VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 41

(Pages 751-1230)

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.

APRIL-JUNE 1989

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41 Van Natta ____ (1989)

EARL R. HALL, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-02464
April 4, 1989
Order on Reconsideration

The insurer's counsel seeks authorization of a supplemental client-paid fee for services rendered on review, which culminated in our March 10, 1989 Order on Review. Specifically, counsel requests authorization for an additional client-paid fee, not previously authorized, for "unexpected time incurred in monitoring and reporting" to its client.

Pursuant to our March 10, 1989 order, we affirmed a Referee's order that declined to grant claimant permanent total disability. In addition, we approved a client-paid fee, not to exceed $160. On March 16, 1989, we received the insurer's counsel's request for authorization of a supplemental client-paid fee. That same day, claimant petitioned the Court of Appeals for judicial review of our March 10, 1989 order.

We have previously held that, when our prior order has addressed either the carrier's counsel's entitlement to, or the amount of, a client-paid fee, our authority to consider requests for attorney fee authorizations is contingent upon our retaining jurisdiction over the order. See Robert D. Janini, 40 Van Natta 1127 (1988); Jane E. Stanley, 40 Van Natta 831 (1988). Here, our March 10, 1989 order addressed the insurer's counsel entitlement to, as well as the amount of, a client-paid fee. Inasmuch as that our order has been appealed, we lack jurisdiction to address this supplemental request for authorization.

We are authorized to withdraw an order for reconsideration after the filing of a petition for judicial review with the Court of Appeals. 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 exercise this authority to withdraw our March 10, 1989 Order on Review. 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.

NIELS MARTIN, Claimant
David J. Hollander, Claimant's Attorney
Industrial Indemnity, Insurance Carrier

Own Motion 89-0154M
April 5, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his July 15, 1978 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim for the payment of temporary disability benefits as it contends claimant's recent treatment does not satisfy the requirements of the own motion law.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. We find no evidence of any treatment

or surgery which would satisfy the requirements set forth above. Claimant did have injections in August and November 1988, apparently for diagnostic purposes. These injections were not, in our opinion, surgery and do not justify the payment of temporary disability benefits. We conclude we are without jurisdiction to grant the relief claimants seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

CELINE M. ZIMMERMAN, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-13751
April 5, 1989
Order on Review

Reviewed by Board Members Crider and Ferris

Claimant requests review of Referee Podnar's order which upheld the insurer's denial of her claim for a fainting spell and associated injuries. We affirm.

ISSUES

The sole issue is whether claimant has proven by a preponderance of the evidence that her fainting episode at work was caused by her work.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation: Claimant's fall was caused by fainting. The cause of claimant's fainting spell is unknown.

CONCLUSIONS

We adopt the Referee's conclusions with the following supplementation: Claimant's testimony that she believes that she fainted due to the heat at work is not sufficient to overcome the sole medical opinion, which is that the cause of her syncope (fainting spell) is unknown. We do not consider this a simple question of causation in which lay testimony is sufficient.

ORDER

The Referee's order dated October 15, 1988 is affirmed. A client-paid fee, not to exceed $577.50, is approved.

DANIEL M. ALIRE, Claimant
Glenn, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 88-13670
April 6, 1989
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee McCullough's order that: (1) increased claimant's unscheduled permanent disability award for a low back and right hip injury from 34 percent (108.8 degrees) as awarded by a Determination Order, to 45 percent (144 degrees); and (2) increased claimant's scheduled permanent disability award for loss of use or function of the right leg from 10 percent (15 degrees), as awarded by a Determination Order, to 14 percent (21 degrees). On review, the issue is extent of permanent disability, unscheduled and scheduled. We affirm.

FINDINGS OF FACT

Claimant was 40 years of age at hearing. In April 1987, while working as a chipperman/welder, he was struck in the right hip and back by a piece of falling steel plate. Claimant suffered a dislocation of the right hip, a right acetabulum fracture, a right sciatic nerve contusion, and a low back strain superimposed on underlying lumbar degenerative changes.

Dr. Karmy, orthopedist, performed surgery on claimant's right hip to correct the dislocation and fracture. Treatment for the low back and sciatic nerve conditions has been conservative. MRI studies of the lumbar spine have revealed central bulging of the annulus fibrosus at L5-S1. However, no disc herniation has been confirmed. Moreover, there is no evidence that would allow us to conclude that the bulging causes any residual symptoms.

Claimant had previously sustained a right leg injury in November 1985, when he was struck by a falling log. As a result, he developed neurological problems in the leg. Sensory branch surgery relieved his pain, but a numbness in the right posterior medial foot remains. This residual symptom has not limited his ability to use his right leg.

In February 1988 claimant returned to work. He operated a banding machine, which involved no lifting and permitted him to sit and stand at his discretion. He performed this job, which is sedentary work, until a strike. At the time of hearing, the strike had recently concluded, but claimant had not yet been called to return. In the meantime, he had been seeking welding/millwright jobs that gave him the option of sitting or standing and did not require extensive climbing over and around machinery.

Claimant became medically stationary on June 7, 1988. On that date, a closing evaluation was conducted by the Orthopaedic Consultants. Range of motion findings revealed that claimant's lumbar flexion is limited to 70 degrees, extension to 15 degrees, lateral bending to 20 degrees, and right rotation to 20 degrees. Right hip flexion is limited to 80 degrees, right hip extension to 5 degrees, internal rotation to 25 degrees, external rotation to 35 degrees, and abduction to 15 degrees. The maneuvers to establish these findings produced a mild degree of pain in the low back/right hip area.

Claimant has not been released to perform his job at injury. It is recommended that he continue to perform activities in which he avoids standing and lifting repetitively.

A Determination Order issued July 20, 1988. Claimant was awarded 34 percent unscheduled permanent disability and 10 percent scheduled permanent disability for the right leg. In evaluating claimant's scheduled permanent disability, the Evaluation Section of the Workers' Compensation Division considered sensory change, weakness, atrophy, and disabling pain.

Claimant has completed the 8th grade and has no GED. In addition to working as a welder, he has been a millwright, forklift operator, and bakery worker. The highest specific vocational preparation value in these jobs is welding, which is 6. Prior to his injury, claimant performed heavy work. Since his injury, he is limited to sedentary work.

Claimant continues to experience residual problems in his right leg. He suffers disabling pain, which limits his ability to walk, stand, and run. Claimant also experiences the feeling of needles poking him on top of the foot. There is no evidence that this sensation itself results in impairment of leg function. However, if claimant steps on something that "catches" the inside of his right foot he will experience pain in his leg, the leg will buckle and he will fall.

Pursuant to his treating phyician's prescription, he wears a right lower leg/foot brace when working or walking on uneven ground to prevent his foot from collapsing inward and causing him to fall. Claimant has a slight degree of muscle weakness, as well as right thigh and calf atrophy. His right hip and low back pain is also disabling, restrictng his ability to lift, work on his knees, sit, and stand.

CONCLUSIONS OF LAW

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of the July 20, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. ORS 656.295(5); OAR 38-10-005; 438-10-010.

The Referee increased claimant's scheduled permanent disability award for the loss of use or function of the right leg from 10 percent to 14 percent. In addition, claimant's unscheduled permanent disability award for the low back was increased from 34 percent to 45 percent. We affirm.

Scheduled Permanent Disability

Pursuant to OAR 436-35-230(5)(b), claimant is entitled to an award ranging from zero to 10 percent of the leg for muscle weakness and atrophy when objective findings are in the thigh of the lower extremity. Here, the Orthopaedic Consultants noted slight weakness and atrophy in claimant's thigh and calf. Considering these findings in light of the aforementioned rule, we agree with the Referee's assessment that an impairment value of 5 is reasonable.

Claimant also complains of a sensation loss and marked hypersensitivity in the right lower extremity. However, these complaints do not pertain to the plantar area, which is the only ratable area under the standards. See OAR 436-35-200(1). Consequently, no impairment value is allowed for these complaints.

Finally, claimant credibly described disabling pain that limited his ability to walk, stand, and run. Disabling pain can result in a loss of use or function. Former OAR 436-35-010(2). When it does, it is rated based on the loss of use or function which results, and no additional value is allowed for the pain alone. id.

After considering claimant's credible testimony and the aforementioned rule, the Referee concluded that claimant's disabling pain had resulted in a permanent loss of use or

function. The Referee further held that an impairment value of 10 was a reasonable assessment for claimant's disabling pain. Combining the 5 percent impairment value for muscle weakness and atrophy with the 10 percent impairment value for claimant's disabling pain, the Referee arrived at a 14 percent award. See OAR 438-35-240. We concur.

SAIF asserts that the disability rating standards incorporate the disabling effects attributable to pain within the impairment ratings for each specific body part. Submitting that the effects of pain are not to be rated separately on a subjective basis, SAIF contends that the Referee's application of the disability standards was incorrect. We understand SAIF to argue that former OAR 436-35-010(2)(a) does not permit assigning a value for loss of use or function due to disabling pain if the particular type of loss is not assigned a value in the balance of the disability standards. We disagree.

To begin, if SAIF's "incorporation" argument was correct, there would be no need for the Department's adoption of former OAR 436-35-010(2)(a). The rule would add nothing to those portions of the disability standards dealing with specific body parts. Yet, the rule expressly acknowledges that disabling pain can result in loss of use or function and, when it does, is rated based on the loss of use or function of a body part due to the injury.

The statutory definition of loss of use or function is not limited to mechanical impairment. Boyce v. Sambo's Restaurant, 44 Or App 305 (1980). In the absence of a more restrictive definition in the Director's rule, we interpret the rule to require an additional value for pain which results in loss of use or function not otherwise measured by the rule. In this regard, we note that the "Evaluator's Worksheet," as compiled by the Evaluation Section in conjunction with the issuance of the Determination Order, provides for the consideration of disabling pain. Specifically, a box marked "disabling pain" is listed in the section designated for scheduled permanent disability, along with such other boxes as range of motion, sensory change, weakness, and atrophy.

Furthermore, the last portion of the aforementioned rule, which states that "no additional value will be allowed for the pain alone," would appear to be a codification of the principle enunciated in Harwell v. Argonaut Insurance Co., 296 Or 505 (1984). Specifically, the Harwell principle provides that pain is considered in determining the extent of permanent disability only if it results in impairment of the function of the body. Harwell, supra, 296 Or at pages 510-11. Conversely, if pain does not impair function, it is not to be considered. id.

Here, objective findings have confirmed that claimant's compensable injury has resulted in weakness and atrophy in the thigh of his right lower extremity. In accordance with the disability standards, he receives an impairment value for this loss of use or function. See OAR 436-35-230(5)(b). In addition, claimant's credible testimony has persuasively established that he suffers disabling pain, which has permanently limited his ability to walk, stand, and run. The loss of use or function attributable to this disabling pain in claimant's leg is separate and distinct from the weakness and atrophy in the thigh of his leg. Thus, as

recognized by the disability standards, claimant also receives an impairment value based on this loss of use or function. See former OAR 436-35-010(2)(a).

Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 10 in this particular case to be reasonable. Combining the aforementioned value with the 5 percent impairment value for weakness and atrophy in the thigh results in a total of 14, which we conclude appropriately compensates claimant for the permanent loss of use or function of his right leg due to the compensable injury.

We note parenthetically that former OAR 436-35-010(2)(a) has recently been amended. See WCD Admin. Order 6-1988 [sic], December 21, 1988; WCD Admin. Order 1-1989, January 24, 1989 (among other amendments, corrected title of December 21, 1988 WCD Admin. order to 7-1988). The amended version of the rule provides that disability is rated on the permanent loss of use or function and that such losses, as defined and used in the Director's standards "shall be the sole criteria for rating permanent disability." OAR 436-35-010(2)(a). The amended rule further states that pain is considered in the rules to the extent it results in measurable impairment and, if there is no measurable impairment, no award of scheduled permanent disability is allowed. OAR 436-35-010(2)(b). Finally, the amended standards also define "impairment" as a decrease in the function of a body part or system as measured by a physician according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment, 2nd Edition, 1984. OAR 436-35-005(1).

An analysis of disabling pain under the aforementioned amended rules would be different from our analysis today. However, since the amended rules were not in effect at the time this claim was closed by the Evaluation Section, they are not applicable. See OAR 438-10-005; 438-10-010.

Unscheduled Permanent Disability

Impairment. Pursuant to OAR 436-35-340, after considering the range of motion findings, we find the following numerical values for the right hip: (1) 2 percent loss of flexion; (2) 5 percent loss of abduction; (3) 3 percent loss of internal rotation; (4) 3 percent loss of external rotation; and (5) 3 percent loss of extension. These values are added and result in a total of 16 percent. See OAR 436-35-340(14).

Pursuant to OAR 436-35-360, after considering the range of motion findings, we find the following numerical values for the low back: (1) 2 percent loss of flexion; (2) 2 percent loss of extension; and (3) 2 percent loss of right rotation. These values are added and result in a total of 6 percent. See OAR 436-35-360(10).

OAR 436-35-350(2) provides for an impairment value of 4 percent for an unoperated disc derangement with any clinically-related residual symptoms. Here, central bulging at L5-S1 was revealed, but, at the time of hearing, claimant suffered no residual symptoms as a result. Consequently, no impairment value is given.

The total values for the right hip and low back are

combined. See OAR 436-35-320(2). A total impairment value equals 21.

The Referee combined this impairment value with a 15 percent value for claimant's disabling pain to arrive at a 33 percent total impairment value. See OAR 436-35-360(11). The Referee reasoned that claimant's residual hip/back pain limited his functional capacity with respect to lifting, working on his knees, as well as sitting and standing. We agree with the Referee's assessment.

Once again, SAIF asserts its "incorporation" argument, contending that the Referee incorrectly applied the disability standards by awarding a separate value for claimant's disabling pain. For reasons similar to those previously stated, we disagree. In this regard, we note that, if SAIF's argument was correct, there would be no need for the Department's adoption of former OAR 436-35-320(1)(a). As with former OAR 436-35-010(2)(a), the aforementioned rule expressly acknowledges that disabling pain can result in loss of use or function and, when it does, is rated based on the loss of use or function of a body part due to the injury. Furthermore, the last portion of the rule which states that "no additional value will be allowed for the pain alone" would also appear to be a codification of the Harwell principle, which has been previously discussed.

Here, objective findings have confirmed that claimant's compensable injury has resulted in reduced ranges of motion in his right hip and low back. In accordance with the disability standards, he receives an impairment value for this loss of use or function. See OAR 436-35-340; 436-35-360. In addition, claimant's credible testimony has persuasively established that he suffers disabling pain, which has permanently limited his ability to lift, work on his knees, sit and stand. The loss of use or function attributable to this disabling pain is separate and distinct from the reduced ranges of motion confirmed in those body parts. Thus, as recognized in the disability standards, claimant also receives an impairment value based on this loss of use or function. See former OAR 436-35-320(1)(a).

Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 15 in this particular case to be reasonable. Combining the aforementioned value with the value for claimant's reduced range of motion findings in the right hip and low back, results in a total impairment value of 33, which we conclude accurately reflects the permanent loss of use or function of his right hip and low back due to the compensable injury.

We note parenthetically that former OAR 438-35-320(1) has recently been amended. See WCD Admin. Order 6-1988 [sic], December 21, 1988; WCD Admin. Order 1-1989, January 24, 1989 (among other amendments corrected title of December 21, 1988 WCD Admin. Order to 7-1988). The amended rule provides that pain is considered in the rules to the extent it results in measurable impairment and, if there is no measurable impairment, no award of unscheduled permanent disability is allowed. OAR 436-35-320(1). Should the pain result in disability greater than that evidenced by the measurable impairment, including the disability due to expected periodic exacerbations of the worker's condition, the loss of earning capacity is considered and rated under OAR 436-35-310 and is included in the worker's adaptability factor.

id. In addition, under the amended rule, chronic conditions limiting repetitive use of an unscheduled body part shall be rated at 5 percent impairment of that part. OAR 436-35-320(4). As previously noted, the amended standards also define "impairment" as a decrease in the function of a body part or system as measured by a physician according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment, 2nd Edition, 1984. OAR 436-35-005(1).

An analysis of disabling pain applied in accordance with the aforementioned amended rules would be different from our analysis today. Yet, because the amended rules were not in effect at the time this claim was closed by the Evaluation Section, they are not applicable. See OAR 438-10-005; 438-10-010.

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. OAR 436-35-290(1), (2), and (3). Here, none of the aforementioned conditions apply. Furthermore, claimant was 40 years of age at hearing. Consequently, his age value is +1. OAR 436-35-290(4).

Education. 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, GED certificate or more education. OAR 436-35-300(2). Here, none of the aforementioned conditions apply. Claimant has an 8th grade education and no GED. Therefore, his formal education value is +1.

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). As previously noted, claimant has not been released to his regular work nor has he returned to his 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 last 10 years is in welding (6), which is assigned a value of +2.

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). These conditions are not applicable to claimant. If no documentation demonstrating competence in some specific vocational pursuit is present, a value of +1 is assigned. Former OAR 436-35-300(5)(a). [We note parenthetically that this rule has also been recently amended. See WCD Admin. Order 6-1988 [sic]. The competency documentation requirement has been deleted and replaced by a requirement that "competence in some specific vocational pursuit" be established.] Here, claimant testified that he had completed training as a welder some 20 years ago. The Referee found such testimony sufficient to demonstrate competence. We disagree. The former rule, which was applicable at the time of claim closure, requires documentation. Inasmuch as no documentation of such training was provided, a value of +1 is assigned.

All the education factors are added for a total value of +4. OAR 436-35-300(5)[sic].

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 claimant's physical capacity before and after the injury. When workers are unable to return to their usual and customary work, but have returned to modified work, the value for this factor shall be based on the difference between the physical capacity necessary to perform the usual and customary work and the physical capacity required to perform the modified job according to a table provided in OAR 436-35-310(3)(a).

Here, claimant's work at injury was heavy. Thereafter, he returned to work in a modified job in a sedentary capacity. SAIF contends that claimant's own description of his limitations would permit him to perform work activities in a medium category. That contention may or may not be true. On this point, we note that the Orthopaedic Consultants recommended that claimant be maintained at his current level of employment, which at the time was his sedentary operation of the banding machine. In any event, if we were to find claimant able to do medium work, that finding would not change his disability under the standard. When workers are unable to return their former work activities, but return to modified work, the adaptability factor is based on the physical capacity of the former and modified jobs. See OAR 436-35-310(3)(a). Accordingly, the adaptability value is +3.

Assembling the factors. The age value is added to the total value for education. (1 + 4 = 5). OAR 438-35-280(4). The sum of the values for age and education are multiplied by the value for adaptability. (5 x 3 = 15). OAR 438-35-280(6). The product of the values for age/education and adaptability is added to the total impairment value to reach the percentage of permanent unscheduled permanent disability to be awarded. (15 + 33 = 48). OAR 438-35-280(7). Accordingly, we conclude that claimant's unscheduled permanent disability award is 48 percent.

Claimant does not ask that his award be increased. Inasmuch as he seeks affirmance of the Referee's order, the award will not be altered. To the extent that this approach is contrary to that followed in Michelle Griffith, 40 Van Natta 2086 (1988), the Griffith approach will not be followed in the future.

Clear and Convincing Evidence. Neither party is prevented or limited from establishing by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the Director under ORS 656.726. See ORS 656.283(7); 656.295(5). To be "clear and convincing," evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 402 (1987).

Here, claimant asserts that his credible testimony concerning disabling pain and physical limitations establishes by clear and convincing evidence that his award pursuant to the standards was insufficient. This assertion was premised on claimant's inaccurate conclusion that the Referee had erroneously considered disabling pain in his application of the standards.

Moreover, as previously discussed, we have considered

claimant's credible testimony in evaluating the extent of his permanent disability resulting from the compensable injury. Although his testimony is probative, we are not persuaded that it establishes by clear and convincing evidence that his loss of earning capacity is greater than that awarded under the standards. In this regard, we find the findings and evaluations offered by the treating physician and examining panel particularly persuasive.

Claimant's counsel is entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order dated October 6, 1988 is affirmed.

Board Member Ferris, dissenting:

I dissent from that portion of the majority opinion which interprets former OAR 436-35-010 (2)(a) and 436-35-320(1)(a) as permitting, in addition to the award for loss of use or function, an increased award for disabling pain. Former OAR 436-35-010(2)(a) states:

> "Disability is rated on the permanent loss of use or function of a body part due to an injury connected with the job. Disabling pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value will be allowed for the pain alone." (Emphasis added).

Former OAR 436-35-320(1)(a) provides as follows:

> "Pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone." (Emphasis added.)

I interpret these rules to mean that the disabling pain is considered in establishing the loss of use or function and, therefore, is not to be considered in addition thereto. Obviously, when pain is disabling, there is a loss of use or function. In support of their position, the majority points out that on the rating sheet there is a box for disabling pain and, therefore, it should be considered separately. The fact is that it is one of several boxes which are considered in establishing the composite of loss of use or function. In addition, the majority states that: "Inasmuch as the standards do not provide a value range for impairment attributable to disabling pain, we consider a value of 10 in this particular case to be reasonable." I would suggest that the reason the rules do not provide a value range for disabling pain is because it is contained in the loss of use or function.

I would further conclude that the aforementioned loss of use or function attributable to claimant's disabling pain is already reflected in the objective findings concerning the weakness and atrophy in the thigh of his right lower extremity, as well as the reduced range of motion findings regarding his right hip and low back. See OAR 436-35-230(5)(b); 436-35-340, 436-35-360(6)-(9).

To award an additional value for claimant's disabling pain alone, as the majority has done, is contrary to the portion of the aforementioned rules I have previously highlighted. In addition, this result is in conflict with the stated intent of the rules' drafter.

In this regard I note that in adopting the disability standards, the Director considered testimony, information, and argument concerning whether the proposed standards adequately considered the worker's functional limitations in rating impairment. See Summary of Testimony and Agency Responses to WCD Admin. Order 3-1988 (June 30, 1988). "Functional limitations" were described as functions that can no longer be performed repeatedly and are mostly based on the consideration of pain.

In response to the functional limitation question, the Director's summary states that the proposed standards were modified to provide for assessment of physical capacity and functional losses at an assessment/rehabilitation facility. The summary went on to provide that such a modification "will assure that the worker's level of physical function will be measured throughout a range of activity levels so the limitation due to pain or resulting from repetitive activity will be fairly and accurately assessed."

Thus, from the language of the aforementioned rule, as well as the stated purpose of its drafter, it is apparent to me that disabling pain is to be considered by the standards, through measuring and assessing the functional loss by means of a range of activity levels.

In conclusion, I submit that the disabling pain attributable to claimant's compensable injury is accurately reflected in the weakness and atrophy findings concerning the thigh of his right leg and the reduced range of motion findings regarding his right hip and low back. Therefore, I disagree with the majority's award of an additional value for this pain over and above that already awarded. I would affirm the Determination Order awards of scheduled and unscheduled permanent disability

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WILLIAM M. ARMSTRONG, Claimant
Gary M. Carlson, Claimant's Attorney
Davis & Bostwick, Defense Attorneys

WCB 85-11296
April 7, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Thye's order that: (1) upheld the insurer's denial of his occupational disease claim for bronchial asthma and/or reactive airway disease; and (2) declined to assess a penalty and attorney fees for an alleged unreasonable denial. We reverse with regard to compensability and affirm with regard to penalties and attorney fees.

ISSUES

1. Compensability.

2. Penalties and Attorney Fees.

FINDINGS OF FACT

Claimant, who is in his mid-30s, has primarily worked as an automobile painter since 1973. He first had respiratory problems in 1974, when he awoke at home gasping for breath. He was taken to the hospital and treated for acute respiratory problems. He returned to work the following day.

Between 1974 and 1984, claimant had an episodic cough, wheezing and shortness of breath. His symptoms did not improve over weekends, but they would improve somewhat while he was on vacation. They never became so severe that he sought treatment for them.

Claimant had been a relatively heavy smoker from the age of 10 until he quit in October, 1985. Claimant previously smoked marijuana. However, he quit this, too, in approximately 1985.

In the fall of 1984, claimant began working for an autobody shop in Gresham, Oregon. He had been there for three to four weeks when he began developing acute respiratory symptoms. He was eventually hospitalized and treated by Dr. Wise, internist. Dr. Wise noted a six-week history of progressive shortness of breath, cough, and fatigue. He diagnosed reactive airway disease with possible Legionnaire's disease, a form of pneumonia. Claimant returned to work briefly in November 1985, but he quit in December due to increasing shortness of breath.

Claimant did not work again until he began painting automobiles for the employer on July 9, 1985. Upon reemployment, he was exposed to paints containing isocyanates. Isocyanates can cause bronchial asthma. Claimant used a canister respirator while performing his job duties. However, within a week or two of returning to work, he began to experience the same symptoms he had experienced in the fall of 1984. He quit working at the end of July.

Claimant subsequently filed a workers' compensation claim for "shortness of breath, wheezing, [and] chest tightness", which was denied by the insurer.

Dr. Wise referred claimant to Dr. Dreisin, a pulmonary specialist. The insurer, in turn, had claimant examined by Dr. Bardana, head of the Division of Allergy and Clinical Immunology at the Oregon Health Sciences University. Dr. Wise and Dr. Dreisin's opinions support the compensability of the claim. Dr. Bardana's opinions oppose compensability.

FINDINGS OF ULTIMATE FACT

Claimant's exposure to isocyanates in the employer's work place was the major contributing cause of a worsening of his bronchial asthma condition such that he was disabled from work and required medical services.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant must prove by a preponderance of the evidence that his work exposure for the employer was the major contributing cause either of the onset or worsening of his condition to the extent that it caused disability or required medical services. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Moreover, given the complex nature of claimant's condition, expert medical evidence is required in order for us to resolve this issue. Kassahn v. Publishers Paper, 76 Or App 105 (1985).

The Referee accepted the opinions of Dr. Bardana over those of Dr. Wise and Dr. Dreisin. On review, claimant argues that we should find the opinions of Dr. Wise and Dr. Dreisin more persuasive than those of Dr. Bardana.

Following testing, Dr. Wise diagnosed "reactive airway disease -- probably in part related to chronic smoking, exacerbated by exposure to fumes and dusts at work." He indicated that it was undetermined if the condition was work-related, although it "appears likely work contributed significantly to symptoms."

Upon referral, Dr. Dreisin diagnosed occupational asthma, likely secondary to exposure to isocyanates as well as chronic cigarette abuse. Dr. Dreisin subsequently had a methacholine challenge test performed on claimant. The test results were positive. Dr. Dreisin concluded that claimant had hyperreactive airways, but that he was asymptomatic at the time.

Claimant was examined by Dr. Bardana in April 1986. Dr. Bardana had lab tests done which disclosed evidence of marijuana use and an allergy to major northwest allergens. Dr. Bardana diagnosed probable chronic bronchitis secondary to chronic cigarette abuse amplified by smoking marijuana. Dr. Bardana testified at hearing that he performed his own methacholine test which returned a negative result. He testified that if claimant had asthma, occupationally-induced or otherwise, the test would have been positive. He felt that the positive methacholine test results obtained by Dr. Dreisin indicated acute bronchitis.

We are more persuaded by the opinions of Drs. Wise and Dreisin, than we are those of Dr. Bardana. We first note that Dr. Wise has treated claimant for his respiratory problems since October 1984. In addition, he has examined and treated claimant during his symptomatic periods. Similarly, Dr. Dreisin examined claimant several times shortly after claimant quit his employment. By contrast, Dr. Bardana examined claimant a single time. That examination took place almost nine months after claimant left his employment and during an asymptomatic period. We conclude that Drs. Wise and Dreisin had a better opportunity to evaluate claimant's condition than did Dr. Bardana. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

Dr. Dreisin diagnosed occupationally-induced bronchial asthma based upon claimant's medical history, the results of the methacholine challenge test, and a test to determine whether the condition was reversible. Dr. Bardana contested each of these

diagnostic factors. We conclude, however, that Dr. Bardana's objections are not well-founded.

With regard to claimant's medical history, Dr. Bardana agreed, in his deposition, that the history did support a bronchial asthma condition. However, Dr. Bardana perceived certain inconsistencies in claimant's history such that he did not credit that history. Our review of claimant's testimony persuades us that those alleged inconsistencies, particularly concerning his marijuana use, do not warrant wholesale rejection of the history. Consequently, contrary to Dr. Bardana's belief, we conclude that Dr. Dreisin's opinions were based upon an accurate history.

Dr. Bardana agreed that a methacholine challenge test, although not the best test to determine sensitivity to isocyanates in particular, did enable a physician to diagnose reactive airways disease. He concluded that, because a test he conducted nine months after claimant's last isocyanate exposure was negative, Dr. Dreisin's results reflected an acute bronchitis condition suffered at that time. However, there is no evidence in the record that claimant did suffer an acute condition when Dr. Dreisin's test was administered. In fact, Dr. Dreisin's chart note at the time indicates that claimant was asymptomatic.

With regard to Dr. Dreisin's test for reversibility, Dr. Bardana agreed that the test was appropriate. He concluded, however, that the results were not conclusive proof of bronchial asthma. In addition, on October 27, 1986, Dr. Bardana reported that there was "no conclusive evidence that [claimant] has suffered any permanent occupational injury." (Emphasis added.) In this regard, Dr. Bardana's opinion lacks persuasiveness for two reasons. First, claimant need not produce proof to a medical certainty. Instead, claimant's proof need only be to a medical probability. Moreover, claimant need not prove permanent disability as a result of his work exposure. Rather, an occupational disease claim can be sustained upon proof of a need for medical services alone. See Johnsen v. Hamilton Electric, 90 Or App 161, 164 (1988).

In sum, Dr. Bardana's opinions, relied upon by the Referee, are not persuasive for the reasons discussed above. Instead, we rely upon the opinions of claimant's treating physicians.

As an alternative ground for his decision, the Referee concluded that the evidence failed to prove that claimant was exposed to isocyanates during his work for the employer. We do not agree. Dr. Dreisin's progress notes of December 13, 1985 disclose that claimant supplied him with labels and cans of the materials he used while at work. Dr. Dreisin noted that some of these items contained isocyanates. Further, while claimant wore a respirator while performing his job duties, Dr. Dreisin persuasively reported that the type of respirator used by claimant was inadequate to protect against exposure to isocyanates.

Penalties and Attorney Fees

This case involved a difficult question of medical causation. Dr. Wise initially reported that it was undetermined whether claimant's condition was work-related. Dr. Bardana's opinions oppose compensability. We conclude that the insurer's

denial was not unreasonable. Therefore, no penalty or associated attorney fee will be assessed.

ORDER

The Referee's order dated March 18, 1987 is reversed. The insurer's September 9, 1985 denial is set aside and the claim remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded an assessed fee of $2,400 for his services at hearing and on Board review, to be paid by the insurer.

Board Member Ferris, dissenting:

Because I would find that claimant has failed to prove that work exposure to paints containing isocyanates was the major contributing cause of a worsening of his bronchial asthma, I dissent.

The medical record contains the opinions of three physicians: Drs. Wise, Dreisin and Bardana. As indicated by the majority, Dr. Wise deemed it "likely" that work contributed to the symptoms of claimant's reactive airways disease. However, where a claimant's condition preexists his employment, as is true here, the test is not whether the symptoms of the preexisting disease have worsened, but instead the test is whether the disease itself has worsened as a result of work place exposures. Devereaux v. North Pacific Ins., 74 Or App 388 (1985). On this question, Dr. Wise deferred to Dr. Dreisin.

Thus, this case really comes down to the question whose opinion is more persuasive as between Dr. Dreisin and Dr. Bardana. The majority is more persuaded by Dr. Dreisin. I think Dr. Bardana's opinion is better reasoned and based upon a more accurate history. Therefore, I would conclude that claimant has failed to sustain his burden of proof.

Dr. Bardana performed an extensive array of tests in order to determine the etiology of claimant's respiratory problems. He performed a methacholine test that produced negative results, thereby indicating that claimant's respiratory difficulties were not occupationally related. Moreover, he performed tests for allergies that indicated a significant response to major northwest allergens. Lab results also indicated frequent use of marijuana. In this regard, claimant admitted that he previously abused marijuana, but he claimed to have discontinued its use prior to the time here in question. He explained the presence of significant amounts of marijuana in his system on the grounds that he had inadvertently consumed marijuana brownies at a party two weeks prior to his examination by Dr. Bardana. Given his prior history of substance abuse, I cannot accept his testimony on this issue. Dr. Bardana concluded that claimant suffered from chronic bronchitis secondary to chronic cigarette abuse amplified by smoking marijuana. His conclusion is well-supported by the evidence and cogently argued.

By contrast, Dr. Dreisin diagnosed occupational asthma secondary to exposure to isocyanates, as well as chronic cigarette abuse. Like Dr. Wise, Dr. Dreisin was convinced that claimant's exposure to isocyanates in the work place contributed to an exacerbation of his respiratory symptoms. However, nowhere does Dr. Dreisin explain the comparative contributions to claimant's underlying condition resulting from his isocyanate exposure and

his chronic cigarette abuse. Nor does Dr. Dreisin address the possible contributions to claimant's condition resulting from his allergies and his use of marijuana.

In addition, 15 months prior to hearing Dr. Dreisin reported that documentation of specific sensitivity to isocyanates would soon be possible at the Providence lab. He expressly noted that availability of this testing would be "an important point should litigation be involved in the future." Dr. Bardana confirmed at hearing that such testing was available at the time of hearing. However, claimant did not undergo such testing despite his physician's recognition of the importance of such testing.

The Referee found that the opinions of Drs. Wise and Dreisin were inadequate to sustain claimant's burden of proof. For the reasons stated above, I concur. I would, therefore, affirm the Referee's order.

DARLENE J. GARRETT, Claimant
Charles D. Maier, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 86-18170
April 7, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee McCullough's order which: (1) upheld the self-insured employer's partial denial of claimant's neck, low back and right shoulder condition; (2) reduced the award for unscheduled permanent disability from the 20 percent (64 degrees) awarded by Determination Order to zero; (3) affirmed a Determination Order award of 15 percent (22.5 degrees) scheduled disability; for loss of use or function of the right leg (knee); and (4) declined to assess a penalty and associated attorney's fee for a late denial. We affirm in part and reverse in part.

ISSUES

The primary issue is compensability. Claimant contends that her compensable injury is a material cause of her neck, low back and right shoulder conditions.

Claimant also contends that if these conditions are compensable, she is entitled to an award for unscheduled permanent disability.

Claimant also contends that she is entitled to a greater award for scheduled disability than the 15 percent scheduled disability to the right leg awarded by Determination Order.

Finally, claimant contends that she is entitled to a penalty and associated attorney's fee for a late denial.

FINDINGS OF FACT

Claimant compensably injured her right knee on October 7, 1985. The employer indicated that it accepted the claim for a right knee injury on the original claim form. On February 24, 1986, Dr. Spady wrote to the employer that the compensable injury had caused claimant's preexisting degenerative disc disease to become symptomatic. Dr. Spady suggested an intensive course of treatment for the degenerative disc problem.

On June 11, 1986, Dr. Strum wrote to a vocational counselor that claimant had fallen and injured her right shoulder as a result of her knee giving way. He reported that the shoulder injury would have to be treated and watched. On October 20, 1986, Dr. Spady wrote to the employer that the knee give way was due to the compensable injury and thus caused the shoulder problems. He suggested further diagnostic procedures to determine if claimant had a rotator cuff injury.

A Determination Order of December 23, 1986 granted claimant awards for 15 percent scheduled disability to the right knee and 20 percent unscheduled disability. Claimant requested a hearing to protest the Determination Order on January 7, 1987.

At hearing, the parties agreed that the employer's argument that claimant had no unscheduled disability was, in effect, a denial of the compensability of the neck, low back and right shoulder conditions.

CONCLUSIONS

We adopt the Referee's "Findings and Opinion" as our conclusions on all issues except the penalty issue.

We conclude that the employer was late in denying the low back and right shoulder claims. When Dr. Spady wrote to the employer on February 24, 1986 that claimant's degenerative condition was caused by the compensable injury and that claimant needed intensive treatment for the back condition, Dr. Spady made a claim for the compensability of the low back. When Dr. Strum, the treating physician, stated that the shoulder problem was caused by the knee, he was indicating that the shoulder problem was caused by the compensable injury. Because he was the treating physician and was relating the shoulder problem to the compensable injury, we conclude that he was making a claim for the shoulder problem which the employer should have responded to. Finally, Dr. Spady, made a claim for the compensability of the right shoulder on October 20, 1986 when he related the shoulder injury to the compensable injury and recommended further diagnostic tests.

The employer did not accept or deny any of these claims within 60 days. Because there is no explanation for the delay in accepting or denying these claims, we find the employer's failure to accept or deny within 60 days unreasonable. We assess no penalty because no amounts are due upon which it may be based. We do award an attorney's fee for the late denial.

ORDER

The Referee's order dated October 23, 1987 is affirmed in part and reversed in part. That portion of the Referee's order which concluded that the employer was not unreasonably late in denying the low back and right shoulder claims is reversed. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning this issue, claimant's attorney is awarded a reasonable attorney's fee of $50, to be paid by the self-insured employer. A client-paid fee, not to exceed $700, is approved.

JESUS A. GUZMAN, Claimant
Eddy R. Swearinger, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 85-09354
April 7, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Howell's order which upheld the insurer's denial of an aggravation claim and which found that the denial was not unreasonable. We affirm.

ISSUES

The primary issue is compensability of an aggravation claim. Claimant also seeks a penalty and associated attorney's fee for an unreasonable denial.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following supplementation: Claimant's increased symptoms at the time he saw Dr. Whitmire on July 16, 1986 were in the area of the mid-back. The mid-back problem is not causally related to the compensable injury. Dr. Whitmire's opinion that claimant had worsened in July 1986 to the point that he could not work is based on his conclusion that the mid-back is causally related to the compensable injury.

CONCLUSIONS

The Board adopts the Referee's conclusions with the folliwing supplemenation. We rely on the report of the Orthopaedic Consultants for the finding that the mid-back condition is unrelated to the compensable injury. This finding is bolstered by the fact that Dr. Whitmire's associate withdrew all billings to the insurer for the mid-back treatments.

Because claimant's increased symptoms in July 1986 were due to a mid-back problem, which is not related to the compensable injury, claimant has failed to prove that he became less able to work due to a worsening of his compensable condition. Therefore, the fact that Dr. Whitmire took claimant off work for more than fourteen days is insufficient to establish an aggravation. The need for time loss must be caused by at least a symptomatic worsening of a compensable condition.

ORDER

The Referee's order of August 31, 1987 is affirmed. A client paid fee, not to exceed $377, is approved.

RODNEY R. HENSEN, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-17944
April 7, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of those portions of Referee McCullough's order that set aside its partial denials of claimant's medical services claims for neck, headache and low back conditions. Claimant cross-requests review of that portion of the order that upheld the employer's denial of claimant's aggravation claim involving the low back. We affirm.

ISSUES

1. The compensability of medical treatment for claimant's neck and headache conditions.

2. The compensability of medical treatment for claimant's low back condition.

3. The compensability of an alleged aggravation of claimant's low back condition.

FINDINGS OF FACT

Claimant compensably injured his back, chest, legs and ribs in April 1986. The injury occurred while claimant was standing on a large, aluminum caul plate. The machinery he was attempting to repair unexpectedly began operating, and the plate on which he was standing went out from under him. Claimant's legs also went out from under him, but he was able to suspend himself from an overhead beam. As he attempted to alternately pull himself up and drop himself down, he was repeatedly struck by another caul plate from the lower cervical spine to the lumbar area. The plate was more than 20 feet long, five feet wide and weighed several hundred pounds. Claimant received conservative treatment for the low back and returned to work soon thereafter. He continued in his regular job until August 1986, when he was terminated for reasons unrelated to his compensable injury. Claimant continued to have intermittent neck, head and low back symptoms following the 1986 injury. Claimant's claim was closed in May 1986.

In September 1986, claimant visited Dr. Jarvis, complaining of headaches and neck pain. Jarvis referred him to Dr. Harris, who prescribed medication and physical therapy. Claimant filed a claim for medical services for his neck and head. The employer denied compensability on December 12, 1986.

In February 1987, claimant consulted Dr. Hill, complaining of low back pain. Hill prescribed conservative treatment for the lumbar strain. Claimant filed a claim for medical services for his low back. The employer denied compensability on April 3, 1987.

Claimant's need for medical services for the neck and head is materially related to the April 1986 compensable injury.

Claimant's need for medical services for the low back is materially related to the April 1986 compensable injury.

Claimant's low back condition did not materially worsen so as to make him more disabled, i.e., less able to work, following the May 1986 closure of his claim.

CONCLUSIONS OF LAW

1. The compensability of claimant's neck and headache conditions.

Claimant asserts that the medical treatment he has received for his neck and headache pain is the compensable result of his April 1986 injury. It is, therefore, his burden to prove that the treatment he received was reasonable and necessary, as well as materially related to the 1986 injury. ORS 656.245(1); Matthews v. Louisiana Pacific Corp., 47 Or App 1083 (1980). After reviewing this

record, we agree with the Referee that claimant's claim for medical services is compensable.

Claimant and his primary witness both credibly testified regarding the mechanism of claimant's 1986 injury. The injury resulted in trauma throughout the spine, including the lower cervical area. Using this history, Drs. Harris and Jarvis opined that the injury was not only capable of producing, but probably did produce, neck and headache symptoms. Although there is some controversy regarding when and if claimant complained of cervical symptoms to persons at work, we are satisfied that he has proved his claim by a preponderance of the evidence.

2. The compensability of claimant's medical services for the low back.

Claimant asserts that the medical services he received for low back symptoms was necessitated by the April 1986 injury. Again, it is his burden of proof. Matthews, supra. We agree with the Referee that claimant has sustained his burden. He credibly testified that he continued to experience low back symptoms following the April 1986 injury. Based on claimant's history of ongoing pain and the mechanism of injury, Dr. Hill, who treated claimant for the low back in 1987, opined that the treatment was materially related to the 1986 injury. As did the Referee, we find Hill's reports and deposition testimony sufficient to sustain claimant's claim.

3. The compensability of an alleged aggravation of claimant's low back condition.

Claimant asserts that his low back claim should have been reopened as an aggravation when he experienced increased symptoms in February 1987. It is, therefore, claimant's burden to prove that following the May 1986 closure of his claim, his compensable low back condition worsened such that he was more disabled, i.e., less able to work than at the time of claim closure. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986). As did the Referee, we find that he has failed to sustain his burden of proof.

While the medical evidence supports the compensability of claimant's ongoing neck and low back conditions, it does not demonstrate that claimant's conditions compensably worsened following claim closure. Neither does claimant's testimony, which suggests that but for being terminated by his employer, claimant would still be employed there. We conclude that the Referee properly upheld the employer's denial of claimant's claim for a low back aggravation.

ORDER

The Referee's order dated November 10, 1987 is affirmed. Claimant's attorney is awarded a reasonable attorney fee of $750 on Board review, to be paid by the self-insured employer. A client-paid fee not to exceed $2,028.28 is approved.

CAROL R. JOHNS, Claimant
Olson Law Firm, Claimant's Attorney
Acker, et al., Defense Attorneys

WCB 86-17959
April 7, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Foster's order that upheld the insurer's denial of her bilateral carpal tunnel syndrome claim. The issue is compensability. We affirm the Referee's order.

FINDINGS OF FACT

Claimant was employed as a production worker for the insured, manufacturing aircraft window seals. She worked from October 21, 1986 until October 29, 1986. Claimant performed a number of different tasks during an average work day. For example, she used an "exacto knife" to trim "flash" from plastic and rubber parts after they were removed from their molds. In addition, she "block sanded" the various parts and refinished painted surfaces with an emery cloth. She also washed and cleaned parts. Claimant worked a total of 66 hours for the insured. She "block sanded" for just over 22 of the total 66 hours.

On October 31, 1986, claimant sought treatment from her family physician, Dr. Pearson, M.D., complaining of pain in her right hand and wrist. Claimant had been asymptomatic prior to her work with the employer. The onset of her right hand and wrist complaints began after eight days with the employer. Dr. Pearson diagnosed the condition as early carpal tunnel syndrome and authorized time loss from November 3, 1986 through November 11, 1986. On November 10, 1986, Dr. Pearson recommended that claimant not return to her prior employment.

The insurer denied the claim on November 19, 1986.

Nerve conduction studies conducted in December 1986 confirmed that claimant experienced right side carpal tunnel syndrome and mild left sided carpal tunnel syndrome. Dr. Nathan, M.D., examined claimant on December 17, 1986. Based on the nerve conduction studies, Dr. Nathan diagnosed bilateral carpal tunnel syndrome, greater on the right than on the left.

Dr. Button, M.D., reviewed claimant's medical records and on January 30, 1987, reported that he concurred with Dr. Nathan.

ULTIMATE FINDINGS OF FACT

Claimant has bilateral carpal tunnel syndrome, which preexisted her employment with the insured. Claimant's employment exposure with the insured from October 21, 1986 through October 29, 1986 did not worsen her preexisting bilateral carpal tunnel syndrome condition.

CONCLUSIONS AND OPINION

The Referee found that claimant suffered from bilateral carpal tunnel syndrome. However, he concluded that claimant failed to establish a relationship between her employment and a worsened underlying carpal tunnel condition. We agree.

Because claimant alleges no specific incident of trauma, but noticed, rather, a gradual onset of carpal tunnel symptoms after working approximately eight days for the insured, we find this case is best analyzed as an occupational disease claim. As such, claimant must show that her preexisting carpal tunnel syndrome condition was worsened by her employment exposure and that her work was the major cause of that worsening. Wheeler v. Boise Cascade, 298 Or 452 (1985); Weller v. Union Carbide, 298 Or 452 (1984). Claimant bears this burden of proof whether her

carpal tunnel syndrome was symptomatic or asymptomatic at the time of employment. Wheeler, supra at 457-58.

Although we will generally defer to the treating physician's opinion, in this case we find the well reasoned opinions of hand specialists, Drs. Nathan and Button, more persuasive. Somers v. SAIF, 77 Or App 259 (1986). Both of these hand experts concluded that claimant's underlying carpal tunnel pathology preexisted her employment with the insured. They also opined that her limited work exposure with the insured was insufficient to worsen her condition beyond, perhaps, making the condition temporarily symptomatic.

In reaching our conclusion, we note that this case involves a complex medical causation question as to whether claimant's work exposure worsened her underlying carpal tunnel condition or simply made it symptomatic. Faced with this complex question, we defer to the opinions of hand experts, Drs. Nathan and Button, as opposed to general practitioner, Pearson. See Ellen L. Hamel, 40 Van Natta 1226 (1988); Kenneth L. Jessie, 40 Van Natta 1592 (1988). Accordingly, claimant failed to establish compensability of her occupational disease claim by a preponderance of the evidence.

ORDER

The Referee's order dated October 30, 1987, is affirmed. A client-paid fee, not to exceed $510, is approved.

BARBARA J. MEHERIN, Claimant
Michael B. Dye, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-00160
April 7, 1989
Order on Remand

This case is before the Board on remand from the Court of Appeals. Meherin v. Stayton Canning Co., 94 Or App 173 (1988). The issue on remand is the compensability of claimant's scoliosis.

FINDINGS OF FACT

Claimant injured her low back on July 21, 1985 in the course of her employment as a cannery worker when she backed into the end of a metal roller. She had never experienced low back problems prior to this injury. She sought medical treatment at an emergency room, was off work for several days and her condition improved. She then attempted to return to work, her condition deteriorated and she began treating with Dr. Boyer, a chiropractor. Dr. Boyer diagnosed a thoracolumbar strain or sprain and noted a mild scoliosis involving the thoracic and lumbar regions.

Claimant returned to her regular work on August 12, 1985 and experienced an exacerbation of low back symptoms about a month later. She then left work and resumed treatment with Dr. Boyer.

On November 20, 1985, the self-insured employer's adjusting agency issued a partial denial which stated that claimant's ongoing symptoms were due to her scoliosis and not to her industrial injury. The claim was closed by Determination Order dated December 19, 1985 with no award of permanent partial disability. On March 25, 1986, the adjusting agency issued a second partial denial which was identical to the first one.

Claimant requested a hearing on the Determination Order and the employer's denials. Regarding the Determination Order, claimant raised the issues of premature closure and extent of disability. Regarding the denials, claimant asserted that they were procedurally invalid under either Bauman v. SAIF, 295 Or 788 (1983) or Safstrom v. Reidel International, Inc., 65 Or App 728 (1983), rev den 297 Or 124 (1984) or, in the alternative, that they were erroneous on the merits. Regarding the Determination Order, claimant contended that it had prematurely closed her claim or, in the alternative, that she was entitled to an award of permanent partial disability. The Referee concluded that the employer's November 1985 denial was invalid under Safstrom and that both the November 1985 and March 1986 denials were invalid under Bauman. In addition, he held that claimant's scoliosis was compensable on the merits. The Referee also set aside the Determination Order as premature and refused to rate the extent of claimant's disability.

On review of the Referee's decision, the Board affirmed. he Board, however, rejected the Referee's conclusion that the employer's denials were invalid under Bauman. Instead, it concluded that both denials were invalid under Safstrom and, in view of the fact that the Determination Order had been set aside and that claimant's claim was still open, held that it was improper at that time to rule on the question of the compensability of claimant's scoliosis.

Claimant appealed the Board's decision, contending that the Board should have addressed the question of the compensability of the scoliosis. The employer agreed with this contention. In view of the parties' agreement, the Court of Appeals remanded the case to the Board for a decision on the compensability of claimant's scoliosis. The court affirmed the Board's order in all other respects.

Scoliosis is lateral curvature of the spine. It can be congenital, developmental or traumatic. Claimant's scoliosis preexisted her July 1985 industrial injury and was not caused or materially worsened by the injury. The scoliosis, however, did interact with the injury by exerting stresses on claimant's spine which adversely affected her recovery from the injury.

FINDINGS OF ULTIMATE FACT

Claimant's July 1985 industrial injury continued to be a material contributing cause of her disability and need for medical services at the time of the hearing. The abnormal spinal stresses associated with claimant's preexisting scoliosis slowed and limited her recovery from the injury.

CONCLUSIONS OF LAW

The Referee concluded that claimant's industrial injury had worsened her underlying scoliosis or, in the alternative, that it had caused the scoliosis to become symptomatic. Either way, he concluded that the scoliosis was compensable. We reject the Referee's first conclusion, but accept his second conclusion in modified form. We conclude that the July 1985 industrial injury continued to be a material contributing cause of claimant's ongoing complaints at the time of the hearing, that these

complaints were adversely affected by the abnormal spinal stresses produced by the scoliosis and that these adverse affects are compensable.

A number of medical professionals offered opinions regarding the relationship between claimant's ongoing low back complaints, the industrial injury and the scoliosis. In November 1985, Dr. Spady, a consulting orthopedic surgeon, opined that claimant's industrial injury had fully resolved and attributed her ongoing complaints to unspecified non-organic causes. He also indicated that the scoliosis had preexisted the industrial accident, had not been adversely affected by the accident and played no role in claimant's ongoing complaints. In December 1985, Dr. Altrocchi, a consulting neurologist, opined that claimant's ongoing complaints were due to the industrial injury independent of the preexisting scoliosis. In February 1986, Dr. Anderson, a consulting chiropractor, opined that claimant's ongoing complaints were due to the industrial injury, but also indicated that the preexisting scoliosis had complicated claimant's recovery from the injury.

Dr. Boyer, the treating chiropractor, opined that claimant's ongoing complaints were due to the industrial injury. Regarding the scoliosis, he initially opined that it was caused by the industrial injury. (Ex. 16). Later, after reviewing x-rays taken in 1981 which confirmed that the scoliosis had preexisted the industrial injury, he opined that the injury had worsened the severity of the scoliosis. (Ex. 20A-1). This conclusion was based upon a comparison of the 1981 x-rays with x-rays taken in 1985 a few days after the industrial injury. In a subsequent deposition, Dr. Boyer also indicated that the injury had caused a reversal in the direction of the scoliosis. (Ex. 21-38 to 39). He dropped this assertion, however, after the employer's counsel pointed out that the 1981 and 1985 x-rays had been taken from opposite sides of claimant's body. (Ex. 21-61 to 62, 21-69 to 70). His final conclusion regarding the scoliosis was that it had complicated claimant's recovery from the industrial injury, but otherwise had little to do with her ongoing complaints. (Ex. 21-69 to 70).

The Referee's conclusion that claimant's industrial injury had worsened her underlying scoliosis was based upon Dr. Boyer's early statements on the subject. As noted in the previous paragraph, those statements were later effectively withdrawn. There is no other evidence which would support the Referee's conclusion. We conclude, therefore, that claimant has failed to prove that her industrial injury caused or materially worsened her underlying scoliosis.

The Referee's alternative conclusion was that claimant's industrial injury had rendered her scoliosis symptomatic. This conclusion was based upon the statements by Drs. Anderson and Boyer regarding the effect of the scoliosis on claimant's symptoms. The Referee expressly rejected Dr. Spady's unexplained opinion regarding non-organic causes for claimant's complaints and characterized Dr. Altrocchi's opinion as "neutral" on the subject. We agree with the Referee, on this record, that the evidence preponderates in favor of the conclusion that there was a material causal relation between claimant's scoliosis and her ongoing complaints. We conclude, however, that it is more consistent with the opinions rendered in this case to say that claimant's ongoing complaints are due to her July 1985 industrial

injury and that the scoliosis slowed and limited claimant's recovery from this injury rather than to say that the injury made the scoliosis symptomatic. That is the gist of the opinions rendered by Drs. Anderson and Boyer and such a reading of those opinions allows for their harmonization with that of Dr. Altrocchi. We too reject the unexplained opinion of Dr. Spady.

In view of the above discussion, claimant's scoliosis is not compensable independent of the industrial injury. The adverse effects of the scoliosis upon the industrial injury, however, are compensable. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987). We set aside the employer's partial denials, therefore, to that extent.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered concerning the compensability issue. ORS 656.388(1). Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 shall not be award. See OAR 438-15-010(5).

ORDER

The Referee's order dated August 22, 1986 is modified in part. The employer's denials dated November 20, 1985 and March 25, 1986 are set aside to the extent that they denied that claimant's ongoing disability and need for medical services was related to her July 1985 industrial injury and that any causal relation existed between claimant's preexisting scoliosis and the industrial injury. The claim is remanded to the employer for processing in accordance with our opinion in this case.

MICHAEL L. MILNER, Claimant
Michael B. Dye, Claimant's Attorney
Dennis Martin (SAIF), Defense Attorney

WCB 86-03204
April 7, 1989
Order on Reconsideration

It has come to our attention that our order dated March 27, 1989 was mislabeled Order of Abatement. To correct this error, we issue this order, which adheres to and republishes our March 27, 1989 order in its entirety, except for the inaccurate labeling. The parties' rights of appeal shall continue to run from the date of our March 27, 1989 order.

IT IS SO ORDERED.

GABINO R. OROZCO, Claimant
Kenneth D. Peterson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-10736
April 7, 1989
Second Order Denying Request

Claimant's counsel requests reconsideration of our March 23, 1989 Order Denying Request for an assessed fee for services rendered in this matter which culminated in our February 3, 1989 Order on Remand. Asserting that our decision is contrary to the jurisdictional principle enunciated in Greenslitt v. City of Lake Oswego, 305 Or 530 (1988), claimant's counsel asks that an assessed fee be awarded.

The Supreme Court does not dispute the efficiency of including attorney fee awards within orders concerning the merits

of the case. Greenslitt, supra, at pages 534-35 & n. 3. Furthermore, the Court has concluded that if the merits of the case are appealed, the attorney fee issue becomes part of the appeal. Id. Yet, the determination of an attorney fee does not directly affect a worker's right to, or the amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986).

Consequently, the Supreme Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt, supra; Farmers Ins. Group, supra. Moreover, the Court has indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt, supra; Farmers Ins. Group, supra, at page 619.

Based on the aforementioned authorities, we have held that, where neither the entitlement to, nor the amount of, an attorney fee has been addressed by a prior order, we have jurisdiction to consider an attorney fee request even though the merits of the case has become final by operation of law. See Jane E. Stanley, 40 Van Natta 831 (1988). Here, our February 3, 1989 Order on Remand stated that since no statement of services had been submitted, no assessed fee would be approved. Thus, our order expressly addressed the issue of claimant's counsel's entitlement to an assessed fee.

Under such circumstances, consistent with the Stanley holding, our authority to consider claimant's request for an assessed fee is contingent upon our retaining jurisidiction over the February 3, 1989 order. However, since the February 3, 1989 order has neither been appealed, abated, stayed nor republished, it has become final by operation of law. ORS 656.295(8); International Paper Co. v. Wright, 80 Or App 444, 447 (1986). Accordingly, we lack jurisdiction to consider claimant's counsel's request for an assessed fee.

As stated in our March 23, 1989 order, the statement of services from claimant's counsel was received prior to expiration of the 30-day appeal period. Under such circumstances, we make every effort to promptly process such requests. See Betty J. Eyler, 40 Van Natta 977 (1988). Yet, in this instance, the 30-day jurisdictional period to further consider our Order on Remand passed before the statement of services reached the record.

In conclusion, we profoundly regret this unfortunate situation. However, because the February 3, 1989 order addressed the entitlement of claimant's counsel to an assessed fee and has become final by operation of law, we lack jurisdiction to consider the fee request.

Accordingly, as supplemented herein, we adhere to and republish our March 23, 1989 order in its entirety. The parties' rights of appeal shall continue to run from the date of our March 23, 1989 order.

IT IS SO ORDERED.

MARIE C. WALSH, Claimant
Francesconi & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-17420
April 7, 1989
Second Order on Reconsideration

The insurer has requested reconsideration of that portion of our March 20, 1989 Order on Reconsideration that awarded a reasonable assessed fee for claimant's counsel's services on review in prevailing against the insurer's request for review of a Referee's order setting aside its partial denial of claimant's psychiatric condition. Asserting that our attorney fee award is inconsistent with several recent decisions, the insurer asks that the award be eliminated.

In our March 8, 1989 Order on Review, we declined to award an attorney fee because claimant's counsel had not filed a statement of services. On March 10, 1989, in response to our order, claimant submitted a statement of services and sought an attorney fee pursuant to ORS 656.382(2). Inasmuch as we retained jurisdiction over the merits of the case, we proceeded to address the request. On March 20, 1989, after review of the statements of services and the retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we awarded a reasonable assessed fee of $1,000.

The insurer contends that our March 20, 1989 order is contrary to the principle enunciated in Jane E. Stanley, 40 Van Natta 831 (1988), and several subsequent decisions. We disagree.

In Stanley, the insurer's counsel submitted a statement of services seeking Board authorization of a client-paid fee some three months after the issuance of an Order on Review. Since our prior order neither addressed the issue of the insurer's counsel's entitlement to, or the amount of, a client-paid fee, we concluded that we had jurisdiction to consider the request for authorization. However, because the request was untimely submitted under OAR 438-15-027(1)(d) and since our order on the merits had become final by operation of law, we declined to authorize the request.

Here, as in Stanley, a statement of services was untimely submitted under the aforementioned rule. Yet, unlike Stanley, the statement was submitted and our reconsideration order issued prior to the expiration of the 30-day statutory appeal period while we still had jurisdiction over the merits of the case. Since our order on the merits of the case had not become final by operation of law, we retained jurisdiction to reconsider our prior order. Such an approach is entirely consistent with the reasoning expressed in Stanley and its progeny.

Accordingly, as supplemented herein, we adhere to and republish our order of March 20, 1989, in its entirety. The parties' rights of appeal shall continue to run from the date of our March 20, 1989 order.

IT IS SO ORDERED.

ROBERT A. WEBSTER, Claimant
Allen, et al., Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 87-09949
April 7, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of Referee Brazeau's order that : (1) declined to leave the record open for the introduction of a medical report submitted by the employer; and (2) set aside its partial denial of claimant's current neck condition. Should we find that the Referee's evidentiary ruling was erroneous, the employer asks that this case be remanded to the Referee for introduction of the report. The issues on review are the Referee's evidentiary ruling, remand, and compensability.

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

On review, the employer asserts that the matter should be remanded on the grounds that the Referee erred in not leaving the record open for an independent medical examination subsequently submitted by the employer.

Claimant requested a hearing on June 26, 1987. Notice of hearing was sent on October 6, 1987. The employer's attorney arranged for a medical examination by Dr. Larson. As of the date of hearing, the employer's attorney did not have the report and requested that the record be left open to receive it. Claimant's attorney objected, pointing out that the employer had almost five months from the time of request for hearing to procure additional medical reports. The Referee sustained this objection.

We do not find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295; Michael J. Bruno, 38 Van Natta 1019 (1986). Furthermore, the Referee found that the report in issue could have been obtained with due diligence in time to comply with the rules of procedure for submitting evidence. We agree. Inasmuch as we find that the employer had ample time to obtain this report and since the record is neither improperly, incompletely, nor insufficiently developed, the motion to remand is denied.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. ORS 656.302(2). Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 shall not be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated November 20, 1987, is affirmed. A client-paid fee, not to exceed $1,953, is approved.

RANDALL S. WILLIAMS, Claimant
Francesconi, et al., Claimant's Attorneys
Kevin Mannix, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 87-09755 & 87-09756
April 7, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Liberty Northwest Insurance (Liberty) requests review of Referee Smith's order which assigned responsibility for claimant's low back condition to it. We reverse.

ISSUES

The sole issue is responsibility. Liberty contends that the Referee erred in shifting responsibility from EBI to Liberty.

FINDINGS OF FACT

Claimant has had a series of low back injuries with various employers. He injured his low back on September 1, 1982, while working for EBI's insured. On September 17, 1985, responsibility shifted from an earlier insurer to EBI by an Order on Review. That order has become final.

Claimant continued to work as a carpenter. He sustained two intervening injuries while working for insureds of SAIF. On August 7, 1986, EBI denied claimant's current treatment as well as responsibility for an aggravation. SAIF, too, denied responsibility. None of these denials was appealed.

On May 7, 1987, claimant saw Dr. Boyd complaining of increased pain over the prior three weeks. Claimant related the increased pain to an incident in the shower.

On May 18, 1987, claimant filed a claim against Liberty's insured alleging that he had experienced a sharp pain in his back on May 15, 1987 when he bent over to pick up a piece of lumber. When claimant bent to pick up the piece of lumber he felt a pop and his back "gave out." The incident caused an exacerbation of claimant's prior injuries.

EBI denied responsibility for the May 15, 1987 incident on June 8, 1987.

CONCLUSIONS

In successive injury cases such as this, in order to shift responsibility from EBI to Liberty, Liberty's employment must have contributed to a worsening of claimant's underlying condition. Hensel Phelps v. Mirich, 81 Or App 290 (1986). However, where the evidence is inconclusive, and the latter employment could have contributed to the cause of the disability, the latter employer becomes responsible. Champion International v. Castelleja, 91 Or App 556, 560 (1988).

The Referee found the medical evidence inconclusive and consequently assigned responsibility to Liberty. We disagree.

Dr. Winslow stated on the "827" form immediately after the May 1987 injury that it was an exacerbation or reinjury of the prior injury. He later stated that the incident appeared to be an exacerbation of his previous injury rather than a new injury.

Dr. Hazel indicated that claimant's prior fusion appeared to be solid. He suggested only symptomatic treatment.

Although neither doctor used "magic words" to indicate that there was no worsening of the underlying condition, we conclude that that is the thrust of their opinions. Dr. Hazel found no change in the fusion and Dr. Winslow described only an "exacerbation." We conclude that this evidence is sufficient to establish that the incident at Liberty's insured did not independently contribute to a worsening of claimant's underlying condition.

ORDER

The Referee's order dated October 2, 1987 is reversed. Liberty Northwest's denial is reinstated and upheld. EBI's denial is set aside and the claim is remanded to EBI for processing according to law. A client-paid fee, not to exceed $2,074, is approved for Liberty's counsel. A client-paid fee, not to exceed $720, is approved for EBI's counsel.

LINDA K. JONES, Claimant
Michael B. Dye, Claimant's Attorney
John Motley (SAIF), Defense Attorney

WCB 88-00565
April 11, 198
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Higashi's order which denied a request that an attorney's fee out of compensation be paid in a lump sum. SAIF moves for dismissal of the request for review.

ISSUES

The first issue is whether the Referee had jurisdiction to consider claimant's attorney's request that the attorney's fee be paid in a lump sum.

The second issue is whether the Referee abused his discretion in declining to allow the attorney's fee to be paid in a lump sum.

FINDINGS OF FACT

These findings of fact are based on the arguments presented to the Referee and on Board review and on the pleadings contained in the administrative file.

Referee Baker granted claimant an award for permanent total disability on December 22, 1987. Referee Baker granted an attorney's fee of $2,000 out of compensation. No party requested review of that order, so it has become final as a matter of law.

On February 4, 1988, more than 30 days after Referee Baker's order, claimant's attorney filed a motion for payment of his attorney's fees in a lump sum. SAIF opposed the motion. Both parties submitted additional argument. On March 14, 1988, Referee Higashi denied the motion without explanation.

Claimant requested review of Referee Higashi's order. SAIF then moved to dismiss the request for review arguing that Referee Higashi lacked jurisdiction to even consider claimant's motion.

CONCLUSIONS

OAR 438-15-085(1) provides:

> "(1) If the claimant consents in the attorney retainer agreement, the Referee or the Board may order the payment of approved attorney fees directly to the claimant's attorney in a lump sum when the fee is to be paid out (sic) an award of compensation for permanent disability. The lump sum shall not be due until the award of compensation becomes final."

By using the word "the" before Referee, the rule appears to contemplate that the Referee who awarded the permanent disability will be the Referee who authorizes payment of a lump sum attorney's fee. As a matter of policy, we conclude that if an attorney wishes a lump sum attorney's fee out of compensation, the attorney should request authorization for a lump sum payment from the Referee who granted the award for permanent disability. Accordingly, claimant's attorney should have requested authorization from Referee Baker while the matter was still pending before him.

We do not voice an opinion whether there is a jurisdictional requirement that the request for a lump sum be made while the original Referee retains jurisdiction over the merits of the case. We merely hold that, as a matter of policy, we will require that the request for a lump sum be made while the original Referee retains jurisdiction over the merits of the case.

Even assuming that the motion was properly before Referee Higashi, we conclude that he did not abuse his discretion in denying the request for a lump sum payment.

ORDER

The Referee's order of March 14, 1988 is affirmed.

JOHNNY D. LANE, Claimant
Brothers, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-16962
April 11, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Nichols' order that: (1) upheld the insurer's denial of his aggravation claim; and (2) declined to assess penalties and attorney fees for the alleged unreasonable denial. We affirm.

ISSUES

(1) Whether the insurer's denial was an improper "back-up" denial;

(2) Compensability of claimant's aggravation claim; and

(3) Penalties and attorney fees for unreasonable denial.

FINDINGS OF FACT

We adopt the findings of fact made by the Referee and set forth under the heading "Summary of Evidence" on pages one and two of her Opinion and Order, inclusive. We also make the following additional findings of fact.

Claimant was employed at injury as the manager of a transmission rebuilding shop. The greater percentage of his time was spent on administrative duties and customer contact. Near the end of his employment, some of his time was spent doing mechanical bench work. The transmissions were removed and replaced by other employees.

Claimant has a history of severe headaches. While employed, both before and after his injury, he took unusually large numbers of aspirin on a regular basis.

Claimant owned, raised and trained a number of horses. On one occasion he came to work scraped and bruised from an altercation with one of the horses. He continues to own and ride horses. He rides about an hour and a half at a time. He discussed the sale of one of his horses with a private investigator, and rode the horse for her to demonstrate its style.

Claimant received temporary disability payments, and his medical bills were paid, from January 11, 1986 until the denial. He has not worked since leaving the employer in early 1985 for reasons unrelated to his compensable injury.

Claimant's current condition is not causally related to his compensable injury.

CONCLUSIONS OF LAW AND OPINION

Claim acceptance or denial

The insurer began paying time loss and claimant's medical bills in January 1986. It did not formally accept or deny the claim until October 1986, when it issued a written denial. Claimant contends that the claim was constructively accepted and that the subsequent denial is impermissible under Bauman v. SAIF, 295 Or 788 (1983).

Bauman, and the line of cases following it, hold that an insurer cannot "back up" and deny a previously accepted condition more than 60 days after notice of the claim. After that time, the insurer is bound by the terms and scope of its written acceptance.

However, the insurer is not responsible, under the rule in Bauman, for conditions outside of its written acceptance. In this case, no part of claimant's aggravation claim was formally accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Therefore, claimant's argument is inapplicable.

Claimant argues that because the medical bills and time loss were paid and because the insurer's internal memoranda indicated that the claim was accepted, the claim should be deemed "constructively" accepted. The law is not with claimant. It is well established that the payment of time loss and/or medical bills, without more, does not constitute acceptance of a claim.

See ORS 656.262(9); Gregg v. SAIF, 81 Or App 395 (1986). It is further established that, when an insurer is silent for more than 60 days, such silence shall be treated as a "de facto" denial. ORS 656.262(10); Barr v. EBI Companies, 88 Or App 132 (1987).

The remedy for a "de facto" denial is not forced acceptance of the claim. Rather, it is penalties and attorney fees for unreasonable delay in processing. ORS 656.262(10); Mischel v. Portland General Electric, 89 Or App 140 (1987). The Referee granted that remedy, and we affirm it.

Compensability

In order to establish an aggravation, claimant must prove "worsened conditions resulting from the original injury." ORS 656.273(1). Claimant relies on the reports of his chiropractors, primarily Dr. Gloar, to carry his burden of proving the causal relationship between his current condition and his work injury. We are not persuaded by these reports. Each of the chiropractors was given a history which omitted claimant's "run-in" with his horse, and his long-term history of severe headaches. An incomplete medical history flaws a physician's evaluation, and may render it unpersuasive. See, e.g. Moe v. Ceiling Systems, 44 Or App 429 (1980).

Further, the Referee found that claimant was neither a credible nor a reliable historian, based on his demeanor. We defer to that finding. Havice v. SAIF, 80 Or App 448 (1986). We therefore conclude that claimant has not proven a causal relationship between his current condition and his compensable accident.

ORDER

The Referee's order dated July 13, 1987 is affirmed.

MARIA R. PORRAS, Claimant
Olson Law Firm, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-11249
April 11, 1989
Order on Remand

This matter is on remand from the Court of Appeals for reconsideration under the standards in Armstrong v. Asten-Hill Co., 90 Or App 200, 205 (1988). Porras v. Castle & Cooke, Inc., 91 Or App 526 (1988). On remand, we issue the following order.

Claimant requests review of those portions of Referee Nichols's order that: (1) declined to grant her permanent total disability; (2) increased her unscheduled permanent partial disability award from 50 percent (160 degrees), as awarded by Determination Order, to 85 percent (272 degrees); (3) permitted the self-insured employer to redesignate unilaterally permanent partial disability benefits previously paid pursuant to the July, 1984, Determination Order as temporary total disability benefits payable under a prior Referee's February, 1985, order, which set aside the employer's 1983 partial denial of claimant's cerebrovascular attack; and (4) declined to assess a penalty and attorney fee for the employer's allegedly unreasonable claims processing above. The employer cross-requests review of that portion of the order that found claimant to be medically stationary as of July 8, 1985.

ISSUES

1. Permanent total disability.

2. Unilateral redesignation of previously paid permanent partial disability benefits as temporary total disability benefits.

3. Penalty and attorney fee for allegedly unreasonable claim processing.

4. Medically stationary date.

We reverse on the issues of permanent total disability, unilateral redesignation of benefits and penalty and attorney fee, and modify the medically stationary date.

FINDINGS OF FACT

Claimant, a Spanish-speaking mushroom picker, compensably injured her low back and left wrist in June, 1982. The diagnoses were lumbosacral sprain and left wrist sprain. The claim was accepted for a disabling injury.

Claimant has had previous injuries dating back to 1979. In that year, she compensably injured her upper back and right shoulder. A claim for that injury was accepted and closed by Determination Order in June, 1980, with no permanent disability award. In February, 1981, claimant filed another claim for a cervical strain, but it was denied. No hearing was requested on the denial. Claimant continued to work through the date of this injury.

After this injury, claimant returned to work in late August, 1982. She missed a week of work the following month due to a flareup caused by excessive bending. In October, 1982, she was taken off work with complaints of pain in the left leg, as well as the low back. A lumbar disc protrusion was suspected, but a myelogram could not be performed due to claimant's pregnancy.

Further chiropractic treatment was denied; and the claim was closed by Determination Order on January 21, 1983, with an award of temporary total disability (TTD) benefits only.

After claimant gave birth to her child, a CT scan and myelogram were performed in June, 1983. Both tests were negative for disc involvement. While in the hospital recovering from the myelogram, claimant suffered a cerebrovascular accident (CVA) on June 24, 1983, with bleeding into the right hemisphere of the brain. She experienced generalized seizures and was paralyzed on the left side of her body. On July 1, 1983, a craniotomy was performed to evacuate the blood clot. She subsequently improved, though her left side remained weak.

The employer issued a partial denial of the compensability of the CVA on July 22, 1983. Claimant continued to have clonic (spasmodic) seizures affecting her left side. She was prescribed anticonvulsant medication to control the seizures. She also experienced pain in the neck, low back, left arm and leg, as well as numbness and weakness in the left arm and leg. For her cerebral and back conditions, claimant treated with Dr. Mahoney, an internist, Dr. Stoody, a neurologist, and Dr. Buza, a neurosurgeon.

Vocational assistance was begun in July, 1984, with objectives of returning claimant to work for the employer-at-injury and helping her to become conversant in English. A second Determination Order was issued on July 23, 1984, awarding additional TTD benefits and 45 percent unscheduled permanent partial disability (PPD). The employer began paying the PPD award in monthly instalments.

