collins, Donna, 85-0154M (1/88)
 Connor, Melvin, 88-0668M (11/88)
 Contreras, Sandra, 88-0635M (11/88)
 Cook, Dalta, 88-0001M (1/88)
 Cook, Steven, 88-0332M (9/88)
 Cooper, Gilbert W., 88-0026M (1,10/88)
 Cooper, Terry S., 88-0351M (9/88)
 Copher, Edwin L., 88-0108M (4/88)
 Copher, Edwin L., 88-0573M (9/88)

Name, WCB Number (Month/Year)

Corbin, Dave, 88-0410M (12/88)
 Corliss, Phillip, 87-0753M (1/88)
 Corliss, Phillip, 88-0710M (11/88)
 Cornell, Thomas D., 88-0452M (10/88)
 Cornwall, Christine B., 87-0719M (11/88)
 Corwin, Jack L., 85-0635M (8,11/88)
 Cosgrove, Pamela, 88-0576M (10/88)
 Cottam, Linda, 86-0697M (8/88)
 Cox, Charley, 88-0185M (6/88)
 Cox, Danny R., 88-0470M (9/88)
 Cozart, Patricia, 88-0594M (10/88)
 Craig, James, 88-0321M (6,9/88)
 Crawford, David, 88-0624M (10/88)
 Crawford, Hoyt W., 86-0068M (8/88)
 Cress, Stanley, 88-0228M (5,8/88)
 Cripps, Donald R., 87-0755M (1/88)
 Croghan, Olin, 88-0373M (7/88)
 Cross, James, 88-0647M (11/88)
 Crowder, Virgie Mae, 88-0250M (5/88)
 Cruzan, Herbert D., 88-0658M (11/88)
 Cuellar, Eloy, 88-0450M (8/88)
 Cummins, Mary J., 88-0208M (5/88)
 Curtiss, Betty, 88-0312M (6/88)
 Cutright, Florence Paulsen, 87-0264M (10/88)
 Dalton, Robert W., 88-0085M (3/88)
 Dalton, Robert, 87-0501M (7/88)
 Dalton, Robert, 88-0568M (9/88)
 Danielson, James L., 87-0259M (5/88)
 Darcy, James G., 86-0600M (2/88)
 Davenport, John D., 88-0273M (6,10/88)
 David Hernandez, Isab., 88-0071M (3,3,10/88)
 Davidson, Raymond, 88-0057M (3/88)
 Davis, Benjamin K., 88-0413M (8/88)
 Davis, Frances, 87-0689M (5/88)
 Davis, Helen R., 88-0747M (12/88)
 Davis, Ivan, 87-0146M (10/88)
 Davis, Wallace J., 87-0744M (4,9/88)
 Davis, Wanda L., 88-0004M (1,2/88)
 Dearmond, Gayford, 87-0475M (7/88)
 Deaton, Orville, 88-0706M (12/88)
 Deitz, Gary M., 88-0387M (7/88)
 DeLaRosa, Simon, 88-0420M (8/88)
 Delgado, Nicholas, 88-0039M (3/88)
 Denny, Carol, 88-0766M (12/88)
 Denton, John, 88-0590M (10/88)
 Denton, John, 88-0718M (12/88)
 Deaton, Orville, 85-0014M (1/88)
 DeRosset, Armand, 88-0512M (10/88)
 DeTour, Ronald L., 87-0604M (8/88)
 Devaney, Mike, 88-0325M (7/88)
 Diaz, Barbara Ann, 87-0154M (2,2/88)
 Dilka, Richard, 88-0103M (3/88)
 Dima, Donald M., 88-0489M (10/88)
 Discant, Gladys, 88-0501M (9/88)
 Doddroe, Robert, 88-0630M (10/88)
 Doggett, Kenneth M., 88-0038M (2/88)

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Name, WCB Number (Month/Year)