In August, 1984, Dr. Buza released claimant for tutoring in English and math. Although he regarded claimant to be unemployable, Buza felt that tutoring would improve her self-image. Claimant objected to tutoring, stating that she was being pushed too hard to return to work. Vocational assistance was terminated in early November, 1984, after Buza wrote that new seizure activity precluded claimant's participation in any light work or tutoring. The vocational consultant, Mr. Hernandez, had not secured a tutor prior to termination of services.

In December, 1984, Dr. Buza expressed difficulty relating claimant's seizure complaints to her physical condition. He questioned whether her symptoms were secondary to actual organic disease and recommended a psychiatric evaluation for emotional and functional overlay. He did not believe, however, that her complaints were of a conscious type.

By Opinion and Order of February 25, 1985, a prior Referee set aside the employer's partial denial of the CVA claim, and remanded the claim for acceptance and processing. The employer neither challenged the July 23, 1984, Determination Order as premature nor requested authorization for an offset of previous payments of PPD awarded by that order.

Subsequently, the employer unilaterally redesignated monthly instalments of PPD, previously paid pursuant to the Determination Order of July 23, 1984, as TTD instalments payable under the Opinion and Order. The employer's claims examiner reasoned that, because the cerebral condition was not yet medically stationary, the Referee's remand of the claim for acceptance effectively set aside the July, 1984, Determination Order as premature. On May 17, 1985, the employer filed Form 1502 with the Department, indicating that TTD benefits had been paid for the period extending through May 17, 1985. That same day, the employer issued claimant a check for $948.73, representing the difference between TTD benefits owed since the 1984 Determination Order and PPD benefits paid. TTD payments were continued thereafter.

In late May, 1985, claimant was hospitalized for increasing seizure activity. Dr. Mahoney observed one seizure, which involved the sudden onset of agitation and an exclamatory outcry; however, it was not accompanied by any clonic activity. A change in anticonvulsant medication yielded improvement. Shortly thereafter, Mahoney instructed claimant not to return to work. He prescribed a quad cane and recommended home care assistance, including child care for her three young children.

Vocational assistance was resumed in June, 1985. Services were delayed initially by claimant's hospitalization. On July 8, 1985, Dr. Mahoney wrote that claimant was medically stationary and that recurrent seizures were minor and not significantly disabling. Nevertheless, development of a

return-to-work plan was delayed for almost two months pending receipt of a physical capacities evaluation from Dr. Mahoney. The evaluation was received in late September, 1985; it indicated that claimant was released for light work. However, claimant refused to participate in vocational assistance, claiming that she had not been declared medically stationary nor released for light work. Her vocational consultant then requested clarification from Mahoney. In December, 1985, the consultant finally received an October 22 report from Mahoney that increased seizure activity, chronic low back pain and left-sided weakness precluded gainful employment.

In September, 1985, claimant saw Dr. Parvaresh, a psychiatrist, for an independent medical examination (IME). During the IME, claimant had a seizure which resolved quickly with medication. Parvaresh was advised that a seizure is "liable to happen" whenever claimant feels any kind of emotional pressure. Parvaresh diagnosed mild organic mental disorder and reported a history of functional overlay which he attributed to claimant's "basic personality make-up." He indicated that no psychiatric treatment is necessary.

That same day, claimant also saw Dr. Zivin, a neurologist, for an IME. During that IME, claimant had two seizures which occurred in rapid succession and lasted for approximately two minutes. She indicated that the seizures were beginning, grabbed her left wrist, tipped her head back, closed her eyes and said "oy oy oy." There was no clonic activity during the seizures, and she could speak and move her fingers. She complained of pain throughout the left arm. Zivin checked her reflexes, pupillary responses and respiration; all were normal. After the seizures, claimant was able to walk without apparent difficulty. Zivin labelled the witnessed seizures "pseudo-seizures" with the psychological underpinning of maintaining dependency behavior, which is fostered and amplified by her family and attendants. Nonetheless, Zivin apparently believed that some of claimant's seizures were true focal motor seizures, though he could not quantify their proportion relative to the so-called "pseudo-seizures." Aside from his diagnosis of seizure disorder, Zivin also diagnosed conversion syndrome, consisting of psychological factors -- manipulation, histrionics and conversion hysteria -- that markedly interfere with claimant's function. He indicated that these factors are fostered and amplified by the responses of her family and support system to her demands.

A third Determination Order was issued on November 19, 1985, awarding additional TTD benefits for the period extending through September 11, 1985, and an additional 5 percent unscheduled PPD, for a total unscheduled PPD award of 50 percent.

In December, 1985, Dr. Stoody reported recurrent episodes of seizure activity despite attempts to control it with medication. He concluded that many of these episodes are "pseudo-seizures" and that a portion of her symptomatology (e.g., motor deficits and walking gait disorder) is functional and secondary to conversion reaction. Stoody later declared his total agreement with Zivin's IME report. Drs. Mahoney and Buza also concurred with Zivin's report.

In January, 1986, claimant saw Dr. Wight for a

psychiatric consultation. During the visit, claimant had a "small seizure," during which she slid from her chair to the floor. Her eyes remained open and, when told that she would be okay, she responded almost immediately. Wight diagnosed conversion hysteria and adjustment disorder with moderate depression.

Claimant is 31 years of age and has had no formal education. She speaks no English and can neither read nor write Spanish. She had not worked prior to obtaining the mushroom plant job in 1977. Aside from mushroom picking, claimant worked one year cleaning mushroom beds. Her duties at the plant involved repetitive bending, standing, reaching and lifting. She last worked at the mushroom plant in 1982.

Currently, she has left-sided pain and weakness. She uses a cane for support and wears support stocking for left leg swelling. She cannot lift with the left arm. Her chronic low back pain is aggravated by standing, bending and prolonged sitting. Left-sided weakness precludes prolonged walking or standing. She currently has up to three seizures per day, each lasting approximately 45 to 90 seconds. She occasionally has a day without seizures. She does very little on a daily basis. If she feels well, she performs domestic tasks, including home and child care. Otherwise, she remains in bed. She receives domestic assistance from her cousin.

At hearing, claimant had a seizure while testifying. Her husband took her to the emergency room. The attending physician did not observe any seizures. He noted that claimant was stressed emotionally and diagnosed recurrent seizures possibly due to hysteria.

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury and CVA materially contributed to the onset of her current seizures and the underlying psychological disorder. The combination of her medical conditions, including the psychological condition, and nonmedical factors renders claimant unable to perform any work at a gainful and suitable occupation. Reasonable efforts by claimant to seek work would have been futile.

Claimant became medically stationary on June 4, 1985.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee concluded that claimant is not permanently and totally disabled and, instead, increased her unscheduled permanent partial disability award. In so concluding, the Referee declined to consider the disabling effects of claimant's current seizures. We disagree with the Referee's exclusion of the seizures and conclude that claimant is entitled to a permanent total disability award.

1. Compensability of Current Seizures

The threshold issue is whether claimant's current seizures may be considered in rating permanent disability. That issue turns on the question of whether the on-the-job injury or its compensable sequela, i.e., the CVA, was a material

contributing cause of those seizures. See Destael v. Nicolai Co., 80 Or App 596, 600 (1986).

It is undisputed that claimant had an organic seizure disorder that was a compensable consequence of the CVA. It is further undisputed, however, that the disorder is now controlled by anticonvulsant medication and that many, if not all, of the current seizures are so-called "pseudo-seizures" with no organic cause. Nevertheless, we are persuaded that the seizures, whether organic or not, are a compensable consequence of the industrial injury and its sequela.

The Referee relied on the IME reports in finding that the pseudo-seizures are consciously controlled by claimant. The Referee went on to exclude the seizures from consideration in rating permanent disability. She did so without addressing the dispositive question of whether the seizures are causally related to the compensable injury and sequela. We can only infer that the Referee found the seizures to be voluntary, i.e., claimant is malingering. We disagree with that implicit finding.

For the purpose of clarity, our discussion is divided into two parts: (1) the diagnosis of the seizures; and (2) their relationship to the compensable injury and its sequela. The medical evidence regarding diagnosis is divided. All but one of the physicians agreed that claimant suffers from a conversion-type disorder in which emotional/mental stress is converted into seizure symptoms lacking an organic cause. The lone dissenter is Dr. Parvaresh, the IME psychiatrist. Parvaresh ruled out conversion disorder as a diagnosis, explaining that claimant's total, emotional preoccupation with her seizures is inconsistent with the total indifference to loss of function typically exhibited by persons with the disorder. Parvaresh concluded, instead, that claimant consciously controls her seizures to manipulate her environment and to maintain her disability. Dr. Zivin, the IME neurologist, also concluded that claimant uses the seizures to manipulate her environment and to retain the posture of total disability and dependence. However, he added that claimant is not completely conscious of her behavior. He explained that claimant's behavior has both conscious/voluntary and subconscious/involuntary elements and that they are inseparable.

After reviewing the previous evidence, we are not persuaded that the seizures are attributable to a conversion disorder. Parvaresh's rationale for ruling out that diagnosis was well-reasoned, based on personal observation, and unrebutted by other medical evidence. We are persuaded, nonetheless, that the seizures are attributable to a genuine, psychological disorder. There is nearly unanimous agreement that the seizures are not voluntary. Dr. Mahoney the treating internist since June, 1983, and Dr. Stoody, the treating neurologist since April, 1984, both opined that claimant is not malingering. Dr. Buza, the treating neurosurgeon since 1983, opined that claimant's disability is real regardless of whether it is a combination of neurological and psychological impairments. Dr. Wight, the consulting neuropsychiatrist, also saw no malingering. Even Dr. Zivin agreed that claimant has a psychological disturbance and is not malingering.

Dr. Parvaresh never offered an opinion on whether claimant voluntarily controls her seizures. He merely opined that

claimant had "conscious control" of the seizures. Although "conscious control" suggests voluntary control, we decline to draw that inference here for two reasons. First, it is not at all clear from his reports whether Parvaresh believed that claimant is completely conscious of her behavior or whether he believed, like Zivin, that there is a subconscious element involved as well. If he believed the latter, that belief would tend to support a finding that the seizures are not voluntary. Second, we do not know what Parvaresh means by "conscious control;" it is not explained in his reports. Absent that explanation, we cannot assess the relevance of that opinion to a determination of whether the seizures are voluntarily controlled.

We find that claimant's current seizures are manifestations of a genuine psychological disorder and are not voluntarily controlled. In so finding, we are persuaded by Dr. Zivin's opinion which is thorough, well-reasoned, see Somers v. SAIF, 77 Or App 259, 263 (1986), and based on personal observation of multiple seizures. Moreover, our finding is supported by the opinions of claimant's treating physicians, see Weiland v. SAIF, 64 Or App 810, 814 (1983), as well as Dr. Wight, the consulting neuropsychiatrist.

We now consider whether the psychological disorder above is compensably related to the industrial injury and its sequela. Drs. Mahoney and Wight related the disorder to the injury and CVA. Wight described the disorder as a "logical consequence" of the profound neurological impairment which followed the 1983 myelogram and resulting CVA.

Drs. Parvaresh and Zivin, on the other hand, disagreed. Parvaresh apparently related the seizures to claimant's "basic personality make-up," while Zivin related the seizures and the underlying psychological condition to various, preexisting factors in claimant's background, such as her language barrier, lack of formal education, and the relatively unsophisticated types of personal interaction and response present within her family and support system.

We find that the seizures and the underlying psychological disorder were materially caused by the industrial injury and CVA. In so finding, we are most persuaded by the opinions of Drs. Mahoney and Wight for the following reasons. First, as treating physician since June, 1983, Mahoney examined claimant on numerous occasions over a lengthy period of time, whereas Parvaresh and Zivin each examined claimant once. Consequently, Mahoney had the best opportunity to observe current "pseudo-seizure" symptoms and to evaluate their relationship to post-CVA organic seizures. Second, the record shows that the current seizures began only after the CVA, which tends to suggest a material relationship between the CVA and the seizures.

Given the previous findings, we conclude that the current seizures and the underlying psychological condition, including other subjective physical complaints attributed to that condition, should be considered in rating claimant's permanent disability.

2. Entitlement to Permanent Total Disability

To prove her entitlement to permanent total disability (PTD), claimant must establish that she is unable to perform any

work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). Claimant does not contend that she is medically incapacitated. Indeed, claimant has virtually conceded that she is not PTD on a medical basis alone. Rather, she asserts entitlement to PTD under the so-called "odd-lot" doctrine. Under that doctrine, an injured worker, capable of performing work of some kind, may still be permanently and totally disabled due to a combination of her physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). Because the injured worker has some capacity for employment, she is statutorily required to make reasonable efforts to find work, although she need not engage in job seeking activities that would be futile. ORS 656.206(3); Welch v. Bannister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

Given claimant's reliance on the odd-lot doctrine, we find that she is medically capable of performing work of some kind. Zivin opined that, when the seizures and psychological condition are excluded from consideration, claimant can perform light to medium work. We previously found both conditions to be compensable consequences of the industrial injury. Hence, Zivin's opinion is discounted accordingly. We find, instead, that claimant is capable of sedentary to light work.

We now must determine whether claimant made reasonable efforts to seek work. Vocational assistance was available to claimant from July through November, 1984, and from June through December, 1985. During those months, Hernandez, the vocational consultant, sought to develop an English tutoring program for claimant in an effort to overcome what he regarded as the primary obstacle to reemployment. However, in 1984 Hernandez could not secure a tutor prior to discontinuation of vocational services for medical reasons. When services were resumed in 1985, claimant was reluctant to participate in tutoring and insisted that she was unable to work. Mahoney later agreed and issued a report to that effect in October, 1985. Therefore, although Hernandez persuasively testified that claimant could have been functional in the English language if she had participated in tutoring during the months that she was released to do so, we cannot conclude that her non-participation was unreasonable.

We further find that English language training would have been insufficient to enable claimant to hold gainful employment. Efforts to seek work were futile. In his vocational summary report, Hernandez listed six light-duty vocations that he felt claimant could perform with functional English proficiency. Yet, he later testified that, if current seizures were also considered, those vocations would not be appropriate because they require physical mobility. Moreover, the summary report indicates that the vocations would possibly require some skill building, presumably because claimant's entire work experience is limited to unskilled manual labor at the mushroom plant. Hernandez further testified that, even with her current seizures, claimant can perform sitting-type jobs like light nursery work or produce packing. We disagree. Dr. Mahoney testified that prolonged sitting aggravates claimant's chronic low back pain. Additionally, claimant testified that she cannot lift with her left arm due to left-sided weakness resulting from the CVA. Those

physical limitations preclude the prolonged sitting and extensive use of both arms that presumably would be required in the suggested sitting-type vocations. Mahoney added that claimant has limitations on standing, bending and walking due to back pain, left-sided weakness and left leg swelling. Vocational factors further exclude claimant from much of the labor market. She has no education, is functionally illiterate in her native Spanish language, and has no transferable skills.

We find that claimant's physical limitations, combined with the nonmedical factors cited above, make efforts to seek work futile. See SAIF v. Simpson, 88 Or App 638, 641 (1987). The combination of medical and nonmedical factors renders claimant unable to perform any work in a gainful and suitable occupation. She is entitled to an award of PTD.

3. Effective Date of PTD Award

An award of PTD under the odd-lot doctrine is effective as of the earliest date that all relevant medical, vocational and social elements exist to support the award. Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-371 (1988); Morris v. Denny's, 50 Or App 533, mod 53 Or App 863, 867 (1981). On the first day of hearing, Dr. Mahoney testified to claimant's physical limitations. That testimony is essential to our finding that further efforts by claimant to seek work would have been futile. Because that finding is necessary to establish claimant's entitlement to PTD under the odd-lot doctrine, we conclude that her PTD award is effective as of January 14, 1986, the first day of hearing.

Redesignation of Permanent Partial Disability Benefits as Temporary Total Disability Benefits

The dispositive issue here is whether an employer which is ordered to pay TTD compensation after its partial denial of a condition has been set aside may unilaterally offset PPD compensation which it previously paid during the period of time for which TTD payments were ordered.

Claimant suffered the CVA in June, 1983. The employer denied the compensability of that accident, and claimant requested a hearing on that partial denial. The hearing was held before a prior Referee. Before the Referee issued his order, the original injury claim was closed by Determination Order in July, 1984, with a 45 percent unscheduled PPD award. The employer began paying the award in monthly instalments. In February, 1985, the prior Referee issued his order setting aside the CVA denial and remanding the claim for acceptance and payment of benefits. The employer subsequently reopened the injury claim for acceptance of the CVA and redesignated previously-paid PPD benefits as TTD benefits payable through May 17, 1985. A check was issued for the balance of TTD benefits due through May 17, 1985, after redesignation. Thereafter, TTD benefits have been paid in full monthly instalments.

Claimant now asserts entitlement to the full amount of TTD benefits, with no offset for previously-paid PPD benefits. The Referee disagreed, reasoning that the setting aside of the CVA denial effectively voided the July, 1984, Determination Order. We disagree with that decision.

The employer relies on the testimony of Mr. Forbes, Assistant Administrator of the Evaluation Division, that its processing of this claim was correct. However, Forbes expressly based his opinion on the assumption that the prior Referee's Opinion and Order set aside the July, 1984, Determination Order, either directly or by operation of law. That assumption is incorrect. The prior Referee did not set aside the July, 1984, Determination Order. Indeed, the issue of premature claim closure was never raised by the parties either during the hearing or, by motion for reconsideration, after issuance of his Opinion and Order. Moreover, there is no authority for the proposition that a Determination Order, which issued after a partial denial of a condition, is automatically set aside by a subsequent Opinion and Order overturning the denial.

Even assuming, arguendo, that the July, 1984, Determination Order had been set aside by operation of law (and an overpayment of PPD resulted), we conclude that the employer's claim processing was improper. The issue here is not whether the employer may recover an overpayment of PPD by offsetting it against current or future compensation benefits due. Rather, the issue is whether the employer may do so without prior approval by either the Evaluation Division, a Referee or the Board. No statutory provision authorizes the employer to offset those benefits without prior approval; hence, we conclude that it may not do so.

The proper course of action in this case would have been to secure Referee approval of the offset. After the CVA denial was set aside and the claim remanded for processing, the employer considered the July, 1984, Determination Order to be void, and regarded previous PPD payments as an overpayment. At that time, the employer knew, or should have known, that the offset issue was properly before the Referee. The statutes permitted the employer to request the Referee's authorization for an offset. See ORS 656.283(1), 656.325(6); Forney v. Western States Plywood, 66 Or App 155, 159 (1983), aff'd 297 Or 628 (1984). However, that issue was not raised before the Referee at the outset of the hearing, before issuance of his Opinion and Order, or, by motion of reconsideration, after issuance of the Opinion and Order. Absent the Referee's authorization, the employer's withholding of TTD compensation was improper.

Penalty and Attorney Fee for Improper Claims Processing

A penalty and attorney fee may be assessed under ORS 656.262(10) and 656.382(1) for the employer's unreasonable refusal to pay compensation. The employer has offered no reasonable explanation for its unauthorized, unilateral offset against TTD compensation awarded by the prior Referee's Opinion and Order. We note further that, although the employer's claims examiner testified that she spoke to someone in the Compliance Division about her processing of the claim and was not criticized for her conduct, that conversation took place after she had already proceeded with the offset. We conclude that the employer's conduct was unreasonable and that a 25 percent penalty should be assessed on the unpaid amount of TTD compensation due. We also assess a related attorney fee. See ORS 656.262(10), 656.382(1).

Medically Stationary Date

The employer cross-requested a hearing on the Determination Order of November 19, 1985, contending that TTD compensation should have been terminated as of July 8, 1985, rather than September 11, 1985. That contention was based on Dr. Mahoney's report of July 8, 1985, that claimant was medically stationary on that date. At hearing, however, Mahoney modified his opinion and testified that claimant was medically stationary on June 4, 1985. The Referee decided, nevertheless, that July 8, 1985, would be used as the medically stationary date because that date was asserted by the employer at the outset of hearing. The employer argues on review that it should not be bound by its initial assertion when subsequent evidence reflects an earlier medically stationary date. We agree with the employer.

We are persuaded that the issue of when claimant became medically stationary was properly before the Referee. Consequently, the Referee was not bound by the employer's initial contention; rather, she was free to make applicable findings based on the evidence presented at hearing. In any event, we may make whatever disposition of this case we deem appropriate under ORS 656.295(6). Destael v. Nicolai Co., 80 Or App 596, 600 (1986).

TTD compensation is designed to compensate claimant for loss of income due to a compensable injury until claimant's condition becomes medically stationary. Taylor v. SAIF, 40 Or App 437, 440, rev den 287 Or 477 (1979). Here, we are persuaded by Mahoney's testimony that claimant became medically stationary on June 4, 1985. Hence, TTD compensation should be terminated as of that date.

ORDER

The Referee's order dated April 14, 1986, is reversed in part, modified in part and affirmed in part. Claimant is awarded permanent total disability compensation, effective January 14, 1986, the first day of hearing. The employer is authorized to offset permanent partial disability compensation paid after that date against the permanent total disability compensation granted by this order. That portion of the order that denied claimant's request that temporary total disability compensation awarded by the Opinion and Order of February 25, 1985, be paid in full, without any offset for previously-paid permanent partial disability compensation, is reversed. The employer shall pay claimant temporary total disability compensation from July 23, 1984, through November 19, 1985, with credit for $948.73, which the employer paid on May 17, 1985, and for other amounts paid thereafter. Claimant's attorney is awarded 25 percent of the increased compensation granted by this order, provided that the total of fees approved by the Referee and the Board does not exceed $6,000 for services at hearing and on Board review. That portion of the order that declined to assess a penalty and attorney fee is also reversed. The employer is assessed a penalty equal to 25 percent of the amount of the aforementioned temporary total disability award. The employer is also assessed a penalty-related attorney fee in the amount of $500. That portion of the order that found claimant medically stationary as of July 8, 1985, is modified. The Determination Order of November 19, 1985, is modified to provide for the termination of temporary total disability compensation as of June 4, 1985, the medically stationary date. The employer is permitted to offset

temporary total disability compensation paid between June 4, 1985, and July 8, 1985, against the permanent total disability compensation awarded herein. The remainder of the Referee's order is affirmed.

Board Member Ferris dissenting:

I dissent. I would affirm the order of the Referee.

FRANK F. PUCHER, JR., Claimant
Myrick, et al., Claimant's Attorneys
Ronald Pomeroy (SAIF), Defense Attorney

WCB 88-17021
April 11, 1989
Order of Dismissal

Claimant has requested review of Referee Melum's order dated January 10, 1989, as reconsidered January 27, 1989. With his request for review, claimant has submitted a "Motion for Waiver of Rule" in which he requests that we waive the time limit for filing a request for review prescribed in ORS 656.289 and OAR 438-11-005. We have reviewed claimant's request for review and motion to determine whether we have jurisidiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS OF FACT

The Referee's order issued on January 10, 1989. The order contained a statement of the parties' right to appeal the order within 30 days of mailing. Claimant subsequently requested that the Referee abate and reconsider his order. On January 18, 1989, the Referee issued an order of abatement to allow for time to evaluate the request for reconsideration and any responses thereto. On January 27, 1989, the Referee issued his order on reconsideration wherein he changed one factual finding from his initial order; otherwise, the January 10, 1989 order was "republished in its entirety." Claimant received a copy of the Referee's order on reconsideration; however his attorney did not receive a copy of the order.

On March 22, 1989, claimant filed his request for Board review. The request for Board review was filed with the Board more than 30 days after the Referee's order on reconsideration was mailed to the parties.

CONCLUSIONS OF LAW

Pursuant to the provisions of ORS 656.289(3), 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 is incorporated by reference into the Board's procedural rules pursuant to OAR 438-11-005(1). As used in the statute, "party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19).

In support of his motion, claimant submits the affidavit of his attorney to the effect that the attorney did not receive a copy of the Referee's order on reconsideration. We accept this statement as fact. Claimant then cites to OAR 438-11-030, which provides that the Board may waive any provision of OAR 438-11 upon a showing of "extraordinary circumstances beyond the control of the party requesting waiver...." Claimant asserts that the failure of his attorney to receive a copy of the Referee's order amounts to "extraordinary circumstances" beyond his control. Claimant,

therefore, requests that we waive the 30-day time limitation of ORS 656.289(3), as incorporated into our rules by OAR 438-11-005.

We find, however, that we are unable to grant the relief requested by claimant. As expressly stated in OAR 438-11-030, our power to waive provisions of our rules can be exercised "[e]xcept as otherwise prohibited by law." In this regard, ORS 656.289 is unambiguous. It requires that a party request Board review of a Referee's order within 30 days of mailing of the order to the parties. Although the Referee's order was not mailed to claimant's attorney, attorneys are not "parties" within the meaning of the statute. See ORS 656.005(19); Berliner v. Weyerhaeuser Company, 92 Or App 264, 266, n 1 (1988); Robert Casperson, 38 Van Natta 420, 421 (1986).

The Referee's order on reconsideration was mailed to claimant. Subject to one adjustment, the order on reconsideration "republished in its entirety" the January 10, 1989 order, which contained a statement of the parties' appeal rights. Claimant did not request Board review within 30 days of the order on reconsideration. We are without authority to waive the statutory limitation period. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

RICHARD L. WHITE, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-19443
April 11, 1989
Order on Review

Reviewed by Board Members Ferris and Crider

Claimant requests review of Referee Huff's order which directed the self-insured employer to pay temporary total disability benefits for August 8 and 9, 1987 and assessed a 25 percent penalty and a $100 attorney's fee. We reverse, modify, and affirm in part.

ISSUES

On review, claimant contends that he is entitled to continuing temporary total disability benefits and to a penalty and attorney's fee based on temporary total disability benefits from August 10, 1987.

The employer contends on review that the Referee erred in awarding temporary total disability benefits for August 9, 1987. The employer also seeks authorization to offset unemployment benefits against temporary total disability benefits in the event that the Board concludes that claimant is entitled to temporary total disability benefits. We decline to consider the offset question because it was not raised at hearing nor considered by the Referee.

FINDINGS OF FACT

Claimant compensably injured his shoulder on June 12, 1987. In late July 1987 claimant was apparently receiving temporary total disability benefits because his treating physician had taken him completely off work. On August 7, 1987, the treating physician released claimant to regular work effective August 10, 1987. Claimant was not then medically stationary.

Claimant reported to work on August 10, 1987, but did not work because the employer terminated him for reasons unrelated to this compensable injury. The employer terminated temporary total disability benefits as of August 7, 1987. August 9 was claimant's regular day off work.

CONCLUSIONS

The Referee concluded that claimant was entitled to temporary total disability benefits for August 8 and 9 and assessed a 25 percent penalty and a $100 attorney's fee for unilateral termination of benefits. He reasoned that the release for regular work was not effective until August 10, 1987. He reasoned that the employer was justified in terminating benefits as of August 10, 1987 because as of that date claimant was released to regular work and for that reason claimant was entitled to no benefits thereafter.

The employer argues that claimant was not entitled to temporary total disability benefits for August 9, 1987 because that was claimant's regular day off work. We agree. The employer concedes that claimant was entitled to temporary total disability benefits for August 8, 1987 and a penalty for the employer's failure to pay temporary total benefits for that day. We consider the $100 fee which the Referee awarded a reasonable fee for obtaining the penalty for August 8.

Since the Referee's decision, the Court of Appeals has held that an employer/insurer is not entitled to unilaterally terminate time loss unless the claimant has both been released to regular work and is medically stationary. Fazzolari v. United Beer Distributors, 91 Or App 592, recon 93 Or App 103, rev den 307 Or 236 (1988). If claimant had returned to work, the employer could have deducted his earnings from the temporary disability benefit. However, we conclude that claimant had not returned to regular work.

Because claimant was not medically stationary, the release to return to regular work was insufficient to allow the employer to terminate claimant's time loss. However, we decline to award a penalty based on time loss benefits on or after August 10, 1987. We find the employer's termination of benefits on or after August 10, 1987 was not unreasonable because before Fazzolari, it was an accepted principle of workers' compensation law in Oregon that a release to regular work was sufficient to allow an employer to terminate time loss benefits. See, Jackson v. SAIF, 7 Or App 109 (1971).

ORDER

The Referee's order dated February 29, 1988 is affirmed in part, modified in part and reversed in part. That portion of the Referee's order which required the employer to pay temporary total disability benefits for August 9, 1987 and which assessed a penalty for failure to pay benefits on that day is reversed. The order is modified to require the employer to pay temporary total disability benefits to claimant from August 10, 1987 until claimant either returns to regular work, is both released to regular work and is medically stationary or until the claim is closed pursuant to law. Claimant's attorney is allowed a reasonable attorney's fee of 25 percent of the increased benefits awarded herein, not to exceed $3,800. That portion of the Referee's order which awarded temporary total disability benefits for August 8, 1987 and assessed a penalty and attorney's fee for a failure to pay benefits on that day is affirmed. A client-paid fee, not to exceed $1,066, is approved.

GIORDANO ZORICH, Claimant
Galton, et al., Claimant's Attorneys
Merrily McCabe (SAIF), Defense Attorney
Scott M. Kelley, Defense Attorney

WCB 85-00696 & 85-01291
April 11, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. SAIF v. Zorich, 94 Or App 661 (1989). The court reversed the Board's order in Giordano Zorich, 38 Van Natta 1570 (1986), which affirmed a Referee's order that denied the SAIF Corporation's request for either an order that claimant reimburse SAIF for temporary disability compensation mistakenly paid to him, or that SAIF be allowed an offset against benefits in the amount of the mistaken payment. The Referee had concluded that he lacked jurisdiction to address the matter because of his determination that neither the claim for reimbursement nor the request for offset was a "matter concerning a claim" within the meaning of former ORS 656.708(3). We affirmed without comment on this issue. The court found that the controversies here are "matters concerning a claim" and remanded to the Board to determine what remedy is within our authority and appropriate. We proceed with our determination.

ISSUE

Appropriate remedy for overpayment of temporary disability compensation.

FINDINGS OF FACT

SAIF overpaid temporary disability compensation to claimant in the amount of $13,729.98.

CONCLUSIONS OF LAW AND OPINION

An insurer or self-insured employer may be authorized to offset overpaid temporary disability compensation against any future awards of permanent partial disability granted on the same claim. Harold D. Bates, 38 Van Natta 992 (1986).

ORDER

The SAIF Corporation is authorized to offset overpaid temporary disability compensation in the amount of $13,729.98 against any future awards of permanent partial disability granted on this claim.

KATHERINE M. BASS, Claimant
Starr & Vinson, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-15376
April 12, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Young's order that affirmed a Determination Order that awarded 5 percent (16 degrees) unscheduled permanent partial disability for a low back injury. We affirm.

Upon our initial review of the record, we noted the absence of an exhibit which was admitted at hearing. We concluded that omission of the exhibit constituted an improper, incomplete, or otherwise insufficient development of this case. See ORS 656.295(5). Therefore, we remanded to the Referee for purposes of

inclusion of the exhibit in the record on review. The exhibit has since been included in the record. We now proceed to a review on the merits.

ISSUE

Whether claimant has proven a permanent worsening of her condition since her last arrangement of compensation such that she is entitled to increased permanent disability.

FINDINGS OF FACT

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

Claimant's permanent impairment as a result of her May 1982 injury is minimal.

CONCLUSIONS OF LAW AND OPINION

In order to obtain an increased award of permanent disability on an aggravation claim filed pursuant to ORS 656.273(1), a worker must prove that the condition resulting from the original injury has permanently worsened since the earlier disability award. Stepp v. SAIF, 304 Or 375, 381 (1987). This is a threshold requirement to recovery of increased permanent partial disability. Id.; see also Davidson v. SAIF, 304 Or 382, 384 (1987). Only if this threshold requirement is met do we consider whether that worsening has resulted in reduced earning capacity. See Smith v. SAIF, 302 Or 396 (1986). Claimant has failed to prove a worsening of her condition since her earlier disability award. We, therefore, need not decide whether she has shown a reduced earning capacity.

We note that the insurer has not requested a reduction in the amount of permanent disability awarded by the Determination Order. Consequently, we need not decide whether the failure of claimant to prove a permanent worsening of her condition mandates a finding that the 5 percent permanent disability awarded by Determination Order is excessive.

However, assuming arguendo that claimant has suffered a permanent worsening of her compensable condition, we consider whether the 5 percent permanent partial disability awarded by Determination Order adequately compensates her for her loss of earning capacity. See ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider her physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

Claimant testified that she experiences pain in her low back with exertion. However, she does not experience stiffness or a reduction in her range of motion, even with exertion. She does not experience radiating pain or numbness. She occasionally takes nonprescription medication to deal with her pain.

Dr. Matteri rated claimant's impairment as "mildly moderate." However, like the Referee, we conclude that Dr.

Matteri's opinion is contradicted by his chart notes and credible lay tesimony. Based upon the credible lay testimony and the persuasive medical evidence in the record, we conclude that claimant's impairment is minimal. Moreover, her relative youth is a moderately positive factor in evaluating her ability to obtain and hold gainful employment. Furthermore, she has considerable experience in performing jobs in the light and medium work categories which she remains capable of performing.

Under these circumstances, where claimant's impairment is minimal and she remains capable of performing a wide variety of employments in "the broad field of general occupations," we find claimant's wage expectations with the at-injury employer to be of less importance than might otherwise be the case. ORS 656.214(5); see Jacobs v. Louisiana-Pacific, 59 Or App 1, 3 (1982) (persuasiveness of post-injury wages depends upon circumstances of individual case).

In sum, we conclude that the 5 percent permanent partial disability awarded by Determination Order adequately compensates claimant for her lost earning capacity resulting from her compensable injury.

Subject to the foregoing supplementation, the Referee's opinion is adopted as our own.

ORDER

The Referee's order dated Janaury 7, 1988 is affirmed. A client-paid fee not to exceed $1,141 is approved.

JOHN M. BIRCHFIELD, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-10266
April 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Knapp's order. The insurer cross-requests review. We affirm.

ISSUES

The primary issue is extent of unscheduled permanent disability. Claimant contends that he is entitled to a greater award for unscheduled disabilty than the 10 percent (32 degrees) awarded by the Referee.

Claimant also contends that he is entitled to temporary total disability compensation from April 23, 1987 though May 1, 1987. He contends that the Determination Order of May 1, 1987 prematurely closed the claim because he was not medically stationary on April 23, 1987. This issue was not raised at hearing nor decided by the Referee; accordingly, we decline to consider it.

Claimant also contends that he is entitled to interim compensation from May 2, 1987 through May 21, 1987. The only period of alleged entitlement to interim compensation raised at hearing was for May 11, 1987 through May 18, 1987. Accordingly, the issue of entitlement to interim compensation for the periods May 2 through May 10 and May 19 through May 21 is not properly before the Board on review and will not be considered.

Claimant also contends that he is entitled to a penalty and associated attorney's fee for the insurer's alleged failure to process an aggravation claim. In particular, he contends that the insurer should be penalized for failing to pay interim compensation from May 1, 1987 through May 21, 1987.

The insurer contends that claimant actually became medically stationary on March 2, 1987. This issue was not raised at hearing nor decided by the Referee; accordingly, we decline to consider it.

FINDINGS OF FACT

Claimant was 39 years old at the time of hearing. He has a high school education plus a few college courses. His work experience has been primarily as a truck driver. He has also worked in the produce department of a grocery store and as an offset printer. Claimant is unable to return to any of his prior jobs.

Claimant compensably injured his shoulder and upper back on August 5, 1986. As a result of that injury claimant has no objective permanent impairment. He does have continuing subjective complaints which result in a minimal permanent impairment. He is precluded from doing all but light and sedentary work by his lack of physical conditioning as well as by psychological residuals from his compensable injury.

Claimant's treating physician, Dr. Baum, took him off work for three days on April 28, 1987. On May 18, 1987 another physician stated that claimant could not work from May 11, 1987 through May 18, 1987 due to a low back strain. Dr. Baum released claimant to return to light duty work on May 21, 1987.

CONCLUSIONS AND OPINION

EXTENT OF DISABILITY

Claimant has the burden of proving the extent of unscheduled permanent disability. Unscheduled disability is measured by loss of earning capacity. ORS 656.214(5). Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impiarment and adapatibility to perform a given job. ORS 656.214(5). Education includes a worker's skills, training and formal education. ORS 656.214(5).

We rely upon the reports of the Orthopaedic Consultants, Western Medical Consultants, the Northwest Pain Center and Dr. Baum for the finding that claimant has no objective impairment. We are particularly persuaded by Dr. Baum's opinion and his concurrence with the other examiners because he is claimant's treating physician.

We rely upon Dr. Baum's assessment that claimant has a minimal impairment based on subjective complaints which are due to poor conditioning and his compensable injury, again because Dr. Baum is the treating physician who has had an opportunity to observe claimant over time.

Considering claimant's minimal impairment, his average education and age, we agree with the Referee that claimant has lost no more than 10 percent of the labor market due to this injury. This conclusion is strengthened by the fact that many of claimant's limitations are due to his lack of phyisical conditioning; only a part of his limitations are due to his compensable injury.

PENALTIES AND INTERIM COMPENSATION

Claimant argues that the insurer should have paid interim compensation from May 11, 1987 through May 18, 1987. We disagree. There is no medical report which can properly be considered an aggravation claim which would trigger the duty to pay interim compensation. In order to triger the duty to pay interim compensation pursuant to an aggravation claim, there must be medically verified inability to work due to the compensable injury. ORS 656.273(6). The only report which could arguably trigger the duty to pay interim compensation is a "disability certificate" from Dr. Janzen which merely states that claimant is unable to work from May 11 to May 18, 1987 due to a "low back strain." Because claimant's accepted injury is to the shoulder and upper back, this report cannot be considered an aggravation claim because it does not relate claimant's inability to work to the accepted claim. Because there was no claim for aggravtion which would trigger the duty to pay interim compensation, no interim compensation or penalties are due.

ORDER

The Referee's order dated February 29, 1988 is affirmed.

VERNON D. CULP, JR., Claimant
Coons & Cole, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 87-13958
April 12, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

On July 20, 1988, the Board issued an Interim Order of Remand. 40 Van Natta 846 (1988). That order, inter alia, instructed the Presiding Referee at the Board's Eugene office, Referee Gruber, to reopen the record for the sole purpose of clearing up confusion over a portion of Dr. Nathan's testimony. On November 2, 1988, Referee Gruber issued an Interim Order on Remand, which clarified Nathan's testimony. Accordingly, we proceed to review this case.

The self-insured employer requests review of Referee Huffman's order that set aside its denial of claimant's occupational disease claim for a bilateral wrist condition. Claimant has requested further remand of this matter for the inclusion of a certain medical document not admitted into the record. The Board affirms the order the Referee.

ISSUES

1. Whether claimant's bilateral wrist condition is a compensable occupational disease.

2. Whether further remand is appropriate.

FINDINGS OF FACT

Compensability

The Board adopts the Referee's findings with the following addition.

Claimant neither sought medical treatment nor experienced

any symptoms in his wrists, until after working approximately one month as a green chain puller for the employer in the summer of 1984. He did not have a condition or disease in either wrist prior to beginning his employment with the employer.

Remand

Claimant seeks further remand for the purpose of admitting a certain medical document into the record. That document, dated June 14, 1984, is a handwritten note concerning claimant's complaints of right wrist pain. It apparently was written and signed by either a nurse of physician employed by the employer. Claimant's attorney was shown the document immediately prior to the hearing. He made no motion to admit the document into the record at that time.

CONCLUSIONS OF LAW

Compensability

The Board adopts the Referee's opinion.

Remand

The Board may remand for further evidence taking only when it "determines that a case has improperly, incompletely or otherwise insufficiently developed or heard by the referee . . . ." 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); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Here, immediately preceding the hearing, claimant's attorney was apprised of and, in fact, shown the document he now wishes to have the Board admit into the record by way of remand. After being so apprised, claimant's attorney did not offer the document at the hearing.

Under such circumstances, we are not persuaded that the record has been either improperly, incompletely, and insufficiently developed. We are similarly unpersuaded that the document was unobtainable with due diligence at the time of hearing. We, therefore, decline to grant clamant's attorney's motion for further remand.

ORDER

The Referee's order, dated March 1, 1988, as amended on November 2, 1988, is affirmed. Claimant's attorney is award an assessed fee of $700, to be paid by the employer. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $1,620.50.

NINA C. GRIGGS, Claimant
Vick & Gutzler, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 87-09271
April 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Galton's order which set aside its denial of an aggravation claim. We affirm.

ISSUES

The insurer contends that the Referee erred in refusing to admit an exhibit. It moves for an order remanding the case to the Referee to consider the excluded exhibit and to write an Opinion and Order taking that exhibit into account. In the alternative, it requests that the Board admit the disputed exhibit and decide the aggravation issue de novo.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact.

CONCLUSIONS

The Board adopts the Referee's conclusions with the following comment: Former OAR 438-07-005(3)(b) did not contain the so-called seven day rule at the time of hearing. The seven day rule had been repealed by an emergency rule dated April 13, 1987. The rules which went into effect on September 15, 1987, the date of hearing, did not affect the temporary repeal of the seven day rule. The seven day rule did not regain life until 180 days after April 13, 1987. Accordingly, under the rules in effect at the time of hearing, exhibit 82 was late and the Referee was within his discretion in declining to admit it because he did not find good cause for the late submission.

Claimant's attorney is statutorily entitled to a reasonable insurer-paid attorney's fee for services on Board review. However, we cannot award such a fee unless claimant's attorney files a statement of services. Because no statement of services has been received to date, no fee shall be awarded.

ORDER

The Referee's order of September 21, 1987 is affirmed. A client-paid fee, not to exceed $905, is approved.

MARY M. HUDSON, Claimant
Emmons, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-04847
April 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Holtan's order which upheld the insurer's denial of an aggravation claim. The insurer cross-requests review of those portions of the Referee's order which set aside a denial of pain center treatment. We affirm in part and reverse in part.

ISSUES

The first issue is whether claimant has proven a

compensable aggravation. The insurer argues that claimant's condition must have aggravated before claimant's aggravation rights expired; it argues that the mere filing of an aggravation claim before aggravation rights expired is insufficient to allow claimant to prove that her condition worsened after her aggravation rights expired.

The second issue is whether pain center treatment is reasonable and necessary treatment for claimant's compensable injury. The insurer contends that the pain treatment is for conditions which are not compensable pursuant to a disputed claim settlement.

FINDINGS OF FACT

The parties entered into a disputed claim settlement on July 19, 1985 which provided:

> "The parties further stipulate that claimant remains entitled to medical treatment pursuant to ORS 656.245 for residuals of the low back injury of March 4, 1982, but that said treatment does not include responsibility for the effects of claimant's rheumatoid disease, degenerative arthritis, lumbar scoliosis, degenerative disc disease, or obesity. The parties further stipulate and agree that the insurer is not responsible for problems involving claimant's feet, ankles, or legs, except as problems of those extremities directly related to the compensable effects of the injury of March 4, 1982."

Claimant's treating physician prescribed pain center treatment on July 8, 1987 for her chronic pain, disc disease and rheumatoid arthritis. Claimant's chronic pain is due to her disc disease.

Claimant filed a claim alleging an aggravation on March 2, 1987. Her aggravation rights under ORS 656.273 expired on March 3, 1987. A hearing on February 23, 1987 is the date of the last arrangement of compensation. On February 23, 1987, Dr. Endicott noted that claimant had increased pain as a result of being questioned at hearing. That note does not establish that claimant was less able to work due to her compensable condition than she had been at the time of the hearing.

CONCLUSIONS

The Pain Center Denial

The Referee concluded that pain center treatment is reasonable and necessary for the treatment of claimant's compensable low back strain. We disagree. Claimant has the burden of proving that the proposed treatment is due to her compensable injury. She has failed to carry her burden of proof. Her treating doctor testified that claimant's disabling problem is her disc disease. That is not a compensable condition. There is no persuasive evidence that claimant's compensable injury is a material cause of her need for pain center treatment.

The Aggravation Denial

ORS 656.273(4)(a) provides that an aggravation claim must be "filed" within five years of the first determination order. ORS 656.273(1) states that a claimant is entitled to additional compensation for worsened conditions resulting from a compensable injury.

The Referee stated:

> "For this aggravation to be compensable, I believe it must have occurred between [the last arrangement of compensation] and the ... expiration of claimant's aggravation rights. To hold otherwise, would be to to extend the aggravation period in this case beyond what I believe the law intended."

Claimant argues that the mere filing of an aggravation period is sufficient to toll the five year limitation on aggravation claims thus allowing claimant to prove that she has worsened by the time a hearing is finally held to protest a denial of that aggravation claim. The Court of Appeals has decided this issue.

> "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 notification to the employer or carrier that a compensable condition has become worse....There has to be a worsening before expiration of the aggravation rights." Perry v. SAIF, 93 Or App 631 (1988).

In this case, there is no evidence to support a worsening before claimant's aggravation rights expired. In addition, the medical evidence indicates no worsening of the compensable condition either before or after the aggravation rights expired. The only thing which may have worsened is the non-compensable degenerative condition. Accordingly, we conclude that claimant has failed to prove a compensable aggravation claim.

ORDER

The Referee's order dated February 22, 1988, is affirmed in part and reversed in part. Those portions of the Referee's order which set aside the insurer's denial of pain center treatment and awarded an attorney fee are reversed. The denial of pain center treatment is reinstaed and upheld. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $2,307, is approved.

RONALD M. LYDAY, Claimant
Mark Malco, Claimant's Attorney
Davis, et al., Defense Attorneys

WCB 86-06814
April 12, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Lyday v. Argonaut Insurance Co., 94 Or App 344 (1988). The court has reversed our prior order which had affirmed Referee Howell's order that dismissed claimant's hearing request on the basis of untimeliness. Relying on its decision in Cowart v. SAIF, 94 Or App 288 (1988), the court has held that claimant has established good cause for his untimely hearing request. Consequently, the court has remanded. Inasmuch as we consider the record to be fully developed, we proceed to address the merits of the case.

Claimant requests review of Referee Howell's order which dismissed his hearing request on the insurer's denial of his aggravation claim for a bilateral knee condition and its partial denial of claimant's claim for a lateral meniscus tear in the right knee, right hip pain and lumbosacral degenerative disc disease. On review, the issues are compensability and aggravation.

FINDINGS OF FACT

In September 1980 claimant sought medical treatment of right knee pain of about 1-year duration. In October 1980 claimant filed a claim with his employer for his right knee condition. The claim was accepted as nondisabling. Two months later, claimant sought treatment for a similar problem with his left knee.

Claimant continued working, but received medical treatment for both knees and for low back pain, which he attributed to bending and heavy lifting at work. He also complained of right hip pain that he experienced at work. His bilateral knee condition was diagnosed as recurvatum (hyperextension). His low back condition was diagnosed as degenerative disc disease, but no pathological change could be found in his hip.

In June 1981, a Determination Order closed the claim. Claimant was awarded no temporary disability compensation, but was awarded 5 percent scheduled permanent disability for loss of use or function of each leg (knee). By stipulation approved January 12, 1982, claimant was awarded an additional 10 percent permanent partial disability for each knee. Claimant quit work at about that time.

Between late 1981 and June 1983 claimant received no treatment for his knees. He did receive vocational training as a dental technician and obtained employment in that occupation. Determination Orders dated October 25, 1983 and November 29, 1983 reclosed the claim following that authorized training program.

In August 1985, claimant retained his attorney to file an aggravation claim for him. He had hip and low back pain for which he wanted medical treatment. Claimant's attorney referred him to Dr. Strom-Ray, a chiropractor. Claimant's attorney also filed an aggravation claim with the insurer on or about August 30, 1985.

Dr. Strom-Ray examined claimant in September 1985 and

diagnosed sacroiliac instability, leg pain, lumbar dysfunction and thoracogenic scoliosis. Claimant was considered not to be medically stationary and chiropractic treatment was carried out over the next 8 weeks.

Claimant was examined in November 1985 by Dr. Puziss, who also reviewed claimant's medical records since September 1980. He found claimant's recurvatum no worse than in 1983, but could not rule out a possible torn lateral meniscus in the right knee. Dr. Puziss recommended an arthrogrom of the right knee. He further diagnosed probable degenerative disc disease of the lumbosacral spine with mild right sacroiliac strain.

In December 1985, the insurer denied claimant's aggravation claim. The insurer also denied compensability of: (1) claimant's right knee problems identified by Dr. Puziss as a possible lateral meniscus tear; (2) his right hip pain; and (3) his lumbosacral condition diagnosed as degenerative disc disease.

FINDINGS OF ULTIMATE FACT

Claimant's right hip and low back conditions are not causally related to his compensable bilateral knee condition.

Claimant's possible right knee lateral meniscus tear is not causally related to his compensable bilateral knee condition.

Claimant's compensable bilateral knee condition has not worsened since the last arrangement of compensation.

CONCLUSIONS OF LAW

COMPENSABILITY

Claimant contends that his degenerative low back condition, his right hip pain, and his possible torn lateral meniscus are causally related to the compensable bilateral knee condition. It is claimant's burden to establish that his bilateral knee condition is a material contributing cause of his subsequent low back, right hip, and right knee torn meniscus conditions. Grable v. Weyerhaeuser, 291 Or 387 (1981).

Whether claimant's bilateral knee condition is a material contributing factor to his current low back, right hip and right knee symptoms is a complex medical question. Thus, although claimant's testimony is probative, the resolution of the issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Low Back Condition

In regard to claimant's low back condition, Dr. Puziss diagnosed probable lumbosacral degenerative disc disease with mild right sacroiliac strain. He did not offer an opinion as to causality. Dr. Strom-Ray found no evidence of degenerative disc disease and opined that claimant's current low back condition was caused by congenital deformities in the spine, low back, and feet. She further opined that claimant's work in the 1980's caused an acceleration of these deformities. She offered no opinion as to a causal relationship between claimant's compensable bilateral knee condition and his current low back condition.

Under these circumstances, we cannot find any evidence relating claimant's current low back condition and his compensable injury. Accordingly, we conclude that claimant has failed his burden of establishing a causal relationship between the two. Therefore, his current low back condition is not compensable.

Right Hip Condition

In regard to claimant's right hip pain, Dr. Puziss could find no objective basis for claimant's complaints. He opined that it was medically probable that the claimant's bilateral knee condition and the right hip pain were unrelated. Dr. Strom-Ray concurred with Dr. Puziss' assessment that claimant's hip pain was not related to his compensable bilateral knee condition. There is no other medical evidence in the record as to a causal relationship between the compensable knee condition and the right hip pain. Accordingly, claimant has failed to carry his burden of proving a causal relationship.

Possible Torn Lateral Meniscus

In regard to Dr. Puziss' diagnosis of a possible torn right knee lateral meniscus, we note that the condition was never confirmed by objective testing. Assuming arguendo that the tear is present, Dr. Puziss could not attribute it to claimant's work or his compensable bilateral knee condition. He felt it likely that if the tear were in fact present, it would be due to some other injury not yet documented. Dr. Strom-Ray testified that she was not qualified to make a judgement whether or not claimant had a torn lateral meniscus. Accordingly, we find no causal relationship between the possible torn lateral meniscus and claimant's compensable knee condition.

AGGRAVATION

To prove a worsening, a claimant must show a change in his condition since the last arrangement of compensation which entitles him to additional temporary or permanent compensation. Smith v. SAIF, 302 Or 396, 399-401 (1986). If the claimant has received an award of permanent partial disability for the compensable condition which anticipated future symptomatic flare-ups, an increase in symptoms alone is not a worsening unless the flare-up is more severe than anticipated by the award or the flare-up requires in-patient hospitalization or results in temporary total disability which exceeds 14 consecutive days. Gwynn v. SAIF, 304 Or 345, 352-53 (1987); International Paper Co. v. Turner, 304 Or 354, 358 (1987).

Claimant received a total of 15 percent scheduled permanent disability for loss of use or function of both knees. Dr. Puziss opined that claimant's compensable bilateral recurvatum had not changed since the findings documented in 1983. Dr. Strom-Ray did not offer any opinion as to the current status of claimant's bilateral recurvatum. Neither physician has recommended that claimant not work as a result of this condition. Given this, we conclude that claimant's compensable bilateral knee condition has not worsened since the last arrangement of compensation.

ORDER

The insurer's denial of December 5, 1985 is upheld.

KARI MERCURIO, Claimant
Callahan, et al., Claimant's Attorneys
Rick Dawson (SAIF), Defense Attorney

WCB 87-10073
April 12, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Brazeau's order that: (1) declined to award temporary disability benefits or interim compensation; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable refusal to pay temporary disability benefits or interim compensation. On review, the issues are entitlement to temporary disability benefits, including interim compensation, and penalties and related attorney fees. We reverse.

FINDINGS OF FACT

Claimant injured her neck and left shoulder in March 1985. This injury was accepted as nondisabling in June 1985. Thereafter, claimant was released for modified work on June 11, 1985. Claimant left work in the latter part of June 1985, for reasons unrelated to her injury.

After leaving the employer, claimant looked for work until November 1986, when 6 1/2 months into a pregnancy, she discontinued her work search. During this time, claimant placed applications with several employers and consulted newspaper advertisements for work as a nurse's aide, which was her former occupation. Her child was born on January 28, 1987. Following this, claimant remained at home to care for her newborn and three other children.

Claimant planned to seek further employment following the birth of her child but was unable to as she began to experience acute neck pain, shoulder pain, and headaches. On March 31, 1987, claimant visited Dr. Stearns, chiropractor, with complaints of headaches, neck and upper back pain. Dr. Stearns found claimant to be not medically stationary and in need of chiropractic treatment.

In an April 10, 1987 report, received by SAIF on April 13, Dr. Stearns reported that claimant had sustained an aggravation of her compensable injury and as a result was temporarily totally disabled. Although claimant's claim was later reopened by SAIF, no temporary disability benefits were paid.

An investigation of the claim by SAIF led to a June 23, 1987 interview with claimant. Following the interview, SAIF determined that claimant had left the work force.

FINDINGS OF ULTIMATE FACT

Claimant's compensable condition worsened since the date of her nondisabling injury. This worsened compensable condition prevented her from securing work.

Claimant has not withdrawn from the labor market.

Claimant was willing to seek work and would have accepted employment had she not sustained a worsening of her compensable condition.

SAIF's refusal to pay temporary disability benefits was unreasonable.

CONCLUSIONS OF LAW

TEMPORARY DISABILITY BENEFITS

The Referee concluded that claimant had withdrawn from the work force, at the time of her aggravation, because she was not "actively seeking" employment. We disagree.

From June 1985 until November 1986, claimant was actively seeking work. She put in several applications at various nursing homes and hospitals, as well as consulting newspaper advertisements. She briefly interrupted this search when she was 6 1/2 months pregnant in order to give birth to her child. The child was born January 28, 1987. Claimant planned to seek work following the birth of her child, but approximately two months after the birth, she began experiencing acute neck and shoulder pain, as well as headaches. She sought treatment from Dr. Stearns who found her compensable condition not medically stationary.

Under these facts, we conclude that claimant remained active in the labor market. She had been seeking employment with but a brief interruption due to her pregnancy. This brief interruption does not constitute removal from the labor market. In making this conclusion, we note that public policy in this state provides for job security for parents during a work leave for care of an infant. ORS 659.360 provides a 12 week leave of absence following child birth, during which the employee is not subject to removal and has a right to her former job or its equivalent at the end of the parental leave period. This suggests that public policy favors treating women who must interrupt work activity for childbirth as workers. Accordingly, at the time of her aggravation, claimant remained in the labor market.

In rendering his opinion, the Referee stated:

> "Although there was evidence that claimant was looking for work and would have accepted offered employment in April 1987 but for the effects of her compensable injury, I am not persuaded that claimant was actively seeking employment at the time she submitted her aggravation claim. Because temporary total disability compensation is payable only to those workers who are actively seeking employment, Cutright, supra, 299 Or 302, claimant's claim for benefits must be denied."

Our reading of Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), however, leads us to conclude that a worker need not be "actively seeking" work. There is no statutory requirement that a claimant actively seek work. Furthermore, there is no requirement that a claimant continuously seek work in order to be part of the workforce. It is sufficient, at least after a worsening, that claimant be willing to seek and accept work if his/her physical condition permits such activity. Chapel of Memories v. Davis, 91 Or App 232 (1988); Sykes v. Weyerhaeuser Co., 91 Or App 41 (1988).

In the present case, claimant's uncontroverted testimony indicates that she was willing to, and did seek work, and would have continued to seek work and would have accepted suitable employment had she not sustained an aggravation of her condition. Further, the medical evidence establishes that claimant's condition did worsen and that her physician reported she was totally disabled, which creates the inference that she was unable to seek employment. Given this, we find that claimant had not withdrawn from the work force at the time of her aggravation. Chapel of Memories, supra; Sykes v. Weyerhaeuser Co., supra.

SAIF further argues that in order to be entitled to interim compensation on an aggravation claim, a worker must "leave work." In support of this argument, SAIF relies on Bono v. SAIF, 298 Or 405 (1984). We are not persuaded by this argument as the claimant in Bono, supra, filed an initial injury claim pursuant to ORS 656.262(4), whereas claimant in the instant case filed an aggravation claim pursuant to ORS 656.273(6). See Avalos v. Bowyer, 89 Or App 546, 550 (1988).

Furthermore, the Supreme Court rejected such an argument in Cutright, supra, stating:

> "The employers argue that Bono v. SAIF, supra, holds that to be entitled to compensation for TTD one must leave work.... The holding in that case is simply that a worker cannot receive interim compensation during a period of time in which the worker is actually working."

299 Or at 295-96 [Emphasis supplied]. In light of this, it is clear that a worker is not required to "leave work", but rather, show an inability to work. Id at 300.

Accordingly, claimant has satisfied the requirements necessary in order to receive interim compensation, i.e. (1) a claim; (a medically verified inability to work resulting from the compensable injury) and (2) notice or knowledge of the claim by the employer or insurer. Avalos v. Bowyer, supra at 549-51.

PENALTIES AND ATTORNEY FEES

We now turn to the issue of penalties and related attorney fees. ORS 656.273(6) provides that the first installment of compensation shall be paid no later than the 14th day after the employer/insurer has notice or knowledge of the medically verified inability to work resulting from the worsened condition. Here, SAIF had knowledge of claimant's medically verified inability to work when it received Dr. Stearns' April 10, 1987 letter. SAIF did not have a valid reason to refrain from paying interim compensation, yet took no action until June 23, 1987 when it interviewed claimant and determined she was not working at that time. Thereafter, it reopened claimant's claim but refused to pay temporary disability benefits. Consequently, SAIF's failure to pay temporary disability benefits, both prior and subsequent to the June 23 interview is unreasonable.

Claimant is entitled to a 25 percent penalty based on temporary total disability between April 10, 1987, the date of claimant's disability through the date claimant is no longer entitled to temporary total disability pursuant to ORS 656.268. ORS

656.262(10); Jones v. Emanuel Hospital, 280 Or 147 (1977). Moreover, a reasonable penalty-related attorney fee of $500 shall be awarded. Spivey v. SAIF, 79 Or App 568, 572 (1986).

ORDER

The Referee's order dated October 2, 1987 is reversed. The SAIF Corporation is directed to pay claimant temporary total disability benefits beginning April 10, 1987 and continuing until such compensation may be terminated pursuant to ORS 656.268. Claimant's attorney is awarded 25 percent of the increased compensation created by this order not to exceed $3,800. SAIF is assessed a penalty equal to 25 percent of the compensation due from April 10, 1987 until temporary total disability is no longer required pursuant to ORS 656.268. Claimant's attorney is awarded $500, to be paid by SAIF for prevailing on the penalties issue.

BENNY C. PARKER, Claimant
Heiling & Morrison, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 85-10591
April 12, 1989
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Parker v. D. R. Johnson Lumber Co., 93 Or App 675 (1988). Concluding that "[c]laimant is entitled to penalties and attorney fees for late payment of temporary total disability benefits now due," the court has "remanded to the referee for a determination of benefits, penalties and attorney fees."

In accordance with the court's mandate, this matter is remanded to Referee Howell for further proceedings consistent with the court's decision and this order.

IT IS SO ORDERED.

GENEVIEVE PUTTBRESE, Claimant
Michael B. Dye, Claimant's Attorney
Stafford Hazelett, Defense Attorney

WCB 87-06549
April 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Seifert's order which upheld the insurer's partial denial of carpal tunnel syndrome. We affirm.

ISSUES

The sole issue is whether claimant has proven by a preponderance of the evidence that her compensable injury of February 27, 1979 is a material cause of her bilateral carpal tunnel syndrome.

FINDINGS OF FACT

Claimant compensably injured her right shoulder and back on February 27, 1979. The injury occured when claimant was carrying a tub over her head. She fell backwards and landed on her right elbow and buttocks. The initial diagnosis was cervical strain syndrome.

Claimant complained of radiating pain into the right hand in May 1979; however, this pain was suggestive of C6 or C7 nerve root problems. During 1979, claimant was treated conservatively and surgically for cervical problems.

In January 1980, claimant reported having right thumb numbness. In November 1980, Dr. Tsai made the first diagnosis of bilateral carpal tunnel syndrome. Claimant has complained of carpal tunnel symptoms since that time. Claimant has bilateral carpal tunnel syndrome.

CONCLUSIONS

We adopt the Referee's opinion, beginning with the third paragraph of the opinion, except that we reject his reliance on Johnson v. Spectra Physics, 77 Or App 1 (1985), for his holding that the denial is not barred by Bauman v. SAIF, 295 Or 788 (1983). The insurer did not specifically accept a carpal tunnel syndrome. Therefore, it is free now to deny it. Johnson v. Spectra Physics, 303 Or 49 (1987).

We agree with the Referee that claimant's testimony at hearing that she had carpal tunnel symptoms from the time of the injury is inconsistent with the complaints which are recorded in the contemporaneous medical reports. We conclude that the contemporaneous histories are more likely to be accurate than claimant's testimony eight years after the compensable injury. Accordingly, we, like the Referee, give more weight to the contemporaneous history than to claimant's testimony.

We also agree that Dr. Raaf is more persuasive than Dr. Ellison because Dr. Ellison bases his opinion on the history of carpal tunnel symptoms beginning immediately after the injury while Dr. Raaf bases his opinion on the more reliable history that claimant did not develop carpal tunnel symptoms until some time well after the compensable injury.

ORDER

The Referee's order dated November 20, 1987 is affirmed.

KENA L. RAMSEY, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Paul Mackey, Defense Attorney

WCB 86-16532
April 12, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is the compensability of that condition. We reverse.

FINDINGS OF FACT

Claimant began working as a dental hygienist for the employer, a dental clinic, in April 1979. In approximately 1982, the clinic experienced a large inflex of refugee and immigrant patients who had received little or no dental care. They also spoke very little of the English language. As a result of these circumstances, the dental work was more restorative and therefore, lengthier and more physically involved than normal dental procedures.

Claimant's primary responsibility was to provide hands-on care to the patients for periodontal therapy. This care included root planing, curettage, deep scalings, giving anesthesia, doing pit and fissure sealants, and polishing alloys. Claimant used her right hand to do the deep scaling and polishing of alloys and teeth. She used

her left hand to do all charting, writing, mixing materials to be applied to the teeth, manipulating the head and retracting tissues in the mouth, whether they be the tongue or the lip, to allow light into the mouth. The language barrier that existed between claimant and the refugee/immigrant patients caused her to use her left hand extensively to keep a good visual field by manipulating the tongue or lip. Claimant was required to exert significant pressure with both hands in order to perform her duties.

In approximately 1983, claimant began to experience progressive bilateral numbness and tingling, although worse on the right. By August 1986, she was dropping objects at work, noticing nighttime and morning wakening with hand numbness and tingling, and was experiencing increased difficulty with aching in her hands, arms and forearms, but particularly on the right.

In 1978, claimant was diagnosed with tendonitis of the right wrist and continued to experience occasional soreness until 1982, when she also began to notice nighttime numbness. At that time, she sought treatment from a number of doctors, including Drs. Button, Nye and Hauge. All three doctors are specialists in hand surgery.

Dr. Button referred claimant to Dr. Long for nerve conduction studies, which were performed on August 22, 1986. The studies revealed a sensory latency on the right of 4.3 msec. and 4.6 msec. on the left. Following a review of these studies, Dr. Long diagnosed median compression neuropathy in the palms, right greater than the left, moderate in degree, involving motor and sensory fibers but without motor or sensory axon loss on the right or left. Drs. Button, Nye and Hauge diagnosed bilateral carpal tunnel syndrome, right greater than the left, and recommended surgical decompression.

On November 13, 1986, the employer denied claimant's occupational disease claim for bilateral carpal tunnel syndrome.

Claimant's duties as a dental hygienist required that she maintain both hands in prolonged flexed positions and engage in continuous repetitive movements. These work activities caused increased pressure on the carpal tunnels due to swelling which in turn led to a dysfunction of the median nerves, thereby requiring claimant to seek medical treatment for her symptoms of numbness, tingling and aching in her hands, forearms and arms.

Claimant's work activities were the major contributing cause of the worsening of her bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW

The Referee found that claimant's work activities had not caused a worsening of her underlying disease process, but rather, an increase in symptoms. Therefore, he declined to set aside the employer's denial of claimant's bilateral carpal tunnel syndrome.

In order to establish a compensable occupational disease, claimant must show that her work activities were the major contributing cause of her bilateral carpal tunnel syndrome or of its worsening. Dethlefs v. Hyster Company, 295 Or 298 (1983). A showing that the activities merely caused the symptoms to flare is not sufficient. Wheeler v. Boise Cascade Corp., 298 OR 452 (1985; Weller v. Union Carbide, 288 Or 27 (1978).

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).

Claimant's position as a dental hygienist exposed her to patients whose poor dental care and language skills required flexed and repetitive use of both hands. Because Dr. Button's opinions were based on an erroneous belief that claimant did not use her left hand as a dental hygienist, we give them no weight.

Dr. Long did not express an opinion regarding causation. Therefore, we are left with the opinions of Drs. Nye and Hauge.

On March 18, 1987, Dr. Nye diagnosed symptomatic bilateral carpal tunnel syndrome. He opined that the clinical symptoms were probably aggravated by the position in which claimant held her hands while performing her work activities and recommended surgical decompression.

On June 17, 1987, Dr. Nye clarified his earlier report. He stated that claimant's carpal tunnel "condition" was aggravated by her job as a dental hygienist but was not caused by it. He explained that "an aggravation of symptoms in this particular process is actually a bringing on of the syndrome. The syndrome is a conglomeration of a symptom complex caused by swelling within the carpal canal, causing secondary compression of the median nerve." Dr. Nye summarized claimant's condition in the following manner:

> "[Claimant's] carpal tunnel syndrome is idiopathic, but the repeated flexed position of her wrist does cause periodic increased swelling, pressure on the nerve, and eventually may aggravate the underlying scarring and make the condition worse. The condition is the symptom complex which in fact is the syndrome. The syndrome is not a disease process but a complex conglomeration of symptoms that make up the syndrome."

Dr. Hauge diagnosed a very significant median nerve compression. In an August 31, 1987 report, he explained that certain types of hand and wrist activities tended to aggravate the already confined space of the carpal tunnel and that intermittent and periodic swelling prevented an adequate blood supply from reaching the neurofibrils within the carpal canal. Dr. Hauge also more specifically opined that the:

> "[P]ositioning of [claimant's] hand in a flexed position, associated with the requirement of rapid repetitive motion of her hands . . . causes increased pressure on the carpal tunnel which directly leads to a dysfunction of the median nerve. Without treatment there is a risk of permanent nerve damage and permanent loss of sensation and function of the thenar musculature. I feel surgery is indicated and should be performed sometime in the near future."

Claimant's condition is the symptom complex which in fact

is the carpal tunnel syndrome. The syndrome is not a disease process but a complex conglomeration of symptoms that make up the syndrome. Her condition is caused by the compression of the median nerves. The record demonstrates that claimant's work activities, which required rapid repetitive motion and flexed positions with her hands, caused increased pressure on the carpal tunnel which directly led to the compression and dysfunction of the median nerves. Even if, as the Referee suggests, the compression of claimant's median nerves did not produce a permanent worsening of her condition, the claim is compensable. It is sufficient that claimant established a temporary worsening of her bilateral carpal tunnel syndrome. See Weller v. Union Carbide, supra; Stupfel v. Edward Hines Lumber Co., 288 Or 39 (1979). The record supports claimant's position. Accordingly, we defer to the opinions of Drs. Nye and Hauge and reverse the Referee's order finding claimant's condition not compensable.

ORDER

The Referee's order dated September 22, 1987 is reversed. The employer's denial is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $2,500 for services at the hearing and on Board review, to be paid by the self-insured employer.

SHASHA M. RAYMOND, Claimant
John E. Uffelman, Claimant's Attorney
David Smith (SAIF), Defense Attorney

WCB 87-12597
April 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Heitkemper's order that: (1) upheld the SAIF Corporation's denial of claimant's low back aggravation claim; and (2) declined to assess penalties and related attorney fees for SAIF's alleged unreasonable denial. We affirm in part and reverse in part.

ISSUES

1. Whether claimant has sustained a compensable aggravation of her low back condition.

2. Whether SAIF's denial of claimant's aggravation claim was unreasonable, thereby entitling claimant to penalties and related attorney fees.

FINDINGS OF FACT

In 1984 claimant was employed as a registered nurse. On April 14, 1984, she injured her upper and lower back while assisting a patient onto a commode. Her symptoms included constant low back ache, pain radiating down the back of her right leg, and numbness in her right foot. Dr. Holmes, osteopath, diagnosed lumbar and cervicothoracic strains and took claimant off work. On April 26, 1984, claimant returned to work.

On April 21, 1986, a Determination Order awarded claimant 10 percent unscheduled permanent disability for her low back condition and 5 percent scheduled permanent disability for the loss of function of her right leg.

On June 14, 1986, claimant again aggravated her low back at

work while lifting a patient. She was taken off work by Dr. Holmes and her 1984 back injury claim was reopened. On December 3, 1986, Dr. Holmes declared claimant medically stationary and released her to work with limitations of no lifting greater than 25 pounds and no frequent bending, stooping, sitting, or standing.

On March 3, 1987, a Determination Order declined to award claimant any permanent disability in excess of that awarded by the April 21, 1986 Determination Order.

Claimant subsequently obtained employment at a nursing home where she engaged primarily in administrative duties. In April 1987 her right leg symptoms began to gradually increase. The symptoms became so severe that on April 16, 1987, Dr. Fish took claimant off work. Claimant had not been released to work as of the time of hearing on October 7, 1987.

On May 26, 1987, Dr. Pasquesi examined claimant and diagnosed sciatic radiation of pain probably secondary to degenerative disc disease, superimposed strains, and lumbosacral instability. He also found that claimant was not medically stationary and was definitely worsening.

On June 19, 1987, the Western Medical Consultants examined claimant. They diagnosed lumbosacral strain and superimposed psychological factors unrelated to claimant's compensable 1984 injury. They also found no objective evidence of neurologic or orthopedic worsening of her back or leg condition.

On July 21, 1987, SAIF denied claimant's aggravation claim.

CONCLUSIONS OF LAW

The Referee found that claimant's symptoms had not worsened since her last arrangement of compensation. Therefore, he concluded that she was no less able to work than before her alleged aggravation and upheld SAIF's denial. We disagree.

Aggravation

To establish a claim for aggravation, claimant has the burden of proving that her condition has worsened since the date of the last arrangement of compensation, and that the worsening was caused in material part by the compensable injury. ORS 656.273; Stepp v. SAIF, 78 Or App 438 (1986). To prove a worsening, claimant must show a change in her condition which renders her less able to work and thus entitles her to additional temporary or permanent disability compensation. Smith v. SAIF, 302 Or 396, 399-402 (1986). If claimant has received an award of permanent partial disability for the condition which anticipated future symptomatic flare-ups, a flare-up that requires inpatient hospitalization or results in temporary total disability which exceeds 14 consecutive days is nonetheless an aggravation. Gwynn v. SAIF, 304 Or 345, 352-53 (1987).

Since claimant experienced a flare-up of her low back and right leg symptoms which produced more than 14 consecutive days of total disability, she has proven an aggravation claim as a matter of law. See Gwynn v. SAIF, 91 Or App 84, 88 (1988).

Penalties and Attorney Fees

ORS 656.262(10) provides that if the insurer unreasonably refuses to pay compensation, it "shall be liable for an additional

amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

SAIF's denial of claimant's aggravation claim was made on July 21, 1987, almost four months prior to the Supreme Court's decision in Gwynn v. SAIF, supra. Therefore, the reasonableness of SAIF's denial must be judged by the legal standard as enunciated in Stepp v. SAIF, supra, and Smith v. SAIF, supra. In order to prove a compensable aggravation claim under that standard, claimant was required to show a change in her condition which rendered her less able to work and thus entitled her to additional temporary or permanent disability compensation. Id.

On April 16, 1987, Dr. Fish, claimant's treating chiropractor, informed SAIF that claimant had "recently suffered an aggravation of her low back pain." He explained that on April 6, 1987, she began to notice "twinges" of pain; by April 8, 1987, "she was in bed with a full-blown disc protrusion and grade III sciatica in the right leg." On May 26, 1987, Dr. Pasquesi performed an independent medical examination on SAIF's behalf. He believed that claimant was definitely "in a state of worsening" and noted that she had not been able to work since April 1987.

The contrary medical evidence upon which SAIF based its denial came from the Western Medical Consultants. On June 19, 1987, the Consultants examined claimant and could find no objective evidence of neurologic or orthopedic worsening in her except for some patchy numbness in the right leg. They diagnosed lumbosacral strain and superimposed psychological factors that were not felt to be a direct result of her 1984 injury. The psychological factors were felt to be greatly magnifying her symptoms and preventing her return to work. They also believed that claimant's symptoms were probably the result of waxing and waning from her previous award with no obvious evidence of an increase in symptoms since that time.

Based on the medical evidence at the time, we cannot say that SAIF's denial of claimant's aggravation claim was unreasonable. Therefore, we decline to assess penalties or related attorney fees.