Dolinar, Henry J., 88-0122M (4/88)
 Douglass, Paul, 87-0285M (6/88)
 Dreweck, Robin D., 88-0336M (11/88)
 Driggers, Roger, 86-0429M (1,9/88)
 Dubay, Kenneth L., 88-0245M (6/88)
 Dugan, Timothy, 88-0411M (3/88)
 Duncan, Robert L., 87-0670M (2,2/88)
 Dunn, Carl R., 88-0260M (11/88)
 Dunster, Wilford A., 88-0640M (11/88)
 Dupont, Ruben F., 88-0064M (2/88)
 Durlam, Eugene D., 88-0031M (2/83)
 Duvall, Linda, 88-0720M (12/88)
 Duyck, Richard J., 88-0182M (5/88)
 Dyson, Daniel J., 88-0053M (2/88)
 Eaton, Eleanor A., 87-0728M (1/88)
 Edwards, Jeffrey, 87-0672M (9/88)
 Edwards, Michael, 88-0033M (2/88)
 Elam, Sanford, 88-0407M (12/88)
 Elder, William H., 88-0339M (6/88)
 Eliason, Mary Jane, 87-0636M (10/88)
 Ellis, Kenneth, 87-0705M (10/88)
 Ellison, Darrell, 88-0310M (7/88)
 Elston, David, 88-0045M (4,6/88)
 English, James C., 87-0160M (4/88)
 English, James C., 88-0641M (11/88)
 Ensign, Gary, 87-0354M (1,2,4/88)
 Erickson, Timothy, 88-0662M (11/88)
 Erwen, Ted, 87-0738M (1,11/88)
 Evans, Betty, 88-0521M (12/88)
 Evison, Marjorie, 87-0531M (2/88)
 Eyman, Ronald L., 88-0114M (8/88)
 Eytchison, Steve, 88-0279M (7/88)
 Fain, Mary C., 87-0627M (1/88)
 Faircloth, Cecil A., 88-0062M (7/88)
 Fandrich, John J., 88-0390M (8/88)
 Faris, Elias N., 88-0719M (12/88)
 Felton, Roxy Dean, 87-0071M (3/88)
 Ferber, Gwynn, 86-0417M (4/88)
 Ferebee, John, 87-0208M (3/88)
 Ferguson, Bill E., 87-0752M (1/88)
 Fields, Eddie, 84-0536M (1/88)
 Fields-Roupe, Kathleen, 88-0386M (10/88)
 Finley, Linda, 88-0234M (7/88)
 Flaherty, Lawrence M., 88-0327M (6,7/88)
 Follett, Larry L., 88-0175M (6/88)
 Ford, Wiley J., 88-0593M (12/88)
 Forsyth, Robert L., 88-0569M (10/88)
 Foster, Jerry F., 87-0511M (10/88)
 Fowler, Sharon L., 88-0028M (2/88)
 France, Roger G., 88-0732M (11/88)
 Franzwa, Peter, 88-0248M (6/88)
 Frazier, Delpha, 88-0374M (8/88)
 Frear, James, 85-0675M (3/88)
 Freeman, Carl A., 88-0560M (9/88)
 Frey, Edward, 88-0167M (4/88)
 Friend, Joseph, 88-0077M (2/88)

Name, WCB Number (Month/Year)

Friend, Joseph, 88-0789M (12/88)
 Frischman, Vern, 88-0262M (11/88)
 Fuller, Clarence, 88-0399M (7/88)
 Fussell, Donald, 88-0403M (12/88)
 Gabilondo, David, 87-0717M (1/88)
 Galego, Arthur C., 85-0451M (8/88)
 Garcia, Jose A., 88-0449M (8/88)
 Garcia, Reyes, 88-0623M (10/88)
 Garner, James E., 88-0440M (8/88)
 Garnett, Harold D., 88-0214M (5/88)
 Garza, Anita, 88-0326M (6/88)
 Gates, David, 87-0239M (7/88)
 Gates, Janyce M., 88-0715M (12/88)
 Gavett, Mark J., 87-0702M (1/88)
 Gay, Walter A., 88-0460M (8/88)
 Gaylor, Delon, 88-0702M (12/88)
 Gearin, Fred, Jr., 87-0460M (8/88)
 Geenty, Richard, 83-0313M (1/88)
 Gettman, Wilbur R., 88-0294M (6/88)
 Gilbert, Frank, 88-0318M (7/88)
 Gill, Charles, 87-0489M (8/88)
 Gipson, DeWayne, 88-0621M (12/88)
 Glenn, Lester, 88-0561M (9/88)
 Goble, Vicki, 88-0550M (11/88)
 Godwin, Randall, 88-0756M (12/88)
 Goetz, Steven, 88-0304M (5/88)
 Goetzelman, George, 88-0474M (8/88)
 Golden, Susan L., 87-0269M (2/88)
 Goodall, C. Dean, 88-0654M (12/88)
 Goodman, Maura D., 88-0670M (11/88)
 Gore, James E., 88-0738M (12/88)
 Gorecki, Thaddeus G., 87-0356M (7/88)
 Grant, Maxine, 87-0023M (1/88)
 Gray, Lois, 88-0790M (12/88)
 Greenwade, Alton W., 88-0170M (4/88)
 Gregg, Robert, 88-0176M (4/88)
 Gregor, Andrew J., 88-0295M (6/88)
 Gregor, Robert, 88-0558M (9/88)
 Griffin, Terrance A., 87-0618M (5/88)
 Grimm, Kenneth, 88-0329M (6/88)
 Griswold, James C., 87-0756M (2/88)
 Grove, Gerald, 85-0361M (3/88)
 Guerra, Michael, 88-0048M (2/88)
 Hafemann, Diana, 88-0178M (5/88)
 Hagan, Debra C., 88-0429M (8/88)
 Hager, Jim, 88-0287M (5/88)
 Hagg, Mary J., 87-0607M (3/88)
 Hagger, Danny G., 87-0639M (5/88)
 Hagner, Leonard, 88-0541M (9/88)
 Hale, Glenn, 87-0750M (1/88)
 Hall, Frances E., 88-0704M (12/88)
 Hall, Marina E., 87-0626M (4/88)
 Hambrick, Alfred P., 88-0728M (12/88)
 Hamilton, Robert, 88-0194M (5/88)
 Hamm, James E., 87-0277M (3/88)
 Hammond, Robert, 87-0305M (1/88)

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Name, WCB Number (Month/Year)