ORDER

The Referee's order dated October 30, 1987 is affirmed in part and reversed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

RODNEY C. ANDERSON, Claimant
Charles D. Maier, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-13452
April 13, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Seymour's order that: (1) upheld the insurer's partial denial of chiropractic care for a back condition in excess of the Medical Director's guidelines; and (2) declined to assess a penalty and associated attorney fees for an allegedly unreasonable denial. The insurer failed to timely file its respondent's brief. We reverse on the merits and affirm on the penalty and attorney fee issue.

ISSUES

1. Reasonableness and necessity of chiropractic treatments.

2. Penalties and attorney fees for allegedly unreasonable denial.

FINDINGS OF FACT

As a result of work activities, claimant developed upper and lower back pain which was accepted as a compensable claim, with a date of injury of November 17, 1985. The claim was closed by Determination Order dated August 21, 1987, awarding claimant 10 percent unscheduled permanent low back disability. The award was increased by stipulation to 20 percent.

Claimant treated with Dr. Anderson, chiropractor, from November 1985 through December 1986. In January 1987, claimant transferred his care to Dr. Kojis, chiropractor. Dr. Kojis treated claimant on a twice per week basis.

In May 1987, claimant came under the care of Dr. Utter, chiropractor. Dr. Utter found that claimant was not medically stationary. He prescribed an initial period of frequent treatments "to accelerate the bodies [sic] natural healing processess [sic]." Dr. Utter continued to treat claimant as of the date of hearing.

On September 30, 1987, the insurer denied treatments in excess of two per month.

Claimant had not returned to any employment as of the date of hearing.

Claimant is credible.

Claimant's chiropractic treatments are palliative in nature. The treatments relieve his back pain for approximately one week at a time. His symptoms worsen when he goes without treatment for more than a week. He treats with Dr. Utter on an "as-needed" basis.

Claimant's current chiropractic treatments are reasonable and necessary as relates to his compensable back condition.

CONCLUSIONS AND OPINION

Medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of a compensable injury. Wetzel v. Goodwin Brothers, 50 Or App 101, 108 (1981). It is claimant's burden to prove the reasonableness and necessity of treatment. McGarry v. SAIF, 24 Or App 883, 888 (1976).

The Referee stated that palliative treatments are compensable "to the extent that they relieve the claimant's pain in order that he is able to work...." He noted in this regard that Dr. Utter's treatments had not enabled claimant to resume work. He also noted that a panel of the Independent Chiropractic Consultants had opined that continued chiropractic treatments were

not reasonable and necessary. Based upon these two factors, he concluded that treatments in excess of two per month were not reasonable and necessary.

Evidence that palliative treatments enable a worker to work is a significant factor supporting a determination that such treatments are reasonable and necessary. West v. SAIF, 74 Or App 317, 321 (1985). However, we do not interpret West as establishing such evidence as a prerequisite to the compensability of palliative care. Rather, we look to a number of factors. Such factors include but are not limited to: the degree to which claimant's pain is reduced so that he is able to function; the period of time during which claimant enjoys the benefits of the treatment; whether claimant undergoes treatment on a scheduled basis or an "as-needed" basis; whether claimant has suffered permanent disability as a result of his compensable injury; and, more generally, whether the persuasive medical evidence supports or opposes the reasonableness and necessity of treatment.

Claimant treats with Dr. Utter on an "as-needed" basis. He experiences "very great" pain when he goes without treatment for extended periods of time. He estimated that Dr. Utter's treatments provide relief for five days on average. He has received a total award of 20 percent permanent partial disability for his back condition. All of these factors weigh in favor of a finding of compensability.

Dr. Utter opined that treatments in excess of two per month are reasonable and necessary. He explained that claimant's condition has stabilized under the present treatment regimen, but that his condition would materially worsen if treatments were limited to two per month. He, too, noted that claimant's pain relief as a result of the treatments lasts approximately one week.

Opposing Dr. Utter's opinion is that of the Independent Chiropractic Consultants who examined claimant in May 1987. They opine that claimant's chiropractic treatments are not reasonable and necessary. Their report contains no discussion of claimant's current treatments other than to note that those treatments provide only temporary relief. However, by definition, palliative treatment results in only temporary symptomatic relief. We reject the Consultants' report to the extent it suggests that treatments which result in only temporary relief are not reasonable and necessary.

We conclude that Dr. Utter's opinion is more persuasive than that of the Independent Chiropractic Consultants. Combined with the additional factors discussed above, we find that claimant's current treatments are reasonable and necessary although their frequency exceeds the Director's guidelines. We are mindful in this regard that the guidelines were not intended to arbitrarily limit a worker's entitlement to medical services under ORS 656.245. See West v. SAIF, supra, 74 Or App at 320.

Penalties and Attorney Fees

Our review of the record discloses nothing unreasonable in the insurer's denial of treatments in excess of two per month. We, therefore, decline to assess a penalty or attorney fee.

In accordance with OAR 438-15-010(5), the insurer's counsel has submitted a statement of services requesting approval

of a client-paid attorney fee. That statement of services reflects both services rendered in preparation of the insurer's respondent's brief and estimated additional services. Because the respondent's brief was not timely submitted, no attorney fee will be approved for those services. See Shirley M. Brown, 40 Van Natta 879, 881-83 (1988) (no award of an assessed fee where claimant's brief untimely filed). However, a reasonable fee will be approved for estimated additional services.

ORDER

The Referee's order dated January 13, 1988 is affirmed in part and reversed in part. That portion of the order which upheld the insurer's partial denial of chiropractic treatments in excess of two per month is reversed. The insurer's denial dated September 30, 1987 is set aside. The insurer is ordered to process claimant's claim for chiropractic treatments in accordance with law. The remainder of the Referee's order is affirmed. Claimant's counsel is awarded $900 as a reasonable attorney fee for his services at hearing and on Board review, to be paid by the insurer. A client-paid fee, not to exceed $160, is approved.

JEFFREY S. EKERSON, Claimant
Charles Robinowitz, Claimant's Attorney
Nelson, et al., Defense Attorneys

Own Motion Number--None
April 13, 1989
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 claim with Fireman's Fund Insurance Company has 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).

IT IS SO ORDERED.

PAUL JACKSON, Claimant
Royce, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-09537
April 14, 1989
Order on Reconsideration

The insurer requests reconsideration of the Board's March 16, 1989 Order on Review that affirmed the Referee's unscheduled permanent disability award, affirmed the Referee's assessment of a penalty-related attorney fee for the insurer's alleged disclosure violation, and approved the client-paid fee of $1,100.

Citing the Court of Appeals' recent decision in SAIF v. Wilson, 95 Or App 748 (March 22, 1989), the insurer argues that the Board's award of a penalty-related attorney fee was improper. In Wilson, the Board had awarded a penalty-related fee under ORS 656.262(10) and ORS 656.382(1) for the employer's failure to timely close a claim. On review, the court reversed. The court found that the employer's failure to seek claim closure had resulted in no delay in the payment of compensation. Therefore, the court concluded that there was no statutory authority on which a penalty-related fee could be assessed.

Shortly before the court's decision in SAIF v. Wilson, the court issued its decision in Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989). Among the issues before the court in Eastmoreland Hospital v. Reeves was the award of a penalty and associated attorney fee for violation of the Board's disclosure rules. The court affirmed the award of reasonable attorney fees for a delay in disclosure, despite the fact that there was no evidence the disclosure violation had resulted in a delay in payment of compensation. The court cited former OAR 438-07-015(2) in support of its conclusion that a disclosure violation may be an unreasonable delay or refusal under ORS 656.262(10).

The insurer's alleged unreasonable conduct here involved a disclosure violation just as it did in Reeves. Moreover, in affirming the Referee's award of a penalty-related attorney fee, we relied in part upon former OAR 438-07-015(2), just as the court did in Reeves. We conclude that the facts here are more akin to those in Reeves than they are to those in SAIF v. Wilson. Consequently, we adhere to our prior decision affirming the Referee's award of a penalty-related attorney fee.

The insurer's counsel also requests that we reconsider the amount of the client-paid fee approved by our March 16, 1989 order. 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. The fact that we omitted reference to these factors in our prior order should not be interpreted as a failure to consider these factors. These

factors were considered in arriving at the amount of the approved client-paid fee. On reconsideration, we adhere to our prior determination on this issue.

Accordingly, our March 16, 1989 order is abated and withdrawn. As supplemented herein, we adhere to and republish our March 16, 1989 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

FRANKLIN L. BEEBE, Claimant
Malagon & Moore, Claimant's Attorneys
Cliff, et al., Defense Attorneys

WCB 85-03872
April 17, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Beebe v. Phibbs Logging & Cutting, 94 Or App 542 (1988). The court has concluded that claimant was not entitled to an award of attorney fees under ORS 656.386(1) for services rendered at hearing in setting aside an order from the Workers' Compensation Department suspending claimant's compensation. Therefore, the court has reversed that portion of the Board's order which agreed with the Referee that claimant was entitled to an insurer-paid attorney fee.

The Board's order affirmed that portion of the Referee's order which had set aside the Department's suspension order. Franklin L. Beebe, 39 Van Natta 687 (1987). In addition, the Board modified the Referee's order by reducing an insurer-paid attorney fee award. Finally, for claimant's counsel's services on review, the Board awarded an insurer-paid attorney fee of $600, but did not reflect the amount, if any, awarded for defending the Referee's award of an insurer-paid attorney fee. The court has remanded to "determine what amount, if any, [the Board] awarded for defending the referee's grant of employer-paid attorney fees and should reduce the award by that amount."

Attorney fees are not "compensation" within the meaning of ORS 656.382(2). Thus, a claimant is not entitled to attorney fees for successfully defending such an award on Board review. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Here, at the Board level, claimant prevailed against the insurer's request for review of a Referee's order setting aside the Department's suspension order and awarding an insurer-paid attorney fee, albeit in a reduced amount. In affirming and modifying the Referee's order, the Board awarded $600 as a reasonable insurer-paid attorney fee for "services on Board review."

Inasmuch as attorney fees are not "compensation," it follows that the attorney fee award for services on review was entirely attributable to claimant's counsel's efforts rendered in defense of the Referee's decision to set aside the suspension order and reinstate claimant's temporary disability benefits. Consequently, we determine that no portion of the $600 attorney fee awarded for services on Board review was related to claimant's defense of the Referee's award of attorney fees.

Accordingly, for services rendered on Board review in defense of the Referee's decision to reinstate claimant's temporary disability benefits, we continue to award claimant's attorney $600, to be paid by the insurer.

IT IS SO ORDERED.

ERNEST M. CARROTHERS, Claimant

Own Motion 89-0183M
April 17, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his February 18, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim as it contends claimant has not required any surgery or hospitalization and, therefore, it not entitled to compensation for temporary disability.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Although claimant did report to the emergency room of the hospital for pain relief, we do not feel this satisfies the requirements set forth above. Claimant's current treatment consists of physical therapy and medication. We conclude we are without authority to grant the relief claimant seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

DANIEL CHRISTIANSEN, Claimant
Imperati, et al., Claimant's Attorneys
Noreen K. Saltveit, Defense Attorney

Own Motion 89-0089M
April 17, 1989
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 claim with SAIF Corporation 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 establishes that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent. Furthermore, for the purposes of ORS 656.625 and OAR 436, Division 45, this consent constitutes an order reopening a claim under ORS 656.278 and the Board's rules if the designated paying agent is an own motion insurer. See OAR 438-12-032(3).

THOMAS SELMAN, Claimant
Malagon, et al., Claimant's Attorneys

Own Motion 89-0167M
April 17, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his July 29, 1980 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's recent surgery, but opposes reopening of this claim for the payment of temporary disability benefits as it contends claimant has removed himself from the work force.

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. SAIF contends claimant has removed himself from the work force and, therefore, is not entitled to compensation for temporary disability benefits. However, we find that the evidence shows claimant has either been receiving temporary disability benefits or has been involved with vocational efforts on his behalf. Although there is a span of time in 1988 with no record of his activities, there is no persuasive evidence that claimant has removed himself from the work force. We conclude claimant is entitled to compensation for temporary disability benefits during his recovery from surgery.

Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date he was hospitalized for the March 1989 surgery 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 $300 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.

ROCHELLE M. GORDON, Claimant
Cliff, Snarskis, et al., Defense Attorneys

WCB 88-15741
April 18, 1989
Order of Dismissal

Reviewed by Board Members Crider and Ferris.

The insurer has moved for dismissal of claimant's request for review on the ground that it did not receive timely notice of the request. The motion is granted.

FINDINGS

The Referee's Order of Dismissal issued December 8, 1988. On December 12, 1988, the Board received a December 1, 1988 letter from claimant requesting "circuit court review now." The letter, which was neither mailed by registered nor certified mail, did not include an acknowledgment of service or a certificate of personal service by mail upon the employer, its insurer, or their legal counsel.

On February 21, 1989, the Board mailed a computer-generated letter to the parties acknowledging the request for review. The insurer's counsel received the Board's acknowledgment letter on February 22, 1989. Receipt of this acknowledgment constitutes the employer's and its representatives first notice of claimant's request for Board review.

ULTIMATE FINDINGS

Claimant's letter was received by the Board within 30 days of the Referee's December 8, 1988 order. However, neither the employer nor its representatives received notice of the letter within 30 days from the date of the Referee's order.

CONCLUSIONS

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).

Here, assuming that claimant's letter constitutes a request for Board review of the Referee's December 8, 1988 order, it was received by the Board on December 12, 1988. Inasmuch as the request was submitted within 30 days of the Referee's order, it is timely. See ORS 656.289(3).

However, the record fails to establish that the remaining parties to this proceeding were either provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Instead, the record suggests that the employer's first notice of claimant's appeal occurred on February 22, 1989, when its insurer's attorney received the Board's February 21, 1989 acknowledgment letter. Under such circumstances, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra; Eugene E. McNutt, 41 Van Natta 164 (January 26, 1989).

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

JOSEPH ANGER, Claimant
Welch, et al., Claimant's Attorneys
Tom Ewing (SAIF), Defense Attorney

WCB 88-12933
April 19, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Thye's order that affirmed a Determination Order award of 13 percent (41.6 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant was 24 years of age at hearing. In January 1987, while working as a delivery truck driver for SAIF's insured, he developed low back pain when he performed some heavy lifting activities. His condition was diagnosed as a lumbar back strain. The claim was accepted.

In October 1987 an MRI study revealed a significant disc protrusion at the L5-S1 level with significant nerve root impingement on the right. Another disc protrusion, of a much less significant degree, was noted at the L4-5 level. In November 1987, Dr. Paxton, neurosurgeon, performed a laminectomy and discectomy at L5-S1. The surgery was successful.

In May 1988, following one month of physical therapy, claimant was found to be asymptomatic, medically stationary and released to work by his treating osteopath, Dr. Takacs. A neurological exam was entirely normal, as was claimant's thoracolumbar range of motion. Claimant was not subject to any sitting, standing, or walking restrictions and he was permitted to frequently bend, squat, and crawl, as well as continuously climb and reach. Lifting restrictions were placed at 25 pounds frequently and no more than 50 pounds. Using the AMA Guidelines for operated disc disease without residual, Dr. Takacs rated claimant's impairment at 5 percent of the whole person.

On July 5, 1988, a Determination Order issued. Claimant was awarded 13 percent unscheduled permanent disability.

Claimant has completed the 11th grade, as well as an alternative education high school program. He has also received an Adult School diploma from a community college. In addition to working as a delivery truck driver, he has been employed as a weekend warehouse supervisor, an assistant manager of a warehouse, a lighting maintenance laborer, a construction laborer, an apprentice cement mason, and in minimum wage positions for various fast-food restaurants. The highest specific vocational preparation value for these experiences is warehouse supervisor, which is 4.

Claimant has not worked since the January 1987 lifting incident. His employer at injury has reported that it has no suitable work available within claimant's physical limitations.

Following a vocational evaluation, claimant was found to have "specific transferable skills and a fairly extensive work history for a gentleman his age." Vocational goals as a kennel assistant/dog trainer and shipping/receiving clerk were identified. A return-to-work plan, with a goal of obtaining employment in the

animal care and training field, was formulated. At the time of hearing, claimant was anticipating further assistance in achieving this goal.

Before his injury, claimant frequently lifted and moved items weighing up to 100 pounds. Such activities are considered heavy duty. Since his injury, claimant is restricted to lifting no more than 50 pounds and up to 25 pounds frequently. Such activities are considered medium duty.

CONCLUSIONS OF LAW

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of the July 5, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. id.

Following the application of the disability standards, the Referee affirmed the Determination Order award of 13 percent unscheduled permanent disability. We agree that claimant has not established his entitlement to an award beyond that granted by the Determination Order.

Pursuant to OAR 436-35-350(2), claimant receives an impairment rating of 5 percent for a laminectomy and single discectomy. The aforementioned rule further provides for a rating of 4 percent for an unoperated disc derangement with any clinically-related residual symptoms. Here, an unoperated disc protrusion at the L4-5 level has been revealed. However, at the time of hearing, no residual symptoms were noted. Therefore, no impairment value is given.

Range of motion findings concerning claimant's back were normal. Consequently, no impairment value for spinal ranges of motion is given. See OAR 436-35-360.

Disabling pain can result in a loss of use or function. Former OAR 436-35-320(1)(a). When it does, it is rated based on the loss of use or function which results, and no additional value is allowed for the pain alone. id.

We have previously held that the former disability rating standards do not incorporate all of the disabling effects attributable to pain within the impairment ratings for each specific body part. See Daniel M. Alire, 41 Van Natta 752 (April 6, 1989). In so holding, we have reasoned that if the so-called "incorporation" argument was correct, there would be no need for the Department's adoption of former OAR 436-35-320(1)(a). Former OAR 438-35-320(1) has recently been amended. Thus, an application of the current version of the aforementioned rule would likely be different than the Alire analysis. However, because the amended rules were not in effect at the time this claim was closed by the Evaluation Section, they are not applicable. See OAR 438-10-005; 438-10-010.

Here, claimant testified that he experiences a "dull, throbbing pain" around the belt line of his lower back if he walks on a level surface for 30 minutes or stands for 10 to 15 minutes. He

also feels low back pain if he bends or squats too fast, reaches overhead, or walks upstairs or uphills. Claimant further stated that his right foot falls asleep if he drives for more than an hour to an hour and one-half.

We have considered claimant's testimony concerning his complaints of pain. However, we find the medical evidence more persuasive. In reaching this conclusion, we particularly rely upon the findings and opinion offered by Dr. Takacs, claimant's treating physician. Other than morning stiffness, Takacs reported that claimant had been pain-free since his surgery. Takacs also placed no restrictions on claimant's sitting, standing, or walking activities. Furthermore, Takacs concluded that claimant could frequently bend, squat, or crawl and could climb or reach continuously. Finally, Dr. Takacs reported that claimant's neurological exam was normal.

Accordingly, after considering the medical and lay evidence, we conclude that the record does not establish that claimant's pain has resulted in a loss of use or function of his low back. Therefore, we are not persuaded that the pain is disabling. See former OAR 436-35-320(1)(a). Inasmuch as claimant's pain is not considered disabling, his impairment under the disability standards consists of the +5 value awarded for his surgery. OAR 436-35-350(2).

The Referee noted that the Evaluation Section had listed claimant's total impairment at 9 percent, apparently including an additional 4 percent impairment for the unoperated disc at L4-5. Although the Referee found no clinically-related residual symptoms resulting from the unoperated disc, which is required under OAR 436-35-350(2), the additional 4 percent was not disturbed. The Referee reasoned that SAIF had not filed a cross-appeal to the Determination Order.

We disagree with the Referee's reasoning. As with all findings concerning the standards, the finder of fact must find, by a preponderance of the evidence presented at the hearing, the level of claimant's impairment due to the industrial injury. Michelle Griffith, 40 Van Natta 2086, 2089 (1988). Our role on review is the same: To review the record de novo, find facts and rate claimant's disability on the basis of the facts found. Griffith, supra.

Here, after conducting our de novo review, we find that the level of claimant's impairment due to the industrial injury is +5. Thus, regardless of whether SAIF filed a cross-appeal to the Determination Order, the impairment value shall be +5.

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. OAR 436-35-290(1), (2), and (3). Here, claimant was 24 years of age at hearing. Consequently, his age value is zero. OAR 436-35-290(4).

Education. 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, GED certificate or more education. OAR 436-35-300(2). Here, claimant has completed an alternative education high school program and received an Adult School diploma from a community college. Therefore, his formal education value is zero.

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). As previously noted, claimant has not been released to his regular work nor has he returned to his 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 last 10 years is as a warehouse supervisor (4). which is assigned a value of +3.

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). These conditions are not applicable to claimant. If no documentation demonstrating competence in some specific vocational pursuit is present, a value of +1 is assigned. Former OAR 436-35-300(5)(a). [We note parenthetically that this rule has also been recently amended. See WCD Admin. Order 6-1988 [sic]. The competency documentation requirement has been deleted and replaced by a requirement that "competence in some specific vocational pursuit" be established.] Here, no documentation demonstrating competence in a special vocational pursuit was submitted. Consequently, a value of +1 is assigned.

All the education factors are added for a total value of +4. Former OAR 436-35-300(5)[sic].

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). When workers are not working and no employment has been offered, the value for this factor shall be based on physical capacity according to a table provided in former OAR 436-35-310(4)(a).

Here, pursuant to Dr. Takacs' recommended restrictions, claimant is able to lift up to 25 pounds frequently, but can lift no more than 50 pounds. Such restrictions meet the physical capacity requirements of medium duty. See OAR 436-35-310(4)(b). Consequently, the adaptability value is +1.

Assembling the factors. The age value is added to the total value for education. (0 + 4 = 4). OAR 438-35-280(4). The sum of the values for age and education are multiplied by the value for adaptability. (4 x 1 = 4). OAR 438-35-280(6). The product of the values for age/education and adaptability is added to the total impairment value to reach the percentage of permanent unscheduled permanent disability to be awarded. (4 + 5 = 9). OAR 438-35-280(7).

SAIF does not seek reduction of claimant's award under the disability standards. Therefore, the award will not be altered. To the extent that this approach is contrary to that followed in Michelle Griffith, supra, the Griffith approach will not be followed in the future.

Clear and Convincing Evidence. Neither party is prevented or limited from establishing by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by

the Director under ORS 656.726. See ORS 656.283(7); 656.295(5). To be "clear and convincing," evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 402 (1987).

Here, claimant asserts that amendments to the Director's disability standards, which were made subsequent to the closure of his claim, constitute "clear and convincing" evidence that his award, as granted pursuant to the prior standards, was inadequate. See ORS 656.295(5). Specifically, claimant contends that OAR 436-35-310(4) now recognizes limitations on functional activities such as walking, standing, bending and squatting in determining the adaptability factor. In addition, claimant notes that OAR 436-35-320(4) provides for a 5 percent value for loss of repetitive motion due to chronic conditions.

We disagree with claimant's assertions. To begin, claimant's argument presupposes that the aforementioned physical limitations have not been addressed. Such an assumption would be inaccurate. In determining the extent of claimant's permanent disability, we, as well as the Referee, applied the disability standards, former OAR 436-35-000 et seq, which were effective at the time of the July 5, 1988 Determination Order. See OAR 438-10-005; 438-10-010. In so doing, claimant's physical limitations have been considered in determining whether he suffers from disabling pain resulting in a loss of use or function. See former OAR 436-35-320(1)(a); Daniel M. Alire, supra. For the reasons previously set forth, we conclude that the record does not establish that claimant has suffered disabling pain.

Furthermore, since the amendments to the disability standards were not in effect at the time this claim was closed, the amendments are not applicable. See OAR 438-10-005; 438-10-010. In any event, the subsequent adoption of amendments to the disability standards does not establish that it is "highly probable" that claimant's permanent disability award was inadequate. Rather, the adoption merely establishes that the disability standards were amended at a time following the closure of claimant's injury claim. Nothing more nor nothing less should be inferred from this action by the Director. Consequently, we hold that amendments to the standards do not constitute clear and convincing evidence that claimant's loss of earning capacity is greater than that previously awarded.

ORDER

The Referee's order dated November 25, 1988 is affirmed.

BARBARA P. BROWN, Claimant
Kenneth D. Peterson, Claimant's Attorney
Davis, et al., Defense Attorneys

WCB 86-03915
April 19, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). The court has reversed our prior order which had reversed Referee Leahy's order that assessed penalties and related attorney fees for an unreasonable denial of medical services. We have been instructed to reconsider this case in light of the court's holding in Armstrong v. Asten-Hill Co., 90 Or App 200, 205 (1988). After conducting our reconsideration, we issue the following order.

Claimant requests review of that portion of Referee Leahy's order which assessed penalties and related attorney fees for an

unreasonable denial of medical services. On review, the issue is penalties and related attorney fees. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to her left arm in 1983. This injury resulted in surgery for a left tennis elbow. In January 1984, a lipoma, on claimant's left elbow, was diagnosed and surgically removed. The question of compensability of this condition was resolved by a December 1984 Disputed Claim Settlement.

In January 1986, claimant returned to Dr. Carpenter, her treating orthopedist, with complaints of left arm pain. She had not sought treatment for her left arm since January 1984. Dr. Carpenter felt it was probable that claimant was experiencing a Reynaud's Phenomena and a cutaneous nerve deficit of the medial epicondyle. He opined that it was related to cigarette smoking and coffee consumption, as well as claimant's compensable injury. Dr. Carpenter then referred claimant to Dr. Eisler, neurologist.

In a letter to Dr. Carpenter, dated January 17, 1986, Dr. Eisler diagnosed claimant's condition as probable post-traumatic lateral cutaneous nerve of the forearm neuroma or neuritis with possible radial nerve involvement. The insurer received this letter on February 5, 1986. In a subsequent letter to Dr. Carpenter, dated February 18, 1986, Dr. Eisler clarified his opinion. He reported that claimant may have some nerve entrapment or irritation, but that her symptoms were more likely due to resistant tennis elbow syndrome.

On February 20, 1986, the insurer denied responsibility for claimant's Reynaud's phenomena and nerve irritation. The insurer did not receive Dr. Eisler's February 18, 1986 report until April 7, 1986. On June 7, 1986, in response to an inquiry from the insurer, Dr. Eisler reiterated claimant's diagnosis as resistant tennis elbow syndrome. This letter was received by the insurer on June 12, 1986.

On July 11, 1986, stating that it had received further clarification from Drs. Carpenter and Eisler that claimant's current problems were related to her compensable injury, the insurer partially modified its February 20, 1986 denial. It accepted responsibility for claimant's current treatment, but continued to deny responsbility for claimant's Reynaud's phenomena and nerve irritation to the extent those conditions existed. Shortly thereafter, the insurer paid the physicians' bills.

FINDINGS OF ULTIMATE FACT

The insurer's February 20, 1986 denial was not unreasonable at the time of issuance.

The receipt of Dr. Eisler's February 18, 1986 letter, on April 7, 1986, did not destroy the insurer's legitimate doubt as to its responsibility for claimant's medical services.

CONCLUSIONS OF LAW

The Referee found that the insurer's denial became unreasonable after its April 1986 receipt of Dr. Eisler's February 18. 1986 report. He therefore assessed penalties and related attorney fees. We disagree.

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). After an insurer reasonably denies a claim, continuation of that denial in the light of new medical evidence becomes unreasonable only if the new evidence destroys any legitimate doubt about liability. Brown v. Argonaut Insurance Co., supra; Norgard v. Rawlinsons, 30 Or App 999 (1977).

Initially, we must decide if the insurer's denial was reasonable at the time it was issued. We first note that claimant had not sought treatment related to her compensable condition for over two years. Furthermore, prior to issuance of the February 20, 1986 denial, the insurer was in possession of Dr. Carpenter's January 8, 1986 report and Dr. Eisler's January 17, 1986 report. Dr. Carpenter's report stated that claimant's condition could be related to cigarette smoking and coffee consumption. Dr. Eisler's report indicated that claimant's condition was probably a form of neuritis. In light of these reports, we conclude that the insurer had a legitimate doubt as to the cause of claimant's condition at the time it issued its denial.

Having found the denial was reasonable when issued, the next question becomes whether medical evidence received by the insurer, after issuance of the denial, caused the denial to become unreasonable.

On February 18, 1986, Dr. Eisler wrote a letter to Dr. Carpenter stating inter alia:

> "At this time it appears to me that although [claimant] may have some entrapment or irritation at the arcade of Froshe, that the symptoms are more likely to be the so-called resistant tennis elbow syndrome."

The insurer received this report on April 7, 1986. Although this report "more likely" relates claimant's symptomatology to her compensable injury, we do not find that it "destroyed" all legitimate doubt as to the insurer's liability. The insurer still had a report from Dr. Carpenter that related claimant's symptoms to noncompensable activities. Further, given Dr. Eisler's initial report relating claimant's condition to possible neuritis, as well as the somewhat equivocal language of the February 18, 1987 report, we conclude that the continuance of the insurer's denial was not unreasonable.

We note that the insurer sought clarification of Dr. Eisler's report in June 1986, at which time, he unequivocally related claimant's current condition to the compensable injury. The insurer received this report on June 12, 1986. The insurer evidently sought clarification from Dr. Carpenter and ultimately rescinded its denial on July 11, 1986, based on the clarifications provided by Drs. Eisler and Carpenter. Since we have found the insurer's doubt to be reasonable following receipt of Dr. Eisler's February 18, 1986 letter, it follows that such doubt remained reasonable until the clarifications provided by both physicians. The insurer issued its

modified denial shortly thereafter. We do not consider this conduct unreasonable. Accordingly, penalties and attorney fees are not warranted. ORS 656.262(10).

ORDER

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

DIANA D. COUCH, Claimant
Flaxel, Todd, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 88-17286
April 19, 1989
Order of Dismissal

Claimant has moved for dismissal of the insurer's request for review on the ground that the request was untimely. The motion is granted.

FINDINGS

The Referee's order issued January 11, 1989. On January 17, 1989, the insurer requested reconsideration. On January 24, 1989, the Referee issued an Order on Reconsideration. Stating that all matters raised in the insurer's request had been considered prior to his decision, the Referee "adhere[d] to my former Opinion and Order." Both Referee orders contained a statement explaining the rights of appeal under ORS 656.289(3) and 656.295.

On February 16, 1989, the insurer mailed its request for review of the Referee's January 24, 1989 Order on Reconsideration, "which reconsidered the Opinion and Order of January 11, 1989." On February 22, 1989, the Board mailed a computer-generated letter to the parties acknowledging the request for review.

CONCLUSIONS

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). The time within which to appeal an order continues to run, unless the order has been stayed, withdrawn, or modified. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (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 January 24, 1989 Order on Reconsideration neither stayed, withdrew, modified, nor abated the Referee's January 11, 1989 Opinion and Order. Rather, on reconsideration, the Referee expressly adhered to his "former Opinion and Order."

By merely adhering to the prior order, the reconsideration order did not extend the time for seeking review. See International Paper Co. v. Wright, supra, at page 447; Fischer v. SAIF, supra, at page 659. Therefore, because the insurer's request for Board review was submitted more than 30 days after the issuance of the Referee's January 11, 1989 order, the request is untimely. ORS 656.289(3); International Paper Co. v. Wright, supra; Fischer v. SAIF, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

TRACEY A. FAST, Claimant
Brian R. Whitehead, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 88-14087
April 19, 1989
Order on Review

Reviewed by Board Members en banc.

Claimant requests, and the insurer cross-requests, review of Referee Davis' order that awarded 15 percent (48 degrees) unscheduled permanent disability for a back and shoulder injury, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant was 25 years of age at hearing. In June 1987, while working as the produce manager for a grocery store, he developed pain in his back and shoulders when lifting a pallet jack. His condition was diagnosed as a severe muscle strain to the upper back and shoulders. His claim for a strained back was accepted.

Claimant attempted to return to work in July, but, following another lifting incident, was taken off work in August by Dr. Hughes, family practitioner. He has not returned to work since. Treatment has been conservative, primarily consisting of massage and chiropractic therapy administered by a number of physicians and therapists.

Claimant had previously suffered an upper back injury in an August 1986 motor vehicle accident. However, following two months of chiropractic care, his symptoms had resolved.

In October 1987, Dr. Khalsa, claimant's then-treating chiropractor, released him to modified work. Shortly thereafter, claimant entered a physical therapy program, administered by Dr. Roy, orthopedist. Claimant combined this therapy with weekly chiropractic treatments from Dr. Khalsa. The therapy program ended in November 1987, when claimant's symptoms had not improved and Dr. Roy suggested that there was nothing further he could do for him.

In December 1987, Dr. Spady, orthopedist, performed an independent medical examination. X-rays revealed mild thoracic scoliosis. Based upon claimant's history, Spady diagnosed an upper back sprain. Noting that the intensity and duration of claimant's symptoms far exceeded objective findings, Spady recommended an MMPI evaluation.

Following the recommended evaluation, Dr. Kimball, psychiatrist, diagnosed no psychological illness. Dr. Spady and Dr. Khalsa agreed with this finding.

Claimant continued to receive chiropractic treatments and physical therapy. In March 1988, he returned to Dr. Hughes, who diagnosed soft tissue pain syndrome, possibly fibrositis. Hughes referred claimant to Dr. Wasner for a rheumatological evaluation. Finding no rheumatic or muscular disease, Wasner diagnosed mid-thoracic back pain, probably structural in nature.

In May 1988, the Orthopaedic Consultants performed an independent medical examination and found claimant's condition medically stationary. Noting that there were no objective and scant

subjective findings, the Consultants diagnosed thoracolumbar strain by history. A psychiatric evaluation conducted by Dr. Klein, in conjunction with the Consultants' examination, was not completed.

Dr. Spady agreed with the Consultants' report. Dr. Hughes agreed that there were no objective findings to explain the amount of subjective discomfort that claimant was describing. An MRI study of claimant's thoracic spine was normal.

On July 27, 1988, a Determination Order issued. Claimant was awarded approximately one year of temporary total disability and no permanent disability.

In August 1988 Dr. Hughes reported that claimant had full range of motion of the neck, shoulders, upper and lower back. Although the objective findings were mild, considering claimant's subjective limitations in activity, Hughes recommended that claimant not return to his former job. Hughes further suggested that claimant avoid lifting over 25 pounds and refrain from pushing, straining or performing repetitive arm, shoulder, and back activities.

Claimant has completed the 9th grade and has no GED. He declined a vocational assistance program designed to obtain a GED, asserting that he was not physically able to participate and that the lack of a GED had not previously hampered him. The former reason for claimant's lack of participation was supported by then-treating physician Khalsa.

Most of claimant's work experience has been in the grocery business. In particular, he has worked for more than two years as a produce manager and assistant produce manager for several employers. The highest specific vocational preparation value for these experiences is produce manager, which is 6. Claimant has neither returned to, nor looked for, work since the August 1987 lifting incident.

Before his injury, claimant frequently lifted and moved boxes weighing up to 40 pounds. Such activities are considered medium duty. Since his injury, he is restricted to lifting items weighing no more than 25 pounds and must avoid engaging in repetitive activities involving the arms, shoulders and back. Most of these activities are considered light duty.

ULTIMATE FINDINGS OF FACT

Claimant has suffered permanent impairment as a result of his compensable injury. This permanent impairment has resulted in a loss of earning capacity of 15 percent.

CONCLUSIONS OF LAW

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of the July 7, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. id.

The Referee found that claimant was experiencing mild disabling pain. Inasmuch as this disabling pain was not reflected in

the range of motion findings, the Referee concluded that claimant had established by clear and convincing evidence that his degree of permanent disability was greater than that indicated by the Director's standards. Accordingly, the Referee awarded 15 percent unscheduled permanent disability, whereas the Determination Order had awarded no permanent disability. We disagree with the Referee's analysis, but agree with the permanent disability award.

Pursuant to OAR 436-35-280(1), there shall be no unscheduled disability if the injury did not result in impairment. "Impairment" means a decrease in the function of a body part or system. Former OAR 436-35-005(1). [We note parenthetically that this rule has been amended. "Impairment" now means a decrease in the function of a body part or system as measured by a physician according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment, 2nd Edition, copyright 1984].

Range of motion findings concerning claimant's back were normal. Consequently, no impairment value for spinal ranges of motion is given. See OAR 436-35-360.

However, disabling pain can result in a loss of use or function. Former OAR 436-35-320(1)(a). When it does, it is rated based on the loss of use or function which results, and no additional value is allowed for the pain alone. id.

Here, the preponderance of the medical and lay evidence establishes that claimant's pain will permanently limit his ability to engage in the work activities he previously performed. Specifically, he must: (1) limit his lifting activities to items weighing no more than 25 pounds; (2) avoid repetitive activities involving his arms, shoulders and back; and (3) be permitted to periodically change his sitting and standing positions. In reaching this conclusion, we find the opinion of Dr. Hughes to be particularly persuasive.

Dr. Hughes has had the opportunity to treat and examine claimant at various times throughout the processing of this claim. This opportunity has provided Dr. Hughes with a unique perspective from which to evaluate claimant's condition and gauge the genuineness of his pain complaints. Although Hughes concedes that claimant's range of motion findings are normal and that the objective findings are mild, he remains convinced that claimant is experiencing a chronic soft tissue pain syndrome, which permanently restricts his ability to perform his former work activities as a produce manager. These complaints of pain are well documented throughout the medical record, including the evaluations conducted by Dr. Khalsa, a former treating chiropractor, and Dr. Wilson, claimant's current treating chiropractor, as well as those performed by independent examiners, such as the Orthopaedic Consultants and Dr. Spady.

The applicable standards do not set forth a range of impairment values for disabling pain. Considering the medical and lay evidence, we conclude that an impairment value of 5 is a reasonable assessment for claimant's disabling pain.

We have previously held that the disability rating standards do not incorporate all of the disabling effects attributable to pain within the impairment ratings for each specific body part. Daniel M. Alire, 41 Van Natta 752 (April 6, 1989). We have reasoned that if the so-called "incorporation" argument was

correct, there would be no need for the Department's adoption of former OAR 436-35-320(1)(a).

The aforementioned rule expressly acknowledges that disabling pain can result in loss of use or function and, when it does, is rated based on the loss of use or function of a body part due to the injury. Furthermore, in Alire, we concluded that the last portion of the rule, which states that "no additional value will be allowed for the pain alone," would appear to be a codification of the principle enunciated in Harwell v. Argonaut Insurance Co., 296 Or 505 (1984). Specifically, the Harwell principle provides that pain is considered in determining the extent of permanent disability only if it results in impairment of the function of the body. Harwell, supra, 296 Or at pages 510-11. Conversely, if pain does not impair function, it is not to be considered. id.

Here, Dr. Hughes' opinion and claimant's testimony have persuasively established that claimant suffers disabling pain, which has permanently limited his ability to lift, stand, and sit. Thus, as recognized by the disability standards, claimant receives an impairment value based on this loss of use or function. See former OAR 436-35-320(1)(a).

We note parenthetically that former OAR 438-35-320(1) has recently been amended. See WCD Admin. Order 6-1988 [sic], December 21, 1988; WCD Admin. Order 1-1989, January 24, 1989 (among other amendments, corrected title of December 21 1988 WCD Admin. order to 7-1988). The amended rule provides that pain is considered in the rules to the extent it results in measurable impairment and, if there is no measurable impairment, no award of unscheduled permanent disability is allowed. OAR 436-35-320(1). Should the pain result in disability greater than that evidenced by the measurable impairment, including the disability due to expected periodic exacerbations of the worker's condition, the loss of earning capacity is considered and rated under OAR 436-35-310 and is included in the worker's adaptability factor. id.

In addition, under the amended rule, chronic conditions limiting repetitive use of an unscheduled body part shall be rated at 5 percent impairment of that part. OAR 436-35-320(4). As previously noted, the amended standards also define "impairment" as a decrease in the function of a body part or system as measured by a physician according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment, 2nd Edition, 1984. OAR 436-35-005(1).

Considering the aformentioned amendments, an analysis of disabling pain applying those rules would be different from our analysis today. Yet, because the amended rules were not in effect at the time this claim was closed by the Evaluation Section they are not applicable. See OAR 438-10-005; 438-10-010.

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. OAR 436-35-290(1), (2), and (3). Here, claimant was 25 years of age at hearing. Consequently, his age value is zero. OAR 436-35-290(4).

Education. 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, GED certificate or more education. OAR 436-35-300(2). Here, none of the aforementioned conditions apply. Claimant has an 9th grade education and no GED. Therefore, his formal education value is +1.

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). As previously noted, claimant has not been released to his regular work nor has he returned to his 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 last 10 years is as a production manager (6), which is assigned a value of +2.

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). These conditions are not applicable to claimant. If no documentation demonstrating competence in some specific vocational pursuit is present, a value of +1 is assigned. Former OAR 436-35-300(5)(a). [We note parenthetically that this rule has also been recently amended. See WCD Admin. Order 6-1988 [sic]. The competency documentation requirement has been deleted and replaced by a requirement that "competence in some specific vocational pursuit" be established.] Here, no documentation demonstrating competence in a special vocational pursuit was submitted. Consequently, a value of +1 is assigned.

All the education factors are added for a total value of +4. Former OAR 436-35-300(5)[sic].

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). When workers are not working and no employment has been offered, the value for this factor shall be based on physical capacity according to a table provided in former OAR 436-35-310(4)(a). As with all findings concerning the standards, this determination is made as of the date of hearing. Michelle Griffith, 40 Van Natta 2086, 2089 (1988).

Here, pursuant to Dr. Hughes' recommended restrictions, claimant is able to lift up to 25 pounds. Thus, claimant's limitations exceed the full range of requirements for light duty, which is the capacity to lift up to 20 pounds occasionally or up to 10 pounds frequently. See former OAR 436-35-310(4)(c). Yet, his limitations do not meet the full range of the requirements of medium duty, which is the capacity to lift up to 50 pounds occasionally or up to 25 pounds frequently. See OAR 436-35-310(4)(b). Under such circumstances, the adaptability value shall be the average of the values for the two categories. See OAR 436-35-310(4). An average of the values for medium duty (+1) and light duty (+4), results in a value of +2.5.

Assembling the factors. The age value is added to the total value for education. (0 + 4 = 4). OAR 438-35-280(4). The sum

of the values for age and education are multiplied by the value for adaptability. (4 x 2.5 = 10). OAR 438-35-280(6). The product of the values for age/education and adaptability is added to the total impairment value to reach the percentage of permanent unscheduled permanent disability to be awarded. (10 + 5 = 15). OAR 438-35-280(7). Accordingly, we conclude that claimant's unscheduled permanent disability award under the standards is 15 percent.

Clear and Convincing Evidence. Neither party is prevented or limited from establishing by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the Director under ORS 656.726. See ORS 656.283(7); 656.295(5). To be "clear and convincing," evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 402 (1987).

Here, the Referee concluded that claimant's disabling pain demonstrated by clear and convincing evidence that his degree of permanent disability was greater than indicated by the standards. Yet, the Referee's conclusion was premised on the inaccurate assumption that disabling pain could not be considered under the disability standards. As previously discussed, we have considered claimant's disabling pain in evaluating the extent of his permanent disability resulting from the compensable injury. After conducting this evaluation, we are not persuaded that the medical and lay evidence concerning claimant's disabling pain establishes by clear and convincing evidence that his loss of earning capacity is greater than that awarded under the standards. In this regard, we find the findings and evaluations offered by Dr. Hughes, as well as the independent examiners, particularly persuasive.

ORDER

The Referee's order dated November 22, 1988 is affirmed, as supplemented. A client-paid fee, not to exceed $1,463.75, is approved.

Board Member Ferris, dissenting:

I take exception to the majority's ruling that, by a preponderance of the evidence, claimant has established entitlement to an award of permanent partial disability. Although they have expressly disavowed the Referee's determination that claimant established his entitlement by "clear and convincing" evidence, I submit that their implementation of disabling pain accomplishes the same result. Since this result is contrary to the disability standards, as well as the intent of its drafters, I dissent.

To begin with, I firmly disagree that claimant has sustained any permanent impairment as a result of his compensable injury whether the impairment be judged by a preponderance of the evidence or by clear and convincing evidence. Consequently, I would find that he is not entitled to an award of permanent disability.

Claimant has been examined by many doctors, none of whom found any objective evidence of impairment. Because of claimant's behavior, claimant was examined by Dr. Kimball, psychiatrist, and Dr. Klein, psychiatrist, neither of whom found any psychological illness. After examining claimant, the Orthopaedic Consultants issued a report dated May 25, 1988, in which they concluded that

"there are no discernible objective orthopedic or neurologic findings in this patient. Even the subjective findings, i. e. tenderness, sensory loss, etc., are scant. The complaints from which the patient suffers do not have objective correlates." Dr. Spady agreed with this report. Dr. Hughes also agreed with the Consultants that there were no objective findings to explain claimant's subjective discomfort. Finally, Dr. Wilson, claimant's treating chiropractor, agreed with the Consultants, but suggested that claimant did have some impairment as the result of his injury.

An MRI performed on claimant on June 21, 1988, did not show any significant abnormalities. Claimant was referred by Dr. Hughes to Dr. Wasner for a rheumatological evaluation. No rheumatological or muscular disease was found. In July, 1988, Dr. Wilson concluded that claimant had minimal impairment and could return to his former employment without limitation, but would need palliative care once or twice a month. In August Dr. Hughes decided that claimant's objective findings were mild, but because of subjective complaints, he could not return to his former job and based on subjective complaints, placed limitations on claimant's abilities.

After weighing these subjective limitations against the lack of objective medical findings, the majority has held, as an ultimate finding of fact, that by a preponderance of the evidence, claimant has established permanent partial disability. Specifically, they have found that "claimant has suffered permanent impairment as a result of his compensable injury. This permanent impairment has resulted in a loss of earning capacity of 15 percent." I would not so hold.

I also disagree with the majority opinion which interprets former OAR 436-35-320(1)(a) as permitting an increased award for disabling pain alone. This rule provides as follows:

> "Pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone."

Based on the reasoning previously expressed in my dissent in Daniel M. Alire, 41 Van Natta 752 (April 6, 1989), I would interpret that rule to mean that the disabling pain is considered in establishing the loss of use or function and, therefore, is not to be considered in addition thereto. It is axiomatic that when pain is disabling, there is a loss of use or function. In other words, if you have disabling pain in your arm, you do not use it as much and it does not function as well. I would further suggest that the reason the disability standards do not provide a value range for disabling pain (which the majority gratuitously establishes) is because it is included in the loss of use or function. The majority cites the new rule as proving its point that pain was not included in former OAR 438-35-320(1) and that this is the reason for the amendment. I submit the change is simply to clarify any ambiguity that may have existed under the former rule.

I believe that to award an additional value for claimant's disabling pain alone, as the majority has done, is contrary to the aforementioned rule. Furthermore, for the reasons I have already discussed in Alire, this result is in conflict with the stated intent of the rules' drafter. It is apparent to me that disabling pain was

and is to be considered by the standards through measuring and assessing the functional loss by means of a range of activity levels.

While I do not believe in long dissents, I cannot close without commenting on the majority's view of the application of clear and convincing evidence. The majority has held that disabling pain is not included in the loss of use and function and impairment standards, but include it as a separate finding under adaptability with a plus 5 percent value. They then conclude their opinion with a statement as follows: "As previously discussed, we have considered claimant's disabling pain in evaluating the extent of his permanent disability resulting from the compensable injury. After conducting this evaluation, we are not persuaded that the medical and lay evidence concerning claimant's disabling pain establishes by clear and convincing evidence that his loss of earning capacity is greater than that awarded under the standards." If they do not believe that the disabling pain has been established by clear and convincing evidence, and I agree that it has not, why is it being included?

In conclusion, I submit that, pursuant to ORS 656.283(7) and 656.295(5), if a party is unable to establish by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the Director's disability standards, then the Determination Order should not be disturbed. Here, assuming for the sake of argument that claimant had established disabling pain, it should not be accorded a separate value under the disability standards. Furthermore, because this disabling pain and the remainder of the record does not establish by clear and convincing evidence that the Determination Order award was inadequate, I would reverse the Referee's award of permanent disability and reinstate the Determination Order.

DAVID TAYLOR, Claimant
Coons & Cole, Claimant's Attorneys

Own Motion 88-0802M
April 20, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his September 9, 1980 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim for the payment of temporary disability benefits.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motionn" 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.

In October 1988, after claimant had been treating for several months, the Board denied own motion relief on the basis that his treatment did not include hospitalization or surgery. In mid-November 1988 claimant was admitted to the hospital through the emergency room for a four-day stay. When admitted, claimant complained of increasing pain over the past three months, a history which is not really consistent with the physical therapy reports for that time period. The hospitalization was for the purpose of bed rest and diagnostic testing, not treatment. We have previously ruled that diagnostic testing does not satisfy the requirements of ORS 656.278. After careful review of this record,

we are persuaded that his claim does not qualify for reopening under the current own motion statute. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

ANDREW W. BARRESSE, Claimant
Carrol Smith (SAIF), Defense Attorney

WCB 88-17447
April 21, 1989
Order Denying Motion to Dismiss

The SAIF Corporation has moved for an order dismissing claimant's request for Board review of the Referee's January 18, 1989 Order of Dismissal. The motion is denied.

FINDINGS

The Referee's Order of Dismissal issued January 18, 1989. On February 16, 1989, the Board received claimant's request for Board review of the Referee's order. The request did not include an acknowledgment of service or a certificate of personal service by mail upon the employer, SAIF, or their legal counsel. However, that same day, SAIF received a letter from claimant, which indicated that he was requesting Board review of this case.

ULTIMATE FINDINGS

Claimant requested Board review within 30 days of the Referee's order. The remaining parties to the proceeding before the Referee received notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS

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).

Contending that claimant neither requested a postponement of his scheduled hearing nor established good cause for his failure to appear at the hearing, SAIF moves to dismiss claimant's request for Board review of the Referee's dismissal order. SAIF's motion is based on the merits of the Referee's decision, rather than whether we have jurisdiction to consider claimant's request for Board review of that decision. Inasmuch as we conclude that we have jurisdiction to review the Referee's decision, the motion to dismiss is denied.

Claimant's request for review has been submitted to the Board within 30 days from the issuance of the Referee's order. Furthermore, SAIF has acknowledged that it received actual notice of claimant's request for review on February 16, 1989, which is within the 30-day appeal period. No contention has been made that the employer has been prejudiced by not directly receiving notice of the request for review. Absent such a finding, we hold that SAIF's timely notice of a request for review is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976).

Consequently, we conclude that we have jurisdiction to consider the merits of this case. See ORS 656.289(3); 656.295(1), (2). Accordingly, the motion to dismiss claimant's request for Board review is denied. Because the time for submission of appellate briefs has expired, this case will be docketed for review.

IT IS SO ORDERED.

DAVID E. ISRINGHAUSEN, Claimant
Lester Huntsinger (SAIF), Defense Attorney

WCB 86-14039
April 21, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Nichols' order that affirmed an award by Determination Order of 5 percent (16 degrees) unscheduled permanent disability for a low back condition. No briefs were submitted on review.

The issue is entitlement to additional unscheduled permanent disability following aggravation. We affirm.

FINDINGS OF FACT

In September 1980, claimant was involved in a work related car accident and sustained a compensable cervical, dorsal and lumbar sprain/strain, superimposed on a preexisting lumbar spondylolisthesis. He was employed as a "cat-skinner" for a logging company at the time of his injury. He received conservative treatment from a number of doctors, including Dr. Gordon, D.O.

Claimant attempted to perform building construction work in 1980 and 1981, but was unable to continue because of increased discomfort in his neck, left arm and back. He worked for several weeks helping to build a houseboat in May 1981, but quit when his symptoms increased.

An April 1983 Determination Order found claimant medically stationary as of February 1983 and awarded him 5 percent unscheduled permanent disability for his low back. Claimant did not request a hearing. At that time, he experienced a constant degree of neck and back pain which increased significantly with strenuous use of his upper extremities and dorsal spine. He also suffered from frequent headaches and intermittent discomfort in his left arm and leg.

In May 1985, claimant's injury claim was reopened when he experienced a severe symptomatic exacerbation after performing carpentry work for several weeks. He initially sought treatment from Dr. Gordon and then transferred his care to Dr. Boyer, chiropractor. Both doctors diagnosed claimant's condition as a recurrence of his injury related headaches and chronic neck and back strain. At the time of his flare-up, claimant demonstrated a number of objective findings not previously documented in the medical record, including recurrent numbness in his left middle ring and little fingers, decreased cervical and lumbar ranges of motion, and positive straight leg raising and ankle dorsiflexion.

A Determination Order, issued October 16, 1986, reclosed claimant's injury claim with no additional award of permanent disability. Claimant requested a hearing. At the time of hearing,

claimant's subjective symptoms were essentially the same as when his claim was closed in April 1983.

FINDINGS OF ULTIMATE FACT

At the time of claim closure in April 1983, claimant had sustained a mild degree of permanent impairment from the combined effect of his injury and spondylolisthesis. As a result, he was restricted from heavy lifting and heavy manual labor.

Claimant has not demonstrated a permanent, injury-related worsening resulting in any further loss in earning capacity.

CONCLUSIONS OF LAW AND OPINION

We disagree with the Referee's statement of the applicable legal standard in this case. She declined to award additional permanent disability because she found that claimant had not demonstrated a "permanent change in his condition" since his claim was last closed in April 1983. Claimant is, instead, required to demonstrate a permanent, injury-related change in his condition resulting in further loss in earning capacity. See Stepp v. SAIF, 304 Or 375, 381 (1987); Smith v. SAIF, 302 Or 109, withdrawn on reconsideration, 302 Or 396, 399-400 (1986).

Nevertheless, we agree with the Referee's ultimate conclusion that claimant is not entitled to an additional award of permanent disability. Although claimant demonstrated new objective findings at the time of his aggravation, his condition has since resolved to its preaggravation status. We are aware that a permanent increase in the severity of a claimant's flare-ups might be a basis for an additional award of permanent disability. However, the fact that claimant experienced a severe symptomatic exacerbation on one occasion is not sufficient to demonstrate a permanent increase in the anticipated severity of his flare-ups.

Moreover, claimant has not otherwise demonstrated any additional loss in earning capacity. When his claim was closed in April 1986, claimant had sustained a mild degree of permanent impairment and was permanently restricted from heavy work. Although he testified to significant current physical restrictions, he did not indicate that his limitations had increased since April 1983. Furthermore, when the Orthopaedic Consultants reexamined claimant in April 1986, they identified the same degree of injury-related permanent low back impairment they noted previously in December 1982. Their opinion is entitled to substantial weight because they had the opportunity to observe claimant both before and after his aggravation.

The only evidence of greater physical limitations is Dr. Boyer's September 1986 physical capacities evaluation restricting claimant to no lifting or carrying over 10 pounds. However, the record indicates that this limitation was associated with claimant's temporary symptomatic flare-up and was not intended to be permanent. Dr. Boyer had previously indicated that claimant's permanent limitations had not changed. Specifically, he stated in his July 12, 1986 report that claimant was "no longer suited for his former employment which involved heavy manual labor . . ." Dr. Boyer did not withdraw that earlier opinion, and the record does not document any permanent change in claimant's condition that would support a more stringent permanent limitation. In light of these factors, we

are persuaded that the 10 pound limitation identified on Dr. Boyer's September 1986 evaluation was temporary rather than permanent.

Finally, we are aware that the most recent evaluation worksheet assigns claimant a slightly higher physical impairment rating than the worksheet prepared for the August 1983 award. However, we are not bound by the impairment ratings of the Evaluation Section and are equally capable of assessing claimant's physical limitations.

We, therefore, conclude that claimant has not demonstrated any permanent change in his condition resulting in further loss in earning capacity. Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated July 7, 1987 is affirmed as supplemented.

TINA M. LINGAR, Claimant
Michael B. Dye, Claimant's Attorney
Nelson, et al., Defense Attorneys

WCB 86-17402
April 21, 1989
Order of Dismissal

On April 6, 1989, we abated and withdrew our March 8, 1989 Order on Review to consider claimant's contention that she had withdrawn her cross-request for review prior to the issuance of our order. The insurer was given 10 days to respond to claimant's contention.

The insurer has not specifically responded to our abatement order. However, a letter from its counsel, which was enclosed with claimant's motion, concedes that claimant had withdrawn her cross-request for review prior to our order. In addition, we have previously acknowledged the insurer's withdrawal of its request for review.

Following further consideration, we find that both claimant and the insurer have withdrawn their respective requests for Board review. Accordingly, the requests for review of the Referee's order are dismissed.

IT IS SO ORDERED.

LINNIE L. LOCKWOOD, Claimant
Cowling & Heysell, Attorneys

WCB 88-11526 & 88-11525
April 21, 1989
Order Denying Motion to Dismiss

The self-insured employer has moved for an order dismissing claimant's request for Board review on the ground that the request has been abandoned. The motion is denied.

FINDINGS

The Referee's order issued January 5, 1989. On January 12, 1989, the Referee issued an amended order. On January 31, 1989, claimant's counsel mailed a request for Board review on claimant's behalf. The request included a certificate of personal service by mail upon the employer and its counsel. In the request, claimant's counsel noted that claimant would be seeking other counsel to handle her appeal.

ULTIMATE FINDINGS

Claimant requested Board review within 30 days of the Referee's orders. All parties to the proceeding before the Referee received notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS

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 employer notes that claimant has neither submitted an appellant's brief nor is there any indication that she has secured other legal counsel. Contending that claimant has "abandoned" her appeal, the employer asks that the request for Board review be dismissed. We disagree with the employer's contention.

Injured workers are encouraged to be represented by counsel. See OAR 438-06-100. However, this suggestion is not a jurisdictional requirement. Furthermore, although the submission of appellate briefs are viewed as a significant aid for Board review, the failure to file one is likewise not a jurisdictional prerequisite. OAR 438-11-020(1); Elmira K. Satcher, 38 Van Natta 557 (1986).

Inasmuch as claimant's request for review has been submitted within 30 days from the issuance of the Referee's orders, and since copies of the request have been similarly timely provided to the other party, we conclude that we have jurisdiction to consider this case. See ORS 656.289(3); 656.295(1), (2). Accordingly, the motion to dismiss claimant's request for Board review is denied.

Because the time for submission of appellate briefs has expired, this case will be docketed for review.

IT IS SO ORDERED.

KIMBERLY L. MURPHY, Claimant
Cynthia Cumfer, Claimant's Attorney
Davis & Bostwick, Defense Attorneys

WCB 88-18012
April 21, 1989
Order Denying Motion to Dismiss

Claimant has moved for dismissal of the insurer's request for review on the ground that the request does not contain a statement of the reason review is requested. The motion is denied.

FINDINGS

The Referee's Opinion and Order issued January 19, 1989. Shortly thereafter, the insurer moved for reconsideration. On February 17, 1989, after granting the motion and addressing the insurer's contentions, the Referee issued an Order on Reconsideration, adhering to his prior order. On March 14, 1989, the insurer mailed its request for Board review of the Referee's Order on

Reconsideration. The request, which was mailed by certified mail, included a certificate of personal service by mail upon claimant and her counsel. The insurer stated that it was requesting Board review of the Referee's February 17, 1989 Order on Reconsideration.

On March 16, 1989, the Board mailed a computer-generated letter to the parties acknowledging the request for review. That same day, claimant filed her cross-request for review of the Referee's February 17, 1989 order. The Board acknowledged this request on March 22, 1989.

ULTIMATE FINDINGS

The insurer requested Board review within 30 days of the Referee's February 17, 1989 order. All parties to the proceeding before the Referee received notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS

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).

Here, claimant contends that the insurer's request should be dismissed because it does not contain any statement of the reason review is requested. In asserting her argument, claimant relies upon that portion of OAR 438-11-005(3), which provides that the request for Board review "should contain a brief statement of the reasons review is requested." We disagree with claimant's contention.

Pursuant to ORS 656.295(1), a request for Board review of a Referee's order need only state that the party requests a review of the order. ORS 656.295 is incorporated by reference into the Board's procedural rules. OAR 438-11-005(1). Considering the clear directive of ORS 656.295, we are not authorized to limit our jurisdiction to less than that provided by the statute.

Consequently, we conclude that the aforementioned portion of OAR 438-11-005(3) is not jurisdictional. Rather, it is implemented as an informational aid, designed to assist the parties and the Board in identifying the specific case and the matters at issue. In reaching this conclusion, we further note that subsection (3) of the rule speaks in permissive terms ("should"), while subsection (2) uses mandatory language ("shall").

Inasmuch as the insurer's request for review of the Referee's order has been submitted within 30 days from the issuance of the order, and since copies of the request have been similarly timely provided to the other party, we conclude that we have jurisdiction to consider this case. See ORS 656.289(3); 656.295(1), (2). Accordingly, the motion to dismiss the insurer's request for Board review is denied.

Upon receipt of the hearing transcript, copies will be

provided to the parties and a briefing schedule will be implemented. Thereafter, the case will be docketed for review.

IT IS SO ORDERED.

HARRY A. JOERS, Claimant
Roll, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys
Davis, et al., Defense Attorneys

WCB 86-16915 & 86-14634
April 25, 1989
Order on Reconsideration

On December 2, 1988, Referee Foster issued an Opinion & Order on Remand in this matter. Pursuant to the Board's earlier Interim Order on Remand, dated September 10, 1988, as corrected September 16, 1988, Referee Foster reopened the record and admitted into evidence two additional medical reports from Dr. Buttler, a chiropractor. See Exs. 16 & 17. After reviewing those reports, the Referee affirmed his earlier Opinion & Order, dated February 25, 1987, which found Liberty Northwest Insurance Corporation ("Liberty Northwest") responsible for claimant's back condition.

We proceed to reconsider our initial Order on Review, dated March 21, 1988, in the light of Dr. Buttler's additional medical reports.

ISSUE

Whether claimant's work activities after June 1, 1986, independently contributed to cause a worsening of his underlying back condition.

FINDINGS OF FACT

Claimant, a truck driver, compensably injured his back in May 1986, while employed by Farmers Insurance's ("Farmers") insured. Shortly thereafter, he was examined by Dr. Buttler. Buttler began treating with a course of regular chiropractic care.

On June 1, 1986, Farmers' insured was purchased by Liberty Northwest's insured. Thereafter, claimant was examined by Dr. Grossenbacher, a surgeon.

Claimant began to experience increased back pain on July 21, 1986, while driving a truck for Liberty Northwest's insured. As a result, he quit work on August 1, 1986, and sought further treatment from Dr. Buttler.

Farmers and Liberty Northwest concede the issue of compensability, but deny responsibility for claimant's current back condition.

In December 1986, claimant was examined by Dr. Simpson, an orthopedist, on two occasions.

On remand, the Referee admitted into evidence two medical reports from Dr. Buttler, dated September 22, 1988, and October 27, 1988.

ULTIMATE FINDINGS OF FACT

Claimant's work activities after June 1, 1986, independently contributed to cause a worsening of his underlying back condition.

CONCLUSIONS OF LAW

In "aggravation/new injury" cases, the employer at risk at the time of the original injury remains responsible, unless there is a finding that work activities at the later employer independently contributed to a worsening of the worker's underlying condition. Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986).

Here, unlike Mirich, claimant's claim with Farmers remained open at the time of his alleged "new injury" in July 1986. Therefore, as we observed in our Order on Review, "this case does not present a true 'aggravation/new injury' question . . . ." We, nonetheless, conclude that the rule of law announced in Mirich, supra, is the correct rule to follow in analyzing the present issue of responsibility.

On July 14, 1986, claimant was examined by Dr. Grossenbacher. Grossenbacher reported, inter alia:

> "Presently, the patient has discomfort, dull aching in the lower back with left leg sciatica which is intermittent. His sitting tolerance is two hours."

Grossenbacher concluded that claimant's back condition was not medically stationary and that "exacerbations and remissions will be present in the future."

One week later, claimant began to experience increased back pain due to his truck driving activities for Liberty Northwest's insured. Accordingly, he testified, inter alia:

> "Q. Okay. And you [claimant] stated before that the symptoms that you had at that point [August 1, 1986] were like those that had bothered you in April and May, they were the same symptoms?"
>
> "A. Yes, just more severe."
>
> "Q. Only more severe, same pain."
>
> "A. (Nodded in affirmative.)"

In September 1986, Dr. Buttler reported, inter alia, that claimant's truck driving activities between July 21 and August 1, 1988, had caused an exacerbation of his underlying back condition. A few months later, Dr. Simpson seemed to agree with Buttler, stating, inter alia:

> "[I]t is more probable than not that this gentleman's back pain which he experienced in late July 1986 was as a result of his work activities at that time and not due to any of his work activities per se at any time in the past including his 'date of injury' of May 1, 1986. In this sense, his work activities between July 21 and August 1, 1986[,] contributed independently to his clinical complaints of back pain as noted by Dr. Buttler on August 1, 1986."

In September 1988, Dr. Buttler further reported, inter alia:

> "It is my opinion that [claimant's] employment in July of 1986 independently contributed to a material worsening of his low back condition. In my opinion, the activity that [claimant] participated in while on the job in July of 1986, caused a further weakening of the musculoligamentous structures of his low back and increased further intervertebral disc derangement and nerve root irritation."

The next month, Buttler issued a follow-up report. Although noting that he had never declared claimant medically stationary prior to August, 1, 1986, Buttler reiterated his opinion that claimant's work acitivities in July, 1986, had worsened his underlying back condition.

The medical evidence in this case is uncontradicted. Dr. Buttler opined that claimant's work activities in July, 1986, independently contributed to cause a worsening of his underlying back condition. See Jordan v. SAIF, 86, Or App 29, 33 (1987); Weiland v. SAIF, 64 Or App 810, 814 (1983). Dr. Simpson agreed. Dr. Grossenbacher offered no opinion on the relative causal contribution, if any, of claimant's work activities in July, 1986.

Accordingly, in the light of Dr. Buttler's additional medical reports, we agree with the Referee and conclude that claimant's work activities in July, 1986, independently contributed to a worsening of his underlying back condition. Liberty Northwest is, therefore, responsible for claimant's current back condition.

The Referee's order dated February 25, 1987, as reconsidered on remand December 2, 1988, is affirmed. A client-paid fee, payable from Farmers' Insurance to its attorney, not to exceed $1,534, is approved. The Board also approves a client-paid fee, payable from Liberty Northwest Insurance Corporation to its attorney, not to exceed $900.

IT IS SO ORDERED.

CAROL J. KNAPP, Claimant
Hayner, Stebbins, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 86-02762
April 25, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Knapp v. Weyerhaeuser Company, 93 Or App 670 (1988). The court held that the self-insured employer's November 22, 1985, so-called "backup" denial had no basis in law in that it was a collateral attack on a final order of the Board, and hence, was not subject to, or limited by, the time restrictions applicable to hearing requests on denials. Thus, the court remanded, instructing that claimant's request for hearing, "should be treated as a challenge to employer's refusal to pay benefits pursuant to the prior orders." Knapp v. Weyerhaeuser, supra, page 674.

Pursuant to the court's mandate, we proceed to address claimant's contentions.

FINDINGS OF FACT

Claimant experienced a worsening of her preexisting spondylolisthesis while working for the employer as a raimann machine operator from January to September of 1983.

In September of 1983, claimant was laid off for reasons unrelated to work. She continued to seek work, and drew unemployment benefits from September 1983 until July 1984. On June 22, 1984, her treating physician, Dr. Bert, orthopedist, authorized time loss.

On August 23, 1984, Dr. Bert performed a lumbar fusion. On October 4, 1984, the employer issued a denial. On August 1, 1985, a prior Referee found claimant's low back condition compensable as an occupational disease and set aside the employer's denial. This order was affirmed by an Order on Review, dated January 15, 1986.

When the employer did not pay temporary disability pursuant to the August 1985 Referee's order, claimant requested a hearing. On October 11, 1985, a second prior Referee ordered the employer to pay temporary total disability from the date authorized by Dr. Bert, June 22, 1984, until termination of temporary total disability was appropriate. This order also authorized the employer to offset any amounts due by claimant's actual receipt of unemployment benefits during this period. This order was affirmed by an Order on Review, dated June 17, 1986. Carol J. Knapp, 38 Van Natta 597 (1986). The Court of Appeals ultimately affirmed the Board's order. Weyerhaeuser v. Knapp, 85 Or App 220 (1987).

The employer paid claimant time loss benefits from the October 11, 1985, Referee's order until November 22, 1985, when it issued a "backup" denial. This denial denied responsibility and unilaterally terminated temporary total disability. At this time, claimant had not returned to regular work, nor had she been released to regular work. Furthermore, the claim had not been closed, either administratively or by Determination Order.

More than 60 days after the "backup" denial, claimant requested a hearing on the issues of compensability, responsibility, temporary total disability, and penalties and attorney fees for failure to pay temporary total disability, and for failure to comply with prior litigation orders. The present Referee determined that the employer's November 22, 1985, denial was a permissible "backup" denial, and that claimant did not have good cause for failing to request a hearing within 60 days of that denial. Therefore, the Referee dismissed claimant's hearing request. This order was subsequently affirmed by the Board.

The court has reversed the Board and Referee decisions, concluding that the employer's denial has no basis in law because it challenged compensability of a claim found compensable by final order. Knapp v. Weyerhaeuser, supra.

CONCLUSIONS OF LAW

ENFORCEMENT OF PRIOR ORDERS

Pursuant to the Court of Appeals' decision, the November 22, 1985, "backup" denial is set aside as invalid. Consequently, the claim is remanded to the employer for immediate processing. This processing will also be performed in compliance

with the previously issued orders, dated August 1, 1985, and October 11, 1985.

Specifically, the August 1, 1985, Referee's order found claimant's occupational disease and August 23, 1984, surgery to be compensable. Therefore, the October 4, 1984, denial was set aside. Despite this decision, the claim has never been submitted for closure or evaluation. Consequently, it has remained in open status.

Furthermore, the October 11, 1985, Referee's order directed temporary total disability paid as follows:

> "The carrier shall pay temporary total disability due the claimant from the date authorized by Dr Bert, June 22, 1984, until termination of total temporary disability is appropriate. The employer may offset any amounts due by the claimant's actual receipt of unemployment benefits."

The employer is not authorized to unilaterally terminate temporary total disability. Former ORS 656.268(1) provides:

> "Claims shall not become closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary..."

Former ORS 656.268(2), further provides:

> "If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section."

Finally, former OAR 436-30-010(7) indicates:

> "A worker who has not been authorized by the worker's attending physician to return to regular employment shall be paid compensation until the determination order has been issued pursuant to ORS 656.268, unless the worker actually returned to work."

See also A. G. McCullough, 39 Van Natta 65, 67 (1987), aff'd Weyerhaeuser v. McCullough, 92 Or App 204 (1988).

Here, claimant was not declared medically stationary; not released by her physician to return to work; and she did not actually return to regular work. The claim was never submitted for closure or evaluation, and hence, no Determination order has ever issued. Accordingly, claimant is entitled to time loss benefits, less unemployment benefits received, from June 22, 1984, onward until temporary disability benefits can be lawfully terminated.

PENALTIES AND ATTORNEY FEES

Penalties and attorney fees are assessed on the following grounds: (1) unreasonable "backup" denial; (2) unilateral termination of temporary total disability; (3) failure to comply with the Referee's order of October 11, 1985; and (4) failure to comply with the Board's affirmance of that order.

Unreasonable denial

Whether a denial is unreasonable involves both legal and factual questions. The legal standard is whether the employer had a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available to the employer at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977).

At the time of the November 22, 1985, "backup" denial, the employer had before it two prior Referee orders, which required the employer to accept and process the claimant's 1983 occupational disease claim, and to pay claimant temporary total disability from June 22, 1984, onward. The employer did neither. We consider such conduct to constitute an unreasonable denial of payment of compensation. Therefore, penalties and attorney fees will be assessed. ORS 656.262(10); 655.382(1).

Unilateral termination of temporary total disability

Additionally, the employer is liable for penalties and attorney fees due to an impermissible unilateral termination of temporary total disability. Georgia-Pacific v. Piwowar, 305 Or 494, 505-507 (1988); Mischel v. Portland General Electric, 89 Or App 140 (1987). Despite the fact claimant's treating physician has authorized time loss, and a prior Referee ordered temporary total disability to be paid subject to an offset, the employer unilaterally terminated temporary total disability payments. This termination was premised on the erroneous assumption that the employer could subsequently deny a claim that had been found compensable. Claimant has not received time loss payments since the date of the denial. Therefore, the employer's impermissible action will also support penalties and attorney fees. ORS 656.262(10); 656.382(1).

Failure to comply with previous orders

The employer is also liable for penalties and attorney fees for failure to comply with prior orders. An employer must pay temporary disability compensation ordered by a Referee within 14 days of the issuance of the order. OAR 436-60-150(3)(e). 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 the employer to liability for penalties and attorney fees. ORS 656.262(10); 656.382(1); Irene M. Gonzalez, 38 Van Natta 954 (1986).

The employer failed to comply with the Referee's August 1, 1985, order, which was subsequently affirmed by the Board. However, the employer is not assessed a penalty for failure to comply with this order, as this issue was decided by the second prior Referee in his order of October 11, 1985. There, the Referee declined to assess penalties and attorney fees for failure to pay, reasoning that a

recent Supreme Court case, Cutright v. Weyerhaeuser, 299 Or 290 (1985), raised a "legitimate doubt" as to the requirement to pay. Based on res judicata principles, we will not disturb that decision.

However, the employer also failed to comply with the October 11, 1985, order directing payment of temporary total disability from June 22, 1984, until lawful termination. This order was subsequently affirmed by the Board. Carol J. Knapp, 38 Van Natta 597 (1986). Nonetheless, the employer still failed to pay claimant temporary total disability.

The statute requires that a penalty must bear a reasonable relationship to the wrong done. Further, there must be an unpaid amount "then due." Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). The wrong, here, is that claimant has not received temporary total disability payments mandated by three orders. Accordingly, claimant is entitled to penalties and attorney fees for late payment of temporary total disability benefits that are due. Parker v. D. R. Johnson Lumber Co., 93 Or App 675 (1988). The amount due will be determined from the date of time loss authorization, June 22, 1984, less unemployment compensation received, wages earned, and temporary total disability already received, until claim closure pursuant to ORS 656.268. The employer shall be assessed a maximum penalty of 25 percent of this amount.

Claimant's counsel is statutorily entitled to a reasonable carrier-paid attorney fee. ORS 656.262(10); 656.382(1). However, we cannot award an "assessed" fee unless claimant's counsel files a statement of services. See OAR 438-15-005(2); 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The self-insured employer's denial, dated November 22, 1985, is set aside and the claim is remanded to the employer for processing according to law. The employer is specifically directed to comply with the Referee's order, dated August 1, 1985. Further, the employer is directed to comply with the second previous order, dated October 11, 1985, and to pay all temporary total disability effective June 22, 1984, and continuing until such compensation can be lawfully terminated, subject to the previously approved offset in unemployment benefits, wages earned, and temporary disability previously received. For its unreasonable conduct, the employer shall also pay claimant a penalty equal to 25 percent of the temporary disability compensation due under this order.

CAROL J. KNAPP, Claimant
Hayner, Stebbins, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 86-12220
April 25, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Blevin's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition; (2) declined to award temporary total disability; and (3) declined to assess penalties and attorney fees, for failure to pay temporary total disability, and for failure to comply with prior litigation orders. On review, the issues are aggravation, temporary total disability, and penalties and attorney fees.

Claimant's aggravation claim, has been rendered moot by our decision on remand from the Court of Appeals decision in Knapp v. Weyerhaeuser Company, 93 Or App 670 (1988). On remand, Carol J. Knapp, 41 Van Natta 851 (Issued this date), we directed the employer to process the original 1983 occupational disease claim until closure, thus, ensuring medical services and temporary disability will be paid, and eventual rating by the Evaluation Division accomplished.

Inasmuch as the claim has never been closed, there has been no award or arrangement of compensation. Consequently, there can be no claim for aggravation, and the employer's denial is a nullity. In addition, the issues of temporary total disability, and penalties and attorney fees related to failure to pay temporary total disability, and failure to comply with prior orders, have been resolved by our Order on Remand.

Claimant's counsel is statutorily entitled to a reasonable carrier-paid fee for prevailing against the "null" aggravation denial. ORS 656.386(1). However, we cannot award an "assessed" fee unless claimant's counsel files a statement of services. See OAR 438-15-005(2); 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order dated, October 19, 1987, as reconsidered November 30, 1987, is reversed. The self-insured employer's denial is set aside as null and void. The Board approves a client-paid fee, payable from the self-insured employer to its counsel, not to exceed $280.

RAYMOND E. PARDEE, Claimant
Malagon & Moore, Claimant's Attorneys
Beers, et al., Defense Attorneys
Brian Pocock, Defense Attorney

WCB 86-16620 & 86-11295
April 25, 1989
Amended Order on Review (Remanding)

On April 4, 1989, we issued an Order of Abatement stating that we had decided to reconsider our Order on Review (Remanding) dated March 15, 1989. In our initial order, we awarded claimant a $400 assessed fee, payable by EBI, for establishing that the Referee had improperly rated the extent of claimant's permanent disability before he became medically stationary. On reconsideration, EBI argues that this fee should have been assessed against Weyerhaeuser Company.

After considering EBI's request and the responses filed by claimant and Weyerhaeuser, we conclude that claimant is not entitled to an assessed fee on the extent issue from either insurer. In establishing that the Referee's extent ruling was premature, claimant did not finally prevail in a rejected case, within the meaning of ORS 656.386(1). Furthermore, claimant is not entitled to an assessed fee under ORS 656.382(2) because he requested Board review on the extent ruling. Finally, he is not entitled to a fee out of compensation because no additional permanent disability was awarded under the Board's order. See ORS 656.386(2).

However, claimant is entitled to a $400 assessed fee, payable by EBI, on the temporary total disability issue. EBI initiated review on that issue, and the Board did not reduce claimant's current award of temporary total disability. Accordingly,

claimant is entitled to an assessed fee under ORS 656.382(2). Moreover, claimant's attorney is entitled to an additional $100 assessed fee for responding to EBI's request for reconsideration.

Subject to this correction and the additional $100 assessed fee for claimant's counsel's services on reconsideration to be paid by EBI, we adhere to and republish our March 15, 1989 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ROCK BROADWAY, Claimant
Bischoff & Strooband, Claimant's Attorneys
Arthur Stevens (SAIF), Defense Attorney

WCB 87-11104
April 27, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The SAIF Corporation requests review of Referee Melum's order that set aside its "de facto" partial denial insofar as it pertained to claimant's current left wrist/forearm symptoms. On review, the issue is compensability. Inasmuch as we find that the denial should be set aside in its entirety, we modify.

FINDINGS OF FACT

Claimant, 27 at the time of hearing, began working with the employer on August 29, 1985. His duties involved folding boxes. At the end of the first day on the job, he developed painful and swollen bilateral forearms, the right worse than the left.

On August 30, 1985, claimant reported to the hospital emergency room. Dr. Broussard diagnosed extensor tendonitis of both forearms. On October 11, 1985, Dr. Grant, M.D., diagnosed right carpal tunnel syndrome. By that time, most of claimant's left wrist/arm symptoms had dissipated.

On December 4, 1985, SAIF accepted claimant's right carpal tunnel syndrome and right deQuervain's syndrome (tenosynovitis of the long abductor and short extensor tendons of the thumb). On December 11, 1985, Dr. Campagna performed a right carpal tunnel release and release of the right extensor tendon.

By February 21, 1986, claimant was beginning to experience recurrent pain in his left wrist.

In May 1986 Dr. Nathan diagnosed mild left carpal tunnel syndrome; Dr. Campagna concurred with that diagnosis. Dr. Grant, however, found no evidence of left carpal tunnel syndrome or other neuropathy/myopathy; instead, he diagnosed probable mild bilateral deQuervain's syndrome. In May 1987 Dr. Campagna also indicated that claimant's symptoms were the result of bilateral deQuervain's disease. Although he indicated that claimant had once had carpal tunnel syndrome, he found no evidence of active carpal tunnel syndrome at that time.

On June 18, 1986, a Determination Order awarded claimant 5 percent scheduled disability for loss of use of his right hand. On August 29, 1986, that award was increased by Opinion and Order to a total of 20 percent scheduled permanent disability for loss of use of his right hand.

On July 15, 1987, claimant filed a request for hearing, alleging a "de facto" denial of his left wrist condition.

Claimant's August 29, 1985 accidental injury was a material cause of his left wrist and forearm disability and need for medical services. The injury made claimant's preexisting left carpal tunnel and deQuervain's syndromes symptomatic such that they became disabling and required medical services.

CONCLUSIONS OF LAW

The Referee found that claimant's work activities were a material cause of his left wrist and forearm symptoms. He concluded that the work activities did not worsen claimant's carpal tunnel syndrome, but rather, caused his condition to become symptomatic. Therefore, he found the claim for the condition not compensable and the claim for the symptoms compensable. We modify the Referee's decision and find that claimant's current left wrist and forearm condition, as well as his symptoms, is compensable.

We must first determine whether claimant's condition is properly characterized as an occupational disease or an industrial injury. An occupational disease is distinguished from an injury both by the fact that the former cannot honestly be said to be unexpected, and the fact that an occupational disease is gradual rather than "sudden in onset." James v. SAIF, 290 Or 242, 248 (1981); Clark v. Erdman Meat Packing, 88 Or App 1 (1987); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975).

In determining whether claimant's condition was "unexpected", we consider the likelihood that the condition would result from the kind, rate and duration of activity or exposure related to folding boxes. If claimant's left wrist/forearm condition was not an inherent hazard of such activity or exposure, an industrial injury, rather than an occupational disease, is indicated. See O'Neal v. Sisters of Providence, supra at 17.

In determining whether claimant's condition was "sudden in onset", we consider whether the condition occurred as a result of a "discrete period" of work activity or exposure. Valtinson v. SAIF, 56 Or App 184, 188 (1982). If the condition resulted from a sufficiently discrete period of work activity, an industrial injury, rather than an occupational disease, is indicated. Professor Larson states that most jurisdictions recognize a period of several days to be sufficiently discrete to satisfy the requirement. 1B A. Larson, The Law of Workmen's Compensation $39.20 (1987). See Valtinson v. SAIF, supra; See also Donald Drake Co. v. Lundmark, 59 Or App 261 (1983).

Here, claimant's condition cannot be viewed as wholly unexpected in view of the repetitive hand and arm movements required by the constant folding of boxes. However, claimant's symptoms developed after just one day of such activity. Therefore, we conclude that claimant's condition is properly characterized as an industrial injury.

In order to establish a compensable injury, claimant must prove that his work was a material contributing cause of his disability. Summit v. Weyerhaeuser Co., 25 Or App 851 (1976). Although an injury may not have worsened the preexisting condition

but precipitated symptoms causing disability or requiring medical services, that is sufficient to make the symptomatic worsening compensable. Claimant need not prove that the compensable injury caused a worsening of his preexisting left carpal tunnel and deQuervain's syndromes in order to establish a compensable claim. See Jameson v. SAIF, 63 Or App 553, 555 (1983). Rather, he need only show that the compensable injury caused those conditions to become symptomatic, causing disability or requiring medical services. Grace v. SAIF, 76 Or App 511, 517 (1985).

The rule enunciated in Wheeler v. Boise Cascade Corp., 298 Or 452 (1985) and Weller v. Union Carbide, 288 Or 27 (1979), that in order to establish his claim, a claimant must prove that his working conditions were the "major contributing cause" of his disability, does not apply to claims for accidental injuries. Therefore, the Wheeler/Weller analysis does not apply in the present case.

Here, it is undisputed that prior to August 29, 1985, claimant's left wrist/forearm was asymptomatic and that one day of folding boxes for the employer caused both wrists and forearms to swell and become painful.

Although the left symptoms were not as severe as the right and for the most part dissipated when claimant was removed from work, they did not completely resolve. Furthermore, following a carpal tunnel release of the right wrist in December 1985, the pain in the left wrist again increased with increased left-handed activity.

The medical reports from Drs. Grant and Campagna, which directly relate claimant's carpal tunnel syndrome to his work activities, are mainly concerned with claimant's carpal tunnel syndrome on the right. Yet, following our review of the medical and lay evidence, we conclude that claimant's box folding activities on August 29, 1985 were also a material cause of the disability and need for medical services concerning his left carpal tunnel and deQuervain's syndromes, resulting in disability and need for medical services. Accordingly, we find the left wrist/forearm claim compensable.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order dated October 27, 1987, as reinstated November 19, 1987, is modified. The SAIF Corporation's "de facto" denial of claimant's left wrist/forearm condition is set aside in its entirety and the claim is remanded to SAIF for processing according to law.

NORMAN G. DYTON, Claimant
David O. Horne, Defense Attorney

WCB 86-14661
April 27, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Lipton's order that: (1) upheld the insurer's two denials of claimant's aggravation claims for his current low back condition; (2) affirmed the Director's proposed order terminating vocational assistance; and (3) refused to exclude a medical report from the record. We affirm in part and reverse in part.

Some of the materials claimant submitted on review were not otherwise in the hearing record. We treat the presentation of these materials as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). The material submitted by claimant subsequent to hearing is irrelevant to whether claimant's condition aggravated in 1986 or whether the Director's order regarding vocational services may be affirmed. Therefore, after de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. We decline to remand for any further taking of evidence.

FINDINGS OF FACT

On February 14, 1984, claimant sustained a compensable low back strain while working as a janitor. He began treating with Dr. Apple, chiropractor, and was taken off work. He was released for light duty in January 1985. Since that time, however, claimant has not been able to find gainful employment.

On May 31, 1984, claimant was examined by Dr. Novick, chiropractor, at Dr. Apple's request. He diagnosed a sacroiliac strain and advised claimant that he could return to modified work requiring no lifting or carrying in excess of 15 to 20 pounds and no bending or lifting.

On July 2, 1984, claimant was examined by the Orthopaedic Consultants. They considered his condition to be stationary with minimal impairment resulting from his injury and recommended that claimant return to his usual janitorial duties following an initial period of sheltering.

In August 1984, claimant began receiving vocational assistance from Assessment Clinical Counseling Evaluation Services.

An October 3, 1984 Determination Order awarded claimant 20 percent unscheduled permanent disability.

On October 24, 1984, claimant underwent a psychological evaluation by Dr. Daniels and Dr. Franzen. The testing revealed significant cognitive and emotional problems.

On November 16, 1984, claimant's vocational assistance was terminated due to psychological problems interfering with his return to work.

On January 11, 1985, Dr. Apple found claimant's condition medically stationary. Claimant continued to suffer from chronic pain

but was released to a job which did not require repetitive bending and twisting.

On April 8, 1985, claimant's vocational assistance file was reopened. On May 10, 1985, his status was changed from a direct employment to an authorized training program. Claimant was placed in a training program to become a hair designer. The manager of the training site objected to claimant's conduct at the school. The insurer terminated the program.

On April 18, 1985, the insurer denied the compensability of claimant's psychological condition. Thereafter, the parties entered into a stipulation and disputed claim settlement. Claimant's total unscheduled permanent disability was increased from 20 to 30 percent. In addition, claimant's psychological condition remained in denied status. The agreements were approved on August 5, 1985.

On April 14, 1986, claimant experienced an exacerbation of his low back condition. Dr. Apple took him off work from April 14 until May 2, 1986. Some time loss benefits were paid during that 19 day period.

On June 16, 1986, claimant experienced another exacerbation. The time period for this exacerbation is not available in the record. He was subsequently able to engage in light duty work.

On August 16, 1986, the insurer denied claimant's aggravation claim. On April 2, 1987, that denial was clarified as a denial of an aggravation of claimant's lumbar strain.

By October 12, 1986, claimant's physical limitations included no lifting over 20 pounds, and no twisting or stooping.

On April 30, 1987, the Director's Review and Order denied claimant additional vocational services since claimant had demonstrated an inability to benefit from vocational assistance due to psychological problems.

Claimant's irrational behavior created substantial interference with his vocational rehabilitation program, thereby preventing adequate participation.

Although claimant has not worked since the compensable injury, he has been cooperative, to the extent he is able, with vocational efforts, has been eager for rehabilitation and has been willing to accept work. He has not withdrawn from the labor force.

CONCLUSIONS OF LAW

Unpersuaded that claimant's compensable injury had worsened, the Referee affirmed the insurer's two denials of claimant's aggravation claim. The Referee found that claimant had experienced a mere waxing and waning of symptoms consistent with his award of 30 percent unscheduled permanent disability.

The Referee also refused to exclude a medical report from the record, stating that he was unaware of any authority allowing such an action.

Finally, the Referee refused to modify the Director's order which terminated vocational assistance since none of the criteria, as outlined in ORS 656.283(2), had been met.

Aggravation

In order to establish a compensable aggravation claim, claimant has the burden of proving that his lumbar strain worsened since August 5, 1985, the date of the last arrangement of compensation (award of 30 percent permanent unscheduled disability), and that the worsening was materially caused by his February 14, 1984 injury. See ORS 656.273(1). "A worsened condition is a changed condition which makes the claimant more disabled, meaning less able to work, either temporarily or permanently, than at the last arrangement of compensation." DeMarco v. Johnson Acoustical, 88 Or App 439, 441-2 (1987), citing Smith v. SAIF, 302 Or 396, 399 (1986). A waxing of symptoms attributable to the compensable condition which continues to the point of total disability and remains so for more than 14 days is a worsening as a matter of law. Gwynn v. SAIF, 304 Or 345 (1987).

Exacerbations were anticipated by claimant's August 5, 1985 award of permanent disability. In January 1985, Dr. Apple opined that any repeated rotation motion of the lumbar spine would aggravate his chronic pain condition. At the same time, Dr. Novick emphasized that claimant would be limited in his ability to lift and carry, work in bent or twisted positions, drive for long periods of time, or engage in repetitive motions involving the lumbar spine. In spite of this anticipation of future exacerbations, claimant established that his condition worsened, at least temporarily, between April 14, 1986 and May 2, 1986. Due to the exacerbation, Dr. Apple completely removed claimant from work during that 19 day period. Therefore, claimant has proven an aggravation of his compensable injury as a matter of law.

The claim shall be remanded to the insurer for processing according to law. However, claimant would be precluded from entitlement to time loss during the period in question if he had removed himself from the labor force. Sykes v. Weyerhaeuser Co., 90 Or App 41 (1988); Karr v. SAIF, 79 Or App 250, 253 (1986). See Cutright v. Weyerhaeuser Co., 299 Or 290 (1985); Steinnon v. SAIF, 68 Or App 735, rev den 298 Or 238 (1984).

In fact, claimant did not withdraw from the work force. He indicated a reluctance to return to work due to his physical limitations, but expressed a willingness to accept employment within his limitations. He neither voluntarily nor involuntarily withdrew from the work force. Therefore, claimant is entitled to temporary disability benefits.

Removal of Medical Report from the Record

We agree with the Referee that there is no authority to support the removal of a medical report from a claimant's record. There was no presumption that the opinions expressed in the November 8, 1984 report were correct. They could be overcome by appropriate evidence developed by claimant.

Termination of Vocational Assistance

We also agree with the Referee that claimant did not demonstrate that the April 30, 1987 Director's Review and Order, which terminated claimant's vocational assistance, should be modified.

ORS 656.283(2) states that an order on Director's Review can be modified only if it:

"(a) Violates a statute or rule; (b) Exceeds the statutory authority of the agency; (c) Was made upon unlawful procedure; or (d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

The Director concluded that interference from claimant's irrational behavior prevented him from adequately participating in the program of vocational assistance. There was sufficient evidence to support the Director's position that claimant's psychological condition was interfering with his training program to the extent that it was necessary to terminate that program. It was not characterized by an abuse of discretion or clearly unwarranted exercise of discretion. Therefore, the Director's order will not be disturbed.

ORDER

The Referee's order, dated July 28, 1987, is affirmed in part and reversed in part. The two denials of claimant's low back aggravation claims, dated October 16, 1986 and April 2, 1987, are set aside and the claims are remanded to the insurer for processing according to law.

CURTIS J. GOODWIN, Claimant
Ginsburg, et al., Claimant's Attorneys
Meyers & Terrall, Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 86-16761 & 86-14760
April 27, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

Liberty Northwest Insurance Corporation requests review of Referee Lipton's order that: (1) set aside its denial of claimant's aggravation claim relating to his low back; and (2) directed it to pay claimant's attorney a fee of $1,650. Claimant's attorney also seeks a carrier-paid fee for services rendered on Board review. We affirm.

ISSUES

1. Responsibility for claimant's low back condition.

2. Whether claimant's attorney is entitled to a carrier-paid fee for services rendered at the hearing level and, if so, whether the amount of the fee assessed by the Referee was excessive.

3. Whether claimant's attorney is entitled to a carrier-paid fee for services rendered on Board review.

FINDINGS OF FACT

Claimant sustained a sprain or strain of his low back on February 24, 1986 in the course of his employment with Sonwick Enterprises (Sonwick), a company insured by Liberty Northwest Insurance Corporation (Liberty Northwest). The injury occurred when claimant slipped and nearly fell while carrying one end of a heavy object. He experienced low back pain immediately after the accident and developed pain down his left leg during the next couple of weeks. He was off work for one day and then returned to modified

work. He began treating with a chiropractor about a week after the accident and received frequent treatments during the next two and a half months. Liberty Northwest accepted claimant's claim for the injury as nondisabling. The Workers' Compensation Department later reclassified the claim as disabling.

Claimant terminated his employment with Sonwick on March 10, 1986 after Sonwick was unable to make its payroll. He was unemployed after that for about two and a half months. Then, on May 29, 1986, he began working as a truck driver for Flavorland Foods (Flavorland), a company insured by Lumberman's Underwriting Alliance (Lumberman's). This work involved a good deal of medium to heavy lifting associated with the loading of berry crates on pallets.

During the month of June 1986, claimant experienced a gradual increase in low back and left leg pain. The increase in pain was not associated with any specific traumatic event. By the end of the month, the pain had almost returned to the level at which it had been immediately after the February 1986 accident at Sonwick. On July 1, 1986, claimant sought treatment for his back and leg pain from Dr. Thomas, an orthopedic surgeon. Dr. Thomas prescribed physical therapy. Claimant's employment with Flavorland ended with the end of the berry season on July 4, 1986. Claimant was totally incapacitated from gainful and suitable employment because of low back and left leg pain from August 28 through October 30, 1986.

Claimant's work activity with Flavorland caused the tissues of his low back to swell and caused an increase in symptoms. The swelling resulted from increased blood flow to the tissues of claimant's low back and white blood cells breaking down into those tissues. This swelling, however, did not result in any damage to the muscles of claimant's low back or to any other fixed tissues of claimant's body. Dr. Thomas opined that claimant's work at Flavorland had worsened his symptoms, but not of his underlying condition.

Claimant filed an aggravation claim with Liberty Northwest in September 1986. Liberty Northwest denied the claim on September 18, 1986 on both compensability and responsibility grounds. Claimant then filed a new injury claim with Fred S. James & Company (Fred S. James), Lumberman's claims processing agent. Fred S. James denied the claim solely on responsibility grounds on November 24, 1986. Claimant timely requested a hearing on both denials and a hearing was scheduled for March 3, 1987.

On January 13, 1987, counsel for Liberty Northwest informed claimant's attorney that it would withdraw its denial of compensability and accede to the issuance of an order pursuant to ORS 656.307. Claimant's attorney filed a request for a .307 order, but no order was issued prior to the hearing, which was held as scheduled on March 3, 1987. Two weeks before the hearing, claimant's attorney participated in a deposition of Dr. Thomas.

At the beginning of the hearing, the parties stipulated that responsibility was the only issue. Claimant's attorney took the position that Liberty Northwest was responsible and questioned claimant on direct examination. On March 6, 1987, three days after the hearing, the Compliance Division issued a .307 order. The Referee issued his order on March 27, 1987. In that order, he concluded that Liberty Northwest was responsible, set aside its denial and ordered it to pay claimant's attorney a fee of $1,650. Claimant's attorney dedicated a total of 18.6 hours to this case through the time of the hearing.

Lumberman's weekly temporary total disability rate is approximately $69 more than that of Liberty Northwest.

FINDINGS OF ULTIMATE FACT

1. Claimant's work activity for Flavorland resulted in a worsening of symptoms associated with his injury at Sonwick, but did not worsen the underlying condition.

2. Claimant's entitlement to receive compensation was at risk until the .307 order issued on March 6, 1987. The fee awarded by the Referee was not excessive.

3. Neither claimant's entitlement to receive compensation nor the amount of that compensation was at risk on Board review.

CONCLUSIONS OF LAW

Responsibility

Responsibility for a claimant's worsened condition is governed by the last injurious exposure rule. Champion International v. Castilleja, 91 Or App 556, 560 (1988). In the successive injury context, the rule places responsibility on the new injury carrier unless that carrier establishes that work activity or exposure for its insured did not worsen the claimant's underlying condition. Id.; Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986).

In the present case, claimant's original injury and thus his "underlying condition" was a lumbar sprain or strain. By definition, a sprain or strain involves damage to the ligaments or muscles. The only doctor to offer an opinion regarding the effect of claimant's subsequent work activity at Flavorland, Dr. Thomas, stated that the activity caused swelling of the low back due to increased blood flow and the breakdown of white blood cells into the tissues. He also indicated, however, that the activity had caused no additional damage to the muscles or ligaments of claimant's low back. Given these facts, we conclude that Lumberman's has established that claimant's work activity for Flavorland did not worsen his underlying condition and thus that Liberty Northwest is responsible.

Attorney Fee for the Hearing Level

The Referee awarded claimant's attorney a fee of $1,650 "for his efforts in overturning Liberty Northwest's denial." The Referee cited no statutory authority for the fee, but the only potential authority was ORS 656.386(1). Liberty Northwest contends that claimant's attorney was not entitled to a fee under this provision because it had conceded compensability prior to the hearing and hence claimant's entitlement to receive compensation was not at risk after that time.

We reject this argument. A claimant's entitlement to receive compensation is at risk as to all potentially responsible carriers until the issue has been resolved by a .307 order. Ronald L. Warner, 40 Van Natta 1194 (1988). This is true even if carriers stipulate to the compensability of the claimant's condition. A stipulation which is contrary to the evidence may be rejected. SAIF v. Casteel, 301 Or 151, 154 (1986). A stipulation, therefore, is not the equivalent of a .307 order.

In the present case, no .307 order issued prior to the hearing. Claimant's entitlement to receive compensation thus was at risk through the date of the hearing and claimant's attorney is entitled to a fee payable by Liberty Northwest under ORS 656.386(1).

Liberty Northwest argues in the alternative that the fee awarded by the Referee was excessive. We disagree. Considering the detailed affidavit of services submitted by claimant's counsel and the factors enumerated in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we conclude that the fee was reasonable.

Attorney Fee for Board Review

Claimant's attorney also submits a statement of services rendered on Board review and requests a carrier-paid fee for those services. We deny this request.

A claimant's attorney is entitled to a carrier-paid fee for services rendered on Board review when a carrier initiates Board review of an issue which threatens the claimant's entitlement to receive compensation or the amount of that compensation and the Board determines that "the compensation awarded to the claimant should not be disallowed or reduced." ORS 656.382(2); Bahler v. Mail-Well Envelope Co., 60 Or App 90, 93-94 (1982); Donald D. Davis, 40 Van Natta 2000.

The compensability of claimant's condition was officially established a few days after the hearing by a .307 order and was not challenged on Board review. Claimant's entitlement to receive compensation, therefore, was not at risk on Board review. The amount of claimant's compensation was not at risk on Board review because the party that sought Board review, Liberty Northwest, had the lower temporary disability rate. Had it prevailed in establishing that Lumberman's was responsible, claimant's compensation would have been increased, not decreased. Under these circumstances, claimant's attorney is not entitled to a carrier-paid fee for services on Board review. Donald D. Davis, supra.

ORDER

The Referee's order dated March 27, 1987 is affirmed. Client-paid fees are authorized as follows: Counsel for Liberty Northwest, $160; Counsel for Lumberman's, $312.50.

MARY M. HUDSON, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 86-06653
April 27, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Baker's order that upheld the insurer's denials of claimant's medical services and aggravation claims for a low back condition and declined to assess penalties and related attorney fees for alleged unreasonable denials. Claimant also raises as an issue the propriety of a July 18, 1985 Disputed Claim Settlement and Stipulation. We affirm.

ISSUES

The issues on review are aggravation, medical services, penalties and attorney fees, and the propriety of the Disputed Claim Settlement and Stipulation.

FINDINGS OF FACT

Claimant, 58 years old at the time of hearing, sustained a compensable injury to her low back in March 1982, when she attempted to sit down in a chair that was no longer beneath her. The claim was accepted and benefits were paid.

On January 12, 1984, the insurer partially denied compensability of claimant's preexisting personality disorder, but accepted responsibility for her short term reality-oriented counseling program related to her compensable injury rehabilitation and recovery.

Claimant's claim was closed by Determination Order dated January 24, 1985, awarding 35 percent (112 degrees) unscheduled permanent partial disability resulting from the injury to her low back.

On July 19, 1985, claimant and the insurer entered into a Disputed Claim Stipulation and Order. The parties acknowledged that a bona fide dispute existed concerning the compensability of claimant's psychological claim. Therefore, in return for $20,000, claimant agreed that the insurer's denial remained in full force and effect, and that claimant would dismiss her request for hearing concerning the January 1985 Determination Order. Further, the parties stipulated that claimant remained entitled to medical treatment for the residuals of her March 1982 low back injury, but such treatment would not include responsibility for the effects of claimant's rheumatoid disease, degenerative arthritis, lumbar scoliosis, degenerative disc disease, obesity, feet, legs, or ankles, except as to medical problems of the extremities directly related to the compensable injury. Additionally, claimant acknowledged that she had voluntarily retired, had not actively sought employment, and was entitled to no further temporary or permanent disability beyond that awarded by the January 25, 1985, Determination Order. Furthermore, claimant agreed that she would be responsible for medical treatment for all medical conditions not specifically accepted by the terms of the settlement and stipulation. However, the parties agreed that the insurer remained responsible for any conditions related to the 1982 compensable injury.

Within one month of this agreement, Dr. Hanson, chiropractor, reported that claimant sought treatment for low back and vague right leg, knee, and toe pain. Additionally she reported several minor complaints ranging from tension, loss of balance, ringing in the ears, depression, and fatigue. X-rays revealed a mild scoliosis, generalized osteoporosis, and mild to moderate degenerative joint disease. Dr. Hanson diagnosed chronic lumbosacral instability with right sacroiliac instability, severe obesity, degenerative joint disease, osteoporosis, and lumbar scoliosis. Dr. Hanson recommended chiropractic manipulation.

On January 15, 1985, claimant was examined by Dr. Peterson, chiropractor. He diagnosed lumbar myofascitis, as a residual to her previous muscular strain, and a herniated lumbar disc. Dr. Peterson treated claimant conservatively with spinal manipulation and ultrasound therapy.

On August 20, 1985, Dr. Foster, family practitioner, examined claimant. Claimant had sought treatment for chronic pain. He recommended a pain clinic.

Claimant was next examined by Dr. Gilberts, general practitioner, who diagnosed lumbar and thoracic sprain. He treated her with trigger point injections and spinal manipulation.

On April 18, 1986, the insurer partially denied chiropractic and osteopathic treatment relating to claimant's rheumatoid disease, degenerative arthritis, lumbar scoliosis, degenerative disc disease, obesity, and problems involving her feet, ankles, or legs, except as directly related to the 1982 injury.

On June 6, 1986, Dr. Hanson reexamined claimant. He diagnosed chronic lumbosacral instability with right sacroiliac instability.

Dr. Stewart, rheumatologist, examined claimant on August 13, 1986. A CT lumbar scan of L3 to L5-S1 did not reveal any arthritic changes of disc involvement, however, the upper lumbar spine showed evidence of disc bulging at L2-3 with mild indentation on the thecal sac without significant stenosis or nerve root encroachment, a flattened disc, and osteophytic spurs. Dr. Stewart treated claimant's pain symptoms with medication, and recommended stretching and strengthening exercises.

On October 23, 1986, claimant began treating with Dr. Endicott, surgeon. Claimant was treated with medication.

On November 11, 1986, Dr. Tsai, surgeon, performed a complete neurosurgical evaluation on claimant. He diagnosed bilateral L5 radicular irritation from history, with no objective neurological findings at the left lower extremity.

On December 8, 1986, claimant filed a claim for aggravation, alleging that her condition had worsened. The claim was denied on December 19, 1986.

Claimant has not worked since 1982. On July 19, 1985, claimant stipulated that she had retired. Claimant receives social security disability benefits. Claimant's condition has not worsened since her last arrangement of compensation.

CONCLUSIONS OF LAW AND OPINION

DISPUTED CLAIM SETTLEMENT AND STIPULATION

Claimant argues that the Disputed Claim Settlement and Stipulation ("DCS") is invalid as it includes a prohibitive release of aggravation and medical services benefits on an accepted claim and therefore should be set aside.

The Referee found that the DCS precluded claimant from any subsequent aggravation claim for additional temporary or permanent disability compensation because she stipulated that she had voluntarily retired from the workforce, and that she was not entitled to any other benefits, except those for medical services relating to her compensable condition. We disagree.

The DCS was entered into by the parties because there was a bona fide dispute over the compensability of the claim and a disagreement over the extent of disability awarded by the January 24, 1985 Determination Order. Claimant, with the advice of counsel,

agreed that certain specified medical conditions were not compensable and that her unscheduled permanent disability award, resulting from her low back injury was adequate. In return, she received a monetary settlement and a lump sum permanent disability award.

We do not interpret the aforementioned DCS to be an attempt to absolve the insurer of responsibility for a previously accepted injury, nor is it a waiver of all future rights related to the accepted injury. See ORS 656.236; 656.289(4). The stipulated agreement merely limits claimant's original determination of extent of permanent disability. It does not bar her future aggravation rights of the accepted low back claim. Cf. EBI Companies v. Freschett, 71 Or App 526 (1984) (DCS barred claimant's future rights to all worker's compensation benefits). Accordingly, claimant's argument is without merit.

AGGRAVATION

In order to establish a compensable aggravation, claimant has the burden of proving that her compensable low back condition has worsened since the July 18, 1985, DCS, the last award of compensation, so that she is more disabled than on the date the DCS was approved. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986); Timothy Dugan, 39 Van Natta 76 (1987).

The only evidence to support a worsening of claimant's condition is her testimony that she suffers more pain symptoms and has had to limit her activity, thereby resulting in a loss of earning capacity. Her testimony is supported by two acquaintances.

We find the resolution of this complicated issue largely dependent on expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Despite the lay testimony, the medical evidence does not substantiate claimant's contention that her compensable condition has worsened. Dr. Tsai, one of claimant's treating physicians, opined that there were no objective findings that her condition has worsened. Dr. Endicott, who also treats claimant, opined that claimant's back condition had not changed and that she was medically stationary.

Considering the testimony, together with the medical evidence, we are not persuaded that claimant is worse now than on the date the DCS was approved.

Even assuming claimant's symptoms have worsened, we find no persuasive evidence that the worsening is related to her compensable, as opposed to the many noncompensable, conditions. In fact, the medical evidence is to the contrary.

Dr. Anderson opined that claimant's symptoms continued to be related to her noncompensable disease process rather than her injury. Dr. Stewart opined that claimant's symptomatology was due to degenerative disc disease and not to her low back injury. Dr. Foster attributed claimant's current symptoms to any one or more of her five noncompensable conditions.

The medical evidence persuades us that claimant's compensable condition was not worsened since the DCS. Therefore, we find that claimant has not proven an aggravation.

MEDICAL SERVICES

Claimant is entitled to medical services for conditions resulting from her compensable injury so long as the nature of the injury or the process of recovery requires. See ORS 656.245(1). The medical treatment is compensable if claimant's 1982 compensable injury continues to be a material contributing cause of her low back condition. Jordan v. SAIF, 86 Or App 29 (1987). Material contributing cause means a substantial cause, but not necessarily the sole cause or even the most significant cause. Van Blokland v. Oregon Health Sciences University, 87 OR App 694 (1987). Treatment for a noncompensable condition is compensable under ORS 656.245(1) if the treatment would not have been undertaken but for the treatment required for a compensable condition. Williams v. Gates, McDonald & Co., 300 Or 278 (1985).

The medical opinions as to the cause of claimant's current symptoms are divided. Dr. Hanson opined that claimant's complaints were due to lumbosacral instability. Dr. Peterson initially opined that claimant suffered from lumbar myofascitis and a herniated lumbar disc. After reviewing Dr. Hanson's medical report, he opined that claimant's pain complaints were a residual of her previous muscular strain. Both doctors noted that chiropractic treatment improved claimant's condition. We find these opinions unpersuasive. We note that neither doctor had the advantage of examining claimant following her original injury. Additionally, neither doctor reviewed claimant's previous medical record, as clearly evidenced by Dr. Hanson's statement that claimant had never before received chiropractic treatment, when in fact she initially sought and received chiropractic treatment shortly after her injury in 1982. Additionally, Dr. Peterson's report indicated that claimant's noncompensable conditions were difficult to separate from her compensable condition and therefore based claimant's treatment regime solely on claimant's history of response to Dr. Hanson's previous treatment.

We also afford little weight to the opinion of Dr. Gilberts, family practitioner, because it was based on an incomplete history. He opined that claimant's need for treatment was related both to her injury and an automobile accident, but his opinion was not explained.

On the other hand, Dr. Anderson opined that claimant's complaints and need for treatment were not the result of her low back injury, but instead the result of her noncompensable conditions. Dr. Foster opined that claimant's back pain was due to rheumatoid arthritis, degenerative arthritis, lumbar scoliosis, obesity, and possibly degenerative disc disease.

We find the opinions of Dr. Anderson and Dr. Foster to be more persuasive. Dr. Anderson has treated claimant for many years and had the advantage of knowing claimant's entire history firsthand. He and his partners first became acquainted with claimant in 1978, the year the medical records first document her noncompensable conditions. Dr. Foster treated claimant for her compensable condition in August 1984. He also had the advantage of evaluating claimant's condition before she became medically stationary.

We conclude that claimant has not shown that her current medical treatment is compensable under ORS 656.245. Therefore, the

insurer's April 18, 1986 denial of claimant's ongoing chiropractic and osteopathic care is upheld.

ORDER

The Referee's order dated February 26, 1987 is affirmed. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $138.

WAYNE C. WEEKS, Claimant
Vick & Gutzler, Claimant's Attorneys
David Jorling, Defense Attorney

WCB 88-13794
April 27, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee Mulder's order that awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function for each of claimant's forearms, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant was 50 years of age at hearing. In March 1987, he filed a claim, contending that his work activities as a utility worker had caused bilateral carpal tunnel syndrome. His claim was accepted.

In April 1987, claimant underwent bilateral carpal tunnel release surgery. Each surgery was performed by Dr. Tanabe, neurosurgeon. In June 1987, Dr. Tanabe released claimant to return to unlimited duties. Thereafter, claimant returned to work, but avoided using heavy power tools.

In June 1988, Dr. Layman, hand surgeon, performed an independent medical examination. Layman noted some hand weakness. It will resolve without residual problems.

An August 1988 Determination Order awarded one month of temporary total disability and some 13 months of temporary partial disability. No permanent disability was awarded.

With either hand, claimant can grip a screwdriver, hammer, and pliers. In addition, he can grip nails, a steering wheel, pencils, pens, brooms, and shovels. If called upon, he "probably could" handle a jackhammer. Since his surgeries, claimant's hands will "get tired easier."

ULTIMATE FINDINGS OF FACT

The medical and lay evidence does not establish that claimant has suffered a permanent loss of use or function as a result of his compensable condition.

CONCLUSIONS OF LAW

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS

656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of the August 4, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. id.

The record, as well as the parties' positions, do not suggest that claimant's disability should be evaluated using any method other than a strict application of the standards. Consequently, our evaluation is based on a strict application of the Director's disability standards. See Michelle Griffith, 40 Van Natta, 2086, 2089 (1988).

The Referee acknowledged Dr. Layman's conclusion that claimant had suffered no permanent impairment. The Referee further noted that grip strength tests performed by Layman were of limited assistance because no numerical evaluations of reduced strength were provided.

Despite this lack of medical support, the Referee relied upon claimant's credible testimony concerning his loss of grip strength and found that claimant retained 80 percent or less of grip strength in both of his hands. Relying on OAR 436-35-110(3)(d), the Referee awarded 10 percent scheduled permanent disability for each forearm. We disagree.

Scheduled disability is based on the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2); OAR 436-35-005. Decreased grip strength due to atrophy or other anatomical changes (except amputations), where up to 80 percent of the strength is retained, equals 10 percent permanent disability of the forearm. OAR 436-35-110(3)(d). A worker's or other lay testimony may or may not carry the worker's burden of proving the extent of disability. Garbutt v. SAIF, 297 Or 148, 151 (1984).

Here, in support of the Referee's award, claimant relies upon his credible testimony. Specifically, he reiterates that his strength is "not nearly as good" and he experiences decreased stamina since his compensable condition and surgeries.

When compared with the medical evidence, we do not consider claimant's credible testimony sufficient to establish that he has sustained permanent impairment as a result of his compensable condition. In reaching this conclusion, we primarily rely upon the findings and opinion offered by Dr. Layman.

Grip strength measurements suggested that claimant's right hand was stronger than his left. However, Dr. Layman did not suggest that these measurements indicated permanent impairment in either hand. In fact, Layman opined that claimant's complaints of weakness were normal and would gradually resolve. Moreover, characterizing the objective findings as normal, Dr. Layman expressly concluded that claimant's permanent impairment was zero. Finally, although claimant's treating surgeon, Dr. Tanabe, did not render an opinion concerning permanent impairment, we do consider it noteworthy that he released claimant to unlimited work duty.

In conclusion, we find these medical findings and conclusions to be more persuasive than claimant's credible testimony concerning his reduced stamina and loss of grip strength. Consequently, we conclude that claimant's compensable condition has

not resulted in a permanent loss of use or function. Accordingly, we hold that he is not entitled to an award of permanent disability.

ORDER

The Referee's order dated October 25, 1988 is reversed. The August 4, 1988 Determination Order is reinstated and affirmed.

FRANK ELST, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0210M
April 28, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his September 1, 1966 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's February 1989 surgery and recommends claimant's claim be reopened for the payment of temporary disability benefits from the date of surgery. Claimant seeks benefits from November 10, 1988.

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. The evidence fails to show that claimant's need for a Celestone shot in November 1988 satisfies the criteria set forth above. However, he is entitled to claim reopening from February 2, 1989, when he had surgery. Accordingly, claimant's claim is reopened with temporary disability benefits to commence February 2, 1989 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. 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.

EDWARD O. MILLER, Claimant
Francesconi & Associates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-17723
April 28, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee Fink's order that upheld the insurer's denial of claimant's medical services claim for home nursing care. The issue on review is compensability of medical services. We affirm.

FINDINGS OF FACT

Claimant was 38 years of age at hearing. He was compensably injured in 1970 and 1974. He suffered from psychosis prior to these compensable injuries. He now suffers from three conditions: (1) paranoid psychosis, which is not compensable; (2) an arm, neck and shoulder condition, which is not compensable; and (3) complex partial seizure disorder (CPSD), which is the responsibility of this insurer. See Miller v. Coast Packing Co., 84 Or App 83 (1987)

Claimant is treated for his CPSD condition primarily by Dr. Schafer, who prescribes Dilantin to control the seizures.

Claimant is treated for his psychological condition by Dr. Swaback, psychiatrist. He sees claimant for psychotherapy on a regular basis and prescribes phenothiazine drugs, serax, Mellaril, and trihexyphenidyl.

On August 15, 1986, Dr. Swaback opined that claimant needed nursing care in his home, at least four hours per day. He reported that claimant was dependent on his son and needed assistance in taking his medicine and meal planning. He also opined that nursing care in the home would provide emotional support and assistance in planning claimant's daily activities.

Home nursing care was denied on December 15, 1986, by the insurer as not reasonable and necessary for treatment of claimant's CPSD condition.

Dr. Duncan, psychiatrist, opined on December 30, 1986, that claimant needed home nursing care to help regulate medicines and to assist in resocialization. He restated that opinion in March, 1987.

Dr. Swaback reported on February 19, 1987, that claimant was getting along with the help of his son, but at a lower level than with nursing home care.

On April 28, 1987, Dr. Swaback reported that he was concerned about what would happen if claimant's son moved from their home. He reported that he was treating claimant for paranoid psychosis.

As of the hearing, claimant was still living with his son.

ULTIMATE FINDING OF FACT

Claimant has failed to prove that home nursing care is a reasonable and necessary medical service for his compensable condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the issue of home nursing care as a reasonable and necessary medical service for claimant's CPSD condition was previously determined by a Referee, adversely to claimant, and allowed to become the law of the case. He found that claimant was barred by the doctrines of res judicata and collateral estoppel from raising the issue. In the alternative, he found the services not to be reasonable and necessary.

Claimant argues that res judicata and collateral estoppel do not apply and that the services are reasonable and necessary. We agree that neither res judicata nor collateral estoppel apply. However, we agree with the Referee that claimant has failed to prove that home nursing care is reasonable and necessary to treat the compensable condition.

We note that the relevant issue at the prior hearing was the compensability of services provided by claimant's sister prior to that hearing. The issue was not the need for services at the time of hearing. Collateral estoppel applies "only to material

issues or determinative facts which were actually or necessarily adjudicated in the prior action." Million v. SAIF, 45 Or App 1097, 1102 (1980).

Res judicata applies to every claim which could have been alleged under the same "aggregate set of operative facts which compose a single occasion for judicial relief." Million v. SAIF, supra.

The insurer argues that the issue of home nursing care as a reasonable and necessary medical service for claimant's compensable condition was actually decided, contrary to claimant, in the prior Referee's order and claimant is therefore collaterally estopped from raising the issue again. We disagree.

What was decided in the previous Referee's order was that as of September 2, 1986, the date of hearing, the services provided by claimant's sister which were treated or considered by the parties as home nursing care, was not a reasonable and necessary medical service for claimant's compensable CPSD condition. The difficulty with applying either collateral estoppel or res judicata to medical services is that compensable conditions may worsen over time; a claimant's overall condition, including other noncompensable conditions, may change radically over time; and the need for medical services for the various conditions may change.

In workers' compensation law, "claim preclusion" is the name give to the preclusive effect of a prior adjudication on a claim and "issue preclusion" is the preclusive effect of a prior adjudication of an issue. North Clackamas School District v. White, 305 Or 48, modified, 305 Or 468 (1988); Leonard A. Chambers, 40 Van Natta 117,969 (1988).

Thus, the scope of the previous cause of action was necessarily limited to claimant's medical services claim concerning those treatments rendered on or before the previous hearing. Treatments rendered after the prior hearing represent separate causes of action which are not barred by the rule of claim preclusion. See Billy J. Eubanks, 35 Van Natta 131 (1983).

The rule of issue preclusion also does not apply because the previous hearing only determined that home nursing care was not a reasonable and necessary medical service at the time of the prior hearing.

Turning to the merits, the reports of Drs. Olmscheid and Duncan recommend home nursing care for claimant, but do not expressly relate the necessity for such treatment to his compensable condition. However, the medical reports of Dr. Swaback, claimant's treating psychiatrist, clearly indicate that nearly all of claimant's present medical treatment is for his psychological condition. Furthermore, his reports made in 1987 indicate that he is treating claimant for his psychosis and that claimant's need for home nursing care is attributable to that treatment. This insurer is not responsible for that treatment. See Miller v. Coast Packing Co. supra. Accordingly, we agree with the Referee that claimant has not established that his current need for home nursing care is a reasonable and necessary medical service for his compensable condition.

ORDER

The Referee's order dated June 9, 1987, is affirmed. A client-paid fee, not to exceed $591, is approved.

Board Member Crider, dissenting.

I dissent. Claimant is very ill. He suffers from a compensable seizure condition and a number of noncompensable conditions, including a paranoid psychosis. His physicians suggest that he requires home nursing care, in part to ensure compliance with a complex medication regimen. The medications include dilantin to control a life-threatening seizure disorder and medications to control the psychosis. Ex. 17. The majority upholds the insurer's denial of nursing care because "nearly all of claimant's present medical treatment is for his psychological condition." While that is true, a material cause of claimant's need for services is the compensable condition; therefore, the denial should be set aside.

Without daily doses of the dilantin, claimant's compensable seizure disorder will not remain under control. Although claimant's noncompliance with the medication protocol is due to the noncompensable psychiatric condition, minimal services must be rendered for the noncompensable condition in order to ensure that the compensable condition is properly treated. Therefore, nursing care to make certain medication is taken regularly is reasonable and necessary for the seizure condition. Van Blokland v. OHSU, 87 Or App 694 (1987); Sharon L. Cave, 40 Van Natta 39 (1988).

Therefore, I would reverse.

WILLIAM J. SNYDER, Claimant
Brian R. Whitehead, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Meyers & Terrall, Defense Attorneys

WCB 86-03293 & 86-07486
May 2, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of those portions of Referee McCullough's order which: (1) found that claimant was entitled to interim compensation; and (2) assessed penalties and related attorney fees for its failure to pay interim compensation. Claimant cross-requests review of those portions of the order which: (1) declined to require SAIF to pay interim compensation; (2) found that claimant was not entitled to temporary partial disability between January 21 and January 30, 1986; (3) declined to award an assessed fee for securing SAIF's concession of compensability; and (4) declined to assess a penalty and related attorney fee for an alleged unreasonable late payment of temporary total disability. On review the issues are interim compensation, temporary disability, insurer-paid attorney fees, and penalties and related attorney fees. The Referee's order is affirmed in part and reversed in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact as set forth in the "Findings and Opinion" section of his order.

FINDINGS OF ULTIMATE FACT

SAIF received medical verification of claimant's inability to work resulting from a worsening of his compensable condition on January 22, 1986. SAIF did not accept or deny the claim within 14 days of its notice, nor did it begin paying interim compensation.

Claimant was not medically stationary between January 21, and January 30, 1986.

Fireman's Fund's termination of claimant's temporary disability benefits between January 21, and January 30, 1986, and subsequent late payment of temporary disability compensation for the time period between January 20, 1986 and February 10, 1986, was unreasonable.

CONCLUSIONS OF LAW

INTERIM COMPENSATION

The Referee determined that claimant was entitled to interim compensation from SAIF in connection with his aggravation claim. Despite this conclusion, the Referee did not require SAIF to pay interim compensation, reasoning that no purpose would be served by requiring SAIF to pay interim compensation as SAIF would be reimbursed by Fireman's Fund in a separate proceeding. We agree with the Referee's conclusion that claimant was entitled to interim compensation from SAIF, and further conclude that SAIF should be required to pay the interim compensation.

In Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984), the Court of Appeals held that in an aggravation/new injury situation, both insurers have a duty to pay time loss benefits within 14 days of the claim unless they deny the claim. Id. at 618-19. The court reasoned that each employer, against whom a claim is filed, has an independent duty to make timely payment of compensation. Id. The fact that another insurer is paying time loss benefits is immaterial. Id.; See also Steven E. Pace, 38 Van Natta 139 (1986). Accordingly, here, the Referee correctly found that claimant was entitled to interim compensation from SAIF.

We disagree however, with the Referee's conclusion that SAIF is not required to pay interim compensation. Such a conclusion is inconsistent with the holdings in Petshow, supra, and Pace, supra. Further, it would effectively put the Board and the Hearings Division in the position of resolving the reimbursement issue between insurers, the resolution of which is not within our jurisdiction. Petshow, supra; Renolds-Croft v. Bill Morrison Co., 55 Or App 487, 491 (1982).

Here, since SAIF failed to timely process claimant's aggravation claim, we conclude that it is statutorily obligated to pay interim compensation from January 22, 1986, the date SAIF received medical verification of claimant's inability to work allegedly from his prior compensable injury, to October 13, 1986, the date of SAIF's denial. See Roger C. Prusak, 40 Van Natta 2037.

Our finding that SAIF had a duty to pay interim compensation from January 22, 1986 through October 13, 1986 has the effect of double compensating claimant for temporary disability

benefits paid by Fireman Fund's until May 15, 1986 at which time the claim with Fireman's was closed. In light of this fact, we conclude that SAIF is entitled to an offset against future permanent disability awards for the interim compensation paid between January 22, 1986 and May 15, 1986. Petshow, supra. This offset shall be recovered from any future permanent disability awards paid on claimant's claim with SAIF.

Having found that claimant was entitled to interim compensation, and that SAIF is required to pay such compensation, we adopt the Referee's conclusion in regard to penalties and related attorney fees for SAIF's unreasonable failure to pay interim compensation.

TEMPORARY PARTIAL DISABILITY

The Referee found that claimant was not entitled to temporary partial disability benefits between January 21 and January 30, 1986, and accordingly authorized Fireman's Fund to recover an offset for amounts paid during that time period. We disagree based on the following reasoning.

ORS 656.268 requires temporary disability benefits to be paid unless claimant is released to work, and medically stationary. See e.g. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 on recon, 93 Or App 103 (1988). Accordingly, a claimant must be both released for work and medically stationary before temporary disability benefits can be terminated. Further, a worker's release to work on a "trial basis" does not extinguish his right to temporary disability benefits. Instead, the amount of benefits is subject to reduction for wages actually earned. Ronald W. Riding, 40 Van Natta 502, 504 (1988).

Dr. Webb, claimant's treating physician, released claimant for work on a "trial basis." Although he imposed no restrictions on claimant, Dr. Webb had not yet found him to be medically stationary and anticipated further treatment. On January 31, 1986, claimant returned for further treatment and Dr. Webb released him from work entirely.

We find that claimant was not yet medically stationary at the time Dr. Webb released him for work on a "trial basis." Accordingly he was entitled to temporary partial disability between January 21, 1986 and January 30, 1986. Fazzolari, supra; Riding, supra. Therefore, we conclude that no offset should be authorized.

As the Referee found that claimant was not entitled to time loss benefits between January 21 and January 30, 1986, he declined to assess a penalty and related attorney fee for late payment of compensation for the period between January 20 and February 10, 1986. Since we have concluded that claimant was entitled to time loss benefits for those time periods, we now address the penalty issue and find Fireman's Fund's late payment to be unreasonable.

As referenced above, a claimant must be both medically stationary and released to work before temporary disability benefits may be terminated. Fazzolari, supra. Although this constitutes a basis for assessing a penalty, we do not assess one purely on that basis. We have previously held that a "trial release" by a physician does not justify termination of temporary disability benefits. Wayne A. Volk, 36 Van Natta 1083 (1984). Given that claimant was not medically stationary and Dr. Webb's release to work was a "trial

release," we find Fireman's Fund's late payment of compensation unreasonable.

ATTORNEY FEE

The Referee did not award claimant an insurer-paid attorney fee for prevailing over SAIF's denial. Although SAIF conceded compensability at the hearing, it issued an ambiguous denial which attempted to preserve the compensability issue. Further, SAIF did not seek an order pursuant to ORS 656.307 and no .307 order was issued. Accordingly, claimant's attorney is entitled to a fee for services rendered at the hearing level on this matter. Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). Further, since SAIF's denial prevented the issuance of a .307 order and attempted to preserve the compensability issue with its denial, we find that the assessed fee is payable by SAIF, even though it was not found responsible. Karen J. Bates, 39 Van Natta 42, 43 (1987); Ronald J. Broussard, 38 Van Natta 59, 61 (1986), aff'd mem. Western Employers Insurance v. Broussard, 82 Or App 550 (1986).

ORDER

The Referee's order dated January 30, 1987 is affirmed in part and reversed in part. The SAIF Corporation is directed to pay interim compensation for the period beginning January 22, 1986 and ending October 13, 1986. Claimant's attorney is awarded 25 percent of the increased compensation granted by this order. However, the total of fees approved by the Referee and Board from claimant's increased compensation shall not exceed $3800. The SAIF Corporation is authorized to offset the interim compensation ordered payable from January 22, 1986 through May 15, 1986, against any future award of permanent disability paid on its claim. That portion of the order which granted Fireman's Fund Insurance an offset for temporary disability benefits paid between January 21, and January 30, 1986 is reversed and no offset is authorized for the payment of these benefits. For its unreasonable late payment of compensation, Fireman's Fund is assessed a penalty, equal to 25 percent of the compensation due between January 20, 1986 and February 10, 1986. Claimant's attorney is awarded a penalty-related fee of $250, to be paid by Fireman's Fund. Finally, claimant's attorney is awarded a reasonable assessed fee of $750 for services at hearing regarding SAIF's denial, payable by SAIF. The remainder of the order is affirmed. A client-paid fee, payable from Fireman's Fund to its counsel, is approved, not to exceed $176.

DANIEL M. ALIRE, Claimant
Glenn, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 88-13670
May 2, 1989
Order Denying Reconsideration

The SAIF Corporation has requested reconsideration of our April 6, 1989 Order on Review that affirmed the Referee's awards of unscheduled and scheduled permanent disability. Specifically, SAIF "challenges the power and authority of the Board to find and rate impairment for disabling pain."

Inasmuch as the "disabling pain" issue has already been thoroughly considered and our reasoning concerning the issue fully enunciated, we conclude that the appropriate forum to address SAIF's contentions is the Court of Appeals. Accordingly, the request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our April 6, 1989 order.

IT IS SO ORDERED.

PAUL JACKSON, Claimant
Royce, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-09537
May 2, 1989
Second Order on Reconsideration

Claimant has requested reconsideration of our April 14, 1989 Order on Reconsideration, which adhered to and republished our March 16, 1989 Order on Review. Specifically, claimant seeks an insurer-paid attorney fee for his counsel's services rendered in successfully responding to the insurer's motion for reconsideration of that portion of our March 16, 1989 order that affirmed the Referee's assessment of a penalty-related attorney fee for the insurer's disclosure violation.

Because penalties and attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to attorney fees for successfully defending those awards on Board review. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Accordingly, our March 16, 1989 order, as reconsidered April 14, 1989, is abated and withdrawn. As supplemented herein, we adhere to and republish our prior orders in their entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

RODGER I. TAYLOR, Claimant
Black, Chapman & Webber, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 87-07054
May 3, 1989
Order of Dismissal

The insurer requests review of Referee St. Martin's order that awarded $1,350 as a reasonable attorney fee for claimant's counsel's services rendered in the insurer's acceptance of claimant's medical services claim prior to hearing. The only issue is the amount of the attorney fee awarded. Under such circumstances, we have no jurisdiction to review the attorney fee. Arbra Williams, 40 Van Natta 506 (1988). The proper forum for review of this attorney fee is the circuit court pursuant to the provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, 305 Or 530, 534 (1988).

Accordingly, the request for review of the Referee's order dated November 19, 1987 is dismissed.

IT IS SO ORDERED.

EBERET WILLIAMS, Claimant
Tamblyn & Bush, Claimant's Attorneys
Meyers & Associates, Defense Attorneys

WCB 87-10555
May 3, 1989
Order Denying Request

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our March 8, 1989 Order on Review. The request is denied.

FINDINGS

On February 26, 1988, the last brief on Board review was filed in this matter.

On March 3, 1989, the Board issued its Order on Review. The Board's order affirmed the Referee's order that set aside the

employer's aggravation 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 or about April 25, 1989, the employer's counsel filed a statement of services seeking 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 orders did not address the issue of either the counsel's entitlement to, or the amount of, a client-paid fee. Betty J. Eyler, 40 Van Natta 977 (1988); 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's rules. Stanley, supra; Eyler, supra.

Consequently, requests for authorization of a client-paid fee for services on Board review 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); former 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. Former OAR 438-05-010; former 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 employer's counsel has submitted a statement of services more than 15 days after filing of the last brief on review and more than 30 days after the issuance of the Board's March 8, 1989 order. Consequently, it is untimely. See former OAR 438-15-027(1)(d) (now 438-15-028(1)(c)); Stanley, supra.

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. Yet, the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which have been implemented.

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

IT IS SO ORDERED.

GENEVA M. WOLFE, Claimant
Bottini, et al., Claimant's Attorneys
Thomas H. Johnson (SAIF), Defense Attorney

WCB 86-09125
May 3, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

The SAIF Corporation requests review of Referee Fink's order that granted claimant permanent total disability, in lieu of awards by Determination Order totaling 35 percent (112 degrees) unscheduled permanent disability for a low back and neck injury. On review, SAIF contends that claimant is not permanently and totally disabled. The issue is extent of permanent disability.

We reverse the Referee's award of permanent total disability, modify the Determination Order award of unscheduled partial disability, and award additional scheduled partial disability.

FINDINGS OF FACT

Claimant, 63 years old at the time of hearing, sustained a compensable cervical and lumbar strain when she fell in March 1981. Her strain is superimposed on preexisting degenerative changes in her cervical and lumbar spine. Her condition is further aggravated by her obesity. She has also demonstrated a moderate degree of functional overlay, manifested by inconsistencies on examination. All treatment has been conservative.

At the time of hearing, claimant continued to experience a constant degree of low back pain. In addition, she is subject to acute flare-ups of severe low back pain and significant loss in lumbar ranges of motion if she does not alternate between sitting and standing, and recline for some part of the day. During her flare-ups, she also experiences less severe neck pain, loss of cervical range of motion, and numbness and cramping in her legs. Claimant had experienced no significant back, neck or leg problems prior to her injury.

Claimant has a 10th grade formal education, a GED, and some additional bookkeeping training. Her work experience has been primarily as a bookkeeper and clerical worker. She also has experience as a dispatcher and parts sorter.

Claimant has not worked since her injury, except for a brief, unsuccessful attempt to return to her job at injury. She initially cooperated in development of a Direct Employment Plan. However, vocational assistance was terminated in 1982 because the responsible counselor determined that assistance was not feasible due to claimant's physical restrictions. Claimant has made little effort to find suitable work since that time. Further vocational assistance was offered in April 1986, but claimant declined because of personal reservations regarding her ability to successfully reenter the labor force.

Claimant's injury claim was last closed in June 1986 with a total award of 35 percent unscheduled permanent disability. She requested a hearing on that Determination Order.

FINDINGS OF ULTIMATE FACT

As a result of the combined effect of claimant's compensable injury, degenerative disease and obesity, she has sustained moderate low back impairment, mildly moderate neck impairment, and a mild loss of use or function in her legs.

As a result of her physical condition, claimant is limited to light work which allows her to change position frequently and involves no stooping, bending, twisting or overhead work. She has not demonstrated that she is incapable of performing this type of work on a regular basis for at least four hours per day. Nor has she made reasonable efforts to find suitable employment.

CONCLUSIONS OF LAW AND OPINION

SAIF contends that the Referee erred in concluding that claimant was permanently and totally disabled. We agree.

Claimant experiences a constant degree of low back pain. In addition, she is subject to acute flare-ups of severe low back pain and significant loss in lumbar ranges of motion if she does not alternate between sitting and standing, and recline for some part of the day. During her flare-ups, she also experiences less severe neck pain, loss of cervical range of motion, and numbness and cramping in her legs.

The medical experts opined that claimant's neck and low back impairment is in the mildly moderate range. They have restricted her to light work which allows her to change her position frequently and involves no overhead work or repetitive bending, stooping or twisting. None of the experts have rendered an opinion on the number of hours per day claimant is capable of working. Claimant testified that she is unable to work for more than two hours each day. She also testified that she experiences acute flare-ups if she stands continuously for more than an hour, sits continuously for more than a half hour, walks more than six blocks at one time, or lifts more than ten pounds.

In order to demonstrate that she is permanently and totally disabled, claimant must prove that she cannot regularly perform work at a gainful and suitable occupation. It is not necessary that claimant be totally incapacitated by virtue of her medical condition, alone. She can establish that she is totally disabled as a result of a combination of medical and nonmedical factors, including age, education and work experience. In order to establish permanent total disability in this manner, however, claimant is statutorily required to make reasonable efforts to find gainful and suitable employment, unless such efforts would be futile because she is clearly unemployable. Finally, part-time work on a regular basis may be gainful employment. In this case, we conclude that claimant is capable of gainful employment if she can perform at least four hours of work on a regular, daily basis.

In assessing claimant's disability, the Referee gave significant weight to her subjective symptoms. We agree that she credibly testified regarding her own perception of her symptoms and

limitations. However, she has a documented history of functional overlay, and there is no persuasive evidence that her overlay is compensable. In light of this history, we are not persuaded that her testimony is completely reliable, and we discount her subjective limitations accordingly.

After considering the medical evidence and claimant's testimony, appropriately discounted, we conclude that she is physically capable of performing light duty work which allows her to change her position frequently and does not require overhead work, bending, stooping or twisting. Claimant's testimony is the only evidence that she is incapable of performing this type of work on a regular basis, at least four hours a day. In light of her functional overlay, her testimony is not sufficient to carry her burden of proof on this issue. Accordingly, she has not demonstrated that she is totally disabled by virtue of her medical condition, alone.

We next consider claimant's disability in light of additional nonmedical factors. We first assess claimant's efforts to find employment. Although she was originally motivated to find work or be retrained, she has made little effort to find employment since 1982. In particular, she turned down SAIF's offer of vocational assistance in April 1986. Under these circumstances, we conclude that she has not made reasonable efforts to locate suitable and gainful employment.

Accordingly, claimant must demonstrate that work search efforts would have been futile. The Referee concluded that "as a practical matter" it would have been an act of futility for claimant to go through the motions of looking for work. We disagree. Although her advanced age and obesity reduce her chances of finding employment, she has transferable skills for light duty work as a result of her training and work experience. Claimant relies on the fact that her DEP plan was terminated in 1982 because her counselor determined that assistance was not physically feasible at that time. However, she has not demonstrated that she is physically incapable of performing suitable and gainful light duty work at the present time. Moreover, we are not persuaded that assistance was not physically feasible in 1982. We note that her physical condition has, if anything, deteriorated since that time. If work search is physically feasible at the present time, it certainly was feasible in 1982.

Under these circumstances, we conclude that work search efforts would not be futile. Furthermore, absent evidence that she was unable to locate employment after reasonable job search efforts, we conclude that claimant has not demonstrated that she is unemployable by reason of medical and nonmedical factors.

Accordingly, we must determine a suitable award of permanent partial disability. We are aware that some portion of claimant's impairment is attributable to her preexisting degenerative disc disease. However, her lumbar strain caused that condition to become symptomatic and permanently disabling. As a result, increased symptoms related to that condition should be considered in determining permanent disability. See Barrett v. D & H Drywall, 300 Or 325, affirmed on reconsideration, 300 Or 553 (1986).

We are also aware that claimant's obesity has interfered with her recovery from her injury. However, SAIF has not demonstrated that claimant unreasonably failed to follow a weight reduction plan. See Nelson v. EBI Companies, 296 Or 246, 252 (1984). Absent that showing, SAIF is responsible for any additional

permanent partial disability resulting from claimant's obesity. See Nelson, supra at 250; Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987); Taylor v. SAIF, 75 Or App 583, 586 (1985).

After considering the medical evidence and claimant's testimony, appropriately discounted, we find that she has sustained moderate low back impairment, mildly moderate cervical impairment and minimal loss of use or function of her legs. Based on this degree of back and neck impairment, claimant's advanced age and obesity, her education, and her training and work experience as a bookkeeper and clerical worker, we conclude that an award of 70 percent unscheduled permanent disability adequately compensates her for lost earning capacity resulting from her neck and back condition. See ORS 656.214(5); former OAR 436-30-380 et seq. We further conclude that an award of 5 percent scheduled permanent disability in each leg adequately compensates claimant for loss of use or function of her legs. See former ORS 656.214(2).

ORDER

The Referee's order dated March 20, 1987 is reversed and the Determination Order modified. In lieu of the Referee's award of permanent total disability, and in addition to the 35 percent (112 degrees) unscheduled permanent disability received under the Determination Order, claimant is awarded 5 percent (16 degrees) scheduled disability in each leg, and 35 percent (112 degrees) unscheduled disability for her neck and back condition for a total unscheduled award to date of 70 percent (224 degrees) unscheduled disability. Claimant's attorney's fee shall be adjusted accordingly.

MARILYN K. BENNETT, Claimant
Rex Q. Smith, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 87-14315
May 4, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation request review of Referee Heitkemper's order that assessed an attorney fee for allegedly unreasonable claims processing. Although claimant motioned the Board for dismissal of SAIF's request for Board review, she later withdrew this motion.

The Board reverses the order of the Referee.

ISSUE

Whether SAIF unreasonably delayed or resisted the payment of compensation.

FINDINGS OF FACT

Claimant sustained a compensable injury to her upper back and left shoulder in July, 1986. Shortly thereafter, she was examined by Dr. McComb, her treating physician. McComb treated conservatively. By April, 1987, McComb had declared that claimant was medically stationary and released her to return to regular work.

Shortly after receiving Dr. McComb's report, dated April 14, 1987, SAIF claims examiner, Ms. Hoyt, submitted claimant's file to the Evaluation Division for claim closure.

On May 28, 1987, claimant was examined by Dr. Snodgrass, a neurologist. Snodgrass had no further recommendations for treatment and suggested to Dr. McComb that he consider declaring claimant medically stationary.

Claimant was examined by the Orthopaedic Consultants on June 26, 1987. The Consultants opined, inter alia, that she would be medically stationary in one-to-two weeks.

In a report, dated July 31, 1987, Dr. McComb reported, inter alia, that claimant was still experiencing left arm pain and that she would hopefully benefit from a few more physical therapy treatments.

Ms. Hoyt promptly forwarded both the Consultants' report of June, 1987, as well as Dr. McComb's report of July, 1987, to the Evaluation Division.

In August, 1988, the Evaluation Division closed claimant's claim by way of a Determination Order.

At the hearing, the parties stipulated that claimant's claim was prematurely closed.

CONCLUSIONS OF LAW

Finding that SAIF had "acted unreasonably in failing to follow up on the ambiguities in Dr. McComb's [July 31, 1987,] report[,]" the Referee assessed SAIF a $1,000 attorney fee. We disagree.

Pursuant to ORS 656.262(10), an insurer may be assessed penalties and attorney fees if it, inter alia, unreasonably delays or resists the payment of compensation. See also ORS 656.382(1). Here, on April 14, 1987, Dr. McComb expressly declared claimant "medically stationary" and released her to return to regular work. Upon receipt of that report, SAIF followed its mandatory burden under former ORS 656.262(2), and requested the Evaluation Division to examine claimant's claim for closure. Thereafter, SAIF forwarded all subsequent medical evidence, including McComb's report of July 31, 1987, to the Evaluation Division. (Tr. 10). On August 25, 1987, the Evaluation Division closed claimant's claim.

We find nothing unreasonable or improper in SAIF's handling of claimant's claim. It complied with its obligation under former ORS 656.262(2), and then faithfully submitted all subsequent medical reports to the Evaluation Division. SAIF had no duty to voluntarily withdraw its request for claim closure after receipt of McComb's report of July 31, 1987.

In sum, we find nothing in McComb's July, 1987, report to warrant a finding that SAIF unreasonably delayed or resisted the payment of compensation by not, thereafter, withdrawing its request for claim closure.

ORDER

The Referee's order, dated February 19, 1988, is reversed.

MICHELLE FLEMING, Claimant
Cash Perrine, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 87-03152
May 4, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of Referee Myers' order which assessed a penalty and related attorney fee for an alleged failure to submit claimant's low back injury claim to Evaluation Division for reclassification from a nondisabling injury to a disabling injury. On review, the sole issue is penalties and related attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

FINDINGS OF ULTIMATE FACT

The employer's failure to submit claimant's injury claim to the Evaluations Division for reclassification as a disabling injury, after being requested to do so by claimant, was unreasonable.

CONCLUSIONS OF LAW

We adopt the conclusions of law and reasoning as set forth in the "Opinion" section of the Referee's order with the following comment.

The employer argues that claimant would not be harmed by its failure to submit her claim for reclassification. We disagree. ORS 656.262(12) provides inter alia, "that a claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation." In light of this, the employer's failure to submit for reclassification would have the effect of precluding a permanent disability award, absent a showing that the accepted condition has worsened. ORS 656.273.

ORDER

The Referee's order dated October 19, 1987 is affirmed. A client-paid fee, not to exceed $310, is approved, payable by the self-insured employer to its counsel.

JUNE M. HEJDUK, Claimant
Vick & Gutzler, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 88-14405
May 4, 1989
Order of Dismissal

The insurer has moved for dismissal of claimant's request for review on the ground that it did not receive timely notice of the request. The motion is granted.

FINDINGS

The Referee's Order of Dismissal issued November 18, 1988. Concluding that claimant had failed to appear at her previously scheduled November 14, 1988 hearing and had offered no excuse or justification for her nonappearance, the Referee dismissed claimant's pending hearing request.

On November 21, 1988, the Referee issued an Amended

Order of Dismissal, which repeated the findings and conclusions contained in the November 18, 1988 order. The amended order contained a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On December 15, 1988, the Hearings Division received claimant's "Motion to Set Aside Dismissal." The motion, which included claimant's affidavit explaining why she had failed to appear at the scheduled hearing, was directed to the Referee. Claimant's submission did not include an acknowledgment of service or a certificate of personal service by mail upon the employer, its insurer, or their legal counsel. However, the cover letter from claimant's counsel indicated that a copy of the materials had been forwarded to the insurer and its counsel.

The insurer received a copy of claimant's motion on December 16, 1988. On December 27, 1988, the insurer's attorney received a copy of claimant's motion. On December 30, 1988, the Board mailed a computer-generated letter to the parties acknowledging a request for review.

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). 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 (1986). 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).

The request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to properly identify a document as a party's request for Board review of a Referee's order. Gerardo v. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but the intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

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).

Here, claimant, through counsel, expressly moved to set aside the Referee's dismissal order. In addition, her motion was specifically directed to the Referee's attention, not to the Board's attention. Under these circumstances, we conclude that claimant's intention was both clear and unmistakable. i.e., she was requesting the Referee to set aside the dismissal order. Consequently, we hold that claimant did not request Board review of the Referee's dismissal order. ORS 656.295(1); Rochelle M. Gordon, supra; Gerardo V. Soto, supra.

Since claimant neither requested Board review of the Referee's November 18, 1988 order, as amended November 21, 1988, within 30 days of its issuance nor were the remaining parties to the proceeding provided with timely notice of a request for Board review of the order, we lack jurisdiction to consider this matter. ORS 656.289(3); ORS 656.295(1), (2). Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

CLARK L. MADDOX, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-06838
May 4, 1989
Order of Dismissal

The insurer requested Board review of Referee Nichols' order that: (1) granted claimant permanent total disability; and (2) assessed penalties and attorney fees for unreasonable claims processing. The parties have submitted a proposed "Stipulation," which is designed to resolve all issues raised or raisable in this matter, in lieu of the Referee's order.

Pursuant to the settlement, the insurer implicitly agrees to withdraw its request for Board review. We have approved the parties' agreement, thereby fully and finally resolving this matter, in lieu of the Referee's order. Accordingly, the request for review is dismissed. A client-paid fee, not to exceed $240, is approved.

IT IS SO ORDERED.

Board Member Crider, dissenting:

The majority has approved a disputed claims settlement and permitted the parties to agree that claimant will get no permanent disability pursuant to a Referee's order finding claimant permanently and totally disabled. I dissent.

Claimant suffered a low back injury; it was accepted; and he has had repeated surgeries. On February 27, 1987, Referee Nichols found claimant PTD. The insurer appealed, submitting a brief contending that claimant was not entitled to permanent total disability benefits because claimant did not make reasonable efforts to seek work and exaggerated his disability. The insurer made no contention that claimant's disability was caused in whole or part by a noncompensable condition.

The parties then submitted a proposed stipulation in which they agreed that the insurer would pay claimant $100,000 as a "prepayment" of all future temporary or permanent disability and all future medical services related to the injury. In other words, it had the effect of wiping out claimant's rights in the claim in exchange for a lump sum payment. The Board properly rejected the proposed stipulation as inconsistent with ORS 656.236(1).