Hampton, Boyd A., 88-0281M (9/88)
 Hampton, Lyman, 88-0643M (11/88)
 Hankins, Ken, 88-0664M (11/88)
 Hansen, Edward, 88-0446M (8/88)
 Hanslovan, Junior W., 88-0617M (10/88)
 Hanson, Craig R., 86-0535M (11/88)
 Hardiman, Donald W., 88-0687M (11/88)
 Hardy, Thomas C., 88-0180M (5/88)
 Harlin, Betty, 87-0516M (6/88)
 Harmes, Robert W., 88-0412M (8,12/88)
 Haron, Louis, 83-0348M etc. (8/88)
 Harper, Betty L., 87-0763M (1,8/88)
 Harris, Melvin, 88-0545M (12/88)
 Harris, Michael, 88-0135M (4/88)
 Harris, Rex L., 88-0186M (5/88)
 Harroun, Elden, 88-0215M (5/88)
 Hart, James, 87-0379M (11/88)
 Hartley, Joann G., 88-0345M (7/88)
 Harvey, Herman C., Jr., 87-0521M (4,5/88)
 Haskins, Tommy B., 88-0733M (12/88)
 Hayes, Larry L., 85-0393M (1/88)
 Heald, Peggy L., 86-0121M (7/88)
 Hegele, Charles, 87-0109M (7/88)
 Helvie, John S., 88-0018M (1/88)
 Hendricks, James, 86-0640M (6/88)
 Hendrickson, Shirley, 86-0169M (1/88)
 Hendrix, Melvin E., 88-0359M (7/88)
 Henshaw, Johnny L., 84-0588M (5/88)
 Herrera, Luciano B., 88-0518M (9/88)
 Herron, James M., 86-0466M (2/88)
 Hewitt, Charles, 88-0792M (12/88)
 Hickman, Darlene, 88-690M (11/88)
 Hickman, Donald, 88-0072M (3/88)
 Hicks, Kenneth B., 88-0238M (5,6/88)
 Hiles, Charles E., 88-0227M (7/88)
 Hill, David, 87-0001M (9/88)
 Hilton, Darrell, 88-0787M (12/88)
 Hinton, Larry L., 88-0323M (8/88)
 Hintz, Raymond, 88-0456M (9/88)
 Hissner-Graham, Shirley, 87-0166M (8/88)
 Hlavka, Joseph, 88-0713M (11/88)
 Hodge, Mary Ann, 88-0328M (12/88)
 Hoehne, Dwain D., 88-0636M (11/88)
 Hoff, Harley, 84-0032M (4/88)
 Hogan, Lester, 88-0405M (7/88)
 Hoisington, Dolores, 88-0507M (9/88)
 Hoke, Harold L., 84-0476M (2/88)
 Hollingsworth, Nettie, 88-0199M (5/88)
 Holst, Albert S., 87-0530M (1/88)
 Holsti, Hugo L., 88-0365M (7/88)
 Holt, Betty L., 88-0646M (11/88)
 Holt, Danny, 88-0060M (5,8/88)
 Homsley, Robert, 88-0547M (9/88)
 Horn, Jimmy, 88-0376M (11/88)
 Hornberger, Julia M., 85-0137M (2/88)
 Houk, Loren, 88-0479M (8,9/88)

Name, WCB Number (Month/Year)

Houser, Roger D., 88-0750M (12/88)
 Howard, David, 88-0300M (5,8/88)
 Howard, James E., 87-0747M (7/88)
 Howell, Donald, 88-0357M (8/88)
 Howell, James, 88-0441M (8/88)
 Howlan, Larry E., 87-0221M (9,10/88)
 Hoyle, Fred L., 88-0301M (8/88)
 Hunter, Harry L., 88-0398M (7/88)
 Hunter, John H., 88-0139M (4/88)
 Hunter-Hicks, Leslie, 88-0786M (12/88)
 Hurley, Howard S., 88-0723M (11/88)
 Hutcheson, Orvilla J., 88-0274M (7/88)
 Hylton, Bobby G., 87-703M (2/88)
 Imbler, George L., 88-0127M (4/88)
 Imbler, George, 88-0553M (9/88)
 Isaacs, Minnie, 88-0237M (5/88)
 Ivanoff, George S., 87-0673M (11,12/88)
 Jackson, Eugene, 83-0153M (1/88)
 Jackson, Hilda, 88-0011M (1/88)
 Jackson, Howard, 87-0656M (1/88)
 Jacobs, Jim G., 88-0192M (5,5,6/88)
 Jacquez, George, 88-0595M (12/88)
 James, Candy, 88-0653M (11/88)
 Janzen, Clarence, 87-0649M (2/88)
 Jaques, Earl M., 88-0751M (12/88)
 Jaquith, Hope M., 88-0613M (10/88)
 Jasmin, Melvin H., 88-0581M (10/88)
 Jeffers, Donald W., 88-0355M (8/88)
 Jenkins, William A., 88-0724M (11/88)
 Jennings, Jeffrey, 88-0530M (9/88)
 Jensen, Leonard J., 86-0694M (3,5/88)
 Jensen, Terry D., 88-0554M (9/88)
 Jespersen, Diane, 88-0204M (5/88)
 Johnson, Charles E., 86-0457M (9/88)
 Johnson, Daryl, 88-0267M (5/88)
 Johnson, Douglas, 88-0711M (12/88)
 Johnson, Robert H., 87-0758M (2/88)
 Johnson, Robert, 88-0177M (9/88)
 Johnson, Susanne, 88-0112M (4/88)
 Johnson, Walter J., 88-0612M (10/88)
 Jones, Allan L., 86-0626M (12/88)
 Jones, Roy L., 88-0205M (5/88)
 Jones, Steven R., 87-0726M (1/88)
 Jones, Tim, 88-0179M (4/88)
 Joseph, Elaine, 87-0740M (5/88)
 Joy, Patricia, 88-0198M (5/88)
 Judd, Carl, 88-0464M (11/88)
 Jurgensmeier, Ada, 87-0020M (8/88)
 Justus, James, 88-0800M (12/88)
 Keen, Gwendolyn, 88-0498M (9/88)
 Keinonen, Stephen P., 87-0589M (11/88)
 Kelley, Sherylyn, 88-0601M (10/88)
 Kellison, Dolores, 88-0024M (2/88)
 Kellogg, Lawrence L., 86-0607M (6,7/88)
 Kelly, David D., 88-0143M (4/88)
 Kelly, John R., 87-0679M (5/88)