The parties then submitted a new proposed stipulation. This stipulation states that claimant has a degenerative hip condition (of which there is concededly no evidence in the record) and that the parties wish to "dispute out" this phantom degenerative hip condition for the same sum of $100,000 that appeared in the earlier stipulation and, apparently, to agree to eliminate the Referee's permanent disability award for the low back injury. They stipulate that claimant is permanently and totally disabled as a

consequence of conditions appearing post-injury. They thereby apparently intend to foreclose him from ever receiving a permanent total disability award in the accepted claim. Fowler v. SAIF, 82 Or App 604 (1986), rev. den., 303 Or 74 (1987). Finally, they agree that claimant has retired and thus will be entitled to no further temporary disability benefits in the accepted claim. Cutright v. Weyerhaeuser, 299 Or 290 (1985). The stipulation does not specifically provide that claimant is entitled to further medical benefits and other benefits for the accepted injury as required by OAR 438-09-010(3)(b).

The settlement should not have been approved as it is a transparent attempt to do what the law does not permit the parties to do - compromise and release an accepted claim. The statute permits an insurer to enter into an agreement whereby it pays an injured worker to relinquish a claim when there is a "bona fide dispute" regarding compensability. ORS 656.289(4). It is the Board's duty to determine whether or not the dispute is bona fide. I submit that the record in this case is insufficient to allow the Board to conclude that it is and, that by approving this settlement without further inquiry, the majority abdicates its obligation under the law.

PAUL D. WYRICK, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-13720 & 87-12573
May 4, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Stone Container Corporation, a self-insured employer, requests review of Referee Young's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition. The issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

The Board adopts the findings of fact set forth in pages one through three of the Referee's Opinion and Order with the following amendments. The parties advised the Referee that the issues in this case concerned the carriers' aggravation denials. Both denials were issued on compensability grounds. No other issues were raised at hearing.

ULTIMATE FACTS

(1) Claimant's back condition has worsened since the last arrangement of compensation.

(2) Claimant's 1979 compensable injury with Stone Container materially contributed to his back condition in 1987.

(3) Claimant's 1986 compensable injury with Cascade Wood Products, Liberty Northwest's insured, did not independently contribute to his back condition in 1987.

CONCLUSIONS AND OPINION

Based on his understanding of an agreement among the parties concerning the issues at the time of the hearing, the Referee

concluded that this case was to be tried solely on responsibility grounds. We do not agree. The issues before the Referee concerned the carriers' aggravation denials. Both denials were made on compensability grounds. The parties did not stipulate to try the case on responsibility grounds alone. Claimant was not, therefore, relieved of his burden to show compensability of his low back condition. For this reason, our analysis differs from that taken by the Referee, although we agree that Stone Container is responsible for claimant's aggravation claim.

Claimant's current condition was brought on by a non-employment related incident. To establish that the claim is compensable, therefore, he must prove that one or more prior compensable injuries materially contributed to his present condition. Bracke v. Baza'r, 293 Or 239 (1982); Grable v. Weyerhaeuser, 291 Or 387 (1981); Anderson v. EBI Companies, 79 Or App 345, rev den. 301 Or 445 (1986). Claimant's treating physician, Dr. Campagna, opined that claimant's nerve root compression at L5-S1 was secondary to claimant's industrial injury in 1979 with Stone Container. Although Dr. Fechtel concluded there was no relationship between claimant's current back condition and the 1979 injury with Stone Container, we give greater weight to Dr. Campagna's well reasoned opinion on this issue. Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810, 814 (1983). The claim is compensable.

With regard to responsibility, the Referee applied the "last employment" presumption adopted by the court in Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). Pursuant to the court's decision in Kearns, in a multiple accepted injury situation, a rebuttable presumption exists that a claimant's last industrial injury contributed independently to the worsened condition and that the insurer on the risk at that time is responsible. Id. at 587. Therefore, the subsequent employer has the burden of showing that the second injury did not independently contribute to the worsening of claimant's condition. The Referee determined that the weight of medical evidence established that the 1986 injury while claimant was employed by Liberty Northwest's insured did not independently contribute to claimant's condition. We agree.

Claimant testified he has never been pain free since the 1979 injury. In addition, the incident at Liberty's insured in 1986 resulted in symptoms similar to those claimant had experienced periodically since 1979. Further, reports from claimant's chiropractor, Dr. Hearns, discuss a disk derangement as early as November 1985, more than a year before claimant's injury at Liberty's insured.

Dr. Campagna's reports also support our conclusion. Not only did Dr. Campagna specifically state that claimant's compensable 1979 injury contributed to his current back problem, he also specifically ruled out any contribution from the 1986 injury. Moreover, while ruling out any contribution from the 1979 injury, Dr. Fechtel did not find that Liberty's 1986 injury contributed to claimant's condition.

Accordingly, we find claimant has shown that his claim is compensable and we assign responsibility to Stone Container Corporation.

ORDER

The Referee's order dated November 13, 1987 is affirmed. A client-paid fee to be paid by Liberty Northwest Insurance Corporation to its counsel, not to exceed $1,521.14, is approved.

RICHARD C. CENTENO, (Deceased), Claimant
MARY FRANCIS WEST, Employer
William B. Wyllie, Claimant's Attorney
Cash Perrine, Attorney
Joseph McNaught (SAIF), Defense Attorney
Mark Braverman, Assistant Attorney General

WCB 87-19246
May 5, 1989
Order on Reconsideration

Claimant's attorney requests Board authorization of an assessed fee for services on review which culminated in our March 28, 1989 Order on Review. In that order, we affirmed the Referee's ruling, in claimant's favor, on a paternity issue. In a prior Order on Reconsideration, issued April 19, 1989, we declined to award an assessed fee because claimant's attorney had not submitted the Statement of Services required under OAR 438-15-010(5).

Claimant's attorney has now submitted the required Statement of Services, requesting an assessed fee of $4,125 for 41.25 hours of work. We understand this statement to correspond to total services rendered on Board review, including services on issues not decided in claimant's favor. Furthermore, the statement also refers to two WCB case numbers which are not presently before us.

We consider this statement, along with the previously submitted attorney retainer agreement and the factors set forth in OAR 438-15-010(6). In particular, we note that the paternity issue was of above average difficulty, and the interest involved was of significant value to claimant. However, the six page brief submitted by claimant's attorney devoted only two pages to the paternity issue. After considering these factors, we conclude that an assessed fee of $1,000 adequately compensates claimant's attorney for his services on review regarding the paternity issue.

Accordingly, our March 28, 1989 order, as republished April 19, 1989, is abated and withdrawn. As amended herein, we adhere to and republish our March 28, 1989 order, as republished April 19, 1989, in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

PATRICIA M. EMERY, Claimant
Victor Calzaretta, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-10862
May 9, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant, pro se, requests review of Referee St. Martin's order that: (1) upheld the self-insured employer's denial of her occupational disease claim for a mental disorder; and (2) rejected her request for a penalty and attorney fee for unreasonable denial of her claim. Claimant also contends that the procedure by which Referee St. Martin issued his order violated her right to due process of law. We treat this contention as a request for remand. The issues are remand, compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

After the conclusion of the hearing in this case, the Referee wrote the parties informing them that he had decided all issues against claimant and requesting that defense counsel draft a proposed Opinion and Order for his signature. He also requested that defense counsel serve a copy of the proposed order on claimant and stated that claimant would have ten days to file any objections to the proposed order. On December 24, 1987, defense counsel completed a proposed Opinion and Order and mailed copies to the Referee and claimant. On December 31, 1987, claimant's attorney mailed a letter to the Referee which contained a number of objections to the proposed order. The Referee adopted and issued the proposed order on December 31, 1987 before receiving claimant's attorney's letter and less than 10 days after defense counsel served the proposed order on claimant. On January 5, 1988, claimant's attorney sent the Referee a letter objecting to the Referee's failure to consider his objections before adopting and issuing the proposed order. At the same time, claimant's attorney filed a request for Board review. In a reply letter, the Referee stated that his failure to allow claimant ten days before issuing the order was an oversight, but that he was unable to take further action because claimant's request for Board review had removed the case from his jurisdiction.

CONCLUSIONS OF LAW

The Board adopts the Referee's conclusions of law with the following additions and alterations.

Claimant's request for remand is denied. The Referee allowed full development of the evidentiary record. He also allowed both parties to argue the case orally at the close of the hearing. In view of this and the fact that we have de novo review of the Referee's findings and conclusions, we conclude that claimant was not denied due process of law and that remand is not warranted.

The Referee concluded that claimant's claim was barred by res judicata because a denial of an earlier mental stress claim had been upheld. We reject this conclusion. Claimant's development of a mental disorder in 1984 did not preclude a later claim for either a new disorder or a worsening of the same mental disorder by subsequent work events. The worsening of a noncompensable condition is compensable if the claimant establishes that work events or conditions were the major contributing cause of the worsening. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979). However, we accept the Referee's alternative conclusion that claimant failed to prove a compensable claim on the merits.

ORDER

The Referee's order dated December 31, 1987 is affirmed. A client-paid fee of up to $1,972.50 is approved.

RICK J. FAWVER, Claimant
Vick & Gutzler, Claimant's Attorneys
Stafford Hazelett, Defense Attorney

WCB 88-04829 & 88-03894
May 9, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Peterson's order that set aside North Pacific Insurance Company's "de facto" denial of claimant's medical services claim for a low back condition. On review, claimant contends that the Referee erred in concluding that claimant's 5-year aggravation rights under a 1980 low back injury claim with North Pacific had expired. We affirm.

We adopt the Referee's "Findings of Fact."

Pursuant to a 1983 Board order, claimant's 1980 "new injury" claim was found to be the responsibility of North Pacific. As a result, North Pacific reimbursed Wausau for claim costs incurred while Wausau processed the claim through the date of the Board's order. Wausau had been processing the claim in accordance with an order designating a paying agent pursuant to ORS 656.307 and a prior Referee's order finding it responsible for claimant's low back condition as an aggravation of a 1976 injury. While performing this function, Wausau had processed the claim to a 1981 Determination Order, as well as to a 1983 Determination Order.

Claimant asserts that North Pacific should have also processed the claim to closure after the Board's responsibility finding. Since North Pacific failed to do so, claimant contends that his aggravation rights under his 1980 "new injury" claim with North Pacific have never started running. In addition, because the claim was processed on Wausau's claim number and since the Determination Orders recited a 1977 aggravation date, claimant argues that his 1980 "new injury" claim has never been closed. We disagree with claimant's contentions.

In accordance with the ".307" order, Wausau processed the claim as one for aggravation under its claim from a 1976 compensable injury. In so doing, Wausau submitted the claim for closure, which resulted in an August 12, 1981 Determination Order. Since Wausau was processing the claim, the Determination Order also carried a notice concerning claimant's aggravation rights under Wausau's claim.

Wausau continued to perform its processing function after the Referee's 1982 order, which found it responsible for the claim. While performing this function, Wausau again submitted the claim for closure, resulting in an April 4, 1983 Determination Order. This Determination Order also contained a notice regarding claimant's aggravation rights under the Wausau claim.

Upon issuance of the Board's August 1983 order, North Pacific became responsible for the claim. In accordance with this responsibility finding, North Pacific reimbursed Wausau for its claim costs. Since the claim was in closed status, North Pacific did not seek a further closure order.

Pursuant to former ORS 656.273(4), claimant's five-year aggravation rights start running from the date of the first determination made under former ORS 656.268(4). Thus, contrary to the Referee's conclusion that claimant's aggravation rights under his North Pacific "new injury" claim began April 2, 1980, claimant's aggravation rights actually began August 12, 1981, the date of the first

Determination Order in this claim. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Yet, regardless of whether the first determination occurred in 1980 or 1981, claimant's 1987 claim for benefits was submitted long after the expiration of his aggravation rights.

Furthermore, we find that the purpose of the ".307" order has been served and that the claim was processed properly. See former ORS 656.307; former OAR 436-60-180; former 436-60-190. As it turns out, the initial processing functions were performed by Wausau, on behalf of the carrier ultimately found responsible, North Pacific. Finally, if administrative error was present because another claim number should have been used or the Determination Orders recited an inaccurate date for the expiration of claimant's aggravation rights, those errors would not alter the operation of former ORS 656.273(4). See Bert E. Miltenberger, 39 Van Natta 68 (1987), aff'd on other grounds, Miltenberger v. Howard's Plumbing, supra.

ORDER

The Referee's order dated March 2, 1989 is affirmed.

JAMES F. HIGGINS, Claimant
Roll & Westmoreland, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-04116
May 9, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Lipton's order that upheld the insurer's denial of claimant's inner ear concussion syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back, legs, cervical spine, and shoulders in 1981 while driving a forklift. He underwent an L5 laminectomy and L4-5 diskectomy. He continued to suffer leg and low back symptoms and was treated by a number of neurologists and orthopedists. No symptoms of dizziness or equilibrium problems were mentioned during this period.

A Determination Order dated October 20, 1982 awarded claimant 15 percent unscheduled permanent disability for his low back. This award was later raised by stipulation to 25 percent.

In 1984 and 1985, claimant continued to report cervical and lumbar symptoms to Drs. Pasquesi, Rosenbaum, Larson, and Raaf. He did not report dizziness or balance problems.

In September, 1985, Dr. Grimm, neurologist, examined claimant and "suspected" paroxysmal positional nystagmus. He referred claimant to Dr. Black, who diagnosed inner ear concussion syndrome with benign paroxysmal positional nystagmus and vertigo, and post-traumatic tinnitus bilaterally. This condition was denied by the insurer.

ULTIMATE FINDING OF FACT

Claimant has not proven that his industrial accident is causally related to his current ear condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not proven the compensability of his inner ear condition, reasoning that claimant's symptoms were not consistent with an inner ear injury. He therefore upheld the insurer's denial.

On review, claimant raises the issue of the compensability of diagnostic services. Yet, it does not appear that reimbursement for diagnostic services was raised as an issue at hearing, nor do we consider it before us now. Further, the issue of whether claimant suffers from vertigo, a symptom that also was not clearly denied, raised or litigated at hearing, is similarly not before us. Instead, as acknowledged by claimant's counsel at hearing, the only issue before us is the compensability of claimant's inner ear condition as diagnosed by Dr. Black.

Claimant has the burden to prove that his present condition is causally related to the original industrial injury. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Where, as here, the issue is a complex medical issue, the issue must be addressed by expert medical testimony. See Kassahn v. Publisher's Paper, 76 Or App 105 (1985).

Claimant relies on the medical reports of Drs. Black and Grimm to establish compensability. We find their reports less persuasive than the reports of Drs. Wilson and Nash for a number of reasons. First, both Grimm and Black saw claimant several years after the industrial accident. Second, the histories given to them are inconsistent with the symptoms described to actual treating physicians over a lengthy period of time. Finally, neither report supporting compensability considers other contributing factors, such as claimant's abuse of alcohol.

Neither Dr. Wilson, an ear specialist, nor Dr. Nash, the treating physician most familiar with claimant's post-injury condition, agreed with Dr. Black's conclusion. We find that their reports, based on more accurate histories, to be more thorough than those of Drs. Grimm and Black. We agree with their opinions that claimant's current inner ear condition is not causally related to his industrial accident.

ORDER

The Referee's order dated August 20, 1987, is affirmed. A client-paid fee, not to exceed $1250, is approved.

MYRON A. SCHMIDT, Claimant
Malagon & Moore, Claimant's Attorneys
Mitchell, et al., Defense Attorneys

WCB 88-06239
May 9, 1989
Order of Dismissal

The self-insured employer has moved the Board for an order dismissing claimant's request for review on the ground that it was untimely. The motion is granted.

FINDINGS

The Referee's "Order of Dismissal and Order to Show Cause" issued July 14, 1988. Pursuant to the order, the employer's motion to dismiss claimant's hearing request for his failure to appear at hearing was granted. The order further

directed claimant to show cause, within 15 days, why the dismissal order should be set aside. The Referee's order contained a statement explaining the rights of the parties under ORS 656.289(3) and 656.295.

On July 25, 1988, claimant's counsel submitted a "Motion to Vacate Order of Dismissal." The motion, which included claimant's counsel's explanation concerning why claimant had failed to appear at the hearing, was directed to the Referee's attention. The Hearings Division received this motion on July 26, 1988. The employer responded to the motion on August 1, 1988. On August 11, 1988, claimant's counsel replied to the employer's response and repeated his request that the Referee set aside the dismissal order.

On August 22, 1988, the Referee issued an "Interim Order." The Referee acknowledged receipt of claimant's motion to vacate and reconsider. However, "due to an internal error," the Referee stated that the motion had not been processed until his jurisdiction had expired. Reasoning that the employer had notice of claimant's motion, the Referee interpreted the motion to be a request for Board review of the dismissal order and forwarded the motion to the Board for processing. On August 25, 1988, the Board mailed a computer-generated letter to the parties acknowledging a request for review.

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). 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 (1986). 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).

The request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to properly identify a document as a party's request for Board review of a Referee's order. Gerardo v. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but the party's intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

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).

Here, claimant expressly moved for an order vacating the Referee's dismissal order. In addition, his motion was specifically directed to the Referee's attention, not to the

Board's attention. Under these circumstances, we conclude that claimant's intention is both clear and unmistakable. i.e., he was asking the Referee to vacate and reconsider the dismissal order. Consequently, we hold that claimant did not request Board review of the Referee's July 14, 1988 dismissal order. ORS 656.295(1); Rochelle M. Gordon, supra; Gerardo V. Soto, supra.

Since claimant neither requested Board review of the Referee's July 14, 1988 order within 30 days of its issuance nor were the remaining parties to the proceeding provided with timely notice of a request for Board review of the order, we lack jurisdiction to consider this matter. ORS 656.289(3); ORS 656.295(1), (2).

Finally, the Referee's August 22, 1988 Interim Order issued more than 30 days after the Referee's July 14, 1988 order, which had neither been abated, withdrawn, stayed, modified, nor republished. Inasmuch as the 30-day statutory appeal period from the July 14, 1988 order elapsed unabated without a timely request for review, it has become final by operation of law. See ORS 656.289(3); International Paper Co. v. Wright, supra; Farmers Insurance Group v. SAIF, supra. Because the July 14, 1988 dismissal has become final, the Referee lacked jurisdiction to issue the August 22, 1988 order. Id. Consequently, the August 22, 1988 order is a nullity.

Accordingly, the request for Board review is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

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

WCB 85-15422 & 85-15423
May 11, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. SAIF v. Bates, 94 Or App 666 (1989). The court has concluded that claimant is entitled to an award of attorney fees pursuant to ORS 656.382(2) for prevailing at the Board level against a request for review filed by Aetna Casualty Company, on behalf of Regina's Restaurant.

The attorney fee to which claimant is statutorily entitled is defined as an "assessed fee." OAR 438-15-005(2). Our rules provide that an assessed fee cannot be awarded without a statement of services. See OAR 438-15-010(5). Inasmuch as claimant's counsel has not submitted a statement of services, an assessed fee cannot currently be awarded. Consequently, once a statement of services is received and, assuming that we still retain jurisdiction, we shall proceed with our consideration of this matter.

IT IS SO ORDERED.

DOROTHY H. DJODJIC-MEAD, Claimant
Douglas Hess, Claimant's Attorney
Mitchell, et al., Defense Attorneys

WCB 88-21223
May 11, 1989
Order of Dismissal

The self-insured employer has moved for an order dismissing claimant's request for Board review on the ground that it did not receive timely notice of the request. The motion is granted.

FINDINGS

The Referee's order issued March 22, 1989. On April 17, 1989, claimant mailed a request for review of the order to the Board. The request, which was mailed by certified mail, did not include an acknowledgment of service or a certificate of personal service by mail upon the self-insured employer or its legal counsel.

On April 25, 1989, the Board mailed a computer-generated letter to the parties acknowledging the request. The employer's counsel received the acknowledgment on April 26, 1989. This receipt of the Board's acknowledgment letter constitutes the employer's first notice of claimant's request for review.

ULTIMATE FINDINGS

Claimant mailed her request for Board review within 30 days of the Referee's order. However, the remaining parties to the proceeding before the Referee did not receive notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS

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).

Here, the 30th day after the Referee's March 22, 1989 order was April 21, 1989. Claimant's request for Board review was filed April 17, 1989, the date she mailed the request by certified mail. See OAR 438-05-046(1)(b). Consequently, claimant's request for Board review was timely. See ORS 656.289(3).

However, the record fails to establish that the remaining parties to this proceeding were either provided with a copy, or received actual knowledge, of claimant's request for review with the statutory 30-day period. Instead, pursuant to the employer's counsel's affidavit, the employer's first notice of claimant's request occurred on April 26, 1989, when its counsel received the Board's April 25, 1989 acknowledgment letter. April 26, 1989, is more than 30 days after the Referee's March 22, 1989 order.

Under such circumstances, we lack jurisdiction to review the Referee's order, which has become final by operation of law.

See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra.

We are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

LEONARD D. NOLLEN, Claimant
Emmons, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-00693
May 11, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Nichols' order that: (1) upheld the insurer's denial of a YMCA membership and chiropractic treatment at a greater frequency than prescribed in the Medical Director's guidelines; (2) refused to assess penalties and attorney fees for the insurer's alleged unreasonable denial of medical services; (3) found claimant's claim to have been properly closed by the December 9, 1986 Determination Order; and, alternatively (4) awarded claimant 35 percent (112 degrees) unscheduled disability for the low back in lieu of the aforementioned Determination Order, which awarded temporary disability only. The insurer argues in its brief that the permanent disability award is excessive. The issues are entitlement to a spa membership, chiropractic treatment in excess of the administrative guidelines, penalties and attorney fees, premature closure and, in the alternative, extent of unscheduled disability. We reduce the extent of disability award; we otherwise affirm.

FINDINGS OF FACT

The Board adopts the Referee's factual findings with the following supplementation.

The onset of claimant's thoracic pain occurred during a single day in February 1985. Claimant's work on that day was light work, involving repetitive bending from a partially forward flexed position.

Claimant was exposed to hepatitis in approximately February 1985. He was subsequently diagnosed as suffering from hepatitis in September 1985.

Claimant undergoes chemotherapy for his nonwork-related polyarteritis nodosa condition once every three months.

Claimant's nonwork-related conditions cause him to tire quickly with minimal exertion. This tendency to tire easily has limited his job search efforts. In addition, his ability to stand for long periods of time and to walk beyond short distances is limited due to these conditions rather than his back strain.

As of December 9, 1986, it was not reasonable to expect further material improvement in claimant's back condition from either further treatment or the passage of time.

Claimant has an eighth grade education. He has vocational experience as a laborer in a trailer factory, as a choker setter, as a cement finisher, and as a production-line mechanic. Claimant is presently capable of performing only light or sedentary work. However, this limitation results from his nonwork-related conditions which cause him to tire easily. Claimant has failed to prove more than a minimal impairment resulting from his compensable thoracic strain.

The chiropractic treatments claimant receives from Dr. Grice are palliative. Claimant has not gone more than one week without receiving treatment. Claimant generally receives treatment on a scheduled basis.

Claimant is not a reliable witness.

CONCLUSIONS OF LAW AND OPINION

Chiropractic Treatment

On January 22, 1987, the insurer denied chiropractic treatments in excess of the Medical Director's guidelines. See OAR 436-10-040(2)(a). Claimant contends that he is entitled to treatments in excess of the guidelines. The Referee concluded otherwise. We agree with the Referee that claimant has failed to prove the reasonableness and necessity of treatment in excess of the guidelines. See James v. Kemper Ins Co., 81 Or App 80, 81 (1986).

The treatments Dr. Grice provides are palliative in nature. Medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of an injury. Wetzel v. Goodwin Brothers, 50 Or App 101, 108 (1981). When palliative treatments reduce a claimant's pain and enable him to work, they are considered reasonable and necessary. West v. SAIF, 74 Or App 317, 321 (1985).

Claimant is currently neither employed nor seeking work. Therefore, the treatments provided by Dr. Grice do not enable claimant to work. In addition, the treatments are generally provided on a scheduled, rather than on an as-needed, basis. Further, claimant has not gone longer than one week between treatments. Consequently, his testimony regarding the effects of a reduced frequency of treatment is purely speculative.

Moreover, the weight of the medical evidence does not support reasonableness of treatment in excess of the guidelines. Dr. Spady, orthopedic surgeon, reported in October 1986 that continuing chiropractic treatments were neither reasonable nor necessary. Dr. Brett, a consulting neurosurgeon, agreed "generally" with Dr. Spady's conclusions. Dr. Frabach, rheumatologist, questioned whether continued chiropractic treatments were going to be of any lasting value. Dr. Peterson, chiropractor, examined claimant and opined that any further chiropractic care was not required by the compensable condition.

While these reports were generated at the request of the

insurer, additional reports generated by claimant also weigh against a finding of reasonableness. In this regard, Dr. Lafrance, neurologist, opined that claimant might need periodic chiropractic manipulation, but he recommended against "regular and repeated" treatment. Dr. Gross, chiropractor, noted that claimant had received two-and-one-half years of chiropractic treatment. He reported that chiropractic treatment at a frequency of two to four times per month might be required to maintain claimant's present status. This compares to eight treatments per month which claimant was receiving at the time of hearing.

In light of this substantial contrary evidence, we are not persuaded by Dr. Grice's opinion regarding the reasonableness of the current treatment frequency. We, therefore, affirm the Referee on this issue.

YMCA Membership

The Referee determined that the evidence presented failed to establish compliance with former OAR 436-10-040(7), which required "special medical circumstances" in order to entitle claimant to reimbursement of expenses for "spa" membership. We need not address this question because we find that claimant's membership at the YMCA is not reasonable and necessary as relates to his compensable condition.

First, it appears that one reason Dr. Grice recommends that claimant undertake swim therapy is to improve his general physical conditioning. However, the record establishes that claimant's poor conditioning results from his nonwork-related conditions rather than his work injury. In addition, claimant's testimony fails to persuade us that the swim therapy has resulted in any improvement in his physical conditioning. We note in this regard that, despite several months of therapy, claimant is only capable of swimming the length of the pool twice on any given day. Even this effort requires a five-to-ten minute break between pool lengths.

Second, to the extent the swimming therapy is directed to claimant's compensable back condition, the evidence again fails to persuade us that the therapy is proving beneficial to claimant. While claimant testified that the swimming renders him less tender in the thoracic spine area, Dr. Gross reported less than one week prior to hearing that claimant exhibited "extreme tenderness" on "very slight digital pressure" to his thoracic spine. Similarly, Dr. Lafrance reported "exquisite" tenderness to even "superficial" pressure in the thoracic area. We are left to conclude that claimant's swim therapy has not resulted in a lessening of his thoracic tenderness.

Penalties and Attorney Fees

Having affirmed the Referee's decision to uphold the insurer's January 22, 1987 denial, we conclude there is no basis for the assessment of penalties and associated attorney fees.

Premature Closure

Claimant's claim was closed by Determination Order dated December 9, 1986. In order to prove that his claim was prematurely closed, claimant must demonstrate that he was not medically

stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 626 (1987). "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17).

Dr. Spady reported on October 13, 1986, that claimant was medically stationary. Dr. Grice disagreed and indicated that Dr. Brett should be consulted. Dr. Brett reported on November 18, 1986, that he generally agreed with Dr. Spady's report. Moreover, claimant's condition had not materially changed in the almost two years since his injury, even though Dr. Grice had provided chiropractic treatment on a three times per week basis during much of that period. While Dr. Grice recommended that claimant participate in swim therapy in December 1986, there is no indication that it could have been expected to improve the compensable condition.

We conclude that the claim was not prematurely closed.

Extent of Permanent Disability

The December 9, 1986 Determination Order awarded claimant no permanent disability. The Referee concluded that claimant was entitled to an award of 35 percent unscheduled permanent partial disability. We conclude that the amount awarded by the Referee is excessive.

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 claimant's 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 former OAR 436-30-380 et seq.

The Referee found that claimant suffered some physical impairment as a result of his compensable condition. However, the Referee did not rate the degree of that impairment. We conclude that claimant has failed to prove more than minimal injury-related impairment.

We acknowledge that claimant testified to significant restrictions on his activities including walking, standing, driving, lifting and bending. He testified that he could only sit for about one hour before he needed to lie down. He testified that he could only walk from one to four blocks at a time. He stated that he could lift approximately twenty pounds from the floor to table height. He reported that he was capable of carrying 20 pounds, but not for very long.

However, his off-work activities support greater capacities. He has done rototilling several times, albeit for brief periods. He mows his own yard and sometimes his neighbor's yard on a riding lawn mower. This activity alone takes an hour. He maintains his own garden which involves picking vegetables. He goes hunting and fishing. For example, in August 1986, he went bow hunting. He maintains ten livestock at his home. He sometimes lifts bales of hay in order to feed them. We conclude that claimant's actual activities belie his stated capabilities.

We are equally unpersuaded by claimant's testimony regarding the severity of his continuing symptoms. We note in this

regard that claimant repeatedly displayed extreme sensitivity to any sort of manual pressure in the thoracic spine area. And yet, claimant undergoes chiropractic manipulation to this same area on a twice weekly basis. In addition, as previously noted, both claimant and Dr. Grice testified that claimant's swim therapy significantly reduced claimant's tendency to experience muscle spasm in response to even light touch. We are constrained to conclude that claimant's testimony regarding the current symptoms of his compensable condition is not reliable.

The record in this case is strongly suggestive of a functional component to claimant's current condition. And, in fact, on April 22, 1987 the Orthopaedic Consultants noted a moderate functional disturbance. In this regard, claimant is generally entitled to compensation for the psychological components of his injury as well as the physiological components. Barrett v. Coast Range Plywood, 294 Or 641, 644 (1983). However, claimant must still establish that his injury was a material cause of his functional problems. The record is totally devoid of any such evidence. Therefore, we do not consider claimant's functional problems in rating his compensable disability.

Dr. Buchanan, claimant's primary treating physician for his nonwork-related conditions, opined that claimant's back symptoms were unrelated to those conditions. We accept this uncontroverted evidence. However, the record does not persuasively distinguish between those physical limitations which result from claimant's work injury and those which result from his nonwork-related conditions. Moreover, the evidence which is included in the record suggests that claimant's limitations are primarily related to his nonwork-related conditions.

In sum, while we are persuaded that claimant experiences some residuals from his 1985 thoracic strain, we are not persuaded that those current residuals result in more than a minimal impairment. In light of his off-work activities, we find that his compensable injury prohibits him from performing only heavy to very heavy labor. Given claimant's age, his lack of advanced education, and his work experience which is confined primarily to physical labor, we conclude that an unscheduled permanent disability award of 15 percent adequately and appropriately compensates him for his compensable injury.

ORDER

The Referee's order dated October 30, 1987 is modified in part and affirmed in part. In lieu of the Referee's award, claimant is awarded 15 percent (48 degrees) unscheduled permanent disability for his back condition. Claimant's attorney fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $885.

RICHARD L. WHITE, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-19443
May 11, 1989
Order on Reconsideration

The self-insured employer requests abatement of our April 11, 1989 Order on Review that modified the Referee's order to direct the employer to pay temporary total disability benefits to claimant from August 10, 1987 until claimant either returns to work, is both released to regular work and is medically stationary or until the claim is closed pursuant to law. In reaching our

decision, we relied upon Fazzolari v. United Beer Distributors, 91 Or App 592, recon 93 Or App 103, rev den 307 Or 236 (1988), a decision rendered subsequent to the hearing and the Referee's order. Contending that Fazzolari represents a "dramatic change in the law" since the time of the hearing, the employer seeks remand to the Referee for the taking of additional evidence concerning this "new standard."

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

The basis for the employer's request could be advanced by any party disadvantaged by the application of an appellate decision rendered subsequent to an appealed Referee's order. Such grounds generally do not warrant remand. See James L. Lance, 39 Van Natta 1153 (1987), aff'd mem Peter Kiewit & Sons v. R. A. Gray Co., 92 Or App 591 (1988). (Counsel's action at hearing taken in reliance upon the Court of Appeals' decision in Runft v. SAIF, 78 Or App 356 (1986), did not constitute grounds for remand when Runft decision was subsequently reversed by Supreme Court, 303 Or 493 (1987)).

In conclusion, after considering the evidence concerning the temporary disability issue, we do not consider the record to have been improperly, incompletely or otherwise insufficiently developed. Consequently, the motion to remand for the taking of additional evidence is denied.

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 11, 1989 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

CHRISTIE G. ADAMS, Claimant
Quintin Estell, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 87-12622
May 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee McCullough's order which declined to assess a penalty and associated attorney's fee for the SAIF Corporation's failure to pay an award for 10 percent (32 degrees) unscheduled disability in a lump sum.

ISSUES

The sole issue is whether SAIF was unreasonable in relying on a rule of the Workers' Compensation Department in failing to pay an award for permanent partial disability in a lump sum.

FINDINGS OF FACT

Claimant sustained a compensable injury on July 10, 1983. A Determination Order of February 7, 1984 granted an award for 10 percent unscheduled disability. A second Determination Order dated May 29, 1986 granted claimant an additional 10 percent unscheduled disability. A stipulation dated June 22, 1987 awarded a further 10 percent unscheduled disability.

SAIF paid the permanent disability awarded by the stipulation in installments rather than in a lump sum.

CONCLUSIONS

Claimant argues that SAIF's failure to pay the permanent disability award was inconsistent with ORS 656.230(2). However, SAIF relied on former OAR 436-60-060(2) which makes payment of a lump sum award for injuries which occured before August 9, 1983 discretionary. Because the only issue is SAIF's reasonableness, we conclude that it was reasonable in relying on an administrative rule. Accordingly, we do not reach the question of whether the rule is consistent with the statute.

ORDER

The Referee's order of November 10, 1987 is affirmed.

BRADLEY D. DUREN, Claimant
Cash Perrine, Claimant's Attorney
Lindsay, et al., Defense Attorneys

WCB 87-04635
May 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Smith's order which: (1) upheld the insurer's partial denial of claimant's medical services claim for claimant's current low back condition; and (2) declined to admit into evidence two medical reports submitted by claimant. Claimant has asked that this case be remanded to the Referee to consider additional evidence. On review, the issues are remand, compensability and admission of evidence. We affirm.

FINDINGS OF FACT

In April 1979, claimant sustained a compensable injury to his lower back, right elbow, and right little finger. Following the injury, he continued to work, but sought treatment from Dr. MacCloskey. The diagnosis was possible nerve root irritation, but most likely musculoskeletal strain in the low back. Claimant continued to experience low back symptoms and, in July 1979, Dr. MacCloskey referred him to Dr. Cother, chiropractor, for manipulation.

In August 1979, claimant was examined by Dr. Kendrick, neurosurgeon. Dr. Kendrick suspected that claimant had a herniated nucleus pulposis L4-5 right; however, a myelogram was normal with no indication of lumbar disc disease. In September 1979, x-rays revealed early, but definite, sacroilitis on the right and possibly on the left, attributable to Reiter's syndrome.

In April 1981, claimant was examined by the Orthopaedic Consultants, who found claimant's lumbar strain medically stationary with minimal impairment. A July 1981 Determination Order closed the claim, awarding 5 percent unscheduled permanent partial disability for the low back injury.

In February 1987, claimant sought treatment for his low back symptoms from Dr. Erdman, chiropractor. Claimant did seek medical treatment for a right arm condition between 1981 and 1987,

but did not seek treatment for his low back. Between 1981 and 1983, claimant continued his work as the manager of a raquetball center. In 1983 claimant began his own business and worked as a full-time carpet cleaner.

In March 1987, the insurer denied claimant's current low back condition and treatment for that condition on the basis that it was not causally related to the April 1979 industrial injury.

Three days prior to the hearing, Dr. Erdman mailed a report, dated September 15, 1987, to the Referee and the insurer's counsel. A second report from Dr. Erdman, dated September 25, 1987, the day of the hearing, was submitted by claimant's counsel at the hearing.

On August 25, 1988, claimant's counsel mailed a report from Dr. Kemple, dated August 4, 1988, to the Board. Dr. Kemple had previously treated claimant and several medical reports authored by him are already in the record.

FINDINGS OF ULTIMATE FACT

Claimant has not shown good cause for the untimely submission of the disputed medical reports of September 15, 1987 and September 22, 1987.

Claimant's April 1979 compensable injury is not a material contributing cause of his current low back condition.

The record was not improperly, incompletely, or otherwise insufficiently developed. Claimant has not established that the matters discussed in Dr. Kemple's August 4, 1988 report were unobtainable with due diligence at the time of hearing.

CONCLUSIONS OF LAW

On August 25, 1988, claimant's counsel mailed to the Board, a report dated August 4, 1988, authored by Dr. Kemple. Claimant requests that the Board consider this "new evidence" which it contends was unobtainable at the time of hearing. We treat this submission as a motion to remand for the taking of further evidence. We deny the motion.

Following our de novo review, we are not persuaded that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Furthermore, as Dr. Kemple had previously treated claimant, and earlier reports authored by him are in the record, we are unconvinced that this evidence was unobtainable with due diligence before the record was eventually closed. See Judy A. Britton, 37 Van Natta 1262 (1985).

Claimant next argues that the Referee erred in excluding two documents from the record. Those documents were September 15 and September 25, 1987 reports from Dr. Erdman. Both documents were submitted in violation of former OAR 438-07-005(3)(b). The September 15, 1987 report was mailed to the Referee on September 22, 1987, three days prior to the hearing, by Dr. Erdman. The September 25, 1987 was submitted the day of the hearing.

Claimant argues that the reports should be admitted as the insurer would not be surprised or prejudiced by the reports. We are not persuaded by claimant's argument. Claimant offers no good cause

for the late submission of the reports and as they were authored by claimant's treating chiropractor, Dr. Erdman, we find that they could have been requested at a more timely date. Although it may be true that the insurer would not be prejudiced, consideration of prejudice is recommended, but not required. See former OAR 438-07-005(4). Accordingly, under former OAR 438-07-005(3)(b), the reports should not have been admitted and the Referee did not err in excluding them. Under these circumstances, the Referee was within his discretion in refusing to admit the aforementioned reports. David W. Huntley, 40 Van Natta 2012. Therefore, we have not considered these documents on review. We now proceed to the merits of the case.

The Referee concluded that claimant's industrial injury was not causally related to his current low back condition. We agree.

In order to establish that his current low back condition is compensable, claimant must prove by a preponderance of the evidence that his April 1979 compensable injury is a material contributing cause of his current low back condition. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

We find that claimant has failed to sustain his burden of proof. The Orthopaedic Consultants felt that it was possible that the industrial injury was still contributing to claimant's current condition, but did not offer an opinion as to the degree of contribution as it depended upon the degree of the present symptoms in relation to the Reiter's syndrome. They noted that it was likely that all of claimant's current symptoms were related to the Reiter's syndrome as a simple strain would ordinarily resolve in a relatively short period of time. The Consultants recommended a rheumatologist be consulted on this point.

Dr. Dordevich, rheumatologist, opined that claimant's current low back and right upper leg and buttock pain were caused by the Reiter's syndrome and not the 1979 industrial injury. He further noted that there was no evidence that trauma is in any way related to the etiology or aggravation of Reiter's syndrome. Dr. Dordevich's conclusion is consistent with the opinion offered by Dr. Kemple. Shortly after the industrial injury, Dr. Kemple concluded that claimant's residual problems would be related to the Reiter's syndrome and not the compensable low back strain. Of further import is the fact that claimant did not seek treatment for back pain between 1981 and 1987, even though he was consulting physicians for right arm symptoms during this time period.

Consequently, we find that claimant has failed to establish a causal relationship between his current low back condition and the 1979 industrial injury.

ORDER

The Referee's order dated October 27, 1987 is affirmed. A client-paid fee, not to exceed $922.50, is approved.

DANIEL R. KOPLIN, Claimant
Doblie & Associates, Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 86-17323 & 86-13693
May 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

EBI Companies request review of Referee Thye's order which: (1) set aside its denial of compensability for claimant's "new injury" claim for a back condition as invalid under Bauman v. SAIF, 295 Or 788 (1983); (2) found EBI responsible for claimant's current back condition; (3) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition; and (4) assessed penalties and attorney's fees against EBI for an unreasonable claims procedure. We affirm as modified.

ISSUES

The issues on review are: (1) the validity of EBI's attempted "backup denial"; (2) responsibility; and (3) penalties and attorney fees.

FINDINGS OF FACT

Claimant, 26 years of age at hearing, suffered a compensable injury to his low back while working for SAIF's insured. This claim was closed by Determination Order on April 29, 1983. Claimant was awarded temporary disability through April 5, 1983, and no permanent disability.

Claimant stepped in a rut in May 1983, and suffered a low back strain. He felt lumbar pain while lifting groceries in September 1983. An October 27, 1983 Stipulation denied any worsening of his compensable injury, but awarded claimant 10 percent unscheduled permanent partial disability.

Claimant was retrained through vocational rehabilitation and was placed with EBI's insured as an office machine servicer in June 1985. On or about August 1, 1986, claimant reinjured his back twisting and bending while working for EBI's insured.

On August 25, 1986, claimant sought treatment with Dr. Berovic, chiropractor, for lumbar and sacrolumbar pain radiating into both legs. The first medical report, signed by Dr. Berovic on August 27, 1986, attributed the symptoms to the 1981 injury. Claimant denied any intervening injuries.

Claimant was referred to Dr. Ott, orthopedist, who found low back strain and an acute ruptured disc on September 2. 1986. Claimant did not tell Dr. Ott of any intervening injury. He referred claimant to Dr. Nelson, orthopedist, who hospitalized claimant on September 11, 1986, for conservative care. Dr. Nelson opined that claimant's condition had worsened in the weeks prior to September 1986. He later wrote that it was medically probable that claimant's disc herniation was caused by a work-related injury on or about August 1, 1986.

Claimant executed an 801 form on September 11, 1986, which attributed two herniated discs to lifting, twisting, and bending work activities for EBI's insured on August 1, 1986.

When claimant was examined by Dr. Baum, orthopedist, in

November 1986 and by Dr. Pasquesi, orthopedist, in October 1986, he told them he hurt his back on the job on August 1, 1986. Dr. Baum recommended surgery.

On September 24, 1986, EBI wrote claimant, in part: "As medical evidence does not indicate a worsening of your underlying condition, which is being processed by SAIF Corporation, we must respectfully deny this claim for benefits."

After receiving Dr. Pasquesi's report, SAIF denied responsibility on November 14, 1986. Thereafter, it petitioned the Compliance Division for the designation of a paying agent as per ORS 656.307.

Surgery was recommended in November 1986, after a myelogram confirmed a central herniated disc at L4-5. On December 11, 1986, the Compliance Division of the Workers' Compensation Department wrote EBI asking for clarification of its position concerning the designation of a paying agent pursuant to ORS 656.307. On May 27, 1987, EBI's attorney wrote the Compliance Division, in part: "After further investigation, it is the position of EBI and its insured that there is an issue of responsibility only, not compensability. Consequently, a .307 order is appropriate."

A copy of this letter was sent to claimant's attorney.

At the June 8, 1987 hearing, EBI denied compensability.

ULTIMATE FINDINGS OF FACT

EBI accepted the compensability of the new injury claim.

EBI subsequently denied the claim more than 60 days after it had notice or knowledge of the claim.

EBI did not originally accept the claim because of fraud, misconduct, or misrepresentation by claimant.

The August 1, 1986, work related injury independently contributed to a worsening of claimant's underlying low back condition.

CONCLUSIONS OF LAW

At the hearing on June 8, 1987, EBI orally denied compensability. Claimant then argued that such a denial was a "backup denial" precluded by the Supreme Court in Bauman v. SAIF, 295 Or 788 (1983). During the latter part of the hearing, EBI introduced evidence in an attempt to show fraud or misrepresentation by claimant. We note that the Referee used the standard approved in Ebbtide Enterprises v. Tucker, 303 Or 459 (1987), in weighing this evidence, i.e., could the insurer's decision have reasonably been affected by the alleged misconduct.

EBI did not present evidence of fraud or illegal conduct on the part of claimant that could have affected its decision to accept the claim. There was evidence that claimant misrepresented his medical history by not informing Drs. Berovic and Nelson about the August 1, 1986 injury. We do not believe this could have reasonably affected EBI's decision to accept on May 27, 1987. By that time, EBI had available to it information from Drs. Nelson

and Baum that claimant's condition had changed substantially in September 1986 and that claimant was now reporting an injury while at work on August 1, 1986. It appears on review that EBI's decision was more affected by information based on an accurate history, i.e., the reports of Drs. Nelson and Baum. We affirm on this issue.

On review, EBI argues that this is not a "backup" denial case and is not controlled by Bauman and Ebbtide. We disagree. In order for Bauman to apply, two things must happen. First, the claim must be accepted by the insurer. Second, the insurer must deny the claim after the 60-day period in ORS 656.262(6) has expired. We agree with the Referee that both conditions have been met in this case.

EBI now argues that it never accepted the claim because its attorney's letter to the Compliance Division indicating the claim was accepted as to compensability does not in every respect comply with ORS 656.262(6). In particular, EBI stresses that a letter to the Compliance Division, with a copy to claimant's attorney, informing the Compliance Division that compensability will not be an issue, is not notice to claimant that his claim has been accepted. We disagree. Upon receipt of a copy of such a letter, we conclude that claimant would logically treat this as an acceptance of compensability and would prepare for hearing accordingly.

EBI argues that because claimant agreed to go forward with the hearing after EBI's denial of compensability, the case is controlled by Stoneman v. SAIF, 45 Or app 701 (1980). We disagree.

In Stoneman, the claimant was prepared to prove a degenerative spinal condition. Both carriers had agreed to an order designating a paying agent pursuant to ORS 656.307, indicating acceptance of compensability. Shortly before the hearing, a court ruling established a new standard for proving a degenerative spinal condition, thereby increasing claimant's burden of proof. Both carriers issued new denials at hearing.

At hearing, claimant complained of insufficient notice. The Referee agreed and offered claimant a continuance and an opportunity to obtain additional medical evidence. Claimant's attorney chose to go forward. The Court of Appeals held that under these circumstances, claimant had waived any notice objections. The court affirmed the Referee's upholding of the denials.

While Stoneman is slightly different on its facts, we agree that its holding would appear to control this case. Would the Court of Appeals decide Stoneman the same way today? Three years after Stoneman was decided in 1980, the Supreme Court decided Bauman. We note that the Court in Bauman did not decide the case on an issue of fairness to the parties or lack of notice to claimant. The decision in Bauman is intended to establish stability in the administration of the entire workers' compensation system. We read the decision in Stoneman as deciding a legal issue between two parties, one of which waived a legal right at hearing. We read Bauman as directing a course of conduct in administering the Workers' Compensation Act which intended to strictly limit an insurer's ability to retract an acceptance as a matter of law. We believe that Stoneman was impliedly overruled by Bauman and we do not believe the Court of Appeals would reach the same result were it deciding the case today.

Responsibility

Because the "backup denial" is precluded, the only question is responsibility for the injury. We analyze the evidence under the last injurious exposure rule.

The rule requires that we make a finding on whether claimant's work activities with EBI's insured contributed to a worsening of the underlying compensable condition. We find that they did and that EBI's insured is the responsible employer.

We rely on the opinion and deposition of Dr. Nelson in finding that claimant suffered a work-related injury on August 1, 1986. We also give some weight to claimant's testimony on this point and to the opinion of Dr. Baum. The original injury with SAIF's insured was to claimant's lower dorsal spine. Although the Stipulation of October 27, 1983 awarded claimant 10 percent unscheduled permanent partial disability "of the low back", the Stipulation recited that the October 8, 1981, injury was to the mid-back. It thus appears that the reference to the "low back" was a misnomer. Although claimant continued to have occasional back pain and some right leg symptoms thereafter, he sought no treatment until the undisputed worsening of his low back condition in August of 1986.

EBI attacked claimant's credibility at the hearing by pointing out that he did not mention an August 1, 1986, injury to Dr. Nelson or Dr. Berovic. EBI also attempted to show that claimant could have been injured in a motorcycle accident at about that time. As the Referee pointed out, the evidence regarding a motorcycle accident is confusing and contradictory. Claimant testified that he did not want to file a claim against his new employer because he feared losing his job. When he realized the seriousness of his condition, he changed his mind. The Referee did not find claimant not to be a credible witness, nor do we. We conclude that claimant's work activity on August 1, 1986, independently contributed to a worsening of claimant's underlying back condition.

Penalties and Attorney Fees

The Referee assessed EBI a penalty of 25 percent of all sums due and an attorney fee of $500 for "unreasonable handling of this claim." EBI correctly argues on appeal that ORS 656.307 cannot provide a basis for assessing a penalty. EBI Companies v. Thomas, 66 Or App 105 (1983). However, we consider EBI's "backup" denial of compensability, orally asserted at hearing after it had provided written notice of its concession of compensability, to have been unreasonable. Consequently, penalties and attorney fees are justified. ORS 656.262(10). Yet, we find there is no amount due and therefore no basis for a penalty. D. Maintenance Co. v. Mischke, 84 Or App 218, rev den 303 Or 483 (1987); Spivey v. SAIF, 79 Or App 568 (1986). However, we may award an attorney fee even if no penalty is assessed. Spivey v. SAIF, supra. We affirm the Referee's award of $500.

ORDER

The Referee's order dated September 11, 1987 is affirmed as modified. For services on Board review, claimant's attorney is awarded $850, to be paid by EBI Companies. A client-paid fee, not to exceed $4,000, payable from EBI to its counsel, is approved.

NORMAN L. MURRAY, Claimant
Breathouwer, et al., Claimant's Attorneys
Meyers & Associates, Defense Attorneys

WCB 86-07093
May 12, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of those portions of Referee Garaventa's order that: (1) set aside its partial denial of rheumatoid arthritis; and (2) assessed penalties and related attorney fees for its alleged unreasonable partial denial. We affirm.

ISSUES

1. Whether the insurer's pre-closure partial denial was procedurally proper.

2. If the partial denial was procedurally proper, whether claimant's rheumatoid arthritis condition is compensable.

3. Penalties and related attorney fees.

FINDINGS OF FACT

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

Claimant's left knee injury was a material contributing cause of the symptomatic worsening of his system-wide rheumatoid arthritis condition.

CONCLUSIONS OF LAW

Procedural Propriety of the Pre-closure Partial Denial

The Referee concluded that the insurer's pre-closure partial denial was prohibited by the court's decision in Roller v. Weyerhaeuser Co., 67 Or App 583 (1984), and, therefore set aside the denial in its entirety. We agree that the partial denial should be set aside, but modify the Referee's reasoning.

At the outset, we note that the insurer accepted a claim for a left knee injury and now concedes that it is responsible for medical treatment of the left knee regardless of whether the treatment stems from the injury or the rheumatoid arthritis in the knee that was aggravated by the injury. Accordingly, the denial purported to deny only the "system-wide rheumatoid arthritis" and reaffirmed its acceptance of claimant's left knee condition. Therefore, the issue becomes compensability of claimant's system-wide rheumatoid arthritis.

Claimant sustained the initial injury to his left knee when he stepped over a balcony rail onto a ledge, caught his left toe in cables, and twisted his left leg. As a result, Dr. Freeman performed an arthroscopy with a partial synovectomy and partial lateral meniscectomy. Dr. Freeman also noted findings suggestive of active rheumatoid arthritis in the knee joint.

Soon after the left knee injury, claimant began to experience pain in both upper extremities, neck, upper back, shoulders, acromioclavicular joints, sternoclavicular joint, hands, and right knee. He had never had such pain prior to the left knee injury. The medical evidence established that the system-wide

rheumatoid arthritis condition and the left knee injury were separable conditions. The symptoms in the rest of claimant's body cannot be said to be a continuation of those symptoms arising from his original compensable left knee injury. They arose subsequent to the injury and can easily be distinguished from the left knee pain. Therefore, to the extent that the insurer partially denied claimant's system-wide rheumatoid arthritis condition, the partial denial was procedurally proper. Consequently, we proceed to address this aspect of the partial denial on the merits.

Compensability of the System-wide Rheumatoid Arthritis Condition

Claimant's disability was 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. Jameson v. SAIF, 63 Or App 553, 555 (1983), citing Weller v. Union Carbide, 288 Or 27 (1979). Rather, in order to establish the compensability of the system-wide rheumatoid arthritis condition, claimant need only show that the compensable left knee injury caused it to become symptomatic. Grace v. SAIF, 76 Or App 511 (1985).

Compensability must be proven by a preponderance of the evidence. Summitt v. Weyerhaeuser Co., 25 Or App 851, 856 (1976). 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 case involves a complex medical question. We give little weight to the opinions regarding causation of Drs. Freeman, Broukhim, or Garber, since all three failed to specifically address the effect that claimant's knee injury had on the system-wide rheumatoid arthritis condition. We also give little weight to the opinions of Drs. Hirsch and Walker since neither was based on a reasonable medical probability. We are therefore left with the opinions of Dr. Nyman, claimant's treating rheumatologist, and Dr. Montanaro, also a specialist in rheumatology.

In a July 20, 1987 deposition, Dr. Nyman opined that claimant's knee injury was not the cause of his system-wide rheumatoid arthritis condition, but rather, its initiating event. (Ex. 81-21). Although Dr. Nyman was unable to cite any specific medical authority, he believed that it was fairly well accepted in the rheumatological community that trauma could initiate rheumatoid arthritis. (Ex. 81-23). In claimant's case, he felt that:

> "[T]he knee injury was the inciting event in the following progression to generalized joint involvement with rheumatoid arthritis." (Ex. 81-21).

Dr. Nyman explained the basis of this opinion, stating that:

> "It is felt that emotional or physical stress can certainly cause the onset or exacerbate the clinical course in those who already have the rheumatoid arthritis. And as can be obtained from the history of [claimant], no such disease or limitation existed prior to the jury [sic] and his

course has been progressive since the injury." (Ex. 81-13).

The most important factor in Dr. Nyman's decision to find a causal relationship between the compensable left knee injury and the development of diagnosed rheumatoid arthritis was the temporal relationship. (Ex. 81-34). We have always, however, been hesitant to infer causation from chronological sequence. See Bradshaw v. SAIF, 69 Or App 587, 589 (1984); Wayne E. Welch, 34 Van Natta 766 (1982). A second important factor in Dr. Nyman's opinion regarding causation was the fact that the location of the injury at the left knee was also the site of the most severe symptoms of rheumatoid arthritis. (Ex. 81-40).

Dr. Montanaro testified that the consensus of opinion in the rheumatological community was that trauma did not incite rheumatoid arthritis. Moreover, he was familiar with the leading textbooks in the field and indicated that each disclaimed any such causal relationship. (Tr. 54-55). He did, however, believe that trauma could temporarily aggravate rheumatoid arthritis. (Tr. 57). He explained the process of a temporary aggravation of rheumatoid arthritis as a result of trauma in the following manner:

> "The process of rheumatoid arthritis is characterized by inflammation in a joint. That inflammation is a result of the lining of that joint being hypertrophied or swollen. It releases many mediators into the joint which cause pain, swelling, redness, heat, all the things that we all recognize as arthritis. When that particularly inflamed joint is put through trauma, which may be as a result of an overuse, a misuse or a direct strain or sprain, then further inflammatory processes may ensue . . ." (Tr. 57).

Dr. Montanaro further explained that once the rheumatoid arthritis condition was established, claimant would tend to experience cycles of remission and flareup. (Tr. 64). He added that, just as the original etiology of the disease was unknown, there was no medical scientific consensus on what caused the cycles of remission and flareup.

Although Dr. Montanaro opined that claimant's left knee injury did temporarily aggravate the rheumatoid arthritis condition in the knee, he also felt that, despite the temporal relationship between the left knee injury and the development of the system-wide rheumatoid arthritis disease process, no causal connection existed beyond the area of the knee itself. (Tr. 77). Dr. Montanaro believed that Dr. Nyman's position, that physical or emotional trauma was capable of inciting rheumatoid arthritis in body parts far away from that area of the body directly traumatized, was a minority position among the rheumatological community. (Tr. 83).

Dr. Nyman, certified as both a rheumatologist and internist, treated claimant for his arthritis condition from the onset of his symptoms until the insurer's issuance of the partial denial. Dr. Montanaro was also eminently qualified with certifications as an internist, allergist and immunologist with a

subspecialty in rheumatology. He examined claimant, however, on only one occasion.

Despite the expertise of these physicians, their opinions with regard to the system-wide rheumatoid arthritis condition are rather conclusory. Dr. Nyman asserts that the temporal relationship and the fact that claimant's most severe arthritic symptoms occurred at the site of the trauma convinced him of the causal relationship between the trauma and system-wide disease process. Dr. Nyman was unable to provide any authority from the rheumatological community to support his opinion. On the other hand, Dr. Montanaro stated only that there was no causal connection between the trauma and the system-wide arthritic condition and dismissed Dr. Nyman's view as a minority position. Dr. Montanaro did not support his opinion regarding the system-wide disease process with persuasive reasoning. Therefore, we find no persuasive reason why we should not defer to the opinion of claimant's treating physician. Weiland v. SAIF, 64 Or App 810 (1983).

In conclusion, a review of the record as a whole persuades us that claimant's compensable left knee injury was a material contributing cause of the symptomatic worsening of his system-wide rheumatoid arthritis condition. Accordingly, we agree with the Referee that the insurer's partial denial should be set aside in its entirety.

Penalties and Related Attorney Fees

The Referee found nothing in the medical evidence to justify the insurer's partial denial, and assessed a reasonable penalty and attorney fee. We agree with the assessment of a penalty, but for a different reason.

ORS 656.262(10) provides that if an insurer unreasonably refuses to pay compensation, the insurer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382.

We previously discussed the complex and somewhat ambiguous medical evidence regarding the causation of claimant's system-wide rheumatoid arthritis condition. Only Drs. Nyman and Montanaro directly addressed the issue and their opinions were diametrically opposed. We conclude that the insurer's partial denial insofar as it denied claimant's system-wide rheumatoid arthritis condition was not unreasonable.

However, that portion of the insurer's partial denial which denied the rheumatoid arthritis condition present in claimant's left knee was unreasonable. All of the medical providers indicated that claimant's compensable injury at least temporarily aggravated his rheumatoid arthritis left knee condition to the extent that it became symptomatic and required medical services. Although the insurer has now conceded compensability of the left knee condition, including the rheumatoid arthritis in that area, its denial indicated that it was originally denying treatment for claimant's left knee arthritis. The insurer had no basis to deny that specific condition. Therefore, we agree with the Referee's assessment of a 25 percent penalty and a $250 attorney fee for this unreasonable denial.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review concerning the denial of compensability. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we

cannot award an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order dated September 2, 1987 is affirmed.

FRANCISCO RODRIGUEZ, Claimant
Ginsburg, et al., Claimant's Attorneys
Julia Philbrook (SAIF), Defense Attorney

WCB 87-19231
May 12, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Hoguet's order that upheld the SAIF Corporation's denial of his accidental injury claim relating to his left shoulder, neck and upper back. He moves that the case be remanded to the Hearings Division for the receipt of testimony from two additional witnesses or, in the alternative, contends that SAIF's denial should be set aside on the record as developed. SAIF moves to strike claimant's motion to remand. We deny SAIF's motion to strike, deny claimant's motion to remand and affirm the order of the Referee.

ISSUES

1. The procedural propriety and substantive merit of claimant's motion for remand.

2. The compensability of claimant's neck, left shoulder and upper back conditions.

FINDINGS OF FACT

Claimant began working for the employer, a wholesale nursery, on September 21, 1987. During the following two months, claimant was often late for work and sometimes came to work intoxicated. He also had difficulty getting along with the other workers. Claimant's immediate supervisor, Bud Hoefer, informed claimant that his job performance was not acceptable and claimant began looking for other employment. When claimant's job performance did not improve, Hoefer and his supervisor, Fred Teufel, discussed the situation and tentatively decided to terminate claimant's employment. They planned to inform claimant of their decision at the end of the workday on November 25, the day before Thanksgiving.

Claimant arrived at work on November 25 at about 7:15 a.m. and Hoefer assigned him and about eight other workers to cut berried variegated holly. The holly bushes were quite tall and the workers had to use orchard ladders to reach the upper branches. Claimant cut holly until about 11 a.m. Hoefer then had him help load the holly onto a truck. At noon, Hoefer drove the truck to the employer's processing plant and unloaded the holly. The workers took a lunch break from that time until 12:45 p.m. They then resumed cutting berried variegated holly.

Hoefer returned to the field at about 1:15 p.m. and assigned the workers to cut unberried holly. The unberried bushes were comparatively small and the workers did not have to use ladders with them. Claimant cut unberried holly until about 2:30 p.m. when

Hoefer again had him help load the holly onto the truck. After the holly was loaded, Hoefer drove the truck back to the employer's processing plant. Claimant and the other workers rode back to the plant in a van.

After arriving at the plant, Hoefer attempted to find Teufel to further discuss the termination of claimant's employment. The holly season was due to end within a few days and Hoefer had come to the conclusion that the end of the season would probably be a better time to let claimant go. Hoefer could not find Teufel and decided not to tell claimant that his employment was about to be terminated. Claimant left the employer's plant and went home.

On the evening of the 25th, claimant went to the home of a friend, Antonio Guzman. Claimant told Guzman that he had fallen from a ladder that day and hurt his shoulder.

Claimant was scheduled to work on the 27th, 28th and 29th of November, but did not go to work. The holly season ended on the 29th. On the morning of the 30th, claimant returned to the employer's plant and was told by Teufel that his employment had been terminated. Claimant then told Teufel that he had fallen from a ladder on the 25th and hurt his shoulder. Hoefer arrived about this time and told Teufel that claimant had not said anything on the 25th about being injured and had exhibited no signs of an injury. Teufel and Hoefer then spoke with some of claimant's co-workers about the alleged injury. None of them knew anything about it.

Later on the 30th, claimant sought treatment from Dr. Wilcox, a chiropractor. Claimant told Dr. Wilcox that he had fallen from a ladder at work and landed on his left shoulder. Dr. Wilcox diagnosed injuries to claimant's left shoulder, neck and upper back and, based upon the history received from claimant, opined that these injuries were work-related. He sent a report to that effect to SAIF, the employer's insurer. SAIF issued a denial of claimant's claim on December 10, 1987.

Claimant filed a request for an expedited hearing on December 17, 1987 and a hearing was scheduled for February 1, 1988. The hearing was held as scheduled and the Referee issued his order upholding SAIF's denial on February 19, 1988. Claimant personally filed a request for Board review on February 26, 1988. In the request, claimant stated, "This is to inform you that I am in the process of obtaining witnesses to speak on my behalf on the above mentioned case which was ruled against me." A short time later, the Board issued a briefing schedule notice which made the appellant's brief due on April 28, 1988.

On April 25, 1988, claimant filed a request for remand with the Board. Attached to the motion were three affidavits, one from claimant, one from a former roommate named Constantino Besera and one from a former co-worker named Delgado Castillo. Castillo alleged the following in his affidavit: He was a casual acquaintance of claimant. He was working on the same crew as claimant on November 25, 1987 and saw claimant fall from a ladder. He did not say anything to claimant at the time because claimant got up and did not appear to be hurt. He did not think that claimant noticed that he had witnessed the fall. He continued working for the employer until "approximately January of 1988." He then left Hillsboro and went to another city to work. He returned to Hillsboro on or about March 18, 1988 and moved into the same apartment complex in which claimant lived. Within a day or so, he happened to encounter

claimant in the parking lot and in the course of conversation mentioned that he had seen claimant fall. In his affidavit, claimant alleged that he had represented to his attorney that none of his co-workers had witnessed his fall and that he was surprised when Castillo told him that he had seen it. Besera alleged in his affidavit that he had been claimant's roommate during November 1987 and that claimant had told him sometime during the week of Thanksgiving that he had fallen from a ladder onto his left shoulder. He further alleged that he and his family had left Hillsboro and gone to Mexico in December 1987 and had returned in late February 1988.

Claimant filed his appellant's brief on April 28, 1988 in accordance with the briefing schedule. SAIF filed a motion to strike claimant's request for remand on May 11, 1988.

Claimant's native language is Spanish. He speaks enough English to communicate effectively with someone who does not speak Spanish. Claimant wore rubber boots while cutting holly on November 25, 1987. The first time that claimant told either Teufel or Hoefer that he had fallen from a ladder at work was on November 30, 1987.

FINDINGS OF ULTIMATE FACT

1. Claimant did not exercise due diligence in attempting to locate Mr. Castillo or Mr. Besera. Claimant did not request that the Referee leave the record open for the testimony of Mr. Besera.

2. Claimant did not injure his left shoulder, neck and upper back in the course of his employment.

CONCLUSIONS OF LAW

1. Remand

For purposes of evaluating claimant's motion for remand, we assume, without deciding, that the allegations contained in the affidavits submitted by claimant are true. SAIF has moved to strike claimant's request for remand for the testimony of Mr. Castillo because claimant discovered that Mr. Castillo witnessed his fall in mid March 1988, but did not file the request for remand until April 25, 1988, more than a month later. SAIF's argument would be plausible had claimant discovered Mr. Castillo before he filed his request for Board review and failed to request that the Referee reopen the record. See OAR 438-07-025. Claimant did not discover Mr. Castillo, however, until more than two weeks after he requested Board review. At that point, the Referee could not reopen the record and nothing would have been gained by a more prompt motion for remand. SAIF's motion to strike is denied.

On the merits of the remand issue, the Board may remand the case if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). The Board will remand for the receipt of newly discovered evidence, however, only if the evidence could not have been submitted to the Referee with the exercise of due diligence. E.g., Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

We are unable to conclude that claimant exercised due diligence in locating either Mr. Castillo or Mr. Besera. Castillo was a co-worker and casual acquaintance of claimant. He continued to work for the employer for a considerable period of time after

claimant's alleged injury. Indeed, Castillo's statement that he left the employer and went to another city in "approximately January of 1988" is not sufficiently precise for us to conclude that he was not still in the Hillsboro area on February 1, 1988, the date of the hearing. Castillo could have been located fairly easily had claimant or his attorney taken the fundamental step of interviewing the other members of the employer's crew who cut holly on November 25, 1987. Remand is not warranted under these circumstances.

Besera was a former roommate of claimant. Claimant was certainly aware of the statements that he had made to Besera. As far as the record reflects, however, claimant made no effort to secure his testimony until after the hearing. He did not request that the Referee keep the record open while Besera was located. In any event, Besera's proffered testimony is duplicative of other testimony which we have accepted, that of Mr. Guzman. Remand for the testimony of Besera, therefore, is also denied.

2. Compensability

The compensability issue in this case is dependent upon our conclusion regarding claimant's credibility. If claimant's testimony is believed, his injuries are compensable. If his testimony is rejected, the evidence is insufficient to support a finding of compensability.

The Referee found claimant not credible based upon his "observations of claimant's attitude, appearance and demeanor while testifying and at counsel table." We normally give considerable weight to a Referee's credibility assessment, especially when it is based on the claimant's demeanor. Claimant contends, however, that we should not defer to the Referee's credibility assessment in this case. Claimant testified in Spanish and utilized an interpreter throughout the hearing. He contends that the interpreter was inadequate and mistranslated his statements on occasion and, in any event, that the lag time between claimant's statements and the interpreter's translation prevented the Referee from assessing claimant's demeanor contemporaneous with his statements. Because of this, claimant contends that the Referee's credibility assessment is not reliable.

The Referee's credibility assessment would have been strengthened considerably had he been more specific concerning what in claimant's "attitude, demeanor and appearance" caused him to doubt claimant's credibility. Nonetheless, we reject claimant's testimony for other reasons.

Claimant's testimony differs in several significant particulars from that of the defense witnesses. Claimant testified that he worked on November 25, 1987 with awkward and potentially hazardous sheets of plastic tied on his shoes for boots. Hoefer testified emphatically that claimant was wearing standard rubber boots. Claimant testified that he understood little English and had trouble communicating with his supervisors. The defense witnesses indicated that they conversed with claimant in English and had no difficulty understanding him. Claimant testified that within a few hours of falling from the ladder he told Hoefer about the accident. Hoefer denied that claimant made any such statement. Claimant testified that he came to work on the morning of November 27, 1987, told Teufel about the accident and asked to be sent to the doctor. Teufel recalled no such conversation. Claimant denied that he

sometimes came to work intoxicated. The defense witnesses all testified that he did.

All of the defense witnesses testified in English. The Referee found them credible on demeanor grounds and we have little difficulty deferring to that assessment. Acceptance of the testimony of the defense witnesses leads to the conclusion that claimant was intentionally untruthful in significant portions of his testimony. A witness who is intentionally untruthful in one part of his testimony should be mistrusted in other parts of his testimony. See ORS 10.095(3); Uniform Civil Jury Instruction No. 2.04. The effect of claimant's intentionally untrue statements on his testimony as a whole makes it difficult for us to conclude that it is more likely than not that his testimony regarding falling from a ladder at work was true. In addition, his knowledge of the the employer's growing dissatisfaction with his work performance before the date of the alleged injury presents a plausible motive for the fabrication of an industrial injury. The evidence provided by Mr. Guzman and Dr. Wilcox is dependent upon the accuracy of claimant's statements to them about the alleged fall. Given this record, we are unable to conclude that the evidence preponderates in claimant's favor. SAIF's denial, therefore, shall be upheld.

ORDER

The Referee's order dated February 19, 1988 is affirmed.

MARILYN A. FARNES, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney
Roberts, et al., Defense Attorneys

WCB 86-00801, 85-06751 & 86-00800
May 17, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee Menashe's order that awarded claimant's attorney a fee of $1,000 for services at a hearing held pursuant to ORS 656.307, to be paid out of claimant's increased compensation. The responsible self-insured employer, in its respondent's brief, contends that the Board does not have jurisdiction to consider an appeal of attorney fees. We affirm.

Issues

(1) Whether the Board has jurisdiction to consider an appeal of attorney fees;

(2) Whether the attorney fee should be paid from or in addition to claimant's compensation; and

(3) The amount of the attorney fee awarded.

FINDINGS OF FACT

Claimant, 51 at hearing, suffered a low back injury in July 1982 while working as a welder for the self-insured employer. In September 1982 she underwent a lumbar laminotomy and nerve root decompression, with removal of herniated intervertebral disc. Her postoperative recovery was impeded by foot drop, for which a foot brace was prescribed. Claimant became medically stationary in June 1983. By Determination Order and Stipulation, she received an award of 35 percent unscheduled permanent partial disability.

In May 1984 claimant began working for the SAIF Corporation's insured, doing light welding. In January 1985, she was assigned to a welding job requiring more standing. In addition, she was assigned to operate a grinder. She stopped working in May 1985, both because of aggravation of her low back condition and because of an April 1985 elbow injury. The elbow injury was accepted by SAIF.

Claimant filed claims with both her former employer and SAIF for her current low back condition. Each carrier denied the claim, suggesting that the other was responsible for claimant's current condition. On March 21, 1986, an order designating a paying agent under ORS 656.307 issued.

Claimant was represented by her attorney at the February 19, 1987 hearing. Counsel took the position that claimant's condition was an aggravation of her original compensable injury, and that the former employer was responsible for the claim. The Referee concurred. Claimant's temporary disability rate under the former employer was substantially higher than it would have been had SAIF's insured been found responsible.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The self-insured employer contends that we lack jurisdiction to consider this appeal, and that the proper forum is the Circuit Court. ORS 656.388(2); Greenslitt v. City of Lake Oswego, 305 Or App 530 (1987). In Greenslitt, the issue was the amount of the fee. 305 Or at 532. In the present case, the issues are the amount of the fee and whether it should be paid from claimant's compensation or by the responsible employer.

The basic provision which defines the category of attorney fee disputes for which review must be sought in circuit court is ORS 656.386(1). The pertinent language provides: "In the event a dispute arises as to the amount [of an attorney fee] allowed by the referee . . . that amount shall be settled as provided for in ORS 656.388(2)." Similarly, ORS 656.388(2) sets forth the circuit court procedure for those cases in which an attorney and the referee, Board or court "cannot agree upon the amount of the fee." (Emphasis added).

We have decided that the language of the statutes, and the policy considerations, support the interpretation that the circuit court proceeding is required only when the sole issue on appeal is the amount of the attorney fee awarded under ORS 656.386(1). Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). Because the aforementioned issue is not the sole issue on appeal here, we have jurisdiction.

Fee out of, or in addition to, compensation

Claimant contends that she is entitled to a carrier-paid attorney fee at hearing for prevailing on the responsibility issue. The Referee awarded a fee, payable out of claimant's compensation. We agree.

Under ORS 656.386(1), a claimant's attorney is entitled to a reasonable carrier-paid fee if the claimant prevails finally

in a hearing before a Referee 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 extent of disability, is at issue. Short v. SAIF, 305 Or 541, 545-46 (1988).

Here, claimant's entitlement to receive compensation was resolved prior to the hearing through the issuance of an order designating a paying agent pursuant to ORS 656.307. See Petshow v. Farm Bureau Insurance Co., 76 Or App 563, 569 (1985), rev den 300 Or 722 (1986); Ronald L. Warner, supra. After the issuance of the .307 order, compensability was not at issue. Thus, no fee may be awarded for services at hearing pursuant to ORS 656.386(1). Larry K. Rose, 41 Van Natta 69 (January 11, 1989). Instead, the attorney fee for claimant's counsel's services is payable from claimant's increased compensation. id.

After considering the factors set forth in OAR 438-15-010(6), we agree with the Referee that an attorney fee of $1,000, payable out of claimant's compensation, is a reasonable award.

ORDER

The Referee's order dated June 9, 1987 is affirmed. A client-paid fee, payable from the self-insured employer to its counsel, is approved, not to exceed $440.

Board Member Crider, concurring in part and dissenting in part:

I concur in that portion of the Board's order which holds that we have jurisdiction to consider the question of entitlement to a carrier-paid fee. I disagree with the majority's conclusion that claimant is not entitled to an insurer-paid fee for participation at hearing. Claimant had a stake in the proceedings. Thus, she is entitled to a fee. SAIF v. Phipps, 85 Or App 436 (1987); Rhonda L. Bilodeau, 41 Van Natta 11 (1989)(Board Member Crider dissenting).