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Name, WCB Number (Month/Year)

Kendall, Geraldine Y., 87-0375M (7/88)
 Kendall, Ronald, 88-0347M (6/88)
 Kennedy, Kenneth, 88-0240M (5/88)
 Kennedy, Richard, 88-0622M (11/88)
 Kent, Hazel, 87-0572M (3/88)
 Ketchum, Harry, 88-0500M (8/88)
 Ketchum, Myron H., 87-0757M (1/88)
 Kibbey, Ralph, 88-0239M (5/88)
 Kindred, Ethel L., 88-0348M (9/88)
 Kleger, John P., 88-0063M (3/88)
 Knapp, Barbara, 88-0362M (8,12/88)
 Knowland, Laurey J., 87-0761M (2,10/88)
 Knowlson, James C., 88-0271M (5/88)
 Knox, Carole J., 88-0461M (8/88)
 Koopman, Kerry L., 88-0537M (9/88)
 Korhonen, Robert, 87-0695M (2/88)
 Kosanke, Lucille V., 88-0465M (8/88)
 Kosel, Lucie Mae, 88-0532M (9/88)
 Kovarik, George, 88-0651M (11/88)
 Kretschmer, Patrick L., 88-0210M (5/88)
 Lacey, David C., 88-0451M (9/88)
 Lacy, Lois A., 88-0049M (2/88)
 Lahy, James E., 88-0620M (10/88)
 Lakey, John, 87-0399M (7/88)
 Lamarra, Laura M., 88-0457M (9/88)
 Landeros, Jose L., 88-0610M (10/88)
 Lane, Cameron, 87-0748M (6/88)
 Lang, Terry, 88-0211M (5/88)
 Langston, Bradley, 88-0201M (5/88)
 Larose, Betty, 88-0315M (6/88)
 Larsen, Frank E., 86-0686M (6/88)
 Lathrop, Daniel, 88-0050M (2/88)
 Laurens, Larry, 88-0513M (9/88)
 Laurila, Jeanette, 88-0352M (9/88)
 Lauritsen, Kerry L., 86-0570M etc. (3/88)
 Lawrence, W.E., 88-0696M (11/88)
 Leaton, Daniel, 88-0583M (10/88)
 Ledin, Larry, 88-0648M (11/88)
 Ledoux, Martin, 87-0731M (1,4/88)
 Lee, Brian David, 88-0366M (3/88)
 Lee, Patricia, 88-0075M (4/88)
 Lee, Terry G., 87-0453M (7/88)
 Lehrmann, James, 88-0259M (5/88)
 Lemar, Ruby, 88-0253M (5/88)
 Lenhart, Guy A., 88-0468M (8/88)
 Lenocker, Paul, 87-0624M (7/88)
 Leonetti, Gregg, 88-0232M (8/88)
 Leroy, Myron J., 88-0288M (10/88)
 LeValley, Richard, 88-0346M (9/88)
 Lewis, Wilbur A., 87-0540M (1/88)
 Libel, Stanley R., 88-0230M (7/88)
 Linton, Gregg, 88-0196M (5/88)
 Liverman, Jack, 88-0490M (8/88)
 Lloyd, John, 87-0446M (7/88)
 Lockett, Camilla, 88-0671M (11/88)
 Lockwood, Betty C., 88-0021M (2/88)

Name, WCB Number (Month/Year)