JESUS GARCIA, Claimant
Richard P. Noble, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB TP-88030
May 17, 1989
Third Party Distribution Order
on Reconsideration

On April 13, 1989, we abated and withdrew our March 14, 1989 Third Party Distribution Order that: (1) found that claimant's life expectancy was five years from the date of his November 1986 surgery; and (2) directed claimant's counsel to distribute funds from the remaining balance of the settlement proceeds sufficient to meet the present value of claimant's permanent total disability benefits and home-care services based on claimant's five-year life expectancy and computed as of December 31, 1987. The paying agency objected to our order, contending that a life expectancy of five years was an unreasonable estimate and that we had failed to address its asserted lien for several of its future claim costs. Having received claimant's response to the paying agency's objections, we proceed with our reconsideration.

For the reasons articulated in our prior order, we continue to find that it is reasonable to expect claimant to survive five years from the date of his November 1986 surgery. i.e., November

1991. Consequently, we conclude that the paying agency is entitled to recover from the remaining balance of the third party settlement the present value of its reasonably anticipated future claim expenditures, as described below, based on the aforementioned five-year life expectancy.

We have previously held that the paying agency has established its entitlement to recover future claim costs for claimant's ongoing permanent total disability benefits, $3,000 in burial expenses, $10,748 in beneficiary support compensation, and $1,500 for his parent's monthly home-care services. This recovery shall be based on the present value of these expenses computed as of December 31, 1987, the date of the paying agency's compilation for actual and future claim costs.

The paying agency contends that we omitted several other future claim costs from its asserted lien. Specifically, the agency submits that we overlooked: (1) chiropractic treatments at a frequency of two per month; (2) bi-monthly home services provided by St. Vincent's; (3) monthly medical supplies provided by Providence Home Service; (4) monthly prescriptions from Payless Drug for medication; and (5) claimant's yearly work-up/assessment.

In response, claimant concedes that St. Vincent's bi-monthly home services and the monthly Payless Drug prescriptions are reasonably anticipated future medical expenditures. However, he contests the remainder of the paying agency's projected lien, arguing that the agency has failed to prove that such expenses are reasonably certain to be incurred.

In support of its lien for the aforementioned disputed future claim costs, the agency has submitted a computer ledger account, a December 31, 1987 compilation provided by a claims supervisor, and an August 18, 1988 letter from a claims examiner setting forth the "estimated" claim costs since the December 1987 compilation. The claims examiner has also included an affidavit, stating that the "omitted future claim costs, are true and accurate to the best of our knowledge."

To support its lien for anticipated future expenditures, the paying agency must establish that it is reasonably certain to incur such expenditures. Donald P. Bond, 40 Van Natta 361, 480 (1988); Leonard Henderson, 40 Van Natta 31 (1988). After reviewing the medical and lay evidence, we are not persuaded that the paying agency has proven by a reasonable certainty that the disputed claim expenditures will be incurred in the future.

In reaching this conclusion, we do not question the examiner's mathematical computations in projecting the paying agency's future expenditures. However, the record fails to establish that the services, upon which these projections are based, are reasonably certain to be incurred in the future. Without support from an attending or consulting physician, we conclude that the fact that these medical costs have previously been incurred does not establish that it is reasonably certain that such disputed expenditures shall continue to be incurred.

Accordingly, as supplemented herein, we adhere to and republish our March 14, 1989 order in its entirety. In addition to our prior distribution directions, claimant's counsel is instructed to pay to the paying agency funds from the remaining balance of

settlement proceeds sufficient to meet the present value of St. Vincent's $127.70 bi-monthly home services and Payless Drug's $99.48 monthly prescriptions. As with the previously approved disbursements, the present value of these expenses shall be based on a life expectancy of five years from the November 1986 surgery, and computed as of December 31, 1987. If the aforementioned sums to be disbursed to the paying agency exceed the remaining balance of settlement proceeds, the paying agency shall receive the entire balance. However, should a balance continue to exist following this distribution, the remaining proceeds shall be disbursed to claimant in accordance with ORS 656.593(1)(d).

IT IS SO ORDERED.

DENISE KUPETZ, Claimant
Peter O. Hansen, Claimant's Attorney
Scheminske & Lyons, Defense Attorneys

WCB 88-02897
May 17, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of those portions of Referee Neal's order which: (1) found that claimant's injury claim was not barred for untimeliness; and (2) set aside its denial of claimant's injury claim. On review, the insurer contends it was prejudiced by the late filing of the claim and, alternatively, that claimant's injury did not arise out of or in the scope of her employment.

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

An insurer bears the burden of proving that there has been prejudice from an untimely filing. Inkley v. Forest Fiber Products Co., 288 Or 337, 348 (1980); Raifsnider v. Caveman Industries, Inc., 55 Or App 780 (1982). The passage of time is not itself sufficient to show prejudice; the carrier must prove some actual prejudice. Ford v. SAIF, 71 Or App 825, rev den 299 Or 118 (1985). Specifically, the insurer must prove actual prejudice which occurred after expiration of the 30-day notice period. Grimes v. SAIF, 87 Or App 597, 601 (1987).

After conducting our review, we agree with the Referee that the insurer has failed to establish that it was prejudiced by the untimely filing of claimant's injury claim.

ORDER

The Referee's order dated June 23, 1988 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $1,000. A client-paid fee, not to exceed $2,603, is approved.

EMBERS LARKINS, Claimant
John C. O'Brien, Jr., Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 86-16480
May 17, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Podnar's order which affirmed a Determination Order that declined to award unscheduled permanent partial disability for claimant's right eye condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

On January 15, 1985, claimant was operating a jackhammer when a piece of concrete flew up and struck him in his right eye. Claimant was initially seen for this injury on January 24, 1986, for right eye pain.

As a result of the injury, claimant experienced symptoms of pain, swelling, and inflammation in the right eye. Claimant filed a claim for "foreign object in the eye," which was accepted by the self-insured employer as a nondisabling injury on February 5, 1985.

Claimant's right eye condition was diagnosed as low grade inflammation, and was successfully treated with medication by treating ophthalmogist, Dr. Crawford. On September 27, 1985, Dr. Crawford found claimant's right eye inflammation to be resolved and the condition to be medically stationary.

Simultaneous with the inflammatory right eye condition, claimant suffered from a glaucoma condition. Claimant reported to ophthalmogist, Dr. Huber, with symptoms of pain, flashing lights, aches and swelling. Subsequent visual field studies revealed somewhat reduced visual acuity in the right eye when compared to the left eye. It was also noted that claimant had elevated intraocular pressures. Evaluation of the optic nerves in both eyes revealed evidence of glaucomatous change. Optic nerve damage was greater in the left eye than the right eye despite a greater reduced visual field in the right eye. Claimant's current need for continuing treatment is for the glaucoma condition.

On March 17, 1986, the insurer issued a partial denial denying claimant's glaucoma and vein occlusion condition. The basis of this denial was that claimant's present condition was not related to the compensable injury. This denial was not appealed.

On March 27, 1986, a Determination Order issued awarding temporary total disability, but no permanent disability.

ULTIMATE FINDINGS OF FACT

Claimant has never suffered a permanent impairment nor a permanent loss of earning capacity as a result of his compensable right eye injury.

CONCLUSIONS OF LAW

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the

compensable injury. ORS 656.214(5). In rating the extent of claimant's unscheduled permanent disability, we consider his physical impairment as reflected in the medical record and the testimony at hearing, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines and not as inflexible mechanical formulas. Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984);

We find that claimant's compensable condition of right eye inflammation has resolved without any permanent impairment or loss of earning capacity. Claimant's treating physician for this condition was Dr. Crawford. On September 27, 1985, he declared the condition resolved and claimant medically stationary. On February 26, 1986, he stated there was no permanent impairment resulting from the compensable injury.

At time of hearing, claimant testified that he continued to suffer right-sided partial facial numbness. Claimant also indicated that upon "lots of bending and stooping" he encountered nosebleeds and severe headaches to the point that he was no longer able to do heavy construction. When compared with the medical evidence, we find this testimony unpersuasive. Specifically, we question: (1) the accuracy of claimant's observations; and (2) a causal relationship of these symptoms with the compensable condition.

A medical history of nosebleeds and severe headaches precipitated by bending and stooping does not exist. The only suggestion of such symptoms is found in Dr. Olmscheid's medical opinion of October 22, 1986. In that opinion, he states that claimant reports headaches occurring at night. There is no medical history of nosebleeds. There is also no medical evidence of the disabling effects of bending and stooping. We are unpersuaded that claimant suffers these disabling symptoms. Even more problematic to claimant's claim is the lack of causal connection of these alleged disabling symptoms to the compensable right eye condition. There is no persuasive medical evidence that these symptoms are related to the compensable injury. Rather, the medical record persuasively demonstrates many of claimant's symptoms are related to his preexisting condition of glaucoma. Claimant's physicians are in agreement that the source of claimant's continuing problems stems from damage to the optic nerve, but disagree as to the causation. Drs. Crawford and Samples related the damage to the glaucoma condition, ruling out traumatic origin. On the other hand, Dr. Olmscheid opined that the compensable injury is responsible for causing the optic nerve damage.

We find more persuasive the medical opinions of Drs. Crawford and Samples that claimant's continuing need for treatment derives from the preexisting glaucoma condition and not from the compensable injury. Both have the necessary expertise, as experts in eye disorders. In addition, Dr. Crawford has the benefit of being claimant's treating ophthalmogist. We are also impressed with the thoroughness of Dr. Samples' examination which included an in-depth study of the visual fields. Consequently, we are persuaded that claimant has not suffered any permanent impairment or disabling pain as a result of the compensable right eye injury. Therefore, we agree with the Referee that claimant has sustained no permanent loss of earning capacity due to the compensable injury, and thereby, is not entitled to an award of unscheduled permanent disability.

ORDER

The Referee's order dated October 9, 1987 is affirmed. A client-paid fee, is approved, not to exceed $342.

MARLIN H. NYRE, Claimant
Hayner, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 86-13391
May 17, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Blevins order that upheld the insurer's partial denial of claimant's current cervical condition. The issue on review is compensability. We affirm.

FINDINGS OF FACT

Claimant fell in January, 1985 while at work. He filed a back injury claim. He continued to work until July 26, 1985. He first sought medical treatment on July 29, 1985.

Claimant was treated conservatively by a number of orthopedists and neurologists. He did not mention cervical symptoms until he was examined by Dr. Matthews in August 1985. Thereafter, he gave varying histories to several doctors regarding his cervical condition. On September 18, 1986, the insurer denied claimant's current cervical condition.

ULTIMATE FINDING OF FACT

The medical and lay evidence does not establish that claimant's January, 1985 compensable injury is a material contributing cause of his current cervical condition, or its worsening.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the evidence established only that claimant suffers from cervical arthritis, but did not establish that this condition is work related. We agree.

We give no weight to claimant's testimony. The Referee found claimant to be a poor historian and found him not to be a credible witness. We agree. The medical record does not support claimant's most recent history. We generally defer to the Referee's credibility findings, unless there is good reason not to do so. Here, we agree with the Referee's conclusion.

In order to establish the compensability of his cervical condition, claimant must establish by a preponderance of the evidence that his industrial accident caused his current condition. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). This presents a complex medical question, requiring expert medical opinion. Kassahn v. Publishers Paper, 76 Or App 105 (1985).

The medical evidence may be summarized as follows. Dr. Serbu, neurologist, concluded that the arthritic ridges in claimant's neck were neither caused by his compensable injury nor did the ridges cause his pain. Dr. Campagna, neurologist, opined that the etiology of the condition was not clear. Dr. Bert, treating orthopedist, previously stated that the surgery for claimant's degenerative changes was unrelated to his compensable

injury. However, after receiving a new history, he testified by deposition that claimant's cervical condition was work related.

Claimant relies on Dr. Bert's opinion to establish compensability. We give little weight to Dr. Bert's opinion because it is based on a faulty history. Specifically, Dr. Bert opined that claimant's cervical condition was work related, i.e., a "grab/pull" incident, only after claimant told him that he experienced neck difficulties shortly after the fall. We are unable to find that any "grab/pull" incident occurred during the January 1985 fall to support Dr. Bert's deposition testimony. That history is inconsistent with the facts and is inconsistent with the histories given other physicians. We give little weight to a medical opinion based on a faulty history. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). Consequently, we find that claimant has not proved by a preponderance that his condition is work related and therefore compensable.

ORDER

The Referee's order dated October 20, 1987 is affirmed.

DONALD REED, Claimant
Roger D. Wallingford, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 88-0523M
May 17, 1989
Order to Produce Records

Claimant has asked the Board to direct SAIF Corporation to produce payroll records in connection with this claim for the years 1981 and 1982, contending that the rate at which benefits are being paid to claimant may be incorrect. After consideration of the evidence, the Board grants claimant's request.

Therefore, SAIF Corporation is directed to obtain claimant's 1981 and 1982 payrolls records and provide them to claimant's attorney within 60 days of the date of this order.

IT IS SO ORDERED.

SANDRA J. SEALEY, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0230M
May 17, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her June 18, 1983 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim as it contends claimant's current treatment does not satisfy the requirements of ORS 656.278.

Claimant argues that her worsening occurred prior to the expiration of her aggravation rights. She did see Dr. Waldman on December 14, 1988, one day before her aggravation rights expired on December 15. However, no claim was filed with SAIF Corporation until the doctor's Form 827 dated December 18, 1988. The law is clear that a claim for aggravation must be filed within five years of the first Determination Order. If filing takes place after five years, the claim is in own motion status and subject to the jurisdiction of the Workers' Compensation Board.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits only when we find that there is a worsening of a compensable injury that requires

either inpatient or outpatient surgery or other treatment requiring hospitalization. Claimant's current treatment involves chiropractic care and does not satisfy the requirements set forth above. Claimant argues that the new law which took effect January 1, 1988 should not be applied to her claim. We have previously ruled that the new law includes all own motion claims reopened on or after January 1, 1988, notwithstanding the date of injury. Andy Webb, 40 Van Natta 586 (1988). We conclude we are without authority to grant the relief claimant seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

VERNE T. SMITH, Claimant
Robert B. Johnstone, Claimant's Attorney
Judy Johnson (SAIF), Defense Attorney
Anne Kelley, Assistant Attorney General

WCB 87-01893
May 17, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Neal's order that declined to assess penalties and related attorney fees for an alleged unreasonable failure to properly calculate the rate of temporary disability benefits. On review, the sole issue is penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Between July 18, 1986 and January 16, 1987, the 26 weeks prior to claimant's compensable injury, claimant could have worked a maximum of 135 days for the employer. Due to fire, rain, mill shut downs and truck break downs, however, he worked only 104 days. He did not work at all during three weeks and worked just one day during two more weeks.

CONCLUSIONS OF LAW

We adopt the Referee's conclusions of law with the following comment.

ORS 656.262(10) states that:

> "If the insurer . . . unreasonably delays or unreasonably refuses to pay compensation, . . . [it] shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

At the time of claimant's 1986 compensable injury, ORS 656.210(2) stated that a worker is "regularly employed" if he is actually employed or available for such employment. The rate of compensation for regularly employed workers is computed as outlined in ORS 656.210. 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. id. Former OAR 436-60-020(4) directs that the rate of compensation for workers employed with unscheduled, irregular or no earnings shall be calculated in a

different manner than outlined for workers paid daily or weekly wages in ORS 656.210.

SAIF's decision to recalculate claimant's compensation in accord with former OAR 436-60-020(4) was based on its classification of his employment status as unscheduled or irregular, due to time missed from work as a result of fire, rain, plant shut down and truck breakdown. Claimant contends that SAIF's action was unreasonable in light of several Board and court decisions. We disagree.

Unless one of the aforementioned events occurred, claimant reported to the job site daily at the same time and was given a load of logs to haul to either a mill or water dump. Moreover, he was always paid 30 percent of the gross of whatever his truck made. As the Referee correctly found, claimant was regularly employed despite the temporary absences.

Despite this finding, SAIF was still required to consult the administrative rules because claimant's remuneration was not based solely upon daily or weekly wages. See former ORS 656.210(2) (now ORS 656.210(2)(c)). In this regard, the present case is distinguishable from Saiville v. EBI, 81 Or App 469 (1986), Robert T. Moon, 39 Van Natta 370 (1987), and Eldon Britt, 31 Van Natta 141, 143 (1983).

Each of these decisions concerned the application of ORS 656.210 and the relevant administrative rules prior to the 1985 amendments of the statute. Before the aforementioned amendments, the Director's rules were only applicable to workers who were not regularly employed. Subsequent to the 1985 amendments, the Director's rules were applicable not only to workers who were not regularly employed, but also applied to workers whose remuneration was not based solely upon daily or weekly wages. See Donald E. Lowry, 40 Van Natta 1957, 1958 (1988).

Here, claimant's remuneration was not based upon a daily or weekly wage. Rather, he was paid by the mile. Under such circumstances, we do not consider it unreasonable for SAIF to have referred to the Director's rules in determining the rate of claimant's temporary total disability benefits. Consequently, we decline to assess a penalty or related attorney fee.

ORDER

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

JAMES D. DeROSA, Claimant
Linda Eyerman, Claimant's Attorney
James E. Griffin, Assistant Attorney General

WCB TP-89014
May 26, 1989
Release of Rights

It is hereby stipulated by and between claimant James D. DeRosa, his attorney Linda Eyerman, his employer The Yamaha Store of Bend, Oregon Inc., its insurer SAIF Corporation, and its counsel James E. Griffin, Assistant Attorney General, as follows:

On or about June 24, 1980 claimant was involved in a motorcycle/truck accident in the course and scope of his employment, in which he suffered

multiple abrasions to his knees and arms, open comminuted segmental fracture of the left humerous, and a tear of the anterior cruciate ligament of the right knee and fracture of the proximal medial tibial tubercle; and

That claimant made claim for certain benefits pursuant to Oregon workers' compensation law, against his employer and SAIF Corporation, which claim was accepted and was duly paid; whereafter a Determination Order issued May 22, 1984 ordering certain disability benefits, claimant appealed said order, which appeal was ultimately settled by the parties August 28, 1985 by stipulation awarding certain further disability benefits; and

Claimant pursued a third party civil claim against the driver of the other vehicle involved in the June 24, 1980 collision, which claim was settled in a gross sum of $15,000 with SAIF Corporation's approval resulting in SAIF Corporation receiving $7,400.63 in partial reimbursement of its lien pursuant to ORS 656.593. The attorney representing claimant, however, omitted and neglected to prosecute an action against other parties then thought to be partially responsible for claimant's injury and damages; and

Thereafter, claimant retained substitute counsel to prosecute a claim of professional negligence against claimant's original attorney for the neglect and omission referred to above, which claim is presently in litigation and which claimant and his attorney presently desire to settle by compromise and seek SAIF Corporation's approval and waiver of the remainder of SAIF Corporation's lien; and

A distribution of the gross proceeds of the proposed settlement of the action against the prior attorney pursuant to ORS 656.593 would not fully compensate SAIF Corporation for the extent of its remaining unsatisfied lien; and

In return for SAIF Corporation's approval of the proposed settlement, and waiver of the balance of its lien rights, pursuant to Roger Riepe, 37 Van Natta 3 (1985) and Robert Pilczynski, 37 Van Natta 39 (1985), claimant offers and wishes to release completely all his rights under Oregon workers' compensation laws arising from or in any way connected to the motor vehicle accident June 24, 1980; now therefore it is hereby

STIPULATED, AGREED AND COVENANTED, subject to the approval of the Workers' Compensation Board, that claimant fully releases and compromises all workers' compensation benefits relating to or any in way connected with the motor vehicle accident of June 24, 1980 and his claim D462658F, in return for SAIF Corporation's approval of the proposed settlement and waiver of any remaining portion of its lien applicable thereto. Claimant in so agreeing, understands that he shall receive no future benefits from SAIF Corporation or The Yamaha Store of Bend, Oregon Inc., that he is releasing both of them, there agents, employees and representatives, of and from any and all claims, causes of action, liabilities or assertions thereof, and he further agrees that, in the event that any claim is made by any person providing medical services to him, or any health insurance carrier for benefits paid to him, that he will indemnify and hold harmless SAIF Corporation and The Yamaha Store of Bend, Oregon Inc. of and from any such claims, financial obligations or liabilities, and will at his sole expense defend them against such claims; and claimant further understands that by this document he is releasing, among other things and without limitation, rights to the expenses of medical care, time loss, disability, and aggravation; and

This document is freely entered into on a voluntary basis, and has been read and understood, and opportunity had for legal advice prior to execution.

This release of rights is found to be reasonable and appropriate pursuant to ORS 656.587 and is hereby approved. Claimant's previously accepted claim, D462658F, is hereby fully compromised effective May 1, 1989.

RODGER I. TAYLOR, Claimant
Black, Chapman & Webber, Claimant's Attorneys
David O. Horne, Defense Attorneys

WCB 87-07054
May 26, 1989
Order on Reconsideration

Claimant requests reconsideration of our May 3, 1989 Order of Dismissal that dismissed the insurer's request for review of the Referee's order that awarded claimant a reasonable attorney fee. Claimant now requests an attorney fee for services on Board review.

Attorney fees are not "compensation" within the meaning of ORS 656.382(2). Therefore, claimant is not entitled to

attorney fees for successfully defending such an award on review. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Furthermore, claimant's brief was not timely filed and was, therefore, not accepted. Consequently, no attorney fee would be awarded in any event. See Shirley M. Brown, 40 Van Natta 879 (1988).

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 3, 1989 order. The parties' rights of appeal shall run from the date this order.

IT IS SO ORDERED

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

WCB 85-15422 & 85-15423
May 30, 1989
Second Order on Remand

Claimant has requested reconsideration of our May 11, 1989 Order on Remand that declined to award an insurer-paid attorney fee for her counsel's efforts in prevailing at the Board level against a request for review filed by Aetna Casualty Company, on behalf of Regina's Restaurant. We declined to award an attorney fee because claimant's counsel had not filed a statement of services. Enclosing a statement of services, claimant seeks an attorney fee pursuant to ORS 656.382(2).

In reaching our determination of a reasonable attorney fee for services on Board review, we note that claimant is not entitled to an attorney fee for services rendered in defending the Referee's award of an attorney fee. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). We further note that claimant was not entirely successful on Board review in her defense of the amount of the Referee's attorney fee award. Therefore, attorney fees for services rendered on Board review in regard to the Referee's award of attorney fees is not recoverable.

After review of the statement of services and the retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we award a reasonable assessed fee of $650 for services on review concerning the compensability/responsibility issue, to be paid to claimant's attorney by Aetna.

Accordingly, our May 11, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 11, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

BEVERLY J. MARTINEZ, Claimant
Shirley Horgen, dba, THE LOLLIPOP TREE, Employer
Olson Law Firm, Claimant's Attorney
W. Bradley Coleman, Attorney
Gary Wallmark (SAIF), Defense Attorney
Carl Davis, Assistant Attorney General

WCB 87-16874
May 30, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Borchers' order that upheld the noncomplying employer's denial of her right shoulder condition.

The Board reverses the order of the Referee.

ISSUE

Whether the noncomplying employer properly denied claimant's accepted nondisabling right shoulder condition.

FINDINGS OF FACT

Claimant began working for the noncomplying employer, a day care center, in March, 1987. In addition to her teaching duties, she regularly swept floors, cleaned bathrooms, and emptied trash. In April, 1987, she began to experience right shoulder pain, but continued working. Her pain worsened on May 27, 1987, while lifting a film projector. The following day, she consulted Dr. Balmer, M.D. She did not inform Balmer that her right shoulder pain was related to her work. Balmer diagnosed mild right shoulder tendonitis and treated with aspirin.

Thereafter, claimant returned to regular work until the end of the school year in early June, 1987. At that point, her job terminated until the following school year. Sometime prior to September 8, 1987, the noncomplying employer informed claimant that she would not be rehired for the 1987-1988 school year. On September 8, 1987, claimant filed an industrial claim for her right shoulder condition.

Apparently as a result of claimant's industrial claim, the Workers' Compensation Department began investigating the complying status of the noncomplying employer. On September 29, 1987, the Department issued a Proposed and Final Order, which found the noncomplying employer to be in noncompliance from January 2, 1985, to September 16, 1987. By letter, dated October 18, 1987, the noncomplying employer requested a hearing to contest the compensability of "any injury" to claimant. That letter contained no notice of hearing rights and was not mailed to claimant.

Claimant was reexamined by Dr. Balmer on November 16, 1987. At that time, she informed Balmer that she believed her right shoulder condition was related to her janitorial duties between March and June 1987. Given that history, Balmer opined that her condition was work related.

On November 25, 1987, SAIF accepted claimant's right shoulder claim as a nondisabling injury. That same day, SAIF notified the noncomplying employer that it could request a hearing on the issue of compensability, if requested within 60 days.

Claimant was examined by Dr. Stevens, an orthopedic surgeon, in January 1988. Stevens diagnosed right shoulder bursitis and tendonitis secondary to repetitive movements.

At the hearing, claimant sought to contest the nondisabling status of her right shoulder condition. By agreement of the parties, that issue was preserved for a later hearing.

CONCLUSIONS OF LAW

Finding claimant not credible, the Referee concluded that claimant had not proven the compensability of her right shoulder condition. We disagree.

Shortly after the Referee issued her order, the Court of Appeals decided the case of Derryberry v. Dokey, 91 Or App 533 (1988). In Derryberry, the Derryberrys were found to be noncomplying employers by an order of the Workers' Compensation Department. Two weeks later, SAIF accepted the worker's industrial injury claim. The Derryberrys promptly requested a hearing on the issues of compensability and whether they were complying employers.

The Derryberry court held that the worker's injury was compensable, inasmuch as the Derryberrys had not properly denied the worker's industrial claim. 91 Or App at 536-37. That is, the Derryberrys' request for hearing contained no notice of hearing rights and was never mailed to the worker.

Here, like Derryberry, the noncomplying employer requested a hearing by mailing a letter to the Department. Again like Derryberry, that letter contained no notice of hearing rights and, so far as the record reveals, was never mailed to claimant. See ORS 656.262(8). Accordingly, inasmuch as the noncomplying employer did not issue a proper denial, claimant is entitled to all benefits under the law for her nondisabling right shoulder injury.

ORDER

The Referee's order dated April 11, 1988 is reversed. Claimant's attorney is awarded an assessed fee of $1,600 for services rendered at the hearing and on Board review, to be paid by the SAIF Corporation as processing agent for the noncomplying employer.

MICHAEL F. YANCEY, Claimant
Vick & Gutzler, Claimant's Attorneys
Sharon Schooley (SAIF), Defense Attorney

WCB 88-13931
May 30, 1989
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Hoguet's order that awarded claimant 11 percent (35.2 degrees) unscheduled permanent disability for a back injury, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

We find that claimant has sustained permanent impairment as a result of his February 1988 compensable back injury. In reaching this conclusion, we rely upon the findings and opinion authored by Dr. Mizrahi, claimant's former treating chiropractor. Mizrahi has had an advantage in examining claimant on a variety of occasions, including shortly after the compensable injury and when claimant's condition became medically stationary. In addition, Mizrahi has submitted a thorough and detailed evaluation of claimant's condition, as well as his permanent physical limitations.

SAIF argues that we should rely on other medical opinions. In particular, it refers to claimant's current treating chiropractor, Dr. Smith, who "basically concurred" with the Orthopaedic Consultants' report, which had found no permanent impairment. We find Mizrahi's report more persuasive.

We consider the Consultants' opinion to be internally inconsistent. Specifically, the Consultants found claimant to be medically stationary, while at the same time diagnosing "resolving" cervical and lumbar strains that "will continue to improve to some degree in the future." In addition, despite Dr. Smith's eventual basic concurrence with the Consultants' opinion, Smith had not considered claimant's condition to be medically stationary and had not released claimant to work following an examination which was conducted shortly after the Consultants' examination.

Finally, we note that the Referee stated that the range of motion findings must be evaluated in active, rather than passive, degrees of motion. In arriving at this conclusion, the Referee applied OAR 436-35-010(3), which states, inter alia, that "[t]he movement in a joint is measured in active degrees of motion." However, the aforementioned rule expressly pertains to the disability standards for rating scheduled permanent disability.

Inasmuch as we are evaluating unscheduled permanent disability, OAR 436-35-010(3) does not apply. Furthermore, because there is no corresponding "active degrees of motion" requirement in rating unscheduled permanent disability, we do not discount range of motion findings on the ground that they are based on passive degrees of motion. Therefore, although we continue to find the Orthopaedic Consultants' opinion unpersuasive for the reasons previously discussed, we do not reach this conclusion because its findings may have been based on passive range of motion findings.

ORDER

The Referee's order dated November 10, 1988 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed fee of $700, to be paid by the SAIF Corporation.

Board Member Ferris, dissenting:

I dissent.

I am more persuaded by the findings and opinions offered by the Orthopaedic Consultants. Following an extensive examination, the Consultants provided a thorough report detailing why they had concluded that claimant had not sustained permanent

impairment resulting from his compensable injury. Furthermore, Dr. Smith, claimant's treating chiropractor, "basically concurred" with the Consultants' report. I consider these opinions to be more persuasive than the opinion of Dr. Mizrahi, claimant's former treating chiropractor, who had briefly treated claimant after his February 1988 compensable injury and did not examine claimant again until October 1988.

Inasmuch as I am not persuaded that claimant has suffered permanent impairment as a result of his compensable injury, I would affirm the Determination Order, which declined to award unscheduled permanent disability.

ROBERT CLOUGH, Claimant
SAIF, Insurance Carrier

Own Motion 87-0692M
May 31, 1989
Own Motion Determination

The Board issued its Own Motion Order in the above-entitled matter on December 21, 1987, reopening this claim for a worsened condition related to claimant's industrial injury of September 12, 1975. The claim has now been submitted for closure.

FINDINGS OF FACT

Claimant was injured in a compensable logging accident in September 1975. That injury has resulted in multiple right hip surgeries, including a full hip replacement. Claimant's injury claim was reopened on October 23, 1987 for a compensable worsening of his condition. On September 7, 1988, he was found medically stationary by Dr. Toomey, his treating physician. Dr. Toomey reexamined claimant in October and November 1988 and continued to find him medically stationary.

Claimant is permanently restricted to sedentary work as a result of his objective physical impairment. He is 46 years of age with a 7th grade education and poor reading and writing skills. His work experience is limited to heavy and medium level jobs. He has no transferable skills for sedentary work.

FINDINGS OF ULTIMATE FACT

Claimant became medically stationary on September 7, 1988. He is not presently employable at work within his physical capabilities. Work search efforts would be futile.

CONCLUSIONS OF LAW AND OPINION

Claimant's injury claim was reopened for aggravation on October 23, 1987, and he became medically stationary on September 7, 1988. He is, therefore, entitled to temporary total disability for that period, less time worked.

Claimant is also entitled to reevaluation of his permanent disability. In December 1988, he was evaluated by a team of medical and vocational experts. At that time, he complained of constant disabling pain in his low back and right hip and leg, and occasional pain in his left leg and upper extremities. The medical and vocational experts noted a significant degree of functional overlay and an obvious lack of motivation in finding employment. Nevertheless, they agreed that claimant is restricted to sedentary activity as a result of

objective physical impairment, without regard to any additional disability attributable to his functional overlay. They further opined that claimant had no transferable skills for sedentary work and would need retraining in order to be employable.

We defer to the opinion of these experts because they conducted the most recent, thorough evaluation of claimant's condition. Their opinion persuades us that claimant is restricted to sedentary activity for which he has no transferable skills. Based on these findings, we conclude that work search activity would be futile, and that claimant is entitled to an award of permanent and total disability. This award shall be effective September 8, 1988. Deduction of overpaid temporary disability benefits from unpaid permanent disability benefits is approved.

IT IS SO ORDERED.

KENNETH C. BAKER, Claimant
Schwabe, et al., Defense Attorneys

WCB 87-14577 & 87-00325
March 7, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Galloway's order that: (1) upheld the insurer's denial of his aggravation claim relating to his neck; and (2) affirmed the award by Determination Order of 10 percent (32 degrees) for his low back. We affirm.

ISSUES

1. Aggravation of claimant's neck condition.

2. Extent of claimant's low back disability.

FINDINGS OF FACT

The Neck Injury

Claimant sustained a compensable cervical strain on October 22, 1982 when he bumped the top of his head on the bottom of an overhead door. Claimant's symptoms included neck pain and headaches. The injury was treated by Dr. Stevens, a family practitioner, and Dr. Stilson, a chiropractor, and improved steadily until March 1983, when Dr. Stilson indicated that claimant was medically stationary. The claim was closed by Determination Order dated March 31, 1983 with no award of permanent partial disability.

Other than a few headaches, claimant experienced no further symptoms due to his 1982 industrial injury for more than four years. Then, on the morning of July 23, 1987, claimant awoke with a sore neck. He sought medical treatment for the pain from Dr. Stilson. There is no evidence that the neck pain which he experienced in July 1987 made him less able to work. The insurer issued an aggravation denial on August 26, 1987.

The Back Injury

Claimant compensably strained his low back in May 1984 when he twisted while lifting a box. The injury was treated conservatively by Dr. Puziss, an orthopedic surgeon. Claimant's claim for the injury was closed by Determination Order dated

April 11, 1985 with no award of permanent partial disability. A stipulation approved several months later granted claimant an unscheduled award of 5 percent (16 degrees).

Claimant experienced an aggravation of his condition in March 1986 and he resumed treatment with Dr. Puziss. Diagnostic tests conducted a short time later revealed a bulging L4-5 disc. Dr. Puziss declared claimant medically stationary in September 1986 and rated his low back impairment as "minimal to mild." (Ex.20). The claim was reclosed by Determination Order dated May 4, 1987 with an additional 5 percent award for a total of 10 percent (32 degrees) unscheduled permanent partial disability.

Claimant was 31 years old at the time of the hearing. He has a GED and his work history includes jobs as a service station attendant, carnival worker, welder, sheet metal worker, woodworker, retail salesperson, truck driver, forklift operator, sandblaster and electrical maintenance worker. Because of his back injury, claimant is unable to perform work requiring heavy or repetitive lifting.

ULTIMATE FINDINGS OF FACT

1. Claimant experienced pain in his neck in July 1987 as a result of his October 1982 industrial injury. There is no evidence that the pain resulted in either a temporary or permanent decrease in earning capacity.

2. Claimant's impairment due to the May 1984 low back injury is in the lower portion of the mild range.

CONCLUSIONS OF LAW

Aggravation of the Neck Condition

To establish an aggravation under ORS 656.273(1), claimant has the burden of proving a worsening of his condition and a causal relation between the worsened condition and his October 1982 industrial injury. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 459, rev den 297 Or 82 (1984). The causal relation between claimant's episode of neck pain in July 1987 and his October 1982 industrial injury is not disputed. The focus of inquiry, therefore, is on the question of a worsening.

To prove a worsening, claimant must show a change in his condition which renders him less able to work and thus entitles him to additional temporary or permanent disability compensation. Smith v. SAIF, 302 Or 396, 399-402 (1986). Claimant experienced an increase in neck pain in July 1987. However, there is no evidence that this increase in pain rendered claimant less able to work. We conclude, therefore, that claimant has failed to prove a worsening of his condition and that the denial of his claim for aggravation should be upheld.

Extent of Low Back Disability

The criterion for rating unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. In determining 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 former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Based upon claimant's mild impairment, his relatively young age, his high school equivalency degree, his varied work history and the other relevant social and vocational factors, we conclude that the award granted by the most recent Determination Order and affirmed by the Referee of 10 percent (32 degrees) unscheduled permanent partial disability adequately and appropriately compensated him for the loss of earning capacity due to his compensable injury.

ORDER

The Referee's order dated January 12, 1988 is affirmed. A client-paid fee of up to $1,498 is approved.

KEITH OTTERSON, Claimant
Peter O. Hansen, Claimant's Attorney
Miller, Nash, et al., Defense Attorneys

Own Motion 89-0145M
June 6, 1989
Own Motion Order

Claimant has appealed the insurer's recent closure of his June 11, 1980 injury claim. Claimant's aggravation rights have expired. The insurer voluntarily paid temporary disability benefits from May 20, 1988 through January 16, 1989.

Pursuant to ORS 656.278(1)(a), injured workers whose claims are in own motion status may be entitled to compensation for temporary disability benefits only when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Claimant's claim was reopened for the payment of temporary disability benefits as of May 20, 1988 even though no hospitalization or surgery was required at that time. This is contemplated and allowed by OAR 438-12-025(3), although the insurer was under no obligation to provide such benefits. Although claimant became medically stationary on June 7, 1988, the insurer continued payments while attempting to provide him with vocational assistance. He was placed in a training program in September 1988 and his benefits continued until completion of the program on January 16, 1989. This program was not an Authorized Training Program and was not subject to the requirements of ORS 656.268(5).

It is apparent that claimant's temporary disability benefits were paid voluntarily, without obligation under the existing law. We find no reason to disturb the closure order as it pertains to temporary disability benefits. With respect to permanent disability benefits, the law restricts our authority in own motion cases so as to preclude an increased permanent disability award. Orville D. Shipman, 40 Van Natta 537 (1988). We conclude, therefore, the January 31, 1989 claim closure should be affirmed in all respects.

IT IS SO ORDERED.

ALMA L. OWENS, Claimant
Kilpatricks & Pope, Claimant's Attorneys
Terrall & Miller, Defense Attorneys

WCB 87-00120
June 6, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of those portions of Referee T. Lavere Johnson's order that: (1) set aside its denial of temporary disability benefits; and (2) set aside its denial of medical services for claimant's right knee condition. We reverse.

ISSUE

Whether claimant's compensable August 15, 1986 right knee injury remains a material contributing cause of her right knee condition.

FINDINGS OF FACT

On August 15, 1986, claimant was employed as a licensed practical nurse. On that date, she compensably injured her right leg. She complained of pain in the upper and inner thigh area of the right leg. On August 16, 1986, claimant sought medical treatment for the condition from Dr. Fleck. He found tenderness in the medial aspect of the right knee and diagnosed a right knee sprain. The claim was accepted as a nondisabling compensable injury. Time loss benefits were authorized for claimant for at least three days. Claimant did not seek medical treatment again for the right knee until January 21, 1987.

In 1983 claimant injured her left knee in a home accident. Dr. Smith, orthopedic surgeon, diagnosed mild chondromalacia of the patella and Pes Anserinous syndrome. Claimant continued to have pain in her left knee through the date of the hearing. In October 1986 the problem had become severe enough that Dr. Smith began discussing the possibility of a proximal wedge osteotomy of the tibia to realign the weightbearing of the left knee so that claimant would stop placing stress on the medial side of her knee joint. In November 1986 claimant saw another physician who recommended that she lose approximately 100 pounds. At the time, she was 5'2" and weighed 204 pounds.

Claimant's compensable right knee injury resolved soon after the initial August 1986 injury date. On November 19, 1986, claimant returned to Dr. Kellogg, her family physician, with increasing left knee complaints. Dr. Kellogg recommended a medical leave from work due to left knee pain from December 1, 1986 until the end of January 1987. Claimant did not have any right knee pain at that time. On January 21, 1987, she complained of pain below the left knee on the inside of the leg and told Dr. Kellogg that her right knee felt like it was going to give out.

On September 28, 1987, claimant falsely informed Dr. Smith that she was having such intense pain in the right knee in December 1986 that Dr. Kellogg recommended a medical leave of absence at that time. In fact, claimant was not having right knee difficulty in December 1986. Based on that false history and claimant's complaints of aching along the medial side of the tibia below the knee joint, Dr. Smith diagnosed a soft tissue strain due to the compensable August 1986 injury. His examination revealed a basically normal right knee.

On February 18, 1987, the insurer denied claimant's claim for temporary disability benefits since the medical evidence did not indicate that the time loss benefits were related to her August 1986 injury. On April 7, 1987, the insurer further denied authorization for physical therapy, contending that her current condition was not related to the August 1986 industrial injury.

On April 20, 1987, Dr. Smith again examined claimant's right knee and concluded that the knee itself was fine.

ULTIMATE FACTS

Claimant's compensable right knee condition resolved shortly after the August 15, 1986 injury. Whatever right knee symptoms claimant began to experience in January 1987 were not materially caused by the compensable August 1986 injury.

CONCLUSIONS OF LAW

Although the Referee found that claimant was not a credible witness, he concluded that her January 1987 symptoms were similar enough to the August 1986 symptoms to warrant a finding of material relationship. We disagree.

Claimant's entitlement to temporary disability benefits and medical services depend upon whether her compensable August 1986 right knee injury remains a material contributing cause of her current right knee condition. Joy D. Gillham, 38 Van Natta 1424 (1986).

Claimant was not a credible witness. On August 16, 1986, she sought medical treatment for upper, inner right thigh pain. Dr. Fleck found tenderness in the medial aspect of the right knee. Thereafter, although claimant's regular visits to Dr. Kellogg for left knee pain were well documented, there was no indication at any time that she was having any right knee pain. In November 1986, when Dr. Kellogg recommended a medical leave for claimant, he unambiguously stated that the recommendation was based on claimant's left knee pain. Again, there was no indication that claimant was having any difficulty with her right knee at that time.

Finally, on January 21, 1987, claimant complained to Dr. Kellogg that her right leg felt like it was going to give out on her. On January 28, 1987, claimant complained to Dr. Smith of aching along the medial side of the tibia below the knee joint. The site of these symptoms did not correspond with the site of the symptoms following the compensable injury in August 1986, which were located in the upper, inner right thigh.

Dr. Smith opined in his January 1987 report that claimant's right knee pain was due to a soft tissue strain suffered at the time of the August 1986 injury. Dr. Smith was subsequently deposed, however. In that deposition, he explained that, if the facts were as he understood them when he authored the January 1987 report, then he would stand by that report. (Ex. 14-13). The "facts" he was referring to were that claimant was having so much difficulty with her right knee in December 1986 that she needed a leave of absence from work. (Ex. 14-14). We have already found that such was not the case. Dr. Smith indicated that, if claimant was not having extreme right knee difficulty in December 1986, then he would change his opinion and find that there was no causal relationship between the compensable August 1986 injury and her then current condition. (Ex. 14-10).

Although Dr. Kellogg opined in June 1987 that claimant was still disabled from work as a result of trauma to the right knee, he did not offer an opinion regarding the causal relationship between the August 1986 industrial injury and claimant's then current condition. Accordingly, we give his opinion little weight.

Based on the medical and lay evidence, we conclude that claimant has not shown that a material causal relationship exists

between her compensable August 1986 right knee injury and her right knee symptoms as they developed in January 1987.

ORDER

The Referee's order dated October 1, 1987 is reversed. The insurer's denials of temporary disability benefits and medical services, dated February 18, 1987 and April 7, 1987, are reinstated and upheld.

SANDRA L. BERKEY, Claimant
Brown & Tarlow, Claimant's Attorneys
Merrily McCabe (SAIF), Defense Attorney

WCB 86-00608
June 8, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Berkey v. Fairview Hospital, 94 Or App 28 (1988). In our Order on Review, dated July 14, 1987, we found, inter alia, that claimant was not entitled to interim compensation because she had not proven a "medically verified inability to work." ORS 656.273(6). The court disagreed and remanded this case "for a determination of the amount of temporary disability and to determine whether SAIF's failure to pay interim compensation justifies penalties and attorney fees." We proceed with our determination.

FINDINGS OF FACT

Claimant sustained a compensable injury to her left shoulder in December, 1984. After the closure of her claim in December, 1985, she continued to receive treatment for her injury from Dr. Winkler, her treating physician. On March 13, 1986, Winkler wrote to SAIF, requesting that it reopen claimant's claim due to increased pain in her left shoulder. SAIF received Winkler's report on March 17, 1986. In a report dated March 18, 1986, claimant's vocational counselor stated that Winkler had instructed claimant to refrain from seeking work due to her shoulder condition. SAIF received the vocational counselor's report on March 27, 1986.

SAIF issued an aggravation denial on July 22, 1986, but did not pay interim compensation. Claimant was neither working nor seeking work between March 27, 1986, the date SAIF received the vocational counselor's report, and July 22, 1986, the date of SAIF's denial. SAIF's failure to pay interim compensation was not unreasonable.

CONCLUSIONS OF LAW

Interim Compensation

A worker is entitled to the payment of interim compensation within 14 days of the date the insurer has notice or knowledge of a "medically verified inability to work resulting from the worsened condition." ORS 656.273(6). Here, SAIF received the report from claimant's vocational counselor on March 27, 1986. The Berkey court has found that that report satisified the requirements of ORS 656.273(6). 94 Or App at 31. Therefore, we find that SAIF should have commenced payment of interim compensation no later than the 14th day after March 27, 1986.

We turn to the proper period of time SAIF's payments must cover. In Silsby v. SAIF, 39 Or App 555 (1979), the court found that the worker had proven a compensable aggravation. 39 Or

App at 560. However, because there was no "medical verified inability to work," ORS 656.273(6), until after the worker's aggravation claim had been denied, the court held that the worker was not entitled to interim compensation. 39 Or App at 563.

Shortly after Silsby, the court further addressed the matter of the proper period of interim compensation payments. Kosanke v. SAIF, 41 Or App 17 (1979); see also Stone v. SAIF, 57 Or App 808 (1982). In Kosanke, the court affirmed the Board's finding that the worker had not established a compensable aggravation. It went on to further affirm the Board's finding that the worker's period of interim compensation did not run from the date of his disability, but, rather, from the date the carrier received notice of his inability to work pursuant to ORS 656.273(6). In so doing, the Kosanke court distinguished Silsby, stating:

> "In Silsby v. SAIF, [citation omitted], compensation was ultimately held to be owing from the date of disability. However, the fact that compensation was due for the period of time between disability and notice in Silsby was due to the fact that the claim in that case was ultimately sustained. In the present case, by contrast, the aggravation was not allowed. Therefore, all claimant was entitled to under ORS 656.273(6) was payment from 14 days after notice." 41 Or App at 17, n. 2. [Emphasis added].

The aforementioned holdings lead us to conclude that, pursuant to ORS 656.273(6), interim compensation runs from the date of notice of a medically verified inability to work resulting from the worsened condition until the date of acceptance or denial of the claim. If the claim is compensable, temporary disability compensation (as opposed to interim compensation) is due from the date of disability. If the claim is not compensable, interim compensation runs only from the date of notice of a medically verified inability to work. Here, like Kosanke and unlike Silsby, claimant has not proven a compensable aggravation claim. Accordingly, we conclude that claimant is entitled to interim compensation for the period March 27, 1986 (the date of notice) through July 22, 1986 (the date of SAIF's denial).

Penalties and Attorney Fees

Penalties and attorney fees are assessable when a carrier unreasonably refuses to pay compensation or to deny a claim. ORS 656.262(10).

Here, SAIF did not pay interim compensation. However, prior to the Berkey decision, the law was unsettled as to whether a vocational counselor's report could satisfy the "medically verified" requirement of ORS 656.273(6). Under such circumstances, we conclude that SAIF had a legitimate doubt as to whether the vocational counselor's report triggered a duty to pay interim compensation. Therefore, we do not consider its conduct to have been unreasonable. Consequently, we decline to assess penalties and attorney fees for SAIF's refusal to pay interim compensation.

Accordingly, claimant is awarded interim compensation

payable from March 27, 1986 through July 22, 1986. Claimant's attorney is awarded an approved fee, payable from claimant's compensation, equal to 25 percent of the interim compensation awarded by this order, not to exceed $3,800.

IT IS SO ORDERED.

Board Member Crider, specially concurring:

I concur in the majority's opinion. I write separately to explain my views in more detail.

I have grave doubts about the viability of the doctrine articulated in Kosanke v. SAIF, 41 Or App 17 (1979), the authority upon which we rely. Kosanke's holding that temporary disability compensation benefits due prior to a denial of compensability are calculated differently depending on the outcome of litigation concerning compensability appears to fly in the face of the Supreme Court's teaching concerning the relationship between so-called interim compensation and temporary disability compensation. That holding, of course, is that interim compensation is calculated in exactly the same manner as is temporary disability compensation.

We simply use the term interim compensation to apply to temporary disability compensation that must be paid pursuant to ORS 656.262 before the issuance of an acceptance or denial of a claim. Bono v. SAIF, 298 Or 405 (1984); Jones v. Emanuel Hospital, 280 Or 147 (1977). Only the Court's recent reaffirmance of the Kosanke holding, in Spivey v. SAIF, 79 Or App 568 (1986), constrains me to the view that the Court believes the Kosanke doctrine to remain viable.

Temporary disability compensation must be paid within 14 days of notice of a claim or, in an aggravation case, within 14 days of notice of medically verified inability to work. ORS 656.273(6). Once the duty to pay is triggered, the amount payable extends back to the date of disability. Silsby v. SAIF, 39 Or App 555 (1979). If the claim is denied, however, the duty to pay compensation for periods of future disability is extinguished unless the denial itself is found invalid. Georgia Pacific Corp. v. Piwowar, 305 Or 494, 501 (1988). But the denial does not relieve the insurer of the duty to pay compensation for the period preceding the denial. Jones v. Emanuel Hospital, supra.

Therefore, when, as here, the Board must determine what compensation is due for the period preceding the denial, the issuance of the denial should be irrelevant. As the Supreme Court said in Bono v. SAIF, supra:

> "There is no independent interim compensation benefits calculation in ORS 656.262(4). The amount of interim compensation payments is determined in the same manner as the amount of temporary total disability benefits."

Id., at 409. Relying on this proposition, the Bono Court rejected the claimant's contention that, in an original claim, interim compensation benefits must be paid for the period following filing of a claim without respect to when claimant left work due to the injury. The Court declared that the period for which compensation is due is the same whether payments are "interim compensation" or

whether the claim has already been accepted. If this principle were applied to an aggravation case such as this one, where the insurer contends that interim compensation benefits need not have been paid for the period before it had notice of the aggravation claim, although claimant became disabled prior to the notice simply because the claim was not ultimately found compensable, it would require rejection of the insurer's contention.

The effect of the Kosanke rule is to allow the insurer to flout the duty to pay compensation pending acceptance or denial, gambling that the denial will ultimately be affirmed. If the denial is affirmed, the insurer will be required to pay less in temporary disability compensation than it would be required to pay if the denial were set aside. This is inconsistent with the principle that the duty to pay attaches when notice of medically verified inability to work is received and is independent of the validity or invalidity of a subsequently issued denial.

Were I writing on a clean slate, I would conclude that the claimant is entitled to interim compensation for the period commencing when she became disabled from work and that the Board should make findings accordingly.

MICHAEL W. CORNING, Claimant
Charles D. Maier, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 86-04043 & 88-05307
June 8, 1989
Order on Review (Remanding)

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Borcher's order that dismissed his request for hearing for lack of jurisdiction. We reverse the Referee's dismissal of WCB Case No. 88-05307 and remand for further proceedings. Claimant also requests a carrier-paid attorney fee for services on Board review. We deny this request. The issues are jurisdiction and attorney fees.

FINDINGS OF FACT

Claimant compensably injured his back in May 1985. On March 30, 1987, the insurer issued a partial denial relating to a wrist injury which claimant alleged had occurred in February 1987 during a work hardening program for his back. Claimant requested a hearing on the denial and it was consolidated with requests for hearing on other issues in WCB Case No. 86-04043.

After a hearing, Referee Mirassou issued an Opinion and Order in WCB Case No. 86-04043 on January 19, 1988. Among other things, the order set aside the insurer's denial of claimant's wrist condition and remanded the claim to the insurer "for further processing and payment of all compensation due until closure pursuant to ORS 656.268."

On January 25, 1988, the insurer requested reconsideration of the Referee's order on a number of issues, not including the denial of claimant's wrist condition. On February 5, 1988, Referee Mirassou issued an order abating her January 19 Opinion and Order.

On February 15, 1988, claimant filed a request for hearing which alleged failure of the insurer to pay temporary disability compensation within 14 days of Referee Mirassou's January 19 Opinion and Order and requested a penalty and

associated attorney fee. This request was assigned WCB Case No. 88-05037. On March 4, 1988, Referee Mirassou issued an Order on Reconsideration in WCB Case No. 86-04043 which modified her original Opinion and Order in several respects, but not with respect to the denial of claimant's wrist condition. None of the parties requested Board review of this order within 30 days after it issued.

On March 10, 1988, the insurer requested dismissal of claimant's February 15 request for hearing on the ground that it was filed during the period between Referee Mirassou's Order of Abatement and her Order on Reconsideration. Claimant filed a duplicate of his February 15 request for hearing with the Hearings Division on April 7, 1988. Referee Borchers dismissed claimant's request for hearing by order dated May 6, 1988. The order referenced WCB Case No. 86-04043 as well as WCB Case No. 88-05307. Claimant requested Board review of Referee Borchers' order on May 12, 1988. The request for Board review also referenced both WCB Case No. 86-04043 and WCB Case No. 88-05307.

FINDINGS OF ULTIMATE FACT

Referee Mirassou's Order on Reconsideration in WCB Case No. 86-04043 is final by operation of law. Claimant filed his second request for hearing in WCB Case No. 88-05307 after Referee Mirassou issued her Order on Reconsideration in WCB Case No. 86-04043.

CONCLUSIONS OF LAW

Referee Borchers dismissed claimant's first request for hearing in WCB Case No. 88-05307 on the ground that "no final Order [was] in existence on the date of claimant's Request for Hearing, the Request for Hearing [was] premature [and] the Hearings Division [was] without jurisdiction." Her order does not discuss claimant's second request for hearing in WCB Case No. 88-05307 or what she apparently interpreted to be a request for reconsideration in WCB Case No. 86-04043.

The parties' arguments center on the propriety of claimant's first request for hearing in WCB Case No. 88-05307. The contentions raised by claimant's hearing request clearly pertained to questions concerning a claim. Moreover, the hearing request raised issues regarding claimant's right to receive compensation, as well as the amount thereof. Consequently, we conclude that the Referee had jurisdiction to consider the request. See ORS 656.283(1); 656.704(3). Inasmuch as the Referee dismissed the hearing request without permitting claimant to present evidence concerning his contentions, we conclude that this matter should be remanded for a hearing on the merits of claimant's request. Furthermore, we conclude that the Hearings Division has jurisdiction pursuant to claimant's second request for hearing in WCB Case No. 88-05307. That request was filed on April 7, 1988, long after Referee Mirassou issued her Order on Reconsideration on March 4, 1988. The second request, therefore, vested jurisdiction in the Hearings Division independent of the earlier request. See Leonard A. Chambers, 40 Van Natta 969, 970 (1988). Accordingly, the dismissal of claimant's request for hearing in WCB Case No. 88-05307 was improper and the case will be remanded to the Hearings Division for further proceedings.

To the extent that either of claimant's requests for

hearing in WCB Case No. 88-05307 may be interpreted as a request for reconsideration of Referee Mirassou's orders in WCB Case No. 86-04043, such a request is barred by res judicata because Referee Mirassou's Order on Reconsideration in WCB Case No. 86-04043 is final by operation of law. To the extent that claimant's request for Board review may be interpreted as a request for review of the merits of WCB Case No. 86-04043, the request was untimely and the Board is without jurisdiction to entertain it.

Regarding claimant's request for a carrier-paid fee for services rendered on Board review, no provision of law authorizes the Board to award such a fee at this juncture. Claimant has not prevailed against a denial of his entitlement to receive compensation, see ORS 656.386(1), and has not yet been afforded an opportunity to establish unreasonable resistance to the payment of compensation. See ORS 656.382(1). The request, therefore, is denied.

ORDER

The Referee's order dated May 6, 1988 is reversed. Claimant's request for hearing in WCB Case No. 88-05307 is remanded to the Hearings Division for further proceedings. Claimant's request for Board review in WCB Case No. 86-04043 is dismissed as untimely.

LARRY H. ERBS, Claimant
Haugh & Foote, Claimant's Attorneys
David O. Horne, Defense Attorney

WCB 86-17335
June 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Shebley's order that affirmed a Determination Order awarding no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact and make the following additional findings.

Claimant suffers from a myofascial pain syndrome and a significant degree of functional overlay. His diagnostic studies have been negative for any orthopedic or neurological abnormality.

Claimant's symptoms initially improved with rest and treatment from Dr. Sah, D.O., in the fall of 1984. Claimant sought no additional medical treatment and was able to return to full-time, light duty welding. However, he continued to experience dull headaches, and in late 1985 he sustained an acute flare-up of head and neck pain which caused him to miss time from work. He continues to suffer from acute symptomatic flare-ups characterized by severe headaches, minimal loss in cervical range of motion and back pain. One such exacerbation occurred in July 1986, and claimant has not worked since that time.

Claimant was 36 years old at the time of hearing. He has an 11th grade education and work experience as a truck driver, welder, and laborer in a wood treating plant.

FINDINGS OF ULTIMATE FACT

Claimant uses his work injury as a vehicle for converting his emotional stresses into physical symptoms. This conversion process is nonvolitional.

As a result of his myofascial pain syndrome and functional overlay, claimant experiences intermittent disabling headaches resulting in a minimal degree of permanent physical impairment.

CONCLUSIONS AND OPINION

Claimant contends that the Referee erred in concluding that he had not sustained any permanent disability as a result of his industrial injury. We agree.

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. Functional overlay may be considered in determining the extent of unscheduled permanent disability. See Scheidemantel v. SAIF, 70 Or App 552, 555 (1984).

The Referee held that claimant was entitled to medical treatment for his pain syndrome. He, therefore, must have concluded that claimant's functional overlay was compensable. We agree. Dr. Schaub, M.D., one of the treating physicians, indicated that claimant's pain syndrome was related to his work injury. The only other opinion addressing this question was rendered by Dr. Colbach, psychiatrist, who performed an independent medical evaluation. Although he took the position that claimant's psychological condition was not compensable, Dr. Colbach acknowledged that claimant was using his work injury as a vehicle for converting his emotional stresses into physical symptoms. Under these circumstances, claimant's functional overlay is compensable. See Kobayoshi v. Siuslaw Care Center, et al, 76 Or App 320 (1985).

The Referee apparently did not award permanent disability because "the bulk of claimant's conditions are indeed nonorganic." This analysis ignores the fact that claimant's subjective pain is compensable if it is disabling and renders him less able to work. Harwell v. Argonaut Insurance Co., 296 Or 505 (1984). Claimant has lost time at work as a result of his severe headaches. Furthermore, treating physician Schaub and treating chiropractor Johnson both opined that claimant has sustained some degree of permanent impairment as a result of his subjective pain. Moreover, the record suggests that he will continue to suffer from these disabling headaches unless and until his functional overlay resolves. We are aware that several doctors have opined that claimant has not sustained any permanent impairment. However, those opinions are not persuasive because they focus on mechanical loss and do not consider impairment from pain.

In light of these factors, we are persuaded that claimant has sustained minimal permanent physical impairment as a result of his disabling headaches. In reaching this decision, we recognize that claimant testified to a greater degree of physical impairment. Given claimant's significant degree of functional overlay, however, we are unwilling to defer to his subjective limitations absent supporting medical opinion.

In addition to claimant's minimal physical impairment, we consider the relevant social and vocational factors set forth in

former OAR 436-30-380 et seq., including claimant's age, 11th grade education and work experience as a truck driver, welder, and laborer in a wood treating plant. After considering these factors, we conclude that claimant is entitled to an award of 10 percent unscheduled permanent partial disability for his disabling headaches.

ORDER

The Referee's order dated June 12, 1987 is reversed in part and affirmed in part. That portion of the order that declined to award permanent partial disability is reversed. Claimant is awarded 10 percent (32 degrees) unscheduled permanent partial disability for his head and neck condition. Claimant's attorney is awarded 25 percent of the permanent disability awarded under this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

VIOLA GRIMES, Claimant
Carney, et al., Claimant's Attorneys
Scheminske, et al., Defense Attorneys

WCB 87-00312
June 8, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

The insurer requests review of Referee William Peterson's order that awarded claimant compensation for permanent total disability. We affirm.

ISSUE

Extent of permanent partial disability, including permanent total disability.

FINDINGS OF FACT

We adopt the Referee's Findings.

CONCLUSIONS OF LAW

We adopt the Referee's Opinion, with the following comment. On review, the insurer argues that claimant is precluded from entitlement to additional permanent disability compensation because her original compensable condition has not worsened. The insurer cites Davidson v. SAIF, 304 Or 382 (1987) and Johnson v. Industrial Indemnity, 66 Or App 640 (1984), as authority for its assertion. Those cases hold that in order for a claimant to establish entitlement to additional permanent disability following a final determination of a claim, the claimant must prove that the compensable condition has worsened. The insurer argues that claimant's T12 fracture, which followed a final determination of her original low back claim, was an event that should be viewed separately from the original condition, that the T12 fracture constituted the only worsening post-closure, and that because claimant's original condition has not worsened, she is not entitled to a redermination of her claim.

Claimant's T12 fracture was finally determined to be the compensable result of her original low back condition by a Referee's October 1986 order. We conclude that because of the compensable link between the claimant's original low back condition and the subsequent T12 fracture, a worsening due to the T12 fracture constituted a worsening of claimant's overall compensable condition. She is, therefore, entitled to a redermination of her extent of disability.

After reviewing the record, we agree that claimant is permanently and totally disabled.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order dated November 27, 1987 is affirmed. A client-paid fee, not to exceed $2,061, is approved.

STEVEN L. JEWELL, Claimant
Galton, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-01940
June 8, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee Tenenbaum's order that upheld the insurer's partial denial of claimant's vestibular problems. The issue on review is claimant's contention that his vestibular problems are causally related to his March, 1985, compensable low back injury. We affirm the Referee's order.

FINDINGS

At the time of the hearing, claimant was a 36 year old man whose primary occupation was a karate instructor, a profession he has practiced for many years.

In March, 1985, claimant was employed as a warehouseman. While carrying about 25 pounds of tea boxes, claimant stepped into a depression in the floor and fell backwards onto his buttocks. He was treated for low back pain by his family physician. His claim was accepted and he received compensation for temporary disability.

He returned to work in May, 1985, and continued working until October, 1985. At that time, he consulted Dr. Brightenstein, chiropractor, with complaints of stiff and sore back muscles, some leg aching and weakness, and back complaints related to squatting and bending. He reported no head, neck, or dizziness problems. Between December 1986 and February 1987, claimant saw several physicians for evaluation of permanent impairment. None of them reported dizziness symptoms.

In March, 1987, Brightenstein referred claimant to Dr. Hemenway, an ear specialist, and suggested that "your diagnosis and treatment of possible vestibular disturbance is indicated."

Dr. Hemenway examined claimant and performed a number of tests on his ears. Although most of these tests were negative or inconclusive, Dr. Hemenway diagnosed perilymph fistula of the left ear, and possibly the right, as well as positional nystagmus. Perilymph fistula refers to a tear or hole in the wall between the inner and outer ear allowing fluid to flow into the middle ear. Positional nystagmus is involuntary rapid eye movements.

Dr. Hemenway attributed the fistula(s) to claimant's compensable injury. The insurer denied claimant's medical services claim for this condition and for claimant's complaints of dizziness and lightheadedness.

Claimant has suffered from hypoglycemia for over 10 years. Dr. Hemenway was initially unaware of this medical history. The effects of hypoglycemia could cause symptoms similar to those related by claimant.

Claimant was in a motorcycle accident in July, 1983, and was rendered unconscious. He was also the driver of a car that was struck in the rear, while stopped, by a car traveling 30-35 mph. This 1982 accident resulted in treatment for whiplash. In addition, sometime between 1982 and 1984, claimant was kicked in the face in a karate tournament and suffered an injury to his chin. He also sustained an injury to the temporomandibular joint from that kick.

These injuries could result in fistulas, as could the whiplash injury in 1982. Trauma and surgery can also cause fistulas; they can also develop spontaneously.

We are unable to find that claimant's vestibular problems are causally related to his March, 1985, compensable low back injury.

CONCLUSIONS OF LAW

We adopt the Referee's opinion with the following modification.

The Referee found Dr. Hemenway's opinion unpersuasive. For this reason and because there are several possible causes for claimant's vestibular difficulties, the Referee upheld the insurer's partial denial.

The Referee further noted that the posturography test used by Dr. Hemenway is controversial and is considered experimental by some members of the medical community. She also noted the existence of a lawsuit regarding the number of operations performed by Dr. Hemenway's partner. Neither of these points causes us to discount Dr. Hemenway's opinion.

Nonetheless, we also find Dr. Hemenway's conclusion that claimant's present vestibular condition is causally connected to his 1985 compensable low back injury to be unpersuasive. While Dr. Hemenway continues to attribute claimant's condition to the compensable injury, he conceded that there were several other possible causes for claimant's vestibular problems. His failure to provide a thorough analysis of the potential contributions, if any, from these other causes prompts us to discount his opinion. See Somers v. SAIF, 77 Or App 259,264 (1986).

The burden of proof is on claimant to show that the March, 1985 fall onto his buttocks is more likely than not a material contributing cause of his present dizziness and balance problems. Hutchenson v. Weyerhaeuser, 288 Or 51,56 (1979); James v. Kemper Ins Co., 81 Or App 80,81 (1986). Given the presence of several other contributing events and the unpersuasiveness of Dr. Hemenway's opinion, we agree that claimant his failed to meet the requisite burden of proof.

ORDER

The Referee's order dated August 7, 1987, is affirmed. A client-paid fee, not to exceed $785, is approved.

KAREN L. KEREKES, Claimant
Schwabe, et al., Defense Attorneys

WCB 84-01807
June 8, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant, pro se, requests review of Referee Brown's order that upheld the self-insured employer's denial of medical services relating to her low back. The issue on review is medical services. We affirm.

FINDINGS OF FACT

Claimant, who was employed at a mill, compensably injured her low back on May 18, 1977, while lifting wet boards. Her injury was diagnosed as a low back strain. Her initial treating physician was Dr. Lilly, orthopedic surgeon. Claimant returned to work approximately three weeks following the incident.

X-rays taken of her lower back in November 1977 were normal.

Her claim was closed by Determination Order dated December 23, 1977, which awarded temporary disability benefits but no permanent disability.

Claimant's claim was reopened for aggravation in early 1978. She was off work for approximately five weeks. In November 1978, Dr. Lilly noted no evidence of nerve root compression and no radicular symptoms into the legs. Her claim was subsequently closed by Determination Order dated January 19, 1979, which awarded additional temporary disability benefits only.

Claimant transferred her medical care to Dr. Laubengayer, orthopedic surgeon, in January 1979. He diagnosed chronic low back strain and prescribed exercises and medication. Within one month, claimant reported that she was much better.

Claimant had a baby in August 1980. She returned to Dr. Laubengayer in October 1980, reporting increased low back symptoms. She had no radiating symptoms and x-rays were interpreted by Dr. Laubengayer as being entirely normal.

In April 1981, claimant began treating with Dr. Campagna, neurosurgeon. Claimant reported low back pain radiating up the back and down into her left thigh. Dr. Campagna recommended lumbar myelography to rule out the possibility of a herniated disc. A lumbar myelogram was performed on May 7, 1981. It disclosed no evidence of a protruded lumbosacral disc.

Claimant's claim was reopened as of May 6, 1981. In November 1981, Dr. Campagna released claimant to return to work without restrictions. However, the mill where she had previously been employed had closed; therefore, she did not return to work. Her claim was closed by Determination Order dated November 23, 1981, which again awarded temporary disability benefits only.

Claimant was examined by Dr. McKellar, family physician, on

January 30, 1984. Claimant reported low back pain into the left hip. She reported no radiation into her legs. Dr. McKellar filed a report with the employer. The employer treated the report as a claim for aggravation, and denied it on the basis that claimant's aggravation rights had expired.

On April 5, 1984, Dr. Campagna reexamined claimant. Claimant reported a worsening of symptoms commencing approximately eighteen months earlier. Claimant's complaints included pain radiating to her left hip and leg. Dr. Campagna again recommended a lumbar myelogram to determine whether claimant had experienced a herniated disc. A myelogram performed on April 12, 1984 disclosed a protruded L4 disc. Dr. Campagna requested authorization from the employer to perform surgery.

At the employer's request, claimant was examined by Dr. Balme in June 1984.

On September 28, 1984, the employer denied authorization for the requested surgery on the basis that claimant's need for surgery was not related to the industrial injury.

On June 4, 1986, claimant underwent an L4 diskectomy performed by Dr. Campagna. Claimant's condition was worse as of the date of the hearing than it had been prior to the surgery.

FINDING OF ULTIMATE FACT

We are unable to find that claimant's extruded L4 disc was causally related to her compensable 1977 injury.

CONCLUSIONS OF LAW AND OPINION

It is claimant's burden to prove by a preponderance of the evidence that the 1986 surgery was compensably related to the 1977 lifting injury. This requires proof that the herniated disc, first definitively diagnosed in 1984, resulted from the lifting injury seven years earlier. We find this to be a complex medical question largely dependent upon expert medical opinion. See Weiland v. SAIF, 64 Or App 810 (1983). In this regard, the record here is notable for its lack of a particularly persuasive medical opinion.

Dr. Campagna unequivocally opines that claimant's extruded disc was causally related to her compensable injury. However, as noted by the Referee, Dr. Campagna's opinion is devoid of any explanation for this conclusion. Consequently, we afford his opinion little persuasive value.

Dr. Balme is the only other physician whose opinion can be interpreted to support claimant's position. On June 26, 1984, Dr. Balme reported:

> "Regarding the relationship of her present pain and possible disc protrusion to the 1977 industrial injury, ... , I do feel that, if one has a significant injury to the back, progressive deterioration can occur and, barring further significant injuries, it is difficult to say that the initial injury wasn't the precipitating cause for the ongoing, slow degenerative process."

Although not without ambiguity, Dr. Balme's opinion supports a causal relationship between claimant's disc defect and her compensable injury. However, Dr. Balme examined claimant only once. Moreover, no other physician supports Dr. Balme's theory of an "ongoing, slow degenerative process." We, therefore, conclude that his opinion has limited persuasiveness.

Dr. Laubengayer opines that the extruded disc was unrelated to the 1977 injury. As noted by the Referee, Dr. Laubengayer gives three reasons for his conclusion: First, claimant's clinical exams during the early years of treatment did not reflect a neurological problem; second, claimant responded to treatment for strain; and third, the 1981 myelogram did not reflect a bulging disc. Dr. Laubengayer did not treat claimant after 1981. In addition, Dr. Laubengayer did not himself review the 1981 and 1984 myelograms. These factors reduce the persuasiveness of his opinion. Nevertheless, his reasoning does retain some persuasiveness.

Dr. Paxton interpreted claimant's 1981 myelogram as disclosing an L4-5 bulge. Thus, in temporal terms alone, he had greater reason to attribute claimant's disc defect to her 1977 injury than did those physicians who did not interpret the 1981 myelogram as disclosing a defect. However, Dr. Paxton still concluded that the disc defect was not related to the 1977 injury. Consequently, his opinion supports the employer's position, although, like that of Dr. Campagna, Dr. Paxton's opinion is conclusory.

Dr. Peterson did not believe there was a causal relationship between the 1977 injury and the disc defect. However, Dr. Peterson relied upon his understanding that claimant experienced a symptom-free interval prior to appearance of the disc defect. The record establishes no such symptom-free interval. His opinion is accordingly suspect.

As noted above, none of the medical opinions is particularly persuasive. Dr. Campagna's unexplained opinion is of almost no value to us. Dr. Balme's opinion is some help to claimant, but not sufficient to overcome that of Dr. Laubengayer. Dr. Laugengayer's opinion is the most persuasive in the record. It is supported, albeit weakly, by the opinions of Drs. Peterson and Paxton. Our review of this evidence lead us to conclude that claimant has failed to sustain her burden of proof.

ORDER

The Referee's order dated November 25, 1987 is affirmed. The Board approves a client-paid fee, payable from the employer to its counsel, not to exceed $1,020.

GENE T. LAPRAIM, Claimant
Bottini, et al., Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Carl Davis, Assistant Attorney General

WCB 86-04234, 86-04235, 86-16000 & 86-16001
June 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of those portions of Referee Leahy's order that: (1) set aside its denial of claimant's aggravation claim relating to his low back; (2) directed it to pay an associated attorney fee; (3) directed it to pay interim compensation for the period from August 5 through August 14, 1986; (4) directed it

to pay an associated penalty and attorney fee; and (5) directed it to pay a penalty and attorney fee for its failure to request an order pursuant to ORS 656.307. In its brief, American International Adjustment Company, the adjusting agency for National Union Fire Insurance Company, contends that the Referee erred in not admitting Exhibit 62. The issues are evidence, responsibility, interim compensation, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the findings of fact as contained in the "Facts" section of the Referee's order.

CONCLUSIONS OF LAW

We adopt the conclusions of law as set forth in the "Opinion" section of the Referee's order with the following exceptions and supplementations.

Regarding the evidentiary issue, Exhibit 62 was dated two days prior to the date of the hearing and was submitted within seven days of receipt. Under the law in effect at the time of the hearing, the Referee should have admitted the exhibit. See former OAR 438-07-005(3)(b); Merle Barry, 37 Van Natta 1492 (1985). We nonetheless affirm the Referee on this issue because the exhibit strongly favors the result reached by the Referee and affirmed by the Board. Its exclusion, therefore, was harmless. See James L. Briggs, 37 Van Natta 1049 (1985).

Regarding the attorney fee awarded in connection with SAIF's aggravation denial, SAIF contends that responsibility was the only basis for its denial and that under the rule of Karen J. Bates, 39 Van Natta 42, 43, 39 Van Natta 100 (1987), the Referee should have ordered one or both of the other insurers to pay the fee because they also denied compensability. See also Ronald J. Broussard, 38 Van Natta 59, 61, aff'd mem., 82 Or App 550 (1986). A review of SAIF's denial confirms that the only stated basis for the denial was responsibility. SAIF, however, did not request the designation of a paying agent under ORS 656.307 or otherwise formally concede the issue of compensability. Compensability, therefore, was a potential issue as to SAIF through the time of the hearing and the Referee correctly ordered SAIF to pay the attorney fee for that reason. See Robert L. Montgomery, 39 Van Natta 469 (1987).