Logsdon, E.V., Jr., 88-0131M (4/88)
 Lomas, Michael H., 87-0319M (3,4/88)
 Louvring, Gordon E., 87-0343M (1/88)
 Lovan, Herman, 87-0546M (9/88)
 Lovell, Robert P., 88-0124M (4/88)
 Lovenburg, Floyd, 88-0354M (9/88)
 Lowther, Jeff W., 88-0475M (8/88)
 Lubo, Christopher L., 88-0582M (10/88)
 Lutes, Stephen G., 87-0201M (1/88)
 Lutman, Melvin L., 88-0691M (12/88)
 Luyet, Michael, 86-0086M (2/88)
 Lynch, Raymond D., 88-0203M (5/88)
 Mace, Deborah, 88-0650M (11/88)
 Madsen, Melvin K., 88-0455M (9/88)
 Magill, John B., 88-0714M (12/88)
 Malar, Shirley E., 88-0392M (9/88)
 Mangun-Wolverton, Beverly, 88-0147M (5/88)
 Mansker, Howard, 88-0266M (5/88)
 Mansker, Melba S., 87-0612M (1/88)
 Maplesden, Amos A., 88-0269M (5/88)
 Marsh, Donald, 88-0538M (9/88)
 Marsh, Michael L., 88-0015M (2/88)
 Marsh, Michael L., 88-0384M (8/88)
 Marshall, Raymond, 88-0047M (2/88)
 Marston, Ron, 88-0074M (3/88)
 Martin, Charles E., 87-0561M (11/88)
 Martin, David, 84-0207M (7/88)
 Martin, Jack W., 88-0148M (4/88)
 Martin, Melvin, 88-0675M (11/88)
 Martinez, Arthur, 88-0659M (11/88)
 Martinez, Donnie, 88-0307M (7/88)
 Martushev, Daniel, 88-0772M (12/88)
 Mason, Carl D., 88-0397M (7/88)
 Matlock, William, 88-0731M (12/88)
 May, George R., 87-0136M (5/88)
 May, James R., 88-0343M (7/88)
 McAdams, Valdean, Jr., 88-0283M (5/88)
 McAlister, J.D., 88-0218M (5/88)
 McBride, Roxanne, 88-0385M (7/88)
 McCann, Herbert I., 88-0010M (1/88)
 McClure, Donald W., 88-0629M (10/88)
 McConnell, Roy G., 88-0444M (9/88)
 McCord, Flint L., 88-0051M (2/88)
 McDaniel, William J., 88-0299M (6/88)
 McDaniels, Shelly A., 88-0781M (12/88)
 McDarment, Dorothea L., 87-0741M (5/88)
 McDonald, Sheila J., 88-0749M (12/88)
 McGuire, Marc W., 87-0759M (1/88)
 McKenzie, George J., 88-0236M (5/88)
 McKinstry, Karri, 88-0223M (5/88)
 McMahan, Claude A., 88-0123M (4/88)
 McMillan, James, 88-0524M (9/88)
 McMillan, Patrick D., 88-0424M (7,11/88)
 McMullen, John M., 88-0216M (6/88)
 McQueen, Michael, 88-0431M (9/88)
 McSwain, Malcolm, 88-0614M (12/88)

OWN MOTION JURISDICTION 1988

Name, WCB Number (Month/Year)

Mecklem, Barbara, 88-0737M (12/88)
Medlock, Jarlin, 88-0409M (9/88)
Melhorn, Thomas, 87-0662M (11/88)
Mellott, Patricia, 88-0686M (11/88)
Mercier, Darrel L., 87-0179M (8/88)
Merlock, Alan, 88-0632M (12/88)
Miller, Alan R., 88-0669M (11/88)
Miller, Arthur, 87-0350M (11/88)
Miller, Barbara, 88-0549M (9/88)
Miller, Bernard, 88-0032M (4,10/88)
Miller, David R., 87-0204M (3,6/88)
Miller, George Irving, 87-0217M (4/88)
Miller, Irvin R., 88-0586M (10/88)
Miller, Mark, 88-0637M (11/88)
Miller, Merle, 88-0022M (1/88)
Miller, Thomas, 88-0540M (9/88)
Miller, William, 88-0458M (10/88)
Millsap, Lawrence, 88-0606M (11/88)
Montes, Antonio, 88-0242M (5/88)
Montgomery, Robert L., 88-0172M (5/88)
Moon, Jerry D., 88-0102M (4/88)
Moore, Alan, 88-0286M (7/88)
Moore, Judith A., 86-0332M (6/88)
Morehead, James, 88-0073M (3/88)
Morgan, Linda, 88-0030M (2/88)
Morrison, Michael, 88-0495M (9/88)
Morrow, Steven, 88-0434M (8/88)
Morton, William E., 85-0022M (9/88)
Mossman, Leslie W., 86-0326M (5/88)
Moyer, Sr., Phillip, 88-0604M (10/88)
Mudrow, Robert, 88-0555M (9,12/88)
Mueller, Barbara, 88-0596M (12/88)
Muir, Nelson, 88-0302M (9/88)
Mullen, Gary L., 87-0481M (5,10/88)
Mullen, Lois E., 88-0309M (8/88)
Munday, Henry V., 88-0611M (10/88)
Munson, Karen, 88-0284M (6/88)
Myers, Carl, 88-0436M (8/88)
Nelson, Juanita R., 88-0322M (9/88)
Nelson, Michael L., 88-0508M (9/88)
Nelson, Ricky P., 88-0602M (10/88)
Netherton, Margaret, 88-0570M (9/88)
Netrick, Anthony, 88-0483M (11/88)
Neuman, William, 88-0401M (7/88)
Newingham, Donald, 88-0291M (5/88)
Newton, Jack A., 86-0061M (1/88)
Nichols, Steven, 87-0734M (1/88)
Nicks, Edward J., 88-0364M (7/88)
Niemann, David, 87-0095M (5/88)
Niemi, Robert E., 88-0607M (11/88)
Noah, Donald K., 88-0442M (7/88)
Noel, Carroll, 88-0437M (9/88)
Noggle, Richard, 87-0073M (2/88)
Norrandar, Ralph, 88-0394M (7/88)
Northrup, Frank, 88-0079M (2/88)
Nugent, Carole, 88-0229M (7,3/88)

Name, WCB Number (Month/Year)

Nunez, Gary, 86-0685M (12/88)
Nylen, Lyman M., 88-0542M (9,10/88)
O'Dell, Donald, 88-0639M (11/88)
Oakes, Reeford, 88-0069M (2/88)
Ochsner, Ronald E., 88-0224M (7/88)
Oland, Delmar G., 87-0037M (4/88)
Olson, Robert O., 85-0297M (1/88)
Oran, Sheila, 88-0277M (7/88)
Osborne, Leonard L., 88-0487M (9/88)
Owens, James, 88-0367M (9/88)
Palmer, Frank, 88-0694M (11/88)
Parish, Leonard L., 88-0372M (10/88)
Parker, George W., 88-0514M (9/88)
Parks, Robert, 88-0191M (5/88)
Parr, Chester, 88-0292M (6/88)
Parry, Linda L., 88-0740M (12/88)
Patten, James B., 88-0572M (12,12/88)
Patterson, James, 88-0225M (11/88)
Paul, Vicki, 88-0707M (11/88)
Paulus, Steve M., 87-0583M (7/88)
Payne, Thelma Purcell, 88-0506M (9,11/88)
Peabody, Eileen M., 87-0732M (11/88)
Peck, Hubertina, 88-0472M (12/88)
Pentkowski, Edward J., 85-0111M (11/88)
Pepper, Wanda, 88-0133M (6/88)
Perkins, Kenneth, 88-0575M (10/88)
Pero, Dan L., 88-0469M (8/88)
Pershall, James, 88-0013M (1,2/88)
Persinger, Christopher, 88-0793M (12/88)
Peterson, Charles F., 88-0496M (8/88)
Peterson, Toby, 88-0559M (10/88)
Petrie, Terry A., 86-0096M (2,5/88)
Phibbs, Rena E., 88-0076M (4/88)
Philippi, Wesley I., 87-0410M (6/88)
Phillips, Jerry, 88-0520M (12/88)
Pierce, Rocky, 88-0416M (10/88)
Pieri, John, 88-0275M (6/88)
Piluso, Carla, 88-0784M (12/88)
Piper, Daniel, 88-0316M (7/88)
Pitts, Carl D., 88-0645M (11/88)
Pitzer, Diana J., 86-0665M (9/88)
Poague, Robert, 88-0129M (7,8/88)
Poelwijk, James, 86-0627M (11/88)
Pola, Barry, 88-0404M (8/88)
Potts, Clarence, 87-0469M (1/88)
Powell, Edgar, 85-0656M etc. (2,3/88)
Powell, Edgar, 88-0591M (10/88)
Powell, James H., 87-0045M (1/88)
Powers, Roland, 88-0247M (7//88)
Pressley, Dale, 88-0382M (10/88)
Prince, Ashley, 88-0341M (6/88)
Pritchard, Debra, 88-0564M (10/88)
Pruitt, Willie, 88-0025M (1/88)
Quinlan, Karen M., 87-0492M (6/88)
Quinn, A.J., 88-0528M (10,10/88)
Rapoza, Robert K., 88-0084M (3/88)

OWN MOTION JURISDICTION 1988

Name, WCB Number (Month/Year)

Rasmussen, Robert, 88-0626M (10/88)
 Rauschert, John L., 87-0357M (1,2/88)
 Ray, Robert A., 88-0184M (5,8/88)
 Ray, Sally, 88-0763M (12/88)
 Reason, Lynett, 87-0765M (4/88)
 Reed, Donald, 88-0523M (11/88)
 Reese, Georgia L., 87-0646M (1,7/88)
 Repp, William, 88-0241M (11/88)
 Reynolds, Becky J., 87-0427M (1/88)
 Rice, Richard L., 88-0255M (5/88)
 Richards, Stanley L., 87-0210M (5,9/88)
 Richardson, Phyllis, 88-0471M (8/88)
 Rickard, Ruth A., 88-0126M (4/88)
 Ricksgers, Gary H., 88-0454M (8/88)
 Riggs, Ben, 88-0543M (10/88)
 Riggs, Wilbur, 88-0150M (4/88)
 Riley, John B., Sr., 87-0751M (1,6/88)
 Roberts, Donald L., 87-0621M (1/88)
 Roberts, Donald, 88-0529M (12/88)
 Roberts, George E., 88-0006M (3/88)
 Roberts, William H., 88-0252M (10/88)
 Robinson, Marilyn, 88-0427M (11/88)
 Rodriguez, Alicia, 88-0317M (10/88)
 Rodriguez, Jesus, 88-0535M (9/88)
 Roff, Kenneth L., 88-0043M (10/88)
 Rogers, Brian, 87-0010M (3/88)
 Rogers, Walter Earl, 88-0141M (5/88)
 Rogers, Walter R., 88-0644M (11/88)
 Roppe, Arthur D., 85-0106M (8/88)
 Rose, Richard P., 88-0505M (9/88)
 Ross, Charles A., 88-0066M (3/88)
 Ross, Patricia, 88-0118M (4,9/88)
 Rotter, Kevin, 88-0681M (11/88)
 Rowan, John T., 86-0413M (2/88)
 Ruff, Jerry, 88-0492M (9/88)
 Rundle, Bradford, 88-0296M (7/88)
 Rusher, Douglas, 88-0769M (12/88)
 Russell, Marilyn, 88-0764M (12/88)
 Rutherford, James W., 88-0473M (8/88)
 Samuelson, Glenda, 88-0092M (5/88)
 Sanders, Rene, 88-0155M (7/88)
 Sanford, Dolly A., 88-0169M (4/88)
 Satterfield, Fred, 88-0447M (8/88)
 Sausa, Olegorio, 88-0340M (8/88)
 Schafer, Franklin M., 87-0523M (1/88)
 Schauss, Robert L., 88-0421M (7/88)
 Schehen, Sherwood, 88-0634M (10/88)
 Schiele, Gary M., 88-0615M (10/88)
 Schiller, John, 87-0257M (1/88)
 Schlegel, Richard, 88-0753M (12/88)
 Schmitt, Wendell J., 88-0510M (9/88)
 Schuman, Howard, 88-0618M (12/88)
 Schuster, Danny, 88-0350M (6/88)
 Seaman, Michael, 88-0748M (12/88)
 Searle, Albert, 88-0503M (11/88)
 Sears, Ardith DeJong, 87-0101M (2/88)