Regarding the interim compensation and associated penalty and attorney fee issues, we reverse and modify. Claimant left work as a result of the aggravation of his compensable condition on August 5, 1986. On August 15, SAIF received a report from Dr. Wisdom, claimant's treating orthopedic surgeon, which stated that claimant was currently off work. The report did not state when claimant left work. SAIF did not learn when claimant left work until August 29, when it received a copy of a time loss authorization slip signed by Dr. Wisdom. SAIF paid interim compensation from August 15 through October 17, but not for the period between August 5 and August 15. SAIF issued its denial on October 27.

The Referee concluded that interim compensation was due for the periods from August 5 through August 14 and October 18 through October 27 and found that SAIF had unreasonably failed to pay it. He ordered SAIF to pay the interim compensation and assessed a 25 percent

penalty and an attorney fee of $350. On Board review, SAIF does not contest the assessment of a penalty or attorney fee for its failure to pay interim compensation from October 18 through October 27. With regard to the period from August 5 through August 14, however, SAIF cites two Board cases which state that interim compensation is payable only from the date that an insurer or employer receives notice of a medically verified inability to work, not from the date of disability. Barbara A. Wheeler, 37 Van Natta 122 (1985); Donald Wischnoske, 34 Van Natta 664 (1982). A number of other cases state or apply the same rule. E.g., Kosanke v. SAIF, 41 Or App 17, 20-21 (1979): Rob Cohen, 39 Van Natta 649, 651 (1987); Harold D. Ward, 37 Van Natta 606, 607, 37 Van Natta 709 (1985). Because SAIF first received notice of a medically verified inability to work on August 15, it contends that interim compensation was not due prior to that date.

The Referee relied upon Silsby v. SAIF, 39 Or App 555, 560-62 (1979), in concluding that interim compensation was due from the date of disability rather than the date of notice of the disability. The issue in Silsby was whether that portion of ORS 656.273(6) which states that the first payment of interim compensation is due 14 days after notice of a medically verified inability to work "relates only to the the date the first payment is due (a 'procedural' matter) or to the period during which the claim is compensable (a 'substantive' matter)." 39 Or App at 561 (emphasis in original). The court decided in favor of the former interpretation and thus ruled that ORS 656.273(6) "relates to when compensation payments must actually be made, not to what period of time the payments must cover." 39 Or App at 562.

At first blush, the cases cited in the preceding two paragraphs appear inconsistent. The key to reconciling them is the fact that Silsby involved a compensable aggravation claim; the other cases involved noncompensable claims. Silsby, therefore, stands for the proposition that once an aggravation claim has been accepted or found compensable, temporary disability compensation (as opposed to interim compensation) is due from the date of disability to the date when the employer or insurer received notice of a medically verified inability to work. The cases subsequent to Silsby make it clear that interim compensation (as opposed to temporary disability compensation) is never owed on an aggravation claim for any period prior to the date upon which the employer or insurer receives notice of a medically verified inability to work. See Kosanke v. SAIF, supra, 41 Or App at 21 n.2; see also Botefur v. City of Creswell, 84 Or App 627, 630 (1987).

In the present case, claimant's aggravation claim was held compensable. Temporary disability compensation is owed, therefore, from August 5 through August 14. The Referee erred, however, in holding that interim compensation was due for this period and in assessing a penalty and attorney fee for SAIF's failure to pay it. The Referee assessed one penalty-associated attorney fee of $350 for both periods of interim compensation he found owing (i.e. August 5 through August 14, 1986 and October 18 through October 27, 1986). Because SAIF does not contest the penalty or attorney fee associated with the latter period, we shall reduce but not eliminate the attorney fee award.

Regarding the other penalty and attorney fee issue, SAIF issued its denial on October 27, 1986. The only stated basis of the denial was responsibility, although, as noted previously, SAIF did not attempt to request the designation of a paying agent under ORS 656.307 or otherwise formally concede compensability. The other two potentially responsible insurers issued their denials on November 17 and 24 respectively. Both denied compensability as well as

responsibility. At some time prior to the hearing, claimant's attorney contacted the Compliance Division and requested a .307 order. On December 11, the Compliance Division issued a letter to the insurers requesting their positions on the issuance of a .307 order. The record contains no evidence of a reply by any of the insurers prior to the hearing, which was held on December 18. At the beginning of the hearing, claimant's attorney indicated that the issues were compensability and responsibility. After claimant and his wife testified, the insurers stipulated that claimant's claim was compensable and that only responsibility was contested. SAIF's counsel asserted at that time that SAIF had never denied compensability, only responsibility.

The Referee found that SAIF had unreasonably failed to request a .307 order after the date of its denial, assessed a penalty calculated on the period from October 27, 1986 (the date of the denial) to December 18, 1986 (the date of the hearing) and awarded an associated attorney fee. The Referee cited two cases as authority for his action: SAIF v. Moyer, 63 Or App 498, 501-03, rev den 295 Or 541 (1983) and Elliott v. Loveness Lumber Co., 61 Or App 269, 272 (1983). Another case which was decided after the Referee issued his order may also be read to support his decision: D Maintenance Co. v. Mischke, 84 Or App 218, 224-25, rev den 303 Or 483 (1987). On Board review, SAIF contends that there is no statutory basis for awarding a penalty or attorney fee in cases of delay in requesting a .307 order, citing EBI Companies v. Thomas, 66 Or App 105, 111-12 (1983) and Dorothy M. Pitcher, 37 Van Natta 1700 (1985).

Thomas and Pitcher clearly state that there is no statutory authority for an award of penalties or attorney fees for delay in requesting a .307 order. The penalties and attorney fees in Moyer and, ostensibly, in Elliott and Mischke were based upon another, albeit related, failure: the unreasonableness of the insurers' express or implied denials of compensability. See Industrial Indemnity Co. v. Weaver, 81 Or App 493, 497-98 (1986). In the present case, we have already ruled that by failing to request the designation of a paying agent under ORS 656.307 or otherwise formally conceding compensability, SAIF reserved the issue of compensability. If this implied denial of compensability was unreasonable, a penalty and attorney fee may be assessed under ORS 656.262(10) and 656.382(1). If a denial of compensability was reasonable, however, there is no basis for an award of attorney fees for SAIF's failure to request a .307 order.

After reviewing the medical evidence available to SAIF at the time of its denial, we conclude that there was no reasonable basis for a denial of compensability. The penalty and attorney fee assessed by the Referee, therefore, shall be affirmed, but on this ground.

Finally, a claimant's attorney is entitled to a reasonable fee when a carrier initiates Board review and the Board determines that "the compensation awarded to [the] claimant should not be disallowed or reduced." ORS 656.382(2).

Here, SAIF requested Board review, seeking to shift responsibility for claimant's claim to American International Adjustment Company. As previously discussed, no order designating a paying agent pursuant to ORS 656.307 issued. Consequently, claimant's entitlement to receive compensation remained at risk. See Thomas W. Williamson, supra. Claimant's counsel participated on review, contending that the Referee's responsibility decision should be affirmed. Under such circumstances, we conclude that claimant's attorney is entitled to a fee for services on review concerning the responsibility issue, payable by SAIF, the insurer who initiated Board review.

ORDER

The Referee's order dated December 23, 1986 is affirmed in part and reversed in part. That portion of the order that assessed SAIF a penalty based on interim compensation for the period from August 5 through August 14, 1986 is reversed. The attorney fee awarded in connection with SAIF's unreasonable claims processing is reduced to $150. The remainder of the Referee's order is affirmed. For services on Board review concerning the responsibility issue, claimant's attorney is awarded a reasonable fee of $1,000, to be paid by the SAIF Corporation. A client-paid fee, payable from American International Adjustment Company to its counsel, is approved, not to exceed $150. A client-paid fee, payable from Western Employers Insurance to its counsel, is approved, not to exceed $1,480.

Board Member Crider, specially concurring:

I join in those portions of the Chairman's opinion regarding the claim for aggravation, the associated attorney fee and penalties and attorney fees for failure to request a .307 order. I concur in his result on the question of entitlement to interim compensation for the period from August 5 through August 14, 1986 and the measure of the penalty for SAIF's failure to pay interim compensation at all.

I concur in the Board's decision that claimant is not entitled to interim compensation for the entire period, prior to issuance of the denial, during which claimant was disabled. I do so solely because the result appears to be compelled by the Court of Appeals' recent reaffirmation of the holding in Kosanke v. SAIF, 41 Or App 17 (1979). See Spivey v. SAIF, 79 Or App 568 (1986).

I have grave doubts, however, about the viability of the doctrine articulated in Kosanke v. SAIF, supra. Kosanke's holding that temporary disability compensation benefits due prior to a denial of compensability are calculated differently depending on the outcome of litigation concerning compensability appears to fly in the face of the Supreme Court's teaching concerning the relationship between so-called interim compensation and temporary disability compensation.

We simply use the term interim compensation to apply to temporary disability compensation that must be paid pursuant to ORS 656.262 before the issuance of an acceptance or denial of a claim. Bono v. SAIF, 298 Or 405 (1984); Jones v. Emanuel Hospital, 280 Or 147 (1977).

Temporary disability compensation must be paid within 14 days of notice of a claim or, in an aggravation case, within 14 days of notice of medically verified inability to work. ORS 656.273(6). Once the duty to pay is triggered, the amount payable extends back to the date of disability. Silsby v. SAIF, 39 Or App 555 (1979). If the claim is denied, however, the duty to pay compensation for periods of future disability is extinguished unless the denial itself is found invalid. Georgia Pacific Corp. v. Piwowar, 305 Or 494, 501 (1988). But the denial does not relieve the insurer of the duty to pay compensation for the period preceding the denial. Jones v. Emanuel Hospital, supra.

Therefore, when, as here, the Board must determine what compensation is due for the period preceding the denial, the issuance of the denial should be irrelevant. As the Supreme Court said in Bono v. SAIF, supra:

"There is no independent interim compensation benefits calculation in ORS 656.262(4). The amount of interim compensation payments is determined in the same manner as the amount of temporary total disability benefits."

Id., at 409. Relying on this proposition, the Bono court rejected the claimant's contention that, in an original claim, interim compensation benefits must be paid for the period following filing of a claim without respect to when claimant left work due to the injury. The Court declared that the period for which compensation is due is the same whether payments are "interim compensation" or whether the claim has already been accepted. If this principle were applied to an aggravation case such as this one, where the insurer contends that interim compensation benefits need not have been paid for the period before it had notice of the aggravation claim, although claimant became disabled prior to the notice, simply because the claim was not ultimately found compensable, it would require rejection of the insurer's contention.

The effect of the Kosanke rule is to allow the insurer to flout the duty to pay compensation pending acceptance or denial, gambling that the denial will ultimately be affirmed. If the denial is affirmed, the insurer will be required to pay less in temporary disability compensation than it would be required to pay if the denial were set aside. This is inconsistent with the principle that the duty to pay attaches when notice of medically verified inability to work is received and is independent of the validity or invalidity of a subsequently issued denial.

Were I writing on a clean slate, I would conclude that the claimant is entitled to interim compensation for the period commencing when he became disabled from work and affirm the referee on that issue.

The Beneficiaries of
WILMA F. MACAITIS, (Deceased), Claimant
Quintin B. Estell, Claimant's Attorney
John Motley (SAIF), Defense Attorney

WCB 87-06841
June 8, 1989
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Estate of Macaitis v. SAIF, 95 Or App 473 (1989). The court has concluded that the deceased's estate and counsel have established extraordinary circumstances beyond their control sufficient to permit postponement of the scheduled hearing. Consequently, the court has reversed the Board's order, which had affirmed the Referee's order dismissing the hearing request.

In accordance with the court's mandate, this matter is "remanded for further proceedings not inconsistent with [the court's] opinion." The Presiding Referee is directed to assign this case to a Referee, who shall hold a hearing concerning the issues raised herein.

IT IS SO ORDERED.

CHRIS A. MEIRNDORF, Claimant
Richardson & Andersen, Claimant's Attorneys
James E. Griffin, Assistant Attorney General

WCB TP-89009
June 8, 1989
Third Party Distribution Order

Claimant has petitioned the Board for resolution of a dispute concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Asserting that the SAIF Corporation, as paying agency, has "not participated in the tremendous risks" in prosecuting the third party action, claimant contends that SAIF's share of the settlement proceeds should be reduced. We conclude that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS

In September 1985, while performing his employment duties as a timber faller, claimant was struck in his right eye by "plastic and/or glass particles" when a "falling wedge" split in two, striking him in the right side of his face and breaking his glasses. The claim was accepted.

Claimant, through legal counsel, brought suit against several third parties for his injuries. With SAIF's approval, claimant's cause of action was settled for $86,000. To reach this settlement, $9,838.44 in litigation costs were expended. SAIF advanced $1,313.20 towards these expenses.

SAIF's "third party" lien for its claim costs totals $19,080.83. The amount of this lien is not contested. After deducting claimant's statutory attorney fees, costs, and his statutory 1/3 share of the remainder, a balance in excess of SAIF's asserted lien and advanced costs remains.

A distribution of $20,394.03 from the remaining balance of the third party settlement to SAIF is just and proper.

CONCLUSIONS

If a worker receives 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. If the worker elects to pursue a third party action, and if the worker settles 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). 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).

Because it is the Board's policy to avoid making "equitable distributions on an ad hoc basis," we usually refrain from resolving distribution conflicts in a manner that would depart from the statutory formula. Marvin Thornton, 34 Van Natta 999, 1002 (1982). On rare occasions, circumstances may justify a departure from the statutory distribution formula. See Robert T. Gerlach, 36 Van Natta 293, 296 (1984) (Paying agency's lien reduced to "in effect, reconstruct an agreement the parties substantially entered into, but which subsequently fell apart primarily due to an unfortunate failure of communication.")

Here, claimant contends that he and his counsel were required to bear the financial burden of some $9,838.44 in litigation costs. Considering their ample investment and SAIF's "very limited" participation in this endeavor, as well as the substantial risk of not prevailing against the third party, claimant submits that a "just and proper" distribution to SAIF from the settlement proceeds would be $12,000.

We conclude that the aforementioned circumstances do not provide justification for our departure from the statutory distribution formula. To begin, claimant has neither referred us to, nor are we aware of, any authority that would require a paying agency to provide capital for a third party action initiated by the worker. Thus, SAIF's infusion of $1,313.20 in advanced costs, albeit minor when compared to the total litigation expenditures, represents an action beyond its statutory obligations.

Moreover, claimant is statutorily entitled to receive full reimbursement for these costs prior to the attachment of any portion of SAIF's third party lien to the settlement proceeds. See ORS 656.593(3); 656.593(1)(a). Consequently, we fail to see how reducing SAIF's uncontested lien would represent a "just and proper" distribution of the remaining balance of proceeds from the third party settlement when claimant has already been fully reimbursed for his litigation costs.

Finally, the basic thrust of claimant's contention is that it would be more equitable to order a distribution that results in his receipt of a larger portion of the third party settlement. Such an assertion is available to any claimant or paying agency in a dispute involving the distribution of proceeds from a third party recovery. We have previously reasoned that if such arguments were to prevail, in the long run the results would probably be random, standardless, and, thus, inequitable. Robert L. Cavil, supra, at page 722. This reasoning is based on the following principles. Under the statutory distribution formula, the parties generally know where they stand. On the other hand, if the parties knew only that each would receive that portion of the settlement that the current Board then regarded as equitable, settlement of a third party action would at least be more difficult, if not impossible. Marvin Thornton, supra, at page 1002.

In accordance with the aforementioned rationale, we conclude that a distribution of $20,394.03 from the remaining balance of settlement proceeds is "just and proper." See ORS 656.593(3). This sum is composed of $19,080.83 in claim costs and $1,313.20 in advanced litigation litigation expenses. Accordingly, claimant's attorney is directed to distribute the aforementioned sum to the SAIF Corporation. Any remaining balance shall be disbursed to claimant. See ORS 656.593(3); 656.593(1)(d).

IT IS SO ORDERED.

TRACEY E. MILLER, Claimant
Doblie & Associates, Claimant's Attorneys
Williams, et al., Defense Attorneys

WCB 86-14260
June 8, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer requests review of Referee Mulder's order that set aside its denial of claimant's occupational disease claim for the low back and hip. We reverse.

ISSUE

The compensability of claimant's occupational disease claim for the low back and right hip.

FINDINGS OF FACT

Claimant began working for this employer September 1981. She was asymptomatic in the low back and hips when she began. She worked for the employer for four years, leaving in September 1985 due to a lay off. During her employment, claimant sewed parkas, using her right foot to operate a sewing machine pedal. Claimant experienced low grade pain in the low back, right hip and right leg throughout the time she was employed. She did not seek treatment or lose time from work during the four-year period, however.

Approximately three weeks after leaving her job, claimant's low back and hip pain worsened. She did not seek treatment until October 26, 1985, one day after experiencing a severe onset of pain upon getting up from a couch at home. She visited Dr. Holman, a chiropractor, who diagnosed a subluxation of the lumbosacral and pelvic regions, with attendant sciatic nerve irritation. Claimant has a "unilateral sacralization," a low back anomaly that preexisted her employment. Claimant's employment worsened the symptoms of that condition, but did not worsen the underlying condition.

Claimant played seven softball games in the Summer of 1985. That activity caused some back and hip pain. Claimant also played pool during the Summer, and the bending associated with that activity caused pain.

Claimant remained off work until January 1986, when she became employed by another employer, a metals fabricator. The new job involved moderate bending, turning, lifting and twisting, and claimant's symptoms continued, occasionally becoming worse than when she worked as a seamstress for the first employer. She lost three days of work in May 1986 after experiencing a severe exacerbation while getting out of a shower at home. She sought treatment from Dr. Holman for that exacerbation.

Claimant rides bicycles and does yard work off the job.

Both activities cause occasional low back and hip pain. Claimant's symptoms are present even when she is idle. She last sought chiropractic treatment in September 1986.

Claimant's work activities as a seamstress were not the major contributing cause of her low back and hip conditions, or their worsening.

CONCLUSIONS OF LAW

It is claimant's burden to prove the compensability of her occupational disease. In order to do so, she must establish that her employment as a seamstress for the first employer as the major contributing cause of her condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). Because claimant's condition preexisted her employment, she must also prove that her work worsened her underlying condition, rather than merely causing increased symptoms. Weller v. Union Carbide, 288 Or 27 (1979). Expert medical opinion is necessary for proof of a complex case involving occupational disease. Although a treating physician's opinion is generally afforded added weight, Weiland v. SAIF, 64 Or App 810 (1983), the opinion is less persuasive when it is based on incomplete or inaccurate information. Moe v. Ceiling Systems, 44 Or App 429 (1980).

After reviewing this record, we conclude that claimant has failed to meet her burden of proof. The Referee found claimant's claim compensable, but he did not discuss the standard set forth in Weller, supra. Neither did he find significant several facts unknown to Dr. Holman when Holman offered his medical causation opinion.

With regard to the Weller standard, Dr. Holman testified that claimant's employment, while aggravating her condition and causing increased symptoms, did not cause a worsening of the underlying and preexisting low back and hip condition. Dr. Fabricius, a chiropractor who independently examined claimant, agreed. In fact, Fabricius found no relationship between claimant's work as a seamstress and her current condition. Without medical evidence that claimant's employment worsened her preexisting condition, the standard of Weller is not met.

Even if we were to find that claimant suffered a worsening of her underlying condition, we are not persuaded that her employment as a seamstress was the major cause of her condition. Dethlefs, supra. Claimant testified that she did not become severely symptomatic until three weeks after she left her job. Further, she finally sought treatment as the result of an off-the-job strain at home. Dr. Holman was not aware of that incident, although he ultimately testified that such a strain could be significant in worsening a low back condition. Holman also testified that repetitive lifting, bending, stooping or twisting could potentially worsen a low back condition. Claimant was exposed to all of those motions during her subsequent 1986 employment. Holman suggested that the subsequent employment could have aggravated claimant's condition. He was not aware that claimant played softball and played pool during the Summer prior to her first chiropractic treatment. Therefore, he did not discuss the significance, if any, of those activities. From the aforementioned facts, we conclude that Dr. Holman had insufficient information from which to offer a persuasive medical opinion regarding the causation of claimant's current condition. Claimant has failed to meet her burden of proof.

ORDER

The Referee's order dated August 27, 1987 is reversed. The insurer's denial is reinstated and upheld. A client-paid fee, not to exceed $620.50, is approved.

NEWTON W. ORR, Claimant
Michael B. Dye, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney

WCB 84-05108
June 8, 1989
Order on Reconsideration

The SAIF Corporation requests reconsideration of our May 12, 1989 Order on Review that affirmed a Referee's order granting claimant permanent total disability. Specifically, SAIF contends that claimant is not entitled to a permanent total disability award because he unreasonably failed to participate in pain center therapy and vocational rehabilitation efforts.

Following further consideration, we continue to agree with the Referee that claimant is totally and permanently physically incapacitated from regularly performing work at a gainful and suitable occupation. See ORS 656.206(1)(a). Furthermore, a combination of claimant's physical disabilities and his social/vocational factors have effectively foreclosed him from returning to gainful employment. See Welch v. Banister Pipeline, 70 Or App 699, 701 (1984). Finally, considering claimant's physical and non-physical disabilities, we conclude that it would be futile for claimant to seek regular gainful employment. See Butcher v. SAIF, 45 Or App 318 (1983).

In reaching these conclusions we primarily rely upon the opinion of Dr. Buza, claimant's treating physician. In describing claimant's loss of function as severe, Buza concluded that claimant would not be able to return to any type of employment. Dr. Buza did encourage claimant to participate in pain center and work tolerance programs. However, in view of claimant's psychological reaction to his compensable injury, Buza conceded that claimant was not able to participate in such activities.

Without pain tolerance therapy, vocational rehabilitation efforts could not be implemented and, without such rehabilitation, there was no chance that claimant could be gainfully employed. After reviewing the medical and vocational record, particularly Dr. Buza's opinion, we conclude that claimant was unable to participate in the pain therapy programs. Therefore, claimant's refusal to do so was not unreasonable. In any event, considering the persuasive opinion of Mr. McNaught, vocational rehabilitation counselor, we are not persuaded that vocational services could have enabled claimant to return to work had he been able to participate in the pain therapy and rehabilitation programs.

Accordingly, our May 12, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 12, 1989 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ELAINE OSTER, Claimant
Dale J. Lindamood, Claimant's Attorney
Chuck Lisle (SAIF), Defense Attorney

WCB 86-13642
June 8, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Brown's order which: (1) upheld the SAIF Corporation's denial of claimant's spondylolisthesis condition; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable failure to pay for medical services. On review, the issues are compensability and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "findings."

FINDINGS OF ULTIMATE FACT

SAIF specifically accepted claimant's back strain and possible ruptured disc. Its acceptance did not include spondylolisthesis.

Claimant's compensable low back injury is not a material contributing cause of her spondylolisthesis, nor did it cause a worsening of the spondylolisthesis.

SAIF's failure to pay Dr. Bos' billings was not unreasonable.

CONCLUSIONS OF LAW

At the outset, claimant argues that SAIF is precluded from now denying claimant's spondylolisthesis condition by virtue of the holding in Bauman v. SAIF, 295 Or 788 (1983). We disagree. SAIF specifically accepted a low back strain with possible ruptured disc. (Ex. A). Accordingly, SAIF is not now precluded from denying the spondylolithesis condition. Georgia Pacific v. Piwowar, 305 Or 494, 501-2 (1988). We now turn to the merits of the case.

The Referee concluded that claimant's spondylolisthesis was not causally related to her compensable low back injury. We agree.

The issue of whether claimant's spondylolisthesis is causally related to her industrial injury is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

We find that there is no persuasive evidence in the record to support a causal relationship between claimant's industrial injury and her spondylolisthesis condition. Dr. Bos felt that the spondyloslisthesis preexisted the industrial injury, but was unsure whether the injury aggravated the spondylolisthesis. Dr. Freeman states that the spondylolisthesis preexisted the industrial injury, but does not give an opinion as to the relationship between the two. Dr. Fisher checked the "work related" box on an 827 form, but does not provide an explanation concerning the causal relationship between the spondylolithesis and the industrial injury. In light of these opinions, we find that claimant has failed to carry her burden of proving that the industrial injury is causally related to her spondylolisthesis condition.

Given that claimant has a noncompensable spondylolisthesis condition as well as a compensable low back strain, we do not find SAIF's refusal to pay Dr. Bos' billings unreasonable. Accordingly, no penalty or related attorney fee is warranted. We further find that Dr. Harper's billings were not yet due at the time of the hearing. OAR 436-10-100(3). Therefore, no penalty or related attorney fee is appropriate as to those billings.

ORDER

The Referee's order dated May 11, 1987 is affirmed.

LEW POLLEN, Claimant
Ralph M. Yenne, Claimant's Attorney
Carroll Smith (SAIF), Defense Attorney

WCB 88-10889
June 8, 1989
Interim Order of Remand

Claimant has requested Board review of Referee Neal's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for mental stress; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. The hearing concerning this matter convened on September 21, 1988 in Astoria, Oregon. The hearing was electronically recorded.

Following claimant's request for review, a transcription of the proceedings was requested. ORS 656.295(3). The hearing reporter has advised the Board that a portion of the transcription tape is unintelligible. The first portions of the tape, which concern the testimony of claimant and his employer, are not damaged and are obtainable. The damaged portion apparently pertains to the latter portion of the hearing tape. Specifically, the testimony of a co-worker. The parties have been unable to agree to a stipulation regarding the testimony of the co-worker.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). Since a portion of the hearing transcript is unintelligible and because the parties have been unable to reach an accomodation concerning a submission of stipulated facts, we conclude that this case has been incompletely and insufficiently developed. Consequently, remand is an appropriate action. See ORS 656.295(5).

Accordingly, this matter is remanded to Referee Neal with instructions to take the testimony of the co-worker who testified at the initial hearing. This testimony should be taken in accordance with OAR 438-07-022. Furthermore, if the testimony is to be taken at a hearing, the hearing may be held at any site which affords substantial justice to the parties.

We retain jurisdiction over this matter. Upon completion of the record, Referee Neal shall obtain and certify a copy of the additional record to the Board. This additional record should be provided to the Board within 30 days of the closing of the record. In addition, Referee Neal shall provide an interim order on remand, discussing the effect, if any, the additional evidence has had upon the prior order. Once the Board receives the additional record, copies will be provided to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

ELAINE OSTER, Claimant
Dale J. Lindamood, Claimant's Attorney
Chuck Lisle (SAIF), Defense Attorney

WCB 86-13642
June 8, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Brown's order which: (1) upheld the SAIF Corporation's denial of claimant's spondylolisthesis condition; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable failure to pay for medical services. On review, the issues are compensability and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "findings."

FINDINGS OF ULTIMATE FACT

SAIF specifically accepted claimant's back strain and possible ruptured disc. Its acceptance did not include spondylolisthesis.

Claimant's compensable low back injury is not a material contributing cause of her spondylolisthesis, nor did it cause a worsening of the spondylolisthesis.

SAIF's failure to pay Dr. Bos' billings was not unreasonable.

CONCLUSIONS OF LAW

At the outset, claimant argues that SAIF is precluded from now denying claimant's spondylolisthesis condition by virtue of the holding in Bauman v. SAIF, 295 Or 788 (1983). We disagree. SAIF specifically accepted a low back strain with possible ruptured disc. (Ex. A). Accordingly, SAIF is not now precluded from denying the spondylolithesis condition. Georgia Pacific v. Piwowar, 305 Or 494, 501-2 (1988). We now turn to the merits of the case.

The Referee concluded that claimant's spondylolisthesis was not causally related to her compensable low back injury. We agree.

The issue of whether claimant's spondylolisthesis is causally related to her industrial injury is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

We find that there is no persuasive evidence in the record to support a causal relationship between claimant's industrial injury and her spondylolisthesis condition. Dr. Bos felt that the spondyloslisthesis preexisted the industrial injury, but was unsure whether the injury aggravated the spondylolisthesis. Dr. Freeman states that the spondylolisthesis preexisted the industrial injury, but does not give an opinion as to the relationship between the two. Dr. Fisher checked the "work related" box on an 827 form, but does not provide an explanation concerning the causal relationship between the spondylolithesis and the industrial injury. In light of these opinions, we find that claimant has failed to carry her burden of proving that the industrial injury is causally related to her spondylolisthesis condition.

Given that claimant has a noncompensable spondylolisthesis condition as well as a compensable low back strain, we do not find SAIF's refusal to pay Dr. Bos' billings unreasonable. Accordingly, no penalty or related attorney fee is warranted. We further find that Dr. Harper's billings were not yet due at the time of the hearing. OAR 436-10-100(3). Therefore, no penalty or related attorney fee is appropriate as to those billings.

ORDER

The Referee's order dated May 11, 1987 is affirmed.

LEW POLLEN, Claimant
Ralph M. Yenne, Claimant's Attorney
Carroll Smith (SAIF), Defense Attorney

WCB 88-10889
June 8, 1989
Interim Order of Remand

Claimant has requested Board review of Referee Neal's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for mental stress; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. The hearing concerning this matter convened on September 21, 1988 in Astoria, Oregon. The hearing was electronically recorded.

Following claimant's request for review, a transcription of the proceedings was requested. ORS 656.295(3). The hearing reporter has advised the Board that a portion of the transcription tape is unintelligible. The first portions of the tape, which concern the testimony of claimant and his employer, are not damaged and are obtainable. The damaged portion apparently pertains to the latter portion of the hearing tape. Specifically, the testimony of a co-worker. The parties have been unable to agree to a stipulation regarding the testimony of the co-worker.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). Since a portion of the hearing transcript is unintelligible and because the parties have been unable to reach an accomodation concerning a submission of stipulated facts, we conclude that this case has been incompletely and insufficiently developed. Consequently, remand is an appropriate action. See ORS 656.295(5).

Accordingly, this matter is remanded to Referee Neal with instructions to take the testimony of the co-worker who testified at the initial hearing. This testimony should be taken in accordance with OAR 438-07-022. Furthermore, if the testimony is to be taken at a hearing, the hearing may be held at any site which affords substantial justice to the parties.

We retain jurisdiction over this matter. Upon completion of the record, Referee Neal shall obtain and certify a copy of the additional record to the Board. This additional record should be provided to the Board within 30 days of the closing of the record. In addition, Referee Neal shall provide an interim order on remand, discussing the effect, if any, the additional evidence has had upon the prior order. Once the Board receives the additional record, copies will be provided to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

TAMARA RIDDLE, Claimant
Cynthia L. Barrett, Claimant's Attorneys
Nelson, et al., Defense Attorneys

WCB 88-20712
June 8, 1989
Order Remanding

Claimant, pro se, requests review of Referee Hoquet's order that dismissed her hearing request from the insurer's denial of claimant's injury claim. On review, claimant objects to the Referee's dismissal of her hearing request. We remand.

FINDINGS OF FACT

On November 30, 1988, claimant, through her then attorney of record, requested a hearing from the insurer's November 16, 1988 denial of her injury claim. Pursuant to her retainer agreement, claimant authorized her attorney to appear at any hearing necessary in connection with her claim. Thereafter, the insurer responded to claimant's hearing request, denying the contentions raised by claimant.

A hearing was scheduled for February 16, 1989. On that date, claimant's and the insurer's counsels appeared before the Referee. This "proceeding" was not recorded. On February 23, 1989, the Referee issued an Order of Dismissal. Stating that the insurer had "recently rescinded" its denial and that claimant had withdrawn her hearing request, the Referee awarded claimant's counsel an insurer-paid attorney fee for overturning the denial and dismissed the request for hearing.

On March 22, 1989, claimant, pro se, filed her request for Board review of the Referee's order. Noting her dissatisfaction with her legal counsel, claimant contended that her injury was not work-related.

The record is incompletely or otherwise insufficiently developed.

CONCLUSIONS OF LAW

On review, claimant objects to her then-attorney's actions and protests the Referee's dismissal order. Specifically, she contends that "this was not a work related injury" and that she is attempting to "correctly resolve this misguided case." In response, the insurer reiterates that it has accepted claimant's injury claim. Consequently, it seeks affirmance of the Referee's order.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Here, the record is devoid of any motions, correspondence, or exhibits pertaining to the dismissal of claimant's hearing request. Rather, the record concerning this issue consists of the Referee's February 23, 1989 dismissal order. After noting that claimant's counsel and the insurer's counsel "appeared" on February 16, 1989, the order states that the insurer had rescinded its denial and claimant was withdrawing her hearing request. There is no indication that claimant was present during this February 16, 1989 proceeding. Moreover, no transcript of this proceeding exists.

Considering these circumstances, we find that the record has been incompletely and insufficiently developed. Consequently, we conclude that remand is an appropriate action. ORS 656.295(5).

Accordingly, the Referee's February 23, 1989 order is vacated and this case is remanded to Referee Hoquet with the following instructions. The Referee is directed to conduct further proceedings to determine whether claimant's hearing request should be dismissed. If the Referee finds that the hearing request should be dismissed, a final order shall issue setting forth the Referee's reasoning. Should the Referee find that the hearing request should not be dismissed, this case shall proceed to hearing on the merits. Thereafter, the Referee shall issue a final order.

IT IS SO ORDERED.

RALPH F. SINGLETERRY, Claimant
Galton, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 82-06686
June 8, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee Fink's order that: (1) increased claimant's unscheduled permanent disability for a low back injury from 65 percent (208 degrees), as awarded by Determination Order, to 80 percent (256 degrees); and (2) declined to grant permanent total disability benefits. On review, the issue is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

Prior to claimant's compensable 1982 injury, he experienced right leg weakness causing his leg to occasionally collapse. The record does not persuade us, however, that claimant's leg collapsed on or around Thanksgiving 1985.

As a result of claimant's compensable injury, he has sustained moderately severe permanent physical impairment to his low back. He is physically capable of sedentary to light work. In fact, Dr. Waldram specifically released claimant for janitorial, security or electronics assembly positions. Claimant is restricted from engaging in repetitive bending or lifting greater than ten pounds and he should be allowed to move from a sitting to standing position periodically in a work environment.

Claimant was employable as a janitor, security guard or electronics assembler with rudimentary English language, reading and writing skills. In order to improve his reading and writing skills, he undertook a remedial education skills course through a community college. The teaching was done by videotape with a teacher available for assistance. Claimant was allowed to stand, sit or walk whenever necessary; tasks were designed to be accomplished at his own pace. Nonetheless, claimant declined to cooperate and did not finish the remedial skills program. We find that he quit for reasons other than his physical condition

DELLA M. RADCLIFF, Claimant
Vick & Gutzler, Claimant's Attorneys
Gail Gage (SAIF), Defense Attorney
Alice M. Bartelt, Defense Attorney

WCB 87-10774 & 87-01187
June 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Myers' order which: (1) found that claimant was not entitled to interim compensation; and (2) declined to assess penalties and attorney fees for an alleged unreasonable failure to pay interim compensation. We reverse in part.

ISSUE

The issue on review is whether Dr. Wilson's "off-work " slip constitutes medical verification of an inability to work due to a worsening of claimant's compensable condition.

FINDINGS OF FACT

Claimant was 49 years old at hearing. She compensably injured her back in September, 1983. A February 9, 1984, Determination Order awarded claimant 20 percent unscheduled disability. A stipulation dated July 31, 1984, increased the award to 30 percent unscheduled disability.

Claimant's claim was reopened in October, 1985. A Determination Order of January 8, 1987, awarded temporary total disability, and no additional permanent disability.

On April 15, 1987, claimant executed a change of physicians form in favor of Dr. Wilson, chiropractor. He reported on the form that claimant suffered from continuous pain in the low back. He checked the box indicating claimant was not medically stationary. He also gave claimant an "off-work" slip, taking her off work for two weeks commencing April 15, 1987. On this slip, Dr. Wilson wrote the insurer's name, the claim number, and the date of injury for the 1983 compensable injury.

The insurer received both the change of physician form and the off-work slip on April 20, 1987. It did not pay interim compensation prior to its denial on June 22, 1987.

ULTIMATE FINDING OF FACT

Dr. Wilson's "off-work" slip, and the change of physician form received on the same day by the insurer, constitutes notice of medically verified inability to work due to a worsening of claimant's compensable condition.

CONCLUSIONS OF LAW AND OPINION

The Referee analyzed the evidence as if the "off-work" slip was the only information available to the insurer as to whether claimant was filing an aggravation claim. He concluded that the off-work slip by itself was insufficient to constitute an aggravation claim. We express no opinion on whether it is, by itself, sufficient to constitute an aggravation claim. We believe that the off-work slip, considered with the other information available to the insurer, is an aggravation claim.

Taken together, the off-work slip and the change of physician form received by the insurer on April 20, 1987, constitute a claim for aggravation. They also give notice of a medically verified inability to work resulting from a worsening of her condition and that the worsening is related to the compensable 1983 injury. The insurer did not deny this claim until June 22, 1987, and did not pay interim compensation.

When the insurer receives medical verification that a claimant is unable to work because of a worsened condition, it is obligated to begin paying interim compensation within 14 days unless it denies the claim. ORS 656.273(6). Consequently, the insurer should have either denied the claim within 14 days or paid interim compensation.

We conclude that the insurer should have paid interim compensation from April 20, 1987, the date it received the aggravation claim, to June 22, 1987, the date of its denial. The insurer notes that another insurer paid interim compensation for that period. Yet, in addressing the obligation to pay interim compensation, we look at each insurer's responsibility without considering the duties of another insurer. Steven R. Pace, 38 Van Natta 139 (1986).

Finally, we consider the insurer's failure to process this claim in accordance with ORS 656.273(6) to have been unreasonable. Accordingly, a penalty and attorney fee are justified. ORS 656.262(10); 656.382(1).

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review concerning the penalty issue. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5).

ORDER

The Referee's order dated September 10, 1987, is reversed in part. Claimant is awarded interim compensation from April 20, 1987 through June 22, 1987. Claimant's attorney is awarded 25 percent of this increased compensation not to exceed $3,800. In addition, the insurer is assessed a penalty equal to 25 percent of the interim compensation awarded herein, to be paid to claimant. The remainder of the Referee's order is affirmed.

Board Member Crider, specially concurring:

For the reasons discussed in my concurring opinions in Sandra Berkey, 41 Van Natta 944 (Issued this date), and Gene T. Lapraim, 41 Van Natta 956 (Issued this date), I agree that claimant's interim compensation benefits should run from the date of the insurer's notice of medically verified inability to work to the date of its denial. I remain doubtful of the merit of the rationale for this result, however, given the teaching of Bono v. SAIF, 298 Or 405 (1984).

because: (1) the program was designed to accommodate claimant's pain; and (2) claimant was not a credible witness.

Since claimant's last surgery in 1985, he has failed to make any reasonable effort to obtain gainful employment.

CONCLUSIONS OF LAW

Concluding that claimant had not demonstrated motivation to seek work, the Referee declined to grant claimant permanent total disability benefits. Instead, he increased claimant's unscheduled disability award from 65 percent to 80 percent based on his "severe disability because of his work experience, his lack of education, and his physical condition." The Referee also concluded, after observing claimant at hearing, that he was "essentially, not a credible witness." We agree with the Referee on all counts and affirm.

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as conditions of the labor market. Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders work search futile, SAIF v. Scholl, 92 Or App 594 (1988), he must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

Claimant was not a credible witness. We make this finding based on a number of factors. First, claimant fabricated the alleged injury of November 1985. We arrive at this conclusion because: (1) claimant changed his testimony at hearing as to which day the alleged incident occurred; (2) there is an absence of medical documentation to support claimant's account of the events; and (3) the Emergency Room records from that period are totally inconsistent with the history claimant related at hearing; in fact, they do not record an injury at all. Second, while claimant indicated that he had never experienced neck pain or problems with his leg collapsing on him prior to the compensable injury, the record is replete with contradictory medical charts from the 1960s and 1970s. Third, physicians consistently reported hysterical or functional overlay and did not attribute it to his compensable injury. Fourth, claimant's testimony regarding his cessation of the remedial skills program at the community college was thoroughly and persuasively refuted by contemporaneous vocational reports and the testimony of his vocational counselor at hearing.

In short, we acknowledge that claimant has a significant physical disability as a result of multiple lumbar surgeries, but based on the record we find that he fabricated one incident and consistently misrepresented the level of his symptomatology to medical providers, his vocational rehabilitation counselor and to the Referee at hearing. Therefore, we afford his testimony no weight.

In order to determine the extent of claimant's permanent

disability, we disregard claimant's subjective complaints regarding disabling pain and instead rely upon the voluminous medical and vocational evidence. See Daryl Sims, 39 Van Natta 27 (1987). Since Dr. Waldram, claimant's treating physician, released him to light or sedentary employment and specifically approved three separate job descriptions generated by claimant's vocational rehabilitation counselor, we find no evidence to support claimant's claim for permanent total disability benefits on a medical only basis. Therefore, we must determine whether claimant is permanently and totally disabled under the "odd lot" doctrine.

At the time of hearing, claimant was a 52-year-old Spanish-speaking factory and farm laborer with a first grade education. He is illiterate in Spanish and English but speaks English fluently.

Claimant's physical impairment is significant. As a result of multiple low back surgeries, he is restricted from engaging in repetitive bending or lifting greater than ten pounds and he should be allowed to move from a sitting to standing position periodically in a work environment. According to both Drs. Waldram and Misko, however, claimant is physically capable of sedentary to light work. In fact, Dr. Waldram specifically released claimant for janitorial, security or electronics assembly positions.

Lila Webster, claimant's vocational rehabilitation counselor, testified at hearing that had claimant continued to take his remedial education classes and followed through with vocational efforts, it was highly likely that he would have obtained employment. This vocational testimony was unrefuted by claimant. Ms. Webster also testified that the classroom setting of the basic skills course would have allowed claimant to stand, shift his position and walk as he chose. Regardless of the flexibility of this program, and against the advice of Dr. Waldram (Ex. 222), claimant considered himself physically unable to attend classes and stopped. We find to the contrary and conclude that claimant was physically capable of attending classes. Claimant quit attending because he lacked the motivation required to complete the training and return to gainful employment.

In Willamette Poultry Company v. Wilson, 60 Or App 755 (1982), the claimant was involved in a situation similar to the present case. He was a 41-year-old truck driver who had had a laminectomy and diskectomy performed after an on-the-job back strain. Id. at 757. Vocational consultants concluded that he was capable of light to sedentary work, but claimant refused to take training classes or pursue literacy courses. Id. at 758. Claimant's subjective symptoms of back pain were excessive and unsubstantiated by physical examination. Id. The court declined to grant permanent total disability benefits, reasoning that the claimant's "asserted belief that he hurts too much to seek employment or to develop literacy skills does not relieve him of the statutory requirements" to seek work. Id. at 761.

In the present case, we likewise conclude that claimant's asserted belief that he was unable to work did not relieve him of the statutory requirements to develop literacy skills, if it would help him obtain gainful employment, and to seek such employment. Claimant did neither and therefore is not entitled to permanent total disability benefits under the "odd lot" doctrine.

In rating the extent of claimant's unscheduled permanent disability, we consider his 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).

Following our review of the medical and lay evidence, and considering claimant's moderately severe physical impairment, age, lack of education and limited work experience, decreased adaptability to lighter occupations, mental capacity, and emotional and psychological condition, we conclude that an award of 80 percent unscheduled permanent disability appropriately compensates claimant for his compensable injury.

ORDER

The Referee's order dated July 9, 1987 is affirmed. The Board approves a client paid fee not to exceed $2,123.50.

BEVERLY A. BOND, Claimant
Brian R. Whitehead, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Kevin L. Mannix, Defense Attorney

WCB 86-17765
June 12, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Crawford Risk Management requests review of those portions of Referee McCullough's order that: (1) set aside its "backup" denial of claimant's low back injury claim; and (2) upheld Cigna Insurance Company's "backup" denial of claimant's injury claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

Claimant was injured while working for her employer on January 5, 1985. On January 11, 1985, Cigna accepted the claim and processed it, paying benefits. Then in November of 1986, CIGNA discovered that its coverage had expired on December 31, 1984, and that Crawford Risk Management (Crawford) was actually on risk on the date of injury, and had been since January 1, 1985. Realizing benefits had mistakenly been paid, Cigna issued a "backup" denial on December 10, 1986. On February 4, 1987, Crawford accepted and processed the claim. However, noting the issuance of D. Maintenance Company v. Mischke, 84 Or App 218, rev den 303 Or 483 (1987), Crawford subsequently issued a "backup" denial on October 2, 1987.

CONCLUSIONS OF LAW

The Referee found that although Cigna had accepted and processed the claim, Crawford was actually the insurer on risk at the time of injury. Relying on Mischke, the Referee held that a "backup" denial is permissible where there is a lack of coverage governed by a guaranty contract. Accordingly, he upheld Cigna's "backup" denial and set aside Crawford's subsequent "backup" denial. Because we disagree with the Referee's interpretation and application of Mischke, we reverse.

In Bauman v. SAIF, 295 Or 788 (1983), the Supreme Court announced the general prohibition against "backup" denials. The Court stated:

> "ORS 656.262(6) gives the insurer or self-insured employer 60 days after notice of the claim in which to accept or deny the claim. If, as in this case, the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days has elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. The insurer or self-insured employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability. We need not list all of the possible ramifications of such conduct but it is readily apparent that problems involving lapsed memories, missing witnesses, missing medical reports, and host of other difficulties would arise from the delayed litigation of the compensability of a claim. The statutory scheme in ORS 656.262 envisions a speedy resolution of workers' compensation claims....we hold that once a claim has been accepted the insurer or self-insured employer may not withdraw such acceptance."

Bauman, 295 Or at 793-4.

In Ebbtide Enterprises v. Tucker, 303 Or 459 (1987), the Supreme Court applied the Bauman rule to those cases where the only dispute was one of responsibility between insurers. The Court explained the underlying policy reasons for so holding:

> "In reaching the conclusion in Bauman that backup claim denials are impermissible under the Workers' Compensation Law, we relied not upon a perceived threat to claimant's benefits, but upon the institutional costs of permitting such denials. We identified problems of proof and the need for stability in the system and for speedy resolution of claims as policies advanced by the rule of finality imposed by the statutes. These considerations are as persuasive in disputes between insurers as they are in disputes between an insurer and a claimant."

Ebbtide, 303 Or at 463.

In between the Bauman and Ebbtide decisions, the Court of Appeals rendered the Mischke decision. Mischke held that a "backup" denial issued by a first insurer is permissible, where the second insurer retroactively provides coverage, and that coverage included a

previously accepted and processed claim. Mischke, 84 Or App at 221-222. In Mischke, when the second insurer contracted to provide coverage, the claim had already been accepted and processed by the first insurer. Unlike the case at bar, there was no mistake, the first insurer was actually on the risk at the time of injury. The second insurer simply contractually assumed the responsibilities of the first thereafter. Thus, compensability and responsibility were resolved to the extent of the acceptance. It was at that point that the Bauman principles attached to protect claimant from vacillation by her employer or its insurer. Mischke, 84 Or App at 221-222.

The principle enunciated by Mischke is to maintain the enforceability of guaranty contracts, while at the same time meeting the institutional needs announced in Bauman. This principle, which was subsequently followed in Ebbtide, is designed to ensure the stability of the workers' compensation system, the speedy resolution of claims, and the preclusion of evidentiary problems. We do not consider the institutional policy, as described in these decisions, permits insurers to vacillate and issue "backup" denials, when the insurers have by mistake accepted and processed a claim, only to discover as an afterthought they should not have done so.

Thus, we conclude that, in order for the holding of Mischke to be applicable, the insurer must demonstrate the following elements: (1) the existence of a guaranty contract in accordance with ORS 656.419(1), which places another insurer on risk at the time of injury; and (2) the coverage assumed by the second insurer includes the previously accepted and processed claim at issue.

Turning to the case at hand, the first element of Mischke is met. There exists a guaranty contract involving the employer and the two insurers as provided by law. The dates of this contract mandated that Cigna was on risk through December 31, 1984, and that Crawford was on risk from January 1, 1985. Consequently, in terms of the contract, the insurer on risk at the time of the January 5, 1985, injury was Crawford.

However, the second element is not met. Here, the second insurer had already entered into a contract before the injury arose. Therefore, there was no acceptance of the claim by operation of law, and hence, the issues of compensability and responsibility remained potentially viable and subject to litigation.

In addition, allowing a "backup" denial under these facts would defeat the need for stability and speedy resolution of a claim by placing claimant in a "holding pattern." Further, such a procedure would also give rise to evidentiary problems. For example, permitting the first insurer to "backup" and deny long after the initial acceptance, would require the second insurer to defend against a stale claim. In addition, such a procedure would permit the issue of compensability to be raised at a later date and, potentially resulting in surprise and prejudice to the second insurer in its attempt to thoroughly investigate the claim. For these policy reasons, we do not find the holding of Mischke to be applicable.

In conclusion, Cigna's "backup" denial was invalid Therefore, Cigna's acceptance continued in force and was legally binding, and the duty to pay benefits continued to run. Georgia Pacific Corp. v. Piwowar, 305 Or 494, 502 (1988). Inasmuch as Cigna's denial was invalid, the issue of Crawford's denial is rendered moot.

ORDER

The Referee's order dated November 18, 1987, is reversed. Cigna's Company's "backup" denial is set aside and the claim is remanded to Cigna for processing according to law. Crawford Risk Management's denial is reinstated and upheld. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, payable from Cigna to its counsel, not to exceed $1,936. The Board also approves a client-paid fee, payable from Crawford Risk Management to its counsel, not to exceed $928.

LESLIE DREWS, Claimant
Rasmussen & Henry, Claimant's Attorneys
Nelson, et al., Defense Attorneys

WCB 88-10832
June 12, 1989
Order of Remand

Reviewed by Board Members Johnson and Ferris.

The insurer requests review of Referee Livesley's order that: (1) directed it to recalculate claimant's rate of temporary total disability benefits; and (2) assessed penalties and attorney fees for unreasonable claims processing. On review, the insurer contends that the Referee's order should be vacated and the case remanded to the Hearings Division. We agree and grant the insurer's request for remand.

FINDINGS OF FACT

Claimant requested a hearing, contending that the insurer had improperly calculated the rate of her temporary disability benefits. In her request, claimant indicated that the amount in controversy was less than $1,000. Thereafter, the hearing request was referred to the Expedited Claim Service.

The insurer appeared at hearing through its paralegal. The amount in controversy at hearing exceeded $1,000. The parties did not agree on the oral record to proceed with the hearing as an ordinary hearing process without further delay.

CONCLUSIONS OF LAW

The Referee found that the amount in controversy exceeded $1,000. Reasoning that the insurer's "counsel" had elected to go forward and waive all procedural defects, the Referee concluded that he retained jurisdiction to proceed with the hearing pursuant to the ordinary hearing process. We disagree.

A request for hearing shall be referred to the Expedited Claims Service if the request does not involve the compensability of a claim, aggravation of a previously accepted claim or responsibility between insurers for a condition resulting from an accidental injury or occupational disease. OAR 438-13-010(1)(a). In addition, Expedited Claims Service is available only if the sole issue is entitlement to penalties and/or related attorney fees or the total amount in controversy, exclusive of penalties and/or related attorney fees, is $1,000 or less. OAR 438-13-010(1)(b).

If the Referee finds that the amount in controversy is more than $1,000, exclusive of penalties and/or attorney fees, the Referee shall refer the case for decision under the ordinary hearing process. OAR 438-13-010(2). However, with the consent of the

Referee, the parties may agree on the oral record to proceed with the hearing as referred to the ordinary hearing process without further delay. id.

Here, it is undisputed that the amount in controversy exceeded $1,000. Consequently, the Referee was required to refer the case for decision under the ordinary hearing process. OAR 438-13-010(2). The Referee dispensed with the referral requirement, concluding that the insurer's "counsel" had elected to go forward, thereby waiving all procedural defects. Yet, there is no oral record establishing that the parties agreed, with the consent of the Referee, to proceed with the hearing under the ordinary hearing process without further delay. See OAR 438-13-010(2).

Accordingly, we conclude that the case should have been referred for decision under the ordinary hearing process. Consequently, the Referee's order is vacated and this case is remanded to the Referee with instructions to conduct a hearing under the ordinary hearing process. This hearing shall be convened in consolidation with WCB Case No. 89-07034, a case presently pending before the Hearings Division, which apparently pertains to the insurer's alleged noncompliance with the Referee's order. Upon completion of this consolidated hearing, the Referee shall issue a final, appealable order concerning the issues raised therein.

IT IS SO ORDERED.

LIDA M. FRALY, Claimant
Emmons, et al., Claimant's Attorneys
Jill Reichers, Defense Attorney

WCB 87-06061
June 12, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Myzak's order that increased claimant's unscheduled permanent disability award for a low back injury from 10 percent (32 degrees), as awarded by a Determination Order, to 40 percent (128 degrees). The issue is extent of unscheduled permanent disability.

We affirm and adopt the Referee's order with the following comment. The insurer contends that the Board should apply the disability rating standards in effect at the time the Board reviews this case. We note that current permanent disability rating standards, found at OAR 436-35-270 through 436-35-440, are applicable only to those claims closed, on or after July 1, 1988. OAR 436-35-003. See also OAR 438-10-005.

Accordingly, we evaluated this claim using the guidelines in force at the time the case was tried. See OAR 436-30-380 et seq; Linda L. Carroll, 40 Van Natta 1095 (1988).

Claimant's counsel is statutorily entitled to a reasonable carrier-paid fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." However, we cannot award an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order dated December 23, 1987, is affirmed.

MICHAEL J. HARVEY, Claimant
Malagon, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 87-06987
June 12, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Blevins' order which concluded that claimant was not entitled to temporary disability benefits or to a penalty and associated attorney's fee. We reverse.

ISSUES

The primary issue is whether claimant was entitled to reinstatement of temporary total disability benefits beginning March 5, 1987. Claimant also contends that he is entitled to a penalty and associated attorney's fee for the insurer's failure to pay those benefits.

FINDINGS OF FACT

Claimant compensably injured his low back on June 15, 1986 while working as a seafood processor. He strained his back, but did not herniate a disc.

Dr. Adams released claimant to regular work on August 8, 1986. Claimant apparently returned to work and was then fired for misconduct. In October he complained of increased pain. Claimant was able to do "some of the work he was before" at that time.

Claimant returned to work for the employer again on December 1, 1986. Claimant was terminated for reasons unrelated to his industrial injury on December 3, 1986.

Claimant began treating with Dr. Chatburn, a chiropractor, on March 5, 1987. On April 9, 1987, Dr. Chatburn stated that claimant could not do his regular work and had not been able to do so since March 5, 1987. He believed that claimant had never returned to regular work, only modified part-time work, and that claimant had never been able to do the regular work. Dr. Chatburn believed that claimant had left work due to the effects of the compensable injury.

Claimant was not medically stationary on March 5, 1987. Claimant has never been found medically stationary.

The insurer has never paid temporary total disability benefits after March 5, 1987. The insurer denied temporary total disability benefits on May 21, 1987. One basis for the denial was a res judicata argument which the Referee rejected and which neither party presses on review. The other basis for the denial was that there was no evidence that claimant's condition had worsened since he left work for reasons unrelated to his compensable injury.

CONCLUSIONS

We agree with the Referee's conclusion that claimant was not a credible witness.

The Referee concluded that claimant was not entitled to have temporary total disability payments resumed as of March 5, 1987 because claimant had withdrawn from the labor market by his conduct. He relied upon Cutright v. Weyerhaeuser Co., 299 Or 290 (1985) and

Noffsinger v. Yoncalla Timber Products, Inc., 88 Or App 118 (1987). We find neither case controlling.

The issue in Cutright was whether a claimant who had retired from the work force was entitled to temporary total disability benefits when his compensable condition had aggravated. The Court concluded that he was not, reasoning that the purpose of temporary total disability benefits was to compensate a worker for wages lost due to a compensable injury. A worker who has retired before his condition becomes worse has not lost wages as a result of the worsened condition. This case, unlike Cutright, involves an initial injury claim which is in open accepted status and in which the claimant is not medically stationary. Although claimant was not working for reasons unrelated to his compensable injury at the time Dr. Chatburn concluded that claimant was unable to work, there is no evidence that claimant had withdrawn from the work force.

In Noffsinger, the court found as a fact that claimant had never been disabled from work as a result of his compensable injury. Accordingly, he did not become entitled to temporary disability. Because of its unique facts, we do not find Noffsinger applicable here.

Safeway Stores v. Owsley, 91 Or App 475 (1988) was decided after briefing was completed in this case. In Owsley, claimant had returned to modified work at a wage equal to or exceeding her wage at the time of injury. She was then fired for reasons unrelated to her compensable injury. The court relied on OAR 436-60-030. It concluded that the employer was not obligated to reinstate claimant's temporary disability benefits after she was fired.

This case is distinguishable from Owsley because here claimant seeks reinstatement of temporary total benefits not immediately after the firing, but only after Dr. Chatburn declared that claimant was totally disabled due to his injury. OAR 436-60-030(6)(a) provides that temporary partial disability benefits shall continue to be paid until "the attending physician verifies that the workers' condition is such that he could no longer perform such work and is again temporarily totally disabled." Assuming that claimant had returned to work at his regular wage, a fact which is not clear on this record, claimant's temporary total disability rate was zero when he returned to work. Accordingly, assuming that claimant had returned to work at his regular wage, under Owsley, the insurer had no obligation to reinstate temporary total disability benefits when claimant was fired.

However, under the rule, as a claims processing matter, the insurer was obligated to reinstate temporary total disability benefits when Dr. Chatburn verified that claimant's condition was such that he could no longer perform his regular work. See Rodgers v. Weyerhaeuser Company, 88 Or App 458 (1987). We conclude that the insurer's failure to reinstate claimant's temporary total disability benefits was unreasonable given the plain language of the rule. Accordingly, we assess a 25 percent penalty.

ORDER

The Referee's order dated November 9, 1987 is reversed. The insurer is directed to reinstate claimant to temporary total disability benefits and to continue to pay those benefits until they may be properly terminated according to law. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed

$3,800. The insurer is ordered to pay to claimant as a penalty an amount equal to 25 percent of all temporary total disability benefits due between March 5, 1987 and the date of hearing. Claimant is awarded a reasonable penalty-associated attorney's fee of $750. A client-paid fee, not to exceed $904, is approved.

ELDEN G. MARLOW, Claimant
Coons & Cole, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-14686
June 12, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer requests review of those portions of Referee Foster's order that: (1) awarded additional temporary disability; and (2) increased claimant's unscheduled permanent disability award for his back condition from 50 percent (160 degrees), as awarded by Determination Order, to 75 percent (240 degrees). The insurer also asks the Board to take notice of two documents not otherwise included in the record at the hearing. In his respondent's brief, claimant moves to strike those documents. We affirm.

ISSUES

(1) Remand for the taking of additional evidence;

(2) Entitlement to additional temporary disability benefits;

(3) Extent of unscheduled permanent disability; and

(4) Extent of scheduled permanent disability due to loss of use or function of the left arm.

FINDINGS OF FACT

Claimant, 43 at hearing, compensably injured his low back and neck on May 31, 1983, while working as a sawyer. An April 5, 1984 Determination Order closed the claim with temporary disability through March 12, 1984. The Determination Order also awarded claimant 20 percent unscheduled permanent disability for his low back. Claimant requested a hearing, contending that the claim had been prematurely closed.

On April 4, 1984, claimant returned to his regular work on a trial basis. He completed only four days of work, and had to stop because of increased pain. He has not worked since. On April 26, 1984, Dr. Robertson, orthopedist, recommended that claimant discontinue working.

On June 5, 1984, claimant's treating family physician, Dr. Lott, outlined claimant's physical capacities. Claimant is limited in his ability to bend, squat, climb and reach. He cannot lift more than 10 pounds. Claimant can sit for two consecutive hours, and stand or walk for one half hour.

Claimant was evaluated by the Orthopaedic Consultants on August 14, 1984. They noted claimant had worse symptoms than at the time of their earlier evaluation. There were no increased objective findings. They limited claimant's lifting capabilities to 50 pounds.

Dr. Lott and Dr. Robertson, claimant's attending orthopedic surgeon, recommended pain center treatment. Claimant was accepted

into a pain therapy program in conjunction with alcohol abuse treatment. He completed both programs, but thereafter complied poorly with each program's maintenance plan, including weight loss and conditioning.

On December 6, 1984, Dr. Robertson recommended fusion surgery for claimant's low back. Dr. Holmes, pain center director, concurred in the recommendation. On January 3, 1985, the insurer reopened the claim.

On February 4, 1985, Dr. Robertson performed a mass lateral fusion of claimant's spine at the L5 vertebra. Following the surgery, claimant was given vocational assistance, and a plan for retraining as a construction estimator was developed.

On March 13, 1985, Dr. Robertson reported that he considered the date of his surgery recommendation, December 6, 1984, to be the date on which claimant worsened. Robertson also considered December 6, 1984 to be the date claimant's aggravation claim should be reopened.

On July 21, 1985, Dr. Smith performed a fusion of claimant's cervical spine.

On May 1, 1985, a hearing was held concerning the April 5, 1984 Determination Order. The issues at that hearing were: (1) whether the claim was prematurely closed; (2) claimant's entitlement to treatment for alcohol addiction; and (3) penalties and attorney fees. By Opinion and Order issued July 30, 1985, the Referee found the alcohol abuse treatment compensable, and found that claimant's claim had been prematurely closed. On review, the Board affirmed the compensability issue, but found that the claim had been properly closed on April 5, 1984.

Claimant completed schooling to become a construction estimator. However, he did not follow through well in obtaining interviews for an intern position. For example, at one interview he told the employer that the job was beyond the capacities set for him by his physician. He eventually obtained an intern position with another employer, and worked for eight weeks. At times, pain in his neck and back would force him to leave work early, but he took paperwork home and kept up with his assignments. The employer was happy with claimant's performance. Yet, it concedes that it would have been useful if claimant had had experience bidding on computers, and stronger spelling skills.

Claimant's vocational counselor located an adult education program, which agreed to design a spelling program for him. The program was free. Claimant refused to participate in the program. Claimant also sent out some resumes to potential employers in Arizona, but received no response. He refused to consider potential employment in Southern California.

The Orthopaedic Consultants reevaluated claimant on August 29, 1986. They reported possible habituation to scheduled medications. They rated his permanent impairment at 30 percent. Dr. Robinson concurred with the Consultants' report.

Claimant asked to see another orthopedist. Dr. Lott referred him to Dr. Freeman, who recommended a myelogram and an EMG of the spine, and nerve conduction tests of the left carpal tunnel. Testing revealed mild left carpal tunnel syndrome.

Claimant's aggravation claim was closed by Determination Order on October 2, 1986, with an award of temporary disability commencing December 6, 1984, the date Dr. Robertson recommended the fusion. In addition, claimant was awarded 50 percent unscheduled permanent disability for his low back and neck, 20 percent scheduled permanent disability for his left arm, and 5 percent scheduled permanent disability for his left leg. Claimant requested a hearing.

Claimant was enrolled in a second pain center program from November 1986 through January 1987. While there, he was examined by a psychologist. Claimant had chronic pain, but also had significant behavioral over reaction inconsistent with his functional difficulties.

FINDINGS OF ULTIMATE FACT

Claimant's compensable condition worsened and he became unable to work on April 26, 1984. He is permanently restricted to sedentary work.

Claimant has suffered a 75 percent permanent loss of earning capacity as a result of his compensable injury and a 35 percent permanent loss of use of function of the left arm.

CONCLUSIONS OF LAW AND OPINION

Remand

The insurer requests that the Board consider two documents, the request for hearing relating to the May 1, 1985 hearing, and a Form 1502, showing the date the claim was reopened by the insurer. These documents were not made a part of the record at the time of the May 6, 1987 hearing. We treat such a request as a request for remand for the taking of additional evidence. See Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand a case to the Referee if we find that the record has been incompletely, improperly or otherwise insufficiently developed. ORS 656.295(5). Generally, this may be done only if the evidence was unavailable at hearing by due diligence. See Bernard L. Osborn, 37 Van Natta 1054 (1985). Here, the two proffered documents are dated April 23, 1984 and February 11, 1985, and each shows timely receipt by the insurer. The hearing before us on review was held May 6, 1987. We conclude the documents could, with due diligence, have been made a part of the record. We therefore deny the request for remand, and do not consider the documents in our review.

TTD: Aggravation Date

At hearing, claimant contended that he was entitled to temporary total disability (TTD) beginning April 26, 1984, rather than beginning December 6, 1984, as ordered by the October 2, 1986 Determination Order. The Referee agreed and awarded time loss beginning April 26, 1984.

The insurer contends that claimant was barred under the doctrine of res judicata from raising the issue at the May 6, 1987 hearing because the issue was ripe and should have been raised at the May 1, 1985 hearing. We disagree.

The issue of claimant's substantive right to TTD beginning April 26, 1984 was not waived at the prior hearing. Rather, the

matters at issue pertained to whether the April 5, 1984 Determination Order had prematurely issued, claimant's entitlement to alcohol treatment, and penalties and attorney fees for unreasonable claims processing. None of these issues encompassed the operative facts of claimant's substantive rights to TTD commencing April 26, 1984. Furthermore, on May 1, 1985, claimant's claim was in open status, having been reopened by the insurer as of January 3, 1985. No Determination Order had yet issued identifying the dates to which claimant was entitled to TTD on that claim. Subsequently, the October 1986 Determination Order granted TTD beginning December 6, 1984. Claimant contested the dates specified in that order and properly raised the issue of his substantive entitlement to TTD beginning April 26, 1984, at the May 6, 1987 hearing.

We turn to the merits. Based upon a letter from Dr. Robertson, an October 2, 1986 Determination Order awarded temporary disability benefits beginning December 6, 1984. The Referee found that claimant's condition worsened on April 26, 1984, and ordered temporary disability benefits paid from that date. Claimant saw Dr. Robertson after his failed attempt at return to work, and on that date, Dr. Robertson reported that claimant could not work.

To reopen a claim because of aggravation, claimant must prove that a worsening of his compensable condition renders him more disabled, i. e., less able to work, than at the time of the last arrangement of compensation, and that there is a causal relationship between the worsened condition and the compensable injury. Smith V. SAIF, 302 Or 396 (1986). Claimant was released to light work before the last arrangement of compensation. He asked to try to return to his regular, heavy work, but the attempt caused a worsening of his compensable condition. As a result, Dr. Robertson took him off work beginning April 26, 1984. It is true that it was not until December 6, 1984 that Dr. Robertson decided that surgery was necessary. However, claimant was treated conservatively during the intervening months for the worsened condition. We concur with the Referee that claimant was entitled to temporary disability benefits from April 26, 1984, the date of Dr. Robertson's report.

Extent: Unscheduled disability

The Determination Order awarded claimant 50 percent unscheduled permanent partial disability for his low back and neck condition. The Referee increased that award to 75 percent disability. We affirm.

Dr. Lott, claimant's treating physician, has placed restrictions on claimant which limit him to sedentary work. These limitations include no lifting over 10 pounds, and limited bending, squatting, twisting, and crawling. The Orthopaedic Consultants reported that they felt the restrictions were too limiting, and that claimant could lift up to 50 pounds. Claimant clearly is unable to do the heavy, active work he formerly did. Absent compelling reason to do otherwise, we defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). We find that claimant is restricted to sedentary work.

In rating the extent of claimant's unscheduled permanent disability, we consider the medical and lay evidence of his impairment, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. Claimant has severe impairments, and has had several surgeries as a result of his compensable injury. He

continues to have pain, both organic and psychogenic. In addition, he has developed tendencies to abuse alcohol and drugs to self-medicate for the pain, which have been found compensable.

Following our de novo review of the medical and lay evidence, and considering the aforementioned factors, we agree with the Referee that 75 percent unscheduled permanent partial disability adequately compensates claimant for his loss of earning capacity due to his low back and neck conditions.

Extent: Scheduled

Claimant was awarded 20 percent scheduled permanent disability by Determination Order. The Referee increased that award to 35 percent. We affirm.

After considering claimant's disabling pain, numbness, and limited range of motion in the left arm, as each is attributable to the compensable neck injury, we agree with the Referee that a 35 percent scheduled permanent disability adequately compensates claimant for the loss of use or function of his left arm.

ORDER

The Referee's order dated June 1, 1987, as amended June 19, 1987, is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $500, to be paid by the insurer. A client-paid fee, not to exceed $600, is approved.

JAMES F. ROSS, Claimant
Ackerman, et al., Claimant's Attorneys
J.W. McCracken, Jr., Defense Attorney

WCB 86-06957 & 86-07958
June 12, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Brown's order which upheld the self-insured employer's denial of claimant's claim for a meralgia paresthetica condition. The employer cross-requests review of the Referee's decision not to admit an exhibit into evidence. On review, the issues are compensability and admission of evidence. We affirm the Referee in regard to the evidence issue and reverse in regard to compensability.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in April 1978. The diagnosis of claimant's condition included findings of numbness on the anterior portion of both thighs. In February 1980, claimant experienced left lower extremity discomfort when his lumbar traction was increased to 65 pounds. Dr. Becker, who was treating claimant at that time, reported that there was ilio-inguinal nerve pressure caused by the lumbar traction girdle.

In May 1980 claimant complained of an overall worsening of symptoms, including numbness over the lateral anterior thighs at the lateral femoral cutaneous distribution. Dr. Becker diagnosed meralgia paresthetica and performed a left lateral femoral cutaneous nerve injection. In January 1981, Dr. Becker reported that claimant was comfortable working under most circumstances and that further treatment, other than occasional physical therapy, was not indicated.

In April 1982, claimant was examined by Dr. Freeman, orthopedist. Dr. Freeman diagnosed a probable disc problem at L4-5

matters at issue pertained to whether the April 5, 1984 Determination Order had prematurely issued, claimant's entitlement to alcohol treatment, and penalties and attorney fees for unreasonable claims processing. None of these issues encompassed the operative facts of claimant's substantive rights to TTD commencing April 26, 1984. Furthermore, on May 1, 1985, claimant's claim was in open status, having been reopened by the insurer as of January 3, 1985. No Determination Order had yet issued identifying the dates to which claimant was entitled to TTD on that claim. Subsequently, the October 1986 Determination Order granted TTD beginning December 6, 1984. Claimant contested the dates specified in that order and properly raised the issue of his substantive entitlement to TTD beginning April 26, 1984, at the May 6, 1987 hearing.

We turn to the merits. Based upon a letter from Dr. Robertson, an October 2, 1986 Determination Order awarded temporary disability benefits beginning December 6, 1984. The Referee found that claimant's condition worsened on April 26, 1984, and ordered temporary disability benefits paid from that date. Claimant saw Dr. Robertson after his failed attempt at return to work, and on that date, Dr. Robertson reported that claimant could not work.

To reopen a claim because of aggravation, claimant must prove that a worsening of his compensable condition renders him more disabled, i. e., less able to work, than at the time of the last arrangement of compensation, and that there is a causal relationship between the worsened condition and the compensable injury. Smith V. SAIF, 302 Or 396 (1986). Claimant was released to light work before the last arrangement of compensation. He asked to try to return to his regular, heavy work, but the attempt caused a worsening of his compensable condition. As a result, Dr. Robertson took him off work beginning April 26, 1984. It is true that it was not until December 6, 1984 that Dr. Robertson decided that surgery was necessary. However, claimant was treated conservatively during the intervening months for the worsened condition. We concur with the Referee that claimant was entitled to temporary disability benefits from April 26, 1984, the date of Dr. Robertson's report.

Extent: Unscheduled disability

The Determination Order awarded claimant 50 percent unscheduled permanent partial disability for his low back and neck condition. The Referee increased that award to 75 percent disability. We affirm.

Dr. Lott, claimant's treating physician, has placed restrictions on claimant which limit him to sedentary work. These limitations include no lifting over 10 pounds, and limited bending, squatting, twisting, and crawling. The Orthopaedic Consultants reported that they felt the restrictions were too limiting, and that claimant could lift up to 50 pounds. Claimant clearly is unable to do the heavy, active work he formerly did. Absent compelling reason to do otherwise, we defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). We find that claimant is restricted to sedentary work.

In rating the extent of claimant's unscheduled permanent disability, we consider the medical and lay evidence of his impairment, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. Claimant has severe impairments, and has had several surgeries as a result of his compensable injury. He

continues to have pain, both organic and psychogenic. In addition, he has developed tendencies to abuse alcohol and drugs to self-medicate for the pain, which have been found compensable.

Following our de novo review of the medical and lay evidence, and considering the aforementioned factors, we agree with the Referee that 75 percent unscheduled permanent partial disability adequately compensates claimant for his loss of earning capacity due to his low back and neck conditions.

Extent: Scheduled

Claimant was awarded 20 percent scheduled permanent disability by Determination Order. The Referee increased that award to 35 percent. We affirm.

After considering claimant's disabling pain, numbness, and limited range of motion in the left arm, as each is attributable to the compensable neck injury, we agree with the Referee that a 35 percent scheduled permanent disability adequately compensates claimant for the loss of use or function of his left arm.

ORDER

The Referee's order dated June 1, 1987, as amended June 19, 1987, is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $500, to be paid by the insurer. A client-paid fee, not to exceed $600, is approved.

JAMES F. ROSS, Claimant
Ackerman, et al., Claimant's Attorneys
J.W. McCracken, Jr., Defense Attorney

WCB 86-06957 & 86-07958
June 12, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Brown's order which upheld the self-insured employer's denial of claimant's claim for a meralgia paresthetica condition. The employer cross-requests review of the Referee's decision not to admit an exhibit into evidence. On review, the issues are compensability and admission of evidence. We affirm the Referee in regard to the evidence issue and reverse in regard to compensability.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in April 1978. The diagnosis of claimant's condition included findings of numbness on the anterior portion of both thighs. In February 1980, claimant experienced left lower extremity discomfort when his lumbar traction was increased to 65 pounds. Dr. Becker, who was treating claimant at that time, reported that there was ilio-inguinal nerve pressure caused by the lumbar traction girdle.