Name, WCB Number (Month/Year)

Self, Ira D., 86-0242M (5,8/88)
 Self, Ira, 88-0577M (10/88)
 Serna, Jr., Guadalupe, 87-0058M (11/88)
 Sharp, Gordon, 88-0484M (9/88)
 Shaw, Terry, 88-0661M (11/88)
 Sherman, Harvey, 88-0566M (12/88)
 Sherratt, Pamela, 88-0526M (10/88)
 Shewmaker, Marlon, 88-0597M (10/88)
 Shine, Donn, 88-0012M (6/88)
 Shine, Patrick J., 88-0289M (5/88)
 Shingledecker, Irma L., 86-0359M (1/88)
 Shipman, Orville D., 87-0680M (3/88)
 Shockley, Dorothy, 88-0375M (9/88)
 Short, Kenneth, 86-0387M (1/88)
 Shumaker, Glenn, 88-0128M (4/88)
 Simpson, Donald, 88-0605M (10/88)
 Smets, Virginia, 88-0657M (11/88)
 Smith, Alice L., 88-0378M (8/88)
 Smith, Betty J., 88-0290M (6/88)
 Smith, Carole, 88-0151M (8/88)
 Smith, David A., 88-0160M (4/88)
 Smith, David R., 88-0002M (1/88)
 Smith, Edward G., 88-0381M (7,12/88)
 Smith, Julie A., 88-0433M (8/88)
 Smith, Leland, Jr., 87-0418M (8/88)
 Smith, Tony H., 88-0557M (10/88)
 Smith, Warren E., 88-0494M (11/88)
 Snyder, James F., 88-0162M (4/88)
 Souza, Joseph, 88-0029M (2/88)
 Spencer, Mary I., 88-0042M (4,10/88)
 Springer, Terry, 87-0554M (8/88)
 Stafford, Stanley L., 88-0563M (10/88)
 Steen, Donald R., 86-0537M (4/88)
 Stephens, John R., 86-0019M (3/88)
 Stevens, Mike, 88-0415M (8/88)
 Stewart, Albert F., 88-0213M (5/88)
 Stewart, Craig, 87-0421M (8/88)
 Still, William M., 87-0648M (10/88)
 Stockebrand, Keith, 88-0432M (7/88)
 Stoltenburg, Roy R., 88-0154M (5/88)
 Stone, Jim L., 88-0008M (2/88)
 Storm, Dennis, 88-0745M (12/88)
 Storms, Lenora, 88-0331M (7/88)
 Stratton, Anna B., 88-0603M (10/88)
 Strauss, Steven J., 88-0219M (5/88)
 Strickland, Charles, 88-0574M (10/88)
 Striefel, Richard, 88-0423M (7/88)
 Strome, Frank A., 88-0625M (11/88)
 Strome, Frank A., 88-0761M (12/88)
 Swartout, Sara I., 87-0652M (5/88)
 Swartwout, Sara, 88-0426M (8,9/88)
 Sweet, Gary, 88-0202M (5/88)
 Swenson, Mark A., 88-0742M (12/88)
 Swenson, Mildred, 88-0516M (9/88)
 Swindler, James, 88-0156M (4,5/88)
 Sylvia, George, 88-0666M (12/88)

OWN MOTION JURISDICTION 1988

Name, WCB Number (Month/Year)

Tamerius, Gordon, 87-0650M (1/88)
Tanner, Linda, 88-0136M (7/88)
Taskinen, Richard J., 88-0086M (3/88)
Taylor, David, 88-0608M (10/88)
Taylor, Doris A., 88-0491M (8/88)
Taylor, Wesley, 88-0349M (7,9/88)
Teem, William, 88-0418M (10/88)
Terry, Judith A., 86-0634M (9/88)
Thayer, Alvin, 88-0009M (2/88)
Thissell, John O., 88-0035M (2,11/88)
Thomas, Candy V., 87-0203M (3/88)
Thompson, Donald R., 88-0482M (9/88)
Thompson, Mary E., 88-0515M (9/88)
Thompson, Sam, Jr., 85-0516M (4/88)
Thompson, Vivian, 88-0324M (7/88)
Thompson, Vivian, 88-0551M (10/88)
Tichenor, Dale L., 88-0183M (6,11/88)
Tichenor, Dale, 88-0676M (11/88)
Tindall, James, 88-0095M (4,6/88)
Tindle, Nina, 88-0389M (7/88)
Tippett, Edith M., 88-0716M (12/88)
Tirone, Rosario, 88-0693M (12/88)
Todd, Sam, 88-0356M (9/88)
Toman, Stella, 88-0068M (2/88)
Tompkins, Theodore, 87-0502M (1/88)
Towns, Jerry, 88-0157M (4/88)
Townsend, Randy L., 88-0217M (5/88)
Tribur, Harold, 85-0493M (5,10/88)
Trollope, Stephen, 88-0146M (7/88)
Tunem, Jeff, 88-0721M (12/88)
Tungett, Jack, 86-0361M (10/88)
Tunnell, Marsha, 88-0305M (5,10/88)
Ulery, William, 88-0703M (11/88)
Ulman, Ray, 88-0270M (10/88)
Underhill, Thelma L., 88-0087M (6/88)
Underhill, Thelma, 88-0486M (8/88)
Utter, David L., 88-0600M (10/88)
Valle, Isaias, 87-0477M (5/88)
Vandehey, Kim M., 88-0256M (5,10/88)
Vanderzanden, Eleanor, 88-0276M (9/88)
Vargas, Ricardo, 88-0268M (5/88)
Vilches, Alfonso, 88-0767M (12/88)
Vranizan, James, 88-0599M (12/88)
Wade-Wilson, Teresa, 88-0254M (6/88)
Wagenius, Ann, 88-0244M (6,11/88)
Waldrop, Homer, 88-0417M (10/88)
Walker, Edward, 85-0397M (1/88)
Wall, Barbara, 88-0499M (9/88)
Wall, Cynthia, 88-0567M (12/88)
Wallace, Willard, 88-0739M (12/88)
Wallis (Currier), Annette, 88-0448M (10/88)
Warner, Jim N., 87-0002M (2/88)
Warner, Ronald L., 86-0255M (8/88)
Warner, William, 88-0642M (11/88)
Warren, Deroyn P., 88-0400M (7/88)
Wayne, Dwight, 88-0003M (11/88)

Name, WCB Number (Month/Year)

Weaver, Stephen L., 88-0443M (7/88)
Webb, Andy, 88-0144M (4,5/88)
Weiler, Fred, 88-0263M (8/88)
Wells, Earl, 88-0107M (3/88)
Wendling, Rodney, 88-0396M (7/88)
Werner, Diane, 88-0164M (4/88)
West, Wilbur, 88-0565M (9/88)
Wheatley, Roy T., 86-0349M (4,5/88)
Wheeler, Harriette, 88-0046M (2/88)
White, Charles, 88-0729M (12/88)
White, Frank R., 87-0698M (1/88)
White, Paul, 87-0596M (11/88)
Whitethorn, Rick, 88-0142M (4/88)
Wilburn, James, 88-0153M (4/88)
Wild, Karl, 87-0411M (1,2,2/88)
Williams, Gary E., 87-0749M (1/88)
Williams, Glenn M., 88-0090M (3/88)
Williams, Glenn, 88-0363M (7/88)
Williams, Robert H., 87-0730M (3/88)
Williamson, Walter, 88-0226M (5/88)
Wilson, Suzanne, 87-0393M (1/88)
Wilson, Vaughn, 88-0511M (9/88)
Wincer, Donald S., 86-0406M (7,8/88)
Winningham, Brett, 88-0467M (8/88)
Winter, Michael, 88-0040M (2/88)
Wolf, Paul, 88-0111M (4/88)
Woltersdorf, Guenter, 88-0509M (9/88)
Woodard, Joe, 88-0285M (10/88)
Woodman, Donald E., 88-0110M (4/88)
Woodruff, Ellanora, 87-0307M (5/88)
Woods, Deborah, 88-0104M (7/88)
Wooldridge, Michael, 87-0577M (4/88)
Wright, Bill M., 88-0280M (6/88)
Wright, Donald C., 86-0572M (7/88)
Wright, James, 88-0371M (7/88)
Wright, Susan K., 87-0415M (5/88)
Wuerfel, Timothy, 88-0587M (10/88)
Xistras, George, 88-0674M (11/88)
Yackley, John, 88-0741M (12/88)
Young, Victor E., 88-0779M (12/88)

UNPUBLISHED ORDERS

The following orders issued by the Workers' Compensation Board are not published in this volume. While they contain more explanation than Memorandum Opinions, they were judged to have no precedential value. Copies of any of these orders are available from Van Natta's for a small charge.

Claimant (WCB Number), Date Issued

Robert B. Adams (86-07587), November 9, 1988
Howard M. Agan (85-14189), October 31, 1988
Joe L. Anglin (85-09874), October 5, 1988
Sherryl L. Augustine (86-17328), October 31, 1988
Patsy M. Blair (86-14524), December 21, 1988
Hubert Denton (87-00921), December 7, 1988
Dixie G. Dunnigan (87-02907 & 87-00880), October 27, 1988
Sally J. Duvall (86-09715), November 8, 1988
Ronald W. Freeman (86-02454), October 13, 1988
Raymond A. Godfrey (87-04008), December 7, 1988
Ronald G. Hoffas (87-06037), December 21, 1988
Marga A. Holub (86-12390), November 17, 1988
Susan I. Horvath (87-07687), November 15, 1988
Robert W. Johnson (87-13077), December 14, 1988
James L. Lance (86-17070), December 21, 1988
Donna L. Long (87-08941), October 13, 1988
Martin N. Manning (86-09217 & 86-15879), December 7, 1988
Steven G. Martinez (87-07324), December 7, 1988
Daniel B. McNamara (86-04805), November 8, 1988
Linda McQueen (85-09047 & 85-09974), November 17, 1988
Maurice E. Murphy (87-00574), October 31, 1988
Thomas V. O'Connell (85-01334), November 17, 1988
James L. Patty (87-04221), December 21, 1988
Glenn F. Phippen (86-08795), November 3, 1988
Wesley J. Randall (87-09613), November 8, 1988
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