In May 1980 claimant complained of an overall worsening of symptoms, including numbness over the lateral anterior thighs at the lateral femoral cutaneous distribution. Dr. Becker diagnosed meralgia paresthetica and performed a left lateral femoral cutaneous nerve injection. In January 1981, Dr. Becker reported that claimant was comfortable working under most circumstances and that further treatment, other than occasional physical therapy, was not indicated.

In April 1982, claimant was examined by Dr. Freeman, orthopedist. Dr. Freeman diagnosed a probable disc problem at L4-5

matters at issue pertained to whether the April 5, 1984 Determination Order had prematurely issued, claimant's entitlement to alcohol treatment, and penalties and attorney fees for unreasonable claims processing. None of these issues encompassed the operative facts of claimant's substantive rights to TTD commencing April 26, 1984. Furthermore, on May 1, 1985, claimant's claim was in open status, having been reopened by the insurer as of January 3, 1985. No Determination Order had yet issued identifying the dates to which claimant was entitled to TTD on that claim. Subsequently, the October 1986 Determination Order granted TTD beginning December 6, 1984. Claimant contested the dates specified in that order and properly raised the issue of his substantive entitlement to TTD beginning April 26, 1984, at the May 6, 1987 hearing.

We turn to the merits. Based upon a letter from Dr. Robertson, an October 2, 1986 Determination Order awarded temporary disability benefits beginning December 6, 1984. The Referee found that claimant's condition worsened on April 26, 1984, and ordered temporary disability benefits paid from that date. Claimant saw Dr. Robertson after his failed attempt at return to work, and on that date, Dr. Robertson reported that claimant could not work.

To reopen a claim because of aggravation, claimant must prove that a worsening of his compensable condition renders him more disabled, i. e., less able to work, than at the time of the last arrangement of compensation, and that there is a causal relationship between the worsened condition and the compensable injury. Smith V. SAIF, 302 Or 396 (1986). Claimant was released to light work before the last arrangement of compensation. He asked to try to return to his regular, heavy work, but the attempt caused a worsening of his compensable condition. As a result, Dr. Robertson took him off work beginning April 26, 1984. It is true that it was not until December 6, 1984 that Dr. Robertson decided that surgery was necessary. However, claimant was treated conservatively during the intervening months for the worsened condition. We concur with the Referee that claimant was entitled to temporary disability benefits from April 26, 1984, the date of Dr. Robertson's report.

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The Determination Order awarded claimant 50 percent unscheduled permanent partial disability for his low back and neck condition. The Referee increased that award to 75 percent disability. We affirm.

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In rating the extent of claimant's unscheduled permanent disability, we consider the medical and lay evidence of his impairment, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. Claimant has severe impairments, and has had several surgeries as a result of his compensable injury. He

continues to have pain, both organic and psychogenic. In addition, he has developed tendencies to abuse alcohol and drugs to self-medicate for the pain, which have been found compensable.

Following our de novo review of the medical and lay evidence, and considering the aforementioned factors, we agree with the Referee that 75 percent unscheduled permanent partial disability adequately compensates claimant for his loss of earning capacity due to his low back and neck conditions.

Extent: Scheduled

Claimant was awarded 20 percent scheduled permanent disability by Determination Order. The Referee increased that award to 35 percent. We affirm.

After considering claimant's disabling pain, numbness, and limited range of motion in the left arm, as each is attributable to the compensable neck injury, we agree with the Referee that a 35 percent scheduled permanent disability adequately compensates claimant for the loss of use or function of his left arm.

ORDER

The Referee's order dated June 1, 1987, as amended June 19, 1987, is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $500, to be paid by the insurer. A client-paid fee, not to exceed $600, is approved.

JAMES F. ROSS, Claimant
Ackerman, et al., Claimant's Attorneys
J.W. McCracken, Jr., Defense Attorney

WCB 86-06957 & 86-07958
June 12, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Brown's order which upheld the self-insured employer's denial of claimant's claim for a meralgia paresthetica condition. The employer cross-requests review of the Referee's decision not to admit an exhibit into evidence. On review, the issues are compensability and admission of evidence. We affirm the Referee in regard to the evidence issue and reverse in regard to compensability.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in April 1978. The diagnosis of claimant's condition included findings of numbness on the anterior portion of both thighs. In February 1980, claimant experienced left lower extremity discomfort when his lumbar traction was increased to 65 pounds. Dr. Becker, who was treating claimant at that time, reported that there was ilio-inguinal nerve pressure caused by the lumbar traction girdle.

In May 1980 claimant complained of an overall worsening of symptoms, including numbness over the lateral anterior thighs at the lateral femoral cutaneous distribution. Dr. Becker diagnosed meralgia paresthetica and performed a left lateral femoral cutaneous nerve injection. In January 1981, Dr. Becker reported that claimant was comfortable working under most circumstances and that further treatment, other than occasional physical therapy, was not indicated.

In April 1982, claimant was examined by Dr. Freeman, orthopedist. Dr. Freeman diagnosed a probable disc problem at L4-5

with nerve root involvement in both legs. In May 1982, Dr. Skelley, from the Callahan Pain Center, diagnosed chronic lumbosacral strain and radiculopathy of undetermined etiology. A Determination Order of February 1983 closed claimant's claim awarding 20 percent unscheduled permanent partial disability as well as 10 percent scheduled permanent partial disability for loss of use or function of the left leg.

In October, 1983, claimant sought treatment from Dr. Schroeder, orthopedist. Dr. Schroeder reported that claimant had degenerative disc disease involving the lumbosacral space and noted a sensory loss in the left lower extremity. In December 1983, Dr. Schroeder performed a laminectomy and discectomy at L5-S1. In April 1984, Dr. Schroeder reported that claimant had no leg pain, but still experienced pain in the low back and buttock.

The claim was again closed by an August 1984 Determination Order, which awarded no further permanent disability. The Determination Order was affirmed by a Referee's order issued in February 1986. The Referee's order found that claimant did not have any significant left leg problems at that time.

In March 1986, while performing his work activities, claimant lifted one side of a 130-140 pound drum and pivoted it onto a pallet. Thereafter, he experienced pain in his low back, buttocks and legs. Claimant returned to Dr. Schroeder complaining of anterior thigh and groin pain. Dr. Schroeder suspected an L3-4 disc problem. After a CT scan proved negative for a surgical lesion and because of the consistent subjective complaints of sensory loss in the anterior thighs, Dr. Schroeder referred claimant to Dr. Mundall, neurologist.

Dr. Mundall examined claimant and in May 1986 diagnosed: "recurrent low back pain, suspect lumbar strain; bilateral anterior thigh numbness, worse on the left, consider meralgia paresthetica." Claimant was subsequently referred to Dr. Bascom, general surgeon. Dr. Bascom diagnosed claimant's condition as meralgia paresthetica. This condition was reported to the employer on a Statement of Claim form dated December 1986.

On December 22, 1986, Dr. Bascom performed a bilateral lysis of lateral femoral cutaneous nerves surgical procedure. His operative findings confirmed the diagnosis to bilateral meralgia paresthetica. He reported in January 1987 that the surgery had been successful and that claimant was free from his pre-operative pain, numbness and burning.

The employer's counsel solicited a letter from Dr. Mundall which was authored on July 7, 1987. It was received by the Referee on July 14, 1987, the date of the hearing. (Tr. 1). The Referee did not admit the report into evidence.

FINDINGS OF ULTIMATE FACT

There was no showing of good cause for the submission of Dr. Mundall's July 7, 1987 report on the date of hearing.

The March 1986 incident was a material contributing cause of claimant's meralgia paresthetica condition.

CONCLUSIONS OF LAW

EVIDENCE

The employer argues that the Referee erred in declining to

admit a medical report from Dr. Mundall, dated July 7, 1987, which was submitted for inclusion on July 14, 1987, the day of the hearing. We disagree.

We find that the Referee properly declined to admit Dr. Mundall's report. Under the administrative rules in effect at the time this case went to hearing, carriers were generally required to submit evidence at least twenty days prior to the hearing, and claimants were required to submit any additional evidence no later than ten days prior to the hearing. See former OAR 438-07-005(3). Evidence not submitted within these deadlines was otherwise admissible at the discretion of the Referee upon a showing of good cause. See former OAR 438-07-005(4).

The employer contends that it didn't know that it needed Dr. Mundall's opinion until it received Dr. Bascom's report, dated June 29, 1987. The employer submits that after receiving Dr. Bascom's report, it diligently requested a report from Dr. Mundall as it was unaware that the meralgia paresthetica was considered work related.

We are not persuaded by the employer's contentions. The claim for the meralgia paresthetica condition was made in December 1986. Dr. Bascom performed surgery for that condition in December 1986. As the Referee noted at the time of his ruling, the employer had knowledge that this condition was at issue, approximately six months prior to the hearing. The need for an opinion on causation, in regard to the meralgia paresthetica condition, should have been apparent regardless of Dr. Bascom's opinion. Under these circumstances, the Referee did not abuse his discretion in declining to admit Dr. Mundall's report. Accordingly, we have not considered the report on review.

COMPENSABILITY

The Referee found that claimant had not carried his burden of proving either that the March 1986 incident materially contributed to his meralgia paresthetica condition or that his work activities were the major contributing cause of that condition. We disagree.

At the outset, we find that claimant's claim is one for accidental injury rather than occupational disease. An occupational disease is of gradual onset and is generally not unexpected, given the nature of claimant's continuing work exposure. James v. SAIF, 290 Or 343 (1981). An accidental injury, on the other hand, is generally the unexpected result of either an identifiable incident, or an onset traceable to a discrete time period. Valtinson v. SAIF, 56 Or App 184 (1982). Here, claimant's leg symptoms had resolved in 1984. Then in March 1986, while lifting one side of a drum, he experienced a sudden onset of pain in his low back, buttocks and legs. We conclude that this constitutes an unexpected result of the identifiable March 1986 incident. Valtinson, supra.

To establish compensability, claimant must prove, by a preponderance of the evidence, that the March 1986 incident was a material contributing cause to his disability or need for medical treatment. Summit v. Weyerhaeuser, 25 Or App 851, 856 (1976). "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).

The issue of whether claimant's meralgia paresthetica condition is causally related to the March 1986 incident is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The only medical opinion in the record, as to the causation of claimant's meralgia paresthetica, is offered by Dr. Bascom. He opined that the March 1986 incident significantly contributed to claimant's meralgia paresthetica condition. Although his opinion is conclusory, he is claimant's treating physician and, in fact, performed the surgical procedure for relief of this condition. Furthermore, there is no reason to conclude that Dr. Bascom's opinion was based on anything other than a complete history of claimant's complaints. Under these circumstances, and considering the lack of any contrary opinion, we defer to Dr. Bascom's opinion. Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988); Givens v. SAIF, 61 Or App 490 (1983). Accordingly, claimant's meralgia paresthetica condition is compensable.

ORDER

The Referee's order dated August 17, 1987 is reversed in part and affirmed in part. That portion which upheld the self-insured employer's denial of claimant's claim for his meralgia paresthetica condition is reversed. The denial is set aside and the claim is remanded to the employer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded $2,100, to be paid by the self-insured employer. A client-paid fee, not to exceed $170, is approved.

KENT BABCOCK, Claimant
Coons & Cole, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 89-0289M
June 13, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his October 27, 1978 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's treatment, but opposes claim reopening for the payment of temporary disability benefits as claimant apparently continued to receive his salary from his employer after he became disabled from work.

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 was hospitalized for his compensable condition on October 4, 1988 and we are persuaded that his condition worsened sufficiently to justify claim reopening. The employer has advised the Board that claimant did receive his full salary during the time he was off work, but that the company hoped to be reimbursed by claimant out of his temporary disability benefits. Claimant has subsequently been taken off the payroll as of June 1 due to his inability to work.

We conclude claimant's claim should be reopened with temporary disability benefits to commence October 4, 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 $300 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.

JOHN M. BIRCHFIELD, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-10266
June 13, 1989
Second Order on Reconsideration

The insurer has requested reconsideration of that portion of our April 28, 1989 Order on Reconsideration that awarded claimant an assessed fee for services on review in prevailing against the insurer's contention in its respondent's brief that the temporary total disability awarded by the Referee should be reduced. In so doing, we concluded that since the insurer raised on review an issue that we would not have otherwise addressed, claimant was entitled to an attorney fee for his counsel's efforts in successfully responding to the insurer's contention. See Littleton v. Weyerhaeuser Co., 93 Or App 659 (1988).

The insurer notes that we declined to address its argument on review because it had failed to raise the issue at hearing. Consequently, the insurer argues that we did not find that the compensation awarded to claimant should not be disallowed or reduced. Without such a finding, the insurer asserts that claimant is not entitled to an attorney fee under ORS 656.382(2).

Upon further consideration, we agree that no carrier-paid fee is due. Claimant filed a general request for review of the Referee's order. The insurer filed no cross-request. In his appellant's brief, claimant sought entitlement to time loss benefits from April 23, 1987 to May 1, 1987, the date of the Determination Order. Yet, at hearing, claimant was arguing, inter alia, entitlement to time loss benefits from May 11, 1987 to May 18, 1987. In its respondent's brief, the insurer met claimant's contention by arguing that claimant should not have been entitled to time loss benefits from March 2, 1987 to May 1, 1987. In other words, the insurer contended that claimant became medically stationary March 2, 1987. We declined to address either contention, reasoning that the issues had not been raised at hearing. No carrier-paid attorney fee was awarded.

On reconsideration, we awarded an attorney fee pursuant to ORS 656.382(2), reasoning that the insurer raised on review an issue that we would not have otherwise addressed. Upon further reflection, we hold that claimant introduced the issue of pre-closure temporary disability on review. Once this issue was raised, the insurer was justified in responding to it. Inasmuch as the insurer's response did not raise an issue that would not have been otherwise addressed, claimant is not entitled to attorney fees for services rendered in replying to that response. ORS 656.382(2); Bohrer v. Whyerhaeuser Company, 93 Or App 751, 755-56 (1988); Saiville v. EBI Companies, 81 Or App 469, 473 (1986).

Accordingly, our prior orders are abated and withdrawn. On reconsideration, as modified herein, we adhere to and republish our orders in their entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

CLIFFORD L. CASTLE, Claimant
Francesconi, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 86-10477
June 13, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee St. Martin's order which: (1) found that claimant's low back injury claim was not prematurely closed; and (2) affirmed a Determination Order award of 15 percent (48 degrees) unscheduled permanent disability for a low back injury. We reverse.

ISSUES

The issues on review are premature claim closure and, alternatively, extent of permanent disability.

FACTS

Claimant, 36 years old at the time of hearing, worked as a tire installer and salesman when he compensably injured his low back. He had a prior history of low back injury.

On September 19, 1985, claimant sought medical attention from Dr. Beckstrom, reporting a gradual onset on persistent low back pain. X-rays revealed a disc space narrowing at L5-S1. A subsequent CT scan was normal. Dr. Beckstrom treated conservatively.

Claimant was examined by Dr. Miller, neurologist, who recommended physical therapy. On November 4, 1985, following four weeks of daily physical therapy, claimant was released to return to work.

Claimant worked for one week before increased back pain and leg numbness forced him to seek medical attention. Following further rest and conservative treatment, claimant's pain subsided and he returned to work in January. Once again, his pain symptoms increased and became debilitating.

On January 29, 1986, claimant was examined by Dr. Ragsdale, orthopedist. Dr. Ragsdale diagnosed chronic lumbar strain. Due to claimant's continued pain with accompanying back spasm and episodic alternating leg numbness, he recommended a bone scan to rule out a tumor of the lumbar spine. The bone scan was normal.

On February 12, 1986, claimant was referred to Dr. Hale, Columbia Rehabilitation Clinic, for evaluation. Dr. Hale diagnosed lumbar strain, probable lumbar-facet joint dysfunction, and myofacial dysfunction. Dr. Hale recommended an aggressive eight week rehabilitation therapy program.

On February 25, 1986, Dr. Rosenbaum, neurologist, performed an independent medical examination. Dr. Rosenbaum diagnosed chronic lumbosacral strain. He opined that claimant was medically stationary and could return to medium work.

Claimant was then referred to the Work Center for a physical capacities evaluation. His condition was evaluated as medically stationary.

On April 3, 1986, Dr. Hale reported that claimant had completed four weeks of rehabilitation therapy. Claimant's condition had improved, but he continued to have a moderate amount of back pain. He recommended that claimant continue for four more weeks of therapy before returning to regular work.

Claimant continued with the rehabilitation program until April 14, 1986, when acute low back muscle spasms necesitated physical therapy. He was treated three times per week for two weeks and then outfitted with a TENS unit which provided relief. Thereafter, he returned to the rehabilitation program.

On May 21, 1986, claimant began treating with Dr. Powell, chiropractor. Dr. Powell described claimant's condition to be guarded against further aggravation and exacerbation. He found claimant was not medically stationary.

The Orthopaedic Consultants performed an independent medical examination on June 10, 1986. They opined that claimant's symptomatology could not be substantiated by objective findings. Further, they found that no form of treatment would improve his congenital anomalies, and maximum improvement had been obtained. They recommended claim closure with no increase in permanent impairment.

On June 12, 1986, Dr. Hale stated that claimant was medically stationary on May 12, 1986. He believed claimant could return to light work.

On June 16, 1986, Dr. Powell reported claimant's condition as guarded against further exacerbation and aggravation. He noted that claimant was moving out of state and would continue chiropractic treatment there.

The claim was closed by Determination Order on July 16, 1986 which awarded claimant 15 percent unscheduled permanent disability and temporary disability through the designated medically stationary date of June 12, 1986.

On July 15, 1986, claimant reinstituted his chiropractic treatment with Dr. Phillips. Due to a lack of improvement in claimant's condition, Dr. Phillips terminated these treatments on August 21, 1986. However, Dr. Phillips concluded that claimant was not medically stationary. He recommended a lumbar myelogram due to claimant's persistent low back and left radicular leg pain.

On October 22, 1986, Dr. Preacher, neurologist, performed an independent medical examination. He diagnosed, inter alia, musculoligamentary sprain/strain lumbosacral spine with radiculitis left, with no objective neurological findings to suggest lumbar intraspinal pathology. A CT scan found mild circumferential bulging of the discs at L4-5 and L5-S1 without frank herniation or extrusion, and moderately severe osteoarthritis changes involving the apophyseal joints bilaterally at L4-5 and L5-S1.

On November 10, 1986, claimant began treating with Dr. Painter. A lumbar myelogram was normal. Dr. Painter treated claimant with epidural steriod injections. The claimant's lower back

pain and radiation of the pain into his left leg was alleviated one month after the last injection. Dr. Painter found claimant to be medically stationary on January 1, 1987.

We find the claimant's compensable low back condition was not medically stationary at the time of claim closure.

CONCLUSIONS

The Referee concluded that the claim was not prematurely closed based on the medical evidence available at closure. He further found that claimant's back condition would not be changed by any form of medical or manipulative treatment. We disagree.

"Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). In determining whether a claim was prematurely closed, we ascertain whether claimant's condition was medically stationary on the date of closure. Further, evidence that was not available at the time of closure may be considered where there has been no post-closure changes in claimant's condition and the only question is whether claimant was stationary at the time of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). The present case meets the Scheuning requirements.

Dr. Powell, claimant's treating chiropractor, opined in June 1986, prior to claim closure, that claimant was not medically stationary. Absent persuasive reasons to the contrary, the treating physician's opinion is generally entitled to greater weight. Weiland v. SAIF, 64 Or App 810 (1983).

Furthermore, claimant continued to have low back and left radiating leg pain prior to and after closure. His condition did not improve until he was treated with epidural steroid injections by Dr. Painter in November 1986. The epidural steroid injection treatment was not palliative, but rather was utilized for the purpose of improving claimant's condition. Moreover, claimant's condition markedly improved following the treatment. See Aguiar v. J.R. Simplot Co., 87 Or App 475 (1987).

Following our de novo review of the medical and lay evidence, including evidence that became available after claim closure, we are not persuaded that at the time of closure claimant's condition was medically stationary. Instead, we are persuaded by Dr. Painter, the claimant's treating physician at the time of closure, as well as the results of subsequent curative treatments, that material improvement in claimant's condition could be expected at the time of claim closure. Therefore, the claim was prematurely closed.

Our disposition of the premature claim closure moots the permanent partial disability issue.

ORDER

The Referee's order dated August 27, 1987 is reversed. The July 16, 1986 Determination Order is set aside, and the claim is remanded to the insurer for further processing according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

FRANCIS K. DONAYRI, Claimant
Roll, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 86-08979
June 13, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Leahy's order that: (1) increased claimant's unscheduled permanent disability for a low back injury from 20 percent (64 degrees), as awarded by a Determination Order, to 30 percent (96 degrees); (2) declined to assess a penalty and attorney fee for alleged late payment of a $352.93 medical bill; and (3) declined to assess a penalty and attorney fee for alleged late payment of temporary total disability made on November 6, 1986. The issues on review are the extent of permanent disability, penalties, and attorney fees.

The Board affirms and adopts the order of the Referee, except that we specifically disavow the Referee's statement at page 5 that, "Impairment of the whole person must be documented in the medical record." In fact, a workers' or other lay testimony may or may not carry the worker's burden of proving the extent of disability. Garbutt v. SAIF, 297 Or 148-151 (1984).

ORDER

The Referee's order dated September 23, 1987 is affirmed.

DALE A. PIERCE, Claimant
Dennis H. Henninger, Claimant's Attorney
Acker, et al., Defense Attorneys

WCB 87-01280
June 13, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of Referee Quillinan's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. We reverse.

ISSUE

The issue on review is compensability.

FINDINGS OF FACT

Claimant was diagnosed as having carpal tunnel syndrome in March, 1984. Electrical conduction tests were performed and an acute entrapment was discovered. This condition was not treated.

On November 18, 1985, claimant started employment as a laborer in a potato processing plant. His job duties involved lifting potato bags that weighed from 30 to 100 pounds. In order to lift the sacks, he had to grab and squeeze the bags.

After nine days on the job, claimant complained of numbness in his hands and pain radiating into his wrists. He was diagnosed as having carpal tunnel syndrome and surgery was recommended. He did not inform any doctor who examined him of his prior wrist problems. The results of electrical conduction studies were similar to those performed in 1984.

ULTIMATE FINDINGS OF FACT

Claimant had bilateral carpal tunnel syndrome at the time

he started work. His condition became symptomatic while employed. His preexisting condition was not worsened by his employment.

CONCLUSIONS OF LAW AND OPINION

The Referee analyzed this case as an aggravation case under Smith v. SAIF, 302 Or 396 (1986). She found that because claimant's preexisting condition became symptomatic while employed, his condition was therefore compensable. We disagree.

Here, claimant's claim is one for occupational disease, not aggravation. Therefore the proper analysis is pursuant to Wheeler v. Boise Cascade, 298 Or 452 (1985), and Weller v. Union Carbide Corp., 288 Or 27, (1979).

That is, when a claimant suffers from a preexisting condition, he must prove that his work activity is the major contributing cause of a worsening of that condition. It is not enough to prove, as claimant did here, that his work activity caused his preexisting condition to become symptomatic.

On February 4, 1987, Dr. Stewart, orthopedist, opined that claimant's employment was "...the material contributing cause to the onset and severity of the carpal tunnel syndrome or impingement upon the median nerve...".

After learning of claimant's preexisting condition, and after reviewing the conduction studies done in 1984, Dr. Stewart was of the opinion that "...the short term of employment ...probably did not cause any significant long term pathological changes."

Dr. Nye, a hand specialist, examined claimant without knowing of his prior carpal tunnel condition. After learning of the 1984 tests, Dr. Nye opined that the nine days of employment would have no bearing on the abnormal electrical studies performed in December, 1986.

The nerve conduction studies performed in December, 1986 did not show claimant's condition to be worse than it was in 1984. The medical evidence in this case simply proved that claimant's condition became symptomatic, not that his preexisting condition worsened, even temporarily, because of his activities while working at the potato processing plant.

ORDER

The Referee's order dated September 10, 1987, is reversed. The insurer's denial is reinstated and upheld.

BRUCE D. POLLETTE, Claimant
Charles D. Maier, Claimant's Attorney
Ackerman, et al., Defense Attorneys

WCB 87-18632
June 13, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Borchers's order that: (1) upheld the insurer's partial denial of his medical services claim for current chiropractic treatment; (2) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable denial; and (3) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable delay in providing full disclosure.

ISSUES

1. Compensability of current chiropractic treatment.

2. Penalty and attorney fee for the insurer's allegedly unreasonable denial.

3. Penalty and attorney fee for the insurer's allegedly unreasonable delay in providing full disclosure.

We reverse on the compensability issue and affirm the remainder.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" portion of the Referee's order with the following supplementation.

Claimant had no low back symptoms prior to the compensable injury in 1983. Since that injury, he has had constant low back pain with occasional right leg pain. The nature and location of symptoms have remained the same since the injury. Current symptoms result from congenital low back defects which preexisted the compensable injury. Those congenital defects became symptomatic as a result of the compensable injury. Claimant has suffered no low back injuries since the compensable injury.

On October 21, 1987, the insurer denied claimant's ongoing treatment on the basis that his need for treatment is not related to the compensable injury.

FINDING OF ULTIMATE FACT

The compensable low back injury materially contributed to claimant's current need for treatment. At the time of its partial denial, the insurer had reasonable doubt of its liability for ongoing chiropractic treatment for the low back.

We do not find that the insurer's full disclosure of relevant medical records was untimely.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee upheld the insurer's partial denial, finding insufficient evidence to prove a compensable relationship between the industrial injury and claimant's current need for treatment. We disagree.

For his compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process of recovery requires." ORS 656.245(1). To establish the compensability of medical treatment for a condition, claimant must prove that the compensable injury was a material contributing cause of that condition. Jordan v. SAIF, 86 Or App 29, 32 (1987). Treatment for a condition resulting from a preexisting disease made more symptomatic by the compensable injury is compensable. See Grace v. SAIF, 76 Or App 511, 517 (1985); Von Kohlbeck v. SAIF, 68 Or App 272, 275 (1984).

Dr. Crockett, claimant's treating chiropractor, related his

current condition to the compensable injury, opining that the injury precipitated current symptoms of preexisting low back defects. He based his opinion on the close chronological sequence of the injury and onset of symptoms. The Referee found that basis insufficient to establish compensability, citing Bradshaw v. SAIF, 69 Or App 587 (1984), and Edwards v. SAIF, 30 Or App 21, rev den 279 Or 301 (1977). We disagree with her reasoning.

In Allie v. SAIF, 79 Or App 284 (1986), the court discussed its holdings in Bradshaw and Edwards:

> "As we noted in Bradshaw v. SAIF [citation omitted], 'we have always been hesitant to infer causation from chronological sequence.' In Bradshaw, the claimant prevailed because of the very close connection between the injury and the condition and 'because of the careful elimination of all alternative causes.' 69 Or App at 590. In Edwards v. SAIF [citation omitted], involving a complex medical problem, we refused to rely on a 'natural inference' based on the timing and location of the condition, when the medical evidence did not support such an inference."

79 Or App at 288.

This case is closer to Bradshaw than Edwards. The causation of symptoms of claimant's preexisting back defects, as opposed to causation or worsening of the defects themselves, does not present a complex medical question, particularly where there has been no intervening back injury since the compensable injury. Claimant persuasively testified that, whereas he had no low back symptoms before the injury, he has had constant symptoms thereafter. He further testified that the nature and location of his current symptoms have remained the same since the injury. Based on that history, Crockett related current symptoms to the injury. On the other hand, a panel at Western Medical Consultants conducted an independent medical examination (IME) and concluded that current symptoms are not directly related to the injury. Instead, they related the symptoms to claimant's preexisting spinal defects. However, they never addressed the question of whether the injury precipitated symptoms of the preexisting condition. After reviewing the conflicting opinions, we are most persuaded by Crockett's opinion, because he is the treating physician, see Weiland v. SAIF, 64 Or App 810, 814 (1983), and his opinion is sufficiently thorough and better-reasoned. See Somers v. SAIF, 77 Or App 259, 263 (1986).

However, we do not find that the insurer's partial denial was unreasonable. At the time of the denial, the insurer had the IME report which weighed against compensability of ongoing treatment. Under those circumstances, the insurer had reasonable doubt of its liability for the treatment. See Peterson v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986).

Penalty and Attorney Fee For Untimely Disclosure

We adopt the "FAILURE TO TIMELY PROVIDE MEDICAL REPORTS" portion of the "OPINION" portion of the Referee's order.

ORDER

The Referee's order dated April 18, 1988, is reversed in part and affirmed in part. The portion of the Referee's order that upheld the insurer's partial denial of October 21, 1987, is reversed. Claimant's medical services claim for chiropractic treatment is remanded to the insurer for processing according to law. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed fee of $1,000 for services rendered at hearing and on review on the compensability issue, to be paid by the insurer. The Board approves a client-paid fee not to exceed $391.

RUSSELL T. SEYMOUR, Claimant
Bischoff, et al., Claimant's Attorneys
Charles Lisle (SAIF), Defense Attorney
Cowling, et al., Defense Attorneys

WCB 85-08761 & 86-08402
June 13, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The SAIF Corporation requests review of Referee Peterson's order that: (1) set aside its "de Facto" denial of claimant's "new injury" claim for his low back condition; and (2) upheld a denial of claimant's aggravation claim for the same condition issued by Industrial Indemnity. We affirm.

ISSUE

The issue on review is responsibility.

FINDINGS OF FACT

Claimant, a 49-year-old millwright sustained an injury to his low back, on May 8, 1981. He was welding a cylinder clamp to a large fork-lift, fell backwards and twisted his back. Industrial Indemnity, the carrier on the date of injury, accepted the claim. Claimant sought treatment from Dr. Feld, chiropractor. Dr. Feld diagnosed lumbosacral sprain. Claimant was treated conservatively. All of his low back symptoms resolved by early 1982.

On September 15, 1983, claimant reinjured his low back at work while engaging in heavy lifting for the same employer. He again sought treatment from Dr. Feld, who diagnosed lumbosacral sprain with radiculitis. X-rays revealed moderate discogenic spondylosis. Claimant was treated conservatively.

Claimant was examined by Dr. Donahoo, orthopedic surgeon, at the request of Dr. Feld. Dr. Donahoo diagnosed a probable herniated L4-5 disc. His diagnosis was confirmed by a myelogram, which revealed a two-level disc herniation at L4-5 and L5-S1. Thereafter, claimant underwent a disc excision at L4-5 and L5-S1.

Post operatively claimant's back pain diminished. However, he continued to experience hypersthesia along the lateral aspect of his left leg and foot. Additionally, he began experiencing a feeling of buckling of his lower extremities.

On September 11, 1984, Dr. Patterson, neurologist, conducted a consultative examination for Dr. Donahoo. Dr. Patterson performed a nerve conduction study which revealed no significant neuropathy, except for the previously diagnosed L-5 and S-1 root lesions. Claimant experienced severe back pain during the examination.

Claimant was admitted to the hospital on September 27, 1984 for the treatment of low back pain and left lower extremity radiation and numbness.

An October 5, 1984 lumbar myelogram revealed a L4-5, large extradural defect and a bony encroachment at L5-S1. Claimant underwent an excision of the recurrent L4-5 disc and decompression. Thereafter, his left leg pain diminished.

On November 7, 1984, Dr. Donahoo restricted claimant's work activities to sedentary to medium work. On March 26, 1985, claimant began a modified job as a mechanic and handyman for SAIF's insured. Job duties for the first two months were restricted to half-time light duty with lifting restriction of 30 pounds. After three months, claimant was released to work fulltime with a lifting restriction of 50 pounds. As a condition of employment, an overhead jib crane was to be purchased by the Workers' Compensation Department as a job site modification to assist claimant's work on machinery weighing over 50 pounds.

On June 3, 1985, Dr. Donahoo reported that claimant was medically stationary. Claimant continued to experience socking hypersthesia, a slightly weakened left extensor hallucis longus muscle, and an absent ankle jerk, all representative of residual root involvement at L4-5 and L5-S1.

A July 18, 1985 Determination Order awarded claimant 25 percent (80 degrees) unscheduled permanent partial disability for injury to his low back and 5 percent (7.5 degrees) scheduled disability for loss of use of function of the left leg.

On October 3, 1985, claimant sought treatment from Dr. Donahoo for recurrent low back pain with radiation down the left lower extremity. Claimant, four weeks earlier, had rolled a 300 pound radiator stationed on a dolly across the dairy workshop. Following this incident, he noted a marked increase in low back pain with radiation down the left lower extremity to his knee and a gait list. The persistent pain ultimately led to hospitalization. Dr. Donahoo diagnosed lumbosacral strain. Claimant was treated conservatively.

Claimant was readmitted on October 22, 1985, for a myelogram and CT scan. Diagnostic testing revealed a recurrent L4-5 and L5-S1 herniated nucleus pulposus. One November 7, 1985, Dr. Paxton performed a consultative neurological evaluation at the request of Dr. Donahoo. He recommended against further disc surgery. Dr. Beals, orthopedist, also examined claimant. He diagnosed neurogenic irritation involving his left lower extremity related to scarring along the nerve roots, and low back mechanical instability. Dr. Beals also felt surgery was not indicated.

On January 7, 1986, Dr. Donahoo released claimant to modified work with lifting and postional restrictions. Claimant returned to part-time work in February 1986. In April 1986, claimant stopped working due to a cervical condition unrelated to his employment.

On September 24, 1986, Industrial Indemnity denied further responsibility for claimant's low back condition. A copy of the denial was sent to SAIF and a .307 order was requested from the Workers' Compensation Department.

On January 7, 1987, Dr. Wilson performed a consultative neurological evaluation. He diagnosed low back strain secondary to the 1981 on-the-job-injury, preexisting lumbar spondylosis, post-op L4-5 and L5-S1 lumbar laminectomy, post-op cervical laminectomy, with residual left arm symptoms, and psychological factors affecting physical condition.

At hearing, SAIF orally denied compensability and responsibility for claimant's low back condition. SAIF subsequently withdrew its denial of compensability, but continued to deny responsibility.

Claimant's job duties at the second employer included all aspects of the haying operation, including mowing and raking, checking 65-70 pound bales of hay, changing 18-20 inch truck tires by braking the tires from the rims with only the use of a crow bar and hammer, welding, and repairing engines of all sizes.

Claimant suffered an injury to his low back in September 1985. That injury independently contributed to his underlying low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found the second employer, SAIF's insured, responsible for claimant's low back condition. Additionally, he assessed a 25 percent penalty of all compensation due against SAIF for its unreasonable delay in failing to accept or deny the claim for eight months and then waiting one more month before denying responsibility, which ultimately resulted in claimant's inability to obtain a .307 order and receive time loss compensation. We agree.

In a successive injury case, responsibility rests with the second employer if work activities there independently contribute to a worsening of claimant's underlying condition. Hensel Phelps Const V. Mirich, 81 Or App 290 (1980). A worsening of symptoms alone is not enough to place responsibility on the second employer. There must be a worsening of the underlying condition. Id. Therefore, responsibility shifts from Industrial Indemnity to SAIF if claimant's September 1985 injury contributed independently to a worsening of claimant's low back condition.

The assignment of responsibility for claimant's current low back condition is a complicated medical issue requiring expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967). The medical evidence is uncontroverted. Both Dr. Donahoo, claimant's treating physician, and Dr. Wilson opine that claimant's work involving the moving of the 300-pound radiator was a new injury, ultimately causing hospitalization and further invasive diagnostic procedures. Dr. Donahoo also opined that claimant had suffered a third herniated disc as a result of the incident. The medical history both physicians obtained from claimant indicate that claimant suffered a new injury. Specifically, claimant's inability to get up from bed due to severe pain, and the reoccurrence of left leg pain that had been alleviated following the second disc surgery.

Additionally, claimant's work at the second employer clearly exceeded the maximum 50 pound restriction placed on his work activities by Dr. Donahoo. Claimant credibly testified that he frequently exceeded the restriction while working for employer. We also note that the overhead crane was never obtained during

claimant's employment, even though it was a specific condition of his employment. We conclude that the work duties claimant was required to perform exceeded his allowable work capacity and were capable of causing claimant's 1985 condition.

We are persuaded that claimant's September 1985 injury was a result of a specific independent trauma to his lumbar spine which resulted in a worsening of the underlying condition and was not merely a symptomatic exacerbation of his previous condition. Accordingly, we conclude, as did the Referee, that responsibility for claimant's current condition shifts to SAIF, the insurer at the time of the September 1985 injury.

ORDER

The Referee's order dated May 1, 1987 is affirmed. Claimant attorney is awarded an assessed fee of $760, to be paid by SAIF, for services on Board review.

ROBERT B. SORGE, Claimant
Steven C. Yates, Claimant's Attorney
Arthur Stevens III (SAIF), Defense Attorney

WCB 86-05589
June 13, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Nichols' order that: (1) upheld the SAIF Corporation's "de facto" denial of claimant's aggravation claim for a bilateral knee condition; (2) increased his scheduled permanent disability award for loss of use or function of the left knee from 25 percent (37.5 degrees), as awarded by Determination Order and Stipulation, to 30 percent (45 degrees); and (3) affirmed a Determination Order awarding no scheduled permanent disability for the right knee, and 20 percent (64 degrees) unscheduled permanent disability for a neck and back condition. On review, the issues are aggravation and extent of scheduled and unscheduled permanent disability. We reverse on the aggravation issue.

FINDINGS OF FACT

Claimant compensably injured his left knee in February 1982 while working for SAIF's insured as a forestry technician. Dr. Strukel, orthopedist, diagnosed a torn medical meniscus and performed a menisectomy in April 1982. Claimant's left knee symptoms continued, and Dr. Strukel diagnosed post-menisectomy and post-traumatic degenerative osteoarthritic changes in March 1983.

Claimant returned to modified work for his employer at injury and then began working as a heavy equipment operator. Over the next three years, he sustained additional compensable injuries in a series of falls which occurred when his left knee gave out. Falls in February and November 1984 resulted in further trauma to his left knee and new right knee sprains and contusions. Dr. Strukel provided conservative treatment after the February 1984 fall but recommended no treatment following the November 1984 incident. Additional falls in September 1985 and June 1986 resulted in cervical and upper back strains. Claimant received conservative treatment for those conditions from Dr. Kho, neurologist.

SAIF's insured accepted responsibility for the additional injuries resulting from claimant's falls in 1984, 1985 and 1986. His

injury claim was last closed by a Determination Order, issued November 18, 1986. That order affirmed prior awards of 25 percent scheduled permanent disability for claimant's left knee and 20 percent unscheduled permanent disability for his neck and back conditions. Claimant requested a hearing on that order.

At the time of the November 1986 Determination Order he continued to experience intermittent pain, grating, grinding and give-way in his left knee, as well as less severe problems in his right knee. However, he had received no treatment for his knee condition since May 1984. Furthermore, he was released to his current work as a heavy machinery operator, and he was able to perform this job and also do routine chores on his small farm.

Following claim closure in November 1986, claimant's bilateral knee symptoms progressively worsened. By early February 1987, his symptoms had progressed to the point that he was no longer able to complete his farm chores or performing his heavy equipment operating job. In particular, he was experiencing increasing right leg pain, his knees were giving out more frequently, and he was having greater difficulty crawling up around heavy machinery and walking through mud and over rough terrain.

Claimant sought further treatment from Dr. Strukel on February 10, 1987. Dr. Strukel observed bilateral knee effusion and mild crepitus. At a follow-up examination on March 11, 1987, Dr. Strukel noted bruising on the inner thighs but no effusion in the knees. Claimant attributed the bruising to recent falls resulting from his knees giving way. Dr. Strukel referred claimant to Dr. Chamberlain, orthopedist, for consultation and treatment. Dr. Chamberlain examined claimant on two occasions in April 1987. He reported no objective findings on examination, and further diagnostic studies did not demonstrate any further worsening in claimant's knee condition.

SAIF did not process Dr. Strukel and Dr. Chamberlain's reports as an aggravation claim. Claimant subsequently amended his earlier hearing request to include the insurer's "de facto" aggravation denial.

Claimant, 40 years of age at the time of hearing, is a high school graduate with two years of college. He has work experience as a forestry technician, heavy equipment operator and farmer. He put his farm up for sale shortly after his symptomatic flare-up in February 1987.

At the time of hearing, he continued to experience frequent flare-ups of neck and back stiffness and pain associated with lifting, bending and twisting. Claimant has been both credible and reliable in describing his symptoms and physical limitations.

FINDINGS OF ULTIMATE FACT

When claimant sought further treatment from Dr. Strukel in February 1987, he was more disabled than when his claim was last closed in November 1986.

Claimant has sustained mild permanent physical impairment as a result of his compensable neck and back strains.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that the Referee erred in upholding the insurer's aggravation denial. We agree.

In order to establish a compensable aggravation, claimant must prove that he had a greater injury-related loss of use or function in February 1987 than when his claim was last closed in November 1986. At the time of that closure, he was released to work as a heavy machinery operator and was able to perform this job and also do routine farm chores. By contrast, claimant told Dr. Strukel in February 1987 that he was no longer able to take care of his farm or continue his heavy equipment operating job. Dr. Strukel subsequently opined that claimant's knees were worsening and that he was no longer able "to perform work and activities of daily living at home beyond the sedentary range." There is no persuasive contrary opinion.

We conclude that claimant's reported limitations and Dr. Strukel's opinion establish the increased disability required for a compensable aggravation. In reaching this decision, we are aware that Dr. Strukel observed only minimal objective findings in February 1987, and that Dr. Chamberlain reported no objective findings the following month. We also recognize that claimant has not demonstrated that his underlying knee pathology has worsened. However, increased subjective symptoms are sufficient to establish a compensable aggravation if they result in increased disability. Here, we find no reason to doubt the credibility and reliability of claimant's report of worsened symptoms and increased physical limitations. To the contrary, Dr. Strukel's observation of bruises on claimant's inner thighs supports his statement that his knees were giving out on him more frequently. The fact that claimant put his farm up for sale in February 1987 also supports his report of increased limitations.

Accordingly, we conclude that claimant sustained an aggravation in February 1987, and we set aside SAIF's "de facto" aggravation denial.

Extent of Scheduled Permanent Partial Disability

There is no evidence in the record that claimant's bilateral knee condition has become medically stationary. As a result, it is not appropriate for us to evaluate the extent of claimant's permanent disability. See OAR 438-08-020.

Extent of Unscheduled Permanent Partial Disability

The record indicates that claimant's neck and back condition have been medically stationary since his claim was closed in November 1986. It is, therefore, appropriate to evaluate the extent of permanent disability related to those conditions. We adopt the Referee's opinion on this issue subject to the following comment.

The Referee found that claimant sustained a herniated cervical disc as a result of his fall in September 1985. We, instead, find that claimant's fall resulted in a chronic cervical strain. We are aware that Dr. Kho initially opined that claimant had sustained a herniated disc. However, we conclude that Dr. Kho subsequently changed his diagnosis to cervical strain in light of Dr. Compagna's opinion, significant improvement in claimant's symptoms and further diagnostic studies demonstrating a normal cervical spine.

Notwithstanding our disagreement on this point, we agree with the Referee's determination that claimant's current award of 20 percent unscheduled permanent partial disability adequately compensates him for his neck and back condition.

ORDER

The Referee's order dated July 23, 1987 is reversed in part and affirmed in part. Those portions of the order that upheld the SAIF Corporation's "de facto" aggravation denial and awarded additional scheduled permanent partial disability are reversed. SAIF's denial is set aside, and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded $1,200 for services at hearing and $500 for services on Board review regarding the aggravation issue, to be paid by the SAIF Corporation.

LAWRENCE N. SULLIVAN, Claimant
Malagon, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 84-09511 & 85-14645
June 13, 1989
Order of Remand

The matter is before the Board on remand from the Court of Appeals. Sullivan v. Banister Pipeline American, 91 Or App 493 (1988). We have been directed to determine whether claimant was medically stationary at the time of the February 1986 Determination Order.

The parties have submitted a Stipulation" which resolved several issues pending before the Hearings Division in WCB Case No. 86-15123. Pursuant to the stipulation, claimant agreed that his claim should be considered closed and that he would not contest "any existing or another Determination Order or notice of closure." This stipulation has received Referee approval.

Based on the stipulation, it is the parties' position that "no further action" need be taken in this case. Following our review of this matter, we conclude that claimant has effectively conceded that he was medically stationary at the time of the issuance of the February 1986 Determination Order.

Accordingly, in keeping with the Court of Appeals' mandate, we find that claimant's psychological condition was medically stationary at the time of the February 1986 Determination Order. Consequently, the February 1986 Determination Order did not issue prematurely.

IT IS SO ORDERED.

Board Member Crider dissenting.

The Court has reversed a Board order declaring claimant's psychological condition not compensable and remanded the case to the Board to determine whether the compensable psychological condition was medically stationary at the time the February, 1986 Determination Order issued.

The Board has failed to make the required finding. Therefore, I dissent.

While this case was pending before the Court, a request for hearing on the February, 1986 Determination Order was pending before the Hearings Division.

On June 7, 1988, just days before the Court issued its order, a Referee approved a stipulation which purported to resolve not only the case before him but also the case pending before the

Court. By the stipulation, the parties agreed to resolve the dispute concerning the compensability of the psychiatric condition pursuant to ORS 656.289(4). They agreed that the condition would be deemed noncompensable. The stipulation does not bear the Court's approval nor is there any indication it was even submitted to the Court.

Thereafter, and apparently unaware of the stipulation, the Court held that the claim was compensable. Neither party asked the Court to vacate its order and to remand the case for consideration of the proposed stipulation. Therefore, the Court's holding that the claim is compensable is the law of the case.

On remand, the Board has concluded that the stipulation should be construed as a concession that claimant's psychiatric condition was stationary at the time of the determination order. Further, the Board relies on that "concession" in lieu of any examination of the record in this case.

Upon review of the record, I would find that claimant was not medically stationary at the time of the determination order for the reasons stated in Referee Shebley's order. I would, therefore, set aside the determination order and remand the claim to the insurer for processing.

This is required inasmuch as there remains a compensable claim in this case. The approach of the majority notwithstanding, the party's stipulation does not have the effect of nullifying the court order. See Knapp v. Weyerhaeuser Co., 93 Or App 670 (1988). Parties are not precluded from settling a disputed claim; however, in order to effectively do so, the settlement should be submitted for approval before the tribunal that has jurisdiction over the dispute. ORS 656.289(4). The parties before us having failed to do so, their stipulation should play no part in our deliberations on remand.

VICENTE M. TAISACAN, Claimant
Malagon, et al., Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 87-03602
June 13, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Nichols' order which: (1) declined to consider the issue of claimant's temporary disability rate; and (2) declined to assess penalties and attorney fees for an alleged unreasonable delay in paying the proper temporary disability rate. On review, the issues are res judicata, temporary disability and penalties and attorney fee. We reverse.

FINDINGS OF FACT

Claimant suffered from an asthma/hyperactive airways condition due to his employment as an automatic transmission rebuilder. An occupational disease claim was filed with the SAIF Corporation on April 8, 1985. This "801" form did not contain wage information.

As of January 1985, claimant was receiving from his employer at injury a net weekly wage of $350. SAIF paid claimant temporary disability from March 18, 1985 to July 21, 1985, at a weekly rate of $240.80.

Claimant's occupational disease claim was found compensable by a prior Referee on October 16, 1985. Thereafter, SAIF processed the claim to closure. A Determination Order issued.

A hearing ensued on the issue of extent of permanent disability, entitlement to additional temporary total disability, and an attorney fee based upon SAIF's alleged unreasonable denial of vocational rehabilitation benefits. As a result of the hearing, claimant was awarded 60 percent unscheduled permanent disability, but his request for an additional period of temporary disability and an insurer-paid attorney fee for an alleged unreasonable conduct in denying his entitlement to vocational rehabilitation benefits was rejected.

Claimant was referred for vocational assistance in September 1986, and began an authorized training plan in December 1986. The vocational providers, Alpine Evaluation, reported that claimant's gross monthly wage was $2,000 and his net monthly wage was $1,400.

On February 19, 1987, a prior Referee issued an order to dismiss a request for hearing. The order failed to identify the issues raised in the request for hearing.

CONCLUSIONS OF LAW

The Referee declined to consider the issue of the proper temporary disability rate claimant was entitled to, finding the issue barred under res judicata principles. Because of this holding, the Referee found the penalty and related attorney fee issue moot. We disagree with the application of res judicata to the temporary disability rate issue and reverse.

Res Judicata

The Supreme Court has held that the term res judicata encompasses both claim preclusion and issue preclusion. North Clackamas School Dist. v. White, 305 Or 48, 50 (1988). Claim preclusion provides that where a person has had a full and fair opportunity to litigate a claim to final judgment, than a decision on a particular issue or determinative fact is determinative in a subsequent action between the same parties on the same claim. Issue preclusion provides that where a claim is actually litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a different action between the same parties if the determination was essential to the judgment. White, supra, at 50.

In res judicata parlance, the concept of "same claim" refers to every claim or cause of action included in the pleadings and also to every claim which could have been alleged under the "same aggregate of operative facts which compose a single occasion for judicial relief." See Million v. SAIF, 45 Or App 1097, 1102 (1980).

At the prior hearing, claimant's entitlement to an additional period of temporary total disability was raised. In essence, this claim addressed claimant's entitlement to temporary total disability based upon his receipt of vocational rehabilitation services. Resolution of this claim did not require or include discussion or consideration of the proper temporary total disability rate.

In Drew v. EBI Companies, 96 Or App 1 (1989), the court recently held that the narrow issue of the "correct wage rate" was an issue of fact, not a claim, and thus, the claimant would not be barred by res judicata in bringing the claim. Id. at 4, 5. We find Drew controlling in this case, and therefore conclude that the issue of the correct wage rate is not within the "same aggregate of operative facts and cannot be considered the "same claim" for the purposes of claim preclusion.

Thus, the case before us involves issue preclusion and only those material issues and determinative facts actually litigated and decided in the prior hearing have preclusive effect on later forums. At the prior hearing, the proper rate was not determined and was not essential to the resolution of the additional temporary total disability claim. Similarly, the third request for hearing, and subsequent order of dismissal, also had no preclusive effect. Accordingly, claimant was not barred by res judicata from raising this issue. Claimant has not yet had an opportunity to litigate the issue of correct temporary disability rate, and is therefore, entitled to a hearing on this matter. See ORS 656.283(1).

Temporary disability rate

We therefore turn to the merits of the temporary disability rate issue. Claimant contends that SAIF incorrectly determined the temporary disability rate, and that he is entitled to a rate based upon his net weekly wage of $350. The Referee indicated that if the merits had been reached she would have found that claimant had carried his burden of proof in showing the time loss rate utilized by SAIF was incorrect. We agree with the Referee's assessment, and find claimant was entitled to an increased temporary disability rate.

Calculation of the amount of temporary total disability compensation payable is accomplished by statute. ORS 656.210(1) provides:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser."

Application of the formula requires ascertainment of the claimant's weekly wage. ORS 656.210(2) indicates that the weekly wage rate is to be determined by multiplying the number of days regularly worked by the daily wage rate. Former OAR 436-60-020(3) provides an alternative method of determining the weekly wage rate when the daily rate is unknown by dividing the monthly wage by 4.35.

Further, ORS 656.005(26) defines "wages" as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident." Implicit in both ORS 656.005(26) and 656.210 is the underlying concept that gross wages, rather than net wages, are contemplated in computing the temporary disability rate.

Claimant testified that at the time of injury he was making

$350 a week in take-home pay. Cancelled checks signed by his employer confirms this. In September 1986, the vocational providers reported to SAIF that claimant's gross monthly wage was $2,000 and that his net monthly wage was $1,400. The net monthly wage equates into $350 a week, the same as at the time of injury. By using the gross monthly wage of $2,000, claimant's gross weekly wage can be determined utilizing former OAR 436-60-020(3). Therefore, the $240.80 temporary disability rate calculated by SAIF based on claimant's net weekly wage of $350 was incorrect. The proper weekly wage should have been determined on the basis of claimant's gross weekly wage.

Penalty and attorney fees

Claimant is also entitled to a penalty of up to 25 percent of the temporary total disability not timely paid and an associated attorney fee if SAIF's delay in paying the compensation was unreasonable. ORS 656.262(10); 656.382(1).

SAIF improperly calculated claimant's temporary disability rate by not using the proper weekly wage. This miscalculation has resulted in a delay in payment of compensation. SAIF has offered no explanation for its failure to ascertain and utilize the proper rate. Therefore, we find SAIF's conduct unreasonable, and assess a 25 percent penalty on all of the temporary disability compensation not timely paid and a related attorney fee. See Donna J. Russell, 40 Van Natta 568, 572 (1988).

ORDER

The Referee's order dated October 29, 1987, is reversed. Claimant is awarded the difference between the temporary total disability previously paid and the temporary total disability due based on the corrected rate utilizing claimant's gross weekly wage as a basis. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. Claimant is also awarded a penalty equal to 25 percent of the increased temporary total disability compensation granted herein. For services at hearing and on review concerning this penalty issue, claimant's counsel is awarded an assessed attorney fee of $750, payable by the SAIF Corporation.

PAUL A. WALDRIP, Claimant
S. David Eves, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-05948
June 13, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Seymour's order that: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability award for a left shoulder and low back injury from 30 percent (96 degrees), as awarded by prior Determination Orders, to 60 percent (192 degrees); (3) found that claimant was medically stationary on April 3, 1987; and (4) found that claimant's condition had not worsened since claim closure. On review, the issues are permanent total disability, extent of permanent disability, premature claim closure and aggravation. We affirm.

FINDINGS OF FACTS

We adopt the Referee's findings of fact as supplemented below.

In Drew v. EBI Companies, 96 Or App 1 (1989), the court recently held that the narrow issue of the "correct wage rate" was an issue of fact, not a claim, and thus, the claimant would not be barred by res judicata in bringing the claim. Id. at 4, 5. We find Drew controlling in this case, and therefore conclude that the issue of the correct wage rate is not within the "same aggregate of operative facts and cannot be considered the "same claim" for the purposes of claim preclusion.

Thus, the case before us involves issue preclusion and only those material issues and determinative facts actually litigated and decided in the prior hearing have preclusive effect on later forums. At the prior hearing, the proper rate was not determined and was not essential to the resolution of the additional temporary total disability claim. Similarly, the third request for hearing, and subsequent order of dismissal, also had no preclusive effect. Accordingly, claimant was not barred by res judicata from raising this issue. Claimant has not yet had an opportunity to litigate the issue of correct temporary disability rate, and is therefore, entitled to a hearing on this matter. See ORS 656.283(1).

Temporary disability rate

We therefore turn to the merits of the temporary disability rate issue. Claimant contends that SAIF incorrectly determined the temporary disability rate, and that he is entitled to a rate based upon his net weekly wage of $350. The Referee indicated that if the merits had been reached she would have found that claimant had carried his burden of proof in showing the time loss rate utilized by SAIF was incorrect. We agree with the Referee's assessment, and find claimant was entitled to an increased temporary disability rate.

Calculation of the amount of temporary total disability compensation payable is accomplished by statute. ORS 656.210(1) provides:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser."

Application of the formula requires ascertainment of the claimant's weekly wage. ORS 656.210(2) indicates that the weekly wage rate is to be determined by multiplying the number of days regularly worked by the daily wage rate. Former OAR 436-60-020(3) provides an alternative method of determining the weekly wage rate when the daily rate is unknown by dividing the monthly wage by 4.35.

Further, ORS 656.005(26) defines "wages" as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident." Implicit in both ORS 656.005(26) and 656.210 is the underlying concept that gross wages, rather than net wages, are contemplated in computing the temporary disability rate.

Claimant testified that at the time of injury he was making

$350 a week in take-home pay. Cancelled checks signed by his employer confirms this. In September 1986, the vocational providers reported to SAIF that claimant's gross monthly wage was $2,000 and that his net monthly wage was $1,400. The net monthly wage equates into $350 a week, the same as at the time of injury. By using the gross monthly wage of $2,000, claimant's gross weekly wage can be determined utilizing former OAR 436-60-020(3). Therefore, the $240.80 temporary disability rate calculated by SAIF based on claimant's net weekly wage of $350 was incorrect. The proper weekly wage should have been determined on the basis of claimant's gross weekly wage.

Penalty and attorney fees

Claimant is also entitled to a penalty of up to 25 percent of the temporary total disability not timely paid and an associated attorney fee if SAIF's delay in paying the compensation was unreasonable. ORS 656.262(10); 656.382(1).

SAIF improperly calculated claimant's temporary disability rate by not using the proper weekly wage. This miscalculation has resulted in a delay in payment of compensation. SAIF has offered no explanation for its failure to ascertain and utilize the proper rate. Therefore, we find SAIF's conduct unreasonable, and assess a 25 percent penalty on all of the temporary disability compensation not timely paid and a related attorney fee. See Donna J. Russell, 40 Van Natta 568, 572 (1988).

ORDER

The Referee's order dated October 29, 1987, is reversed. Claimant is awarded the difference between the temporary total disability previously paid and the temporary total disability due based on the corrected rate utilizing claimant's gross weekly wage as a basis. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. Claimant is also awarded a penalty equal to 25 percent of the increased temporary total disability compensation granted herein. For services at hearing and on review concerning this penalty issue, claimant's counsel is awarded an assessed attorney fee of $750, payable by the SAIF Corporation.

PAUL A. WALDRIP, Claimant
S. David Eves, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-05948
June 13, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Seymour's order that: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability award for a left shoulder and low back injury from 30 percent (96 degrees), as awarded by prior Determination Orders, to 60 percent (192 degrees); (3) found that claimant was medically stationary on April 3, 1987; and (4) found that claimant's condition had not worsened since claim closure. On review, the issues are permanent total disability, extent of permanent disability, premature claim closure and aggravation. We affirm.

FINDINGS OF FACTS

We adopt the Referee's findings of fact as supplemented below.

Due to his compensable injuries, claimant is no longer able to engage in the medium work activities he once performed, but is confined to light duty work. Claimant is not able to lift in excess of 20 pounds. Because of the combined effect of his left shoulder and low back condition, claimant has sustained permanent impairment in the moderate range.

Claimant is 34 years old, and a high school graduate. He has low intelligence, but the evidence is inconclusive concerning a learning disability. Claimant has sufficient capacity to learn simple jobs, and possesses basic transferable work skills.

The normal labor market is not foreclosed to claimant. He is capable of working as a security guard, production worker, forklift operator, station attendant, and meter reader.

Claimant has a psychological condition, which has been psychiatrically diagnosed as a preexisting passive personality disorder. The compensable injury is not causally related to any exacerbation of psychological symptoms or a worsening of claimant's psychological condition.

Claimant was medically stationary on April 3, 1987.

The last award of compensation was the Determination Order, dated April 3, 1987, which awarded claimant 30 percent unscheduled permanent disability for his low back and left shoulder. Throughout the month of April 1987, claimant's condition improved.

On April 23, 1987, claimant reported to Dr. Mason with low back and left leg numbness and tingling. While objective medical tests were pending to determine etiology, Dr. Mason authorized time loss effective April 23, 1987 to September 21, 1987.

Dr. Mason's April 23, 1987 medical report does not reflect a worsening of claimant's low back condition. Also, aside from Dr. Mason's report, we find no symptomatic worsening resulting in greater disability between April 3, 1987 and March 1988.

As a result of his compensable injury, preexisting psychological condition, and nonmedical factors, claimant is not permanently and totally incapacitated from regularly performing gainful and suitable employment.

CONCLUSIONS OF LAW

Permanent total disability

The Referee concluded that claimant was not permanently totally disabled as a result of his compensable left shoulder and low back injuries. We agree.

To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful and suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through medical evidence of physical incapacity, or through the "odd-lot" doctrine, under which a disabled person may remain capable of performing work of some kind, but still be permanently disabled due to a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984).

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Welch, supra, 70 Or App at 701; Livesay v. SAIF, 55 Or App 390, 394 (1981). Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206; SAIF v. Simpson, 88 Or App 638, 641 (1987); Welch, supra, 70 Or App at 701.

Claimant is not permanently and totally disabled based on physical factors alone. His long-time treating chiropractor, Dr. Ray, has released claimant for modified work. Based on a physical capacities examination, claimant is capable of of frequently lifting 20 pounds, and occasionally lifting 25 pounds. Dr. Ray opined that claimant was able to do light duty work. He also considered claimant's residual permanent physical impairment within the moderate range. Neurosurgeon, Dr. Mason, based on objective physical findings and claimant's subjective complaints, opined that claimant's physical impairment was moderate. Dr. Zivin, neurologist, considered claimant capable of work duties in the light to medium range.

We further conclude that when claimant's physical disabilities are combined with his social and vocational factors, he has not established permanent total disability under the "odd-lot" doctrine. At the time of hearing claimant was at the vocationally young age of 34 years old. Claimant is a graduate from a mainstream high school, albeit with special aid and instruction. Claimant does have below average intelligence. Several professionals have described claimant as being "functionally illiterate" and have noted difficulties in reading, writing, math calculations, and remembering.

Although claimant has consistently indicated to his physicians that he has a learning disability, the evidence is not persuasive that an alleged learning disability has precluded him from gainful employment. Claimant's vocational rehabilitator, Joan Schroeder, attempted to determine what effect, if any, claimant's alleged learning disability would have from a vocational perspective. She concluded that claimant's learning disability had little vocational impact. Her assessment was based on the reports from the Callahan Center, which unsuccessfully attempted to quantify this alleged disability, and claimant's demonstrated on-the-job ability as a Fish Hatchery Technician. As a result of this successful placement, the vocational rehabilitator concluded that claimant possessed basic work skills, and had the capacity to learn new duties, follow through, and retain information. Accordingly, we consider, but do not find claimant's low intelligence and alleged learning disability to be a significant factor concerning the issue of permanent total disability.

Claimant also has a psychological component to his physical symptoms. His physicians have uniformly noted some form of functional overlay. As such, his physicians have encountered difficulty in obtaining an accurate medical history for their diagnoses and treatment plans. Psychiatrist, Dr. Parvaresh, upon examination, diagnosed "anxiety tension state-chronic" and "passive dependent personality disorder."

It was Dr. Parvaresh's opinion that causation for claimant's psychological condition was his "basic personality make-up, that is his extreme passive dependency and the need for

nurturing." Dr. Parvaresh noted that this psychological condition had been a lifelong problem. He did not recommend psychiatric treatment. Instead, Dr. Parvaresh recommended continued contact with a "caring and understanding vocational counselor." Thus, in essence, Dr. Parvaresh did not rule out, but rather encouraged, a return to work. We therefore do find support in the opinion of Dr. Parvaresh for a finding of permanent total disability.

In the past, claimant has worked as a security guard, mill worker, forklift operator, and farm worker. At the time of his compensable left shoulder injury, he was a greenchain offbearer. Since that time, he has been unemployed with the exception of a Fish Hatchery Technician position from May to August 1986, which was part of an authorized training plan. As previously noted claimant was successful in this training position. Thus, claimant's vocational rehabilitator did not consider him unemployable. She listed numerous possible positions including security guard, production worker, forklift operator, station attendant, and meter reader. She concluded that she did not consider claimant's vocational future to be without hope. Therefore, we do not consider it to be futile for claimant to seek work.

Accordingly, claimant's condition does not satisfy the definition of permanent total disability. ORS 656.206(1)(a). Therefore, it is unnecessary to reach and decide the issue of whether or not claimant sufficiently demonstrated that he is willing to seek regular gainful employment in order to qualify for permanent total disability status. Wiley v. SAIF, 77 Or App 486, 491 (1986). Regardless of whether or not claimant was willing to seek regular gainful employment, or that he made reasonable attempts to do so, we do not consider claimant to be so disabled that such efforts would have been futile. Claimant has failed to prove by a preponderance of the evidence entitlement to permanent total disability resulting from the compensable injuries.

Extent of permanent disability

The Referee concluded that the 30 percent permanent disability awarded by prior Determination Orders was inadequate and increased the award to 60 percent. We agree with the Referee, but do so based on different grounds.

The Referee chose not to consider claimant's psychological condition in rating extent of permanent disability due to the fact that the compensability of claimant's psychological condition had been resolved in a previous Disputed Claim Settlement. We disagree with those portions of the Referee's order which rely on this proposition. The Disputed Claim Settlement dismissed with prejudice the compensability of claimant's psychological claim, partly in exchange for $4,000. Thus, assuming no change in claimant's psychological condition, claimant is barred from raising this issue at a later date.

However, this does not preclude consideration of claimant's psychological condition in a later hearing on the issue of extent of permanent disability. A claim that is not addressed in a Disputed Claim Settlement is not barred by the settlement. See John Partible, 40 Van Natta 2022 (1988); Tana L. Wilson, 40 Van Natta 476 (1988). The operative language of the agreement states: "IT IS FURTHER STIPULATED AND AGREED that this settlement shall not affect claimant's right to litigate extent of disability at a later date."

Thus, based on this prima facie evidence, we conclude the Disputed Claim Settlement resolved only the compensability of claimant's psychological condition and did not reach so far as to preclude consideration of such a condition in subsequent litigation of claimant's extent of permanent disability. Therefore, it follows if claimant has the right to a hearing on extent, he is entitled to the consideration of all relevant factors, including a psychological condition. See ORS 656.214(5).

In order for claimant's psychological symptomology stemming from his preexisting psychological condition to be considered in determining the extent of claimant's disability, claimant must establish that the compensable injuries were a material contributing cause of the present psychological symptoms. Wilkerson v. Davila, 88 Or App 298 (1987). Psychiatrist, Dr. Parvaresh, opined that claimant's psychological condition was long-standing and predated his compensable injuries, and that the compensable injuries had no material effect on the psychological condition. Accordingly, we find claimant's psychological condition is not causally related to his compensable injuries. Therefore, it is not a factor in considering claimant's extent of unscheduled permanent disability. See Harry F. James, 41 Van Natta 506 (1989).

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. 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 the administrative rules. 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).

Therefore, taking into consideration claimant's age, education, mental capacity, previous work experience, transferable work skills, and residual physical limitations, we find that a 60 percent unscheduled permanent disability award adequately compensates claimant for his compensable left shoulder and low back injuries.

Premature claim closure

The Referee concluded that the preponderance of the medical evidence showed that the medically stationary date of February 6, 1987, as determined by the Evaluation Division, was incorrect, and that claimant's correct medically stationary date was April 3, 1987. We agree.

Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary. ORS 656.268(1). An injured worker will be considered medically stationary when no further material improvement of the compensable condition would reasonable be expected from medical treatment, or the passage of time. ORS 656.005(17).

It is claimant's burden to establish that he was not medically stationary when the claim was closed. Brad T. Gribble, 37 Van Natta 92 (1985). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985). Changes in claimant's condition which occur subsequent to the date of closure are not to be considered in determining whether a claim was prematurely closed. Scheuning v. J. R. Simplot & Co., 84 Or App 622, 625 (1987).

Dr. Ray indicated that claimant was medically stationary as of April 3, 1987. At Dr. Ray's deposition, on May 10, 1988, he reconfirmed this date as accurate. As claimant's long time treating physician Dr. Ray was in the best position to express an opinion regarding claimant's medically stationary date as he saw claimant prior to and after April 3, 1987. There is no conflicting medical evidence. Drs. Mason and Zivin did not directly address the issue of when claimant became medically stationary. Dr. Mason did not begin treating claimant until April 23, 1987. His medical report reflecting this examination is not retrospective, and therefore is not relevant on this issue. Dr. Zivin examined claimant in April 1986, January 1987, and finally in August 1987. Throughout, he indicated no change in claimant's condition.

Therefore, we find the medical evidence is persuasive that claimant was medically stationary on April 3, 1987, in that no further material improvement of claimant's condition was reasonably expected from medical treatment, or the passage of time. Claimant has failed to prove that he was not medically stationary on April 3, 1987.

Aggravation

The Referee concluded that claimant did not experience a compensable worsening of his condition. We agree, but on different grounds.

Claimant contends that his condition has worsened, and seeks an additional award of temporary disability commencing April 3, 1987. To reopen a claim because of aggravation, claimant has the burden of proving that his condition has worsened since the date of the last arrangement of compensation, and that the worsening was caused in material part by the compensable injury. ORS 656.273; Stepp v. SAIF, 78 Or App 438 (1986). To prove a worsening claimant must show a change in his condition which renders him less able to work, and thus, entitles him to additional temporary or permanent disability compensation. Smith v. SAIF, 302 Or 396, 399-402 (1986). Where there has been no pathological worsening of claimant's condition, there must be a factual finding that, since the last award or arrangement of compensation, claimant has experienced a symptomatic worsening (i.e., a waxing, exacerbation, or recurrence of symptoms) resulting in reduced earning capacity. Perry v. SAIF, 307 Or 654 (April 18, 1989); Gwynn v. SAIF, 304 Or 345 (1987).

Claimant's last award of compensation was the April 3, 1987 Determination Order. Claimant's treating chiropractor, Dr. Ray, treated claimant both before and after April 3, 1987. Dr. Ray's chartnotes, dated March 27, 1987, through April 28, 1987, indicate that in April 1987 claimant's condition was steadily improving. On April 28, 1987, Dr. Ray declared that there was no significant change. Furthermore, Dr. Ray authorized no time loss for this time period.

Nonetheless, for reasons that are unclear, Dr. Ray referred claimant to Dr. Mason, a neurologist. On April 23, 1987, claimant presented with complaints of low back and left leg numbness and tingling. In reliance on claimant's subjective symptoms, Dr. Mason authorized time loss from April 23, 1987, to September 21, 1987, while awaiting the results of objective tests. At the conclusion of these tests, he found that claimant was not a suitable candidate for surgical intervention, and referred him back to Dr. Ray for ongoing conservative care.

Upon claimant's return, Dr. Ray proceeded to authorize time loss from September 21 to December 23, 1987, describing a continual progression toward improvement of claimant's condition. Yet, Dr. Ray subsequently agreed with Dr. Mason that claimant's condition had not changed between April 1987 and January 1988.

Additionally, Dr. Zivin, neurosurgeon, examined claimant in April 1986, January 1987, and August 1987. His August 1987 report shows that claimant's shoulder condition had not changed since January 1987. Dr. Zivin also found no worsening of claimant's low back condition. With respect to claimant's low back, he stated:

> "The patient's findings of January 1987 should be noted; they were modest at that time. There is no historical explanation for the patient's remarkable alleged worsening and alleged incapacity at the present time. Patient, when seen in January 1987 and by Dr. Mason in April 1987, could conceivably be construed to harbor a mild left L4 root irritation; those features however are strikingly different from the patient's presentation on 8-20-87 at which time his behavior and findings were so enormously histrionic that it would be impossible to delineate any bona fide findings which might be present."

After consideration of the medical record, we make the following observations. We are impressed with the fact that when pressed at deposition as to the date of the alleged worsening, Dr. Ray was unable to specify a date. Although Dr. Ray did not find claimant medically stationary until March 1988, his opinion appears to be based on claimant's improvement and not because of any worsening of claimant's condition.

We also note that although Dr. Mason authorized time loss, he did so without explanation. Dr. Mason testified that he was not privy to claimant's medical records until May or June of 1988, nor had he examined claimant prior to the April 23, 1987, examination. Therefore, at the time of the medical examination on April 23, 1987, Dr. Mason had no prior knowledge of claimant's condition at the time of claim closure on April 3, 1987. Accordingly, we do not find dispositive the fact that Dr. Mason authorized time loss. Rather, we are persuaded that Dr. Mason never identified a worsening of claimant's condition, nor can his medical reports, including the April 23, 1987 one, be construed to establish a worsening. Finally, the August 1987 medical report rendered by Dr. Zivin clearly does not support a worsening. Accordingly, we conclude that the medical evidence is insufficient to prove either a pathological worsening of claimant's condition or symptomatic worsening of his condition resulting in a reduced earning capacity.

Expert medical evidence is not required to prove a compensable aggravation. Lay testimony may be sufficient. Garbutt v. SAIF, 297 Or 148, 151-152 (1984). In this regard, claimant testified that between February and August 1987 his condition was stable, but that by the time he saw Dr. Zivin on August 20, 1987, his condition had worsened. Considering the complexity of claimant's physical conditions, his diagnosed psychological problems, and the thorough opinion and findings offered by Dr. Zivin, we do not find claimant's testimony sufficiently persuasive to establish a worsening of his condition.

We conclude that claimant has failed to prove a compensable worsening of his condition since April 3, 1987. See Leonard Jennsen, 41 Van Natta 263, 267 (1989).

ORDER

The Referee's order dated September 6, 1988, is affirmed. A client-paid fee is approved, payable by the self-insured employer to its counsel not to exceed $1,675.

ROBERT D. JACKSON, Claimant
Tooze, et al., Attorneys

WCB 87-08582
June 14, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Galloway's order that: (1) upheld the insurer's partial denials of claimant's medical services claims; and (2) found certain medical services to be unrelated to claimant's compensable low back condition. The issue on review is medical services. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back in 1969. He was awarded unscheduled permanent disability for his low back condition and has received medical services for that condition. Claimant has filed numerous requests for hearing, and numerous own motion requests, regarding certain medical services. Claimant has a number of noncompensable conditions not related to his compensable low back condition, and has suffered drug abuse problems for several years.

Claimant submitted a number of handwritten "medical services bills" to the insurer. There is no evidence that these "bills", most of which seek drugs unrelated to his compensable condition, actually represent billings from medical providers.

ULTIMATE FINDING OF FACT

The medical and lay evidence does not establish that the "bills" submitted to the insurer by claimant are causally related to his compensable low back injury.

CONCLUSIONS OF LAW AND OPINION

To establish entitlement to compensation for medical services under ORS 656.245(1), a claimant must prove the reasonableness and necessity of the medical services and a causal relationship between the medical services and a compensable injury or disease. Jordan v. SAIF, 86 Or App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985). To prove the reasonableness and necessity of rendered medical services, a claimant must show that at the time the services were rendered they were likely to be of significant curative, palliative, preventative, or restorative benefit. Id. at 320-21.

Claimant has the burden of proving by a preponderance of the evidence that the medical services "claims" submitted by him to the insurer are causally related to his compensable condition. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). The Referee found no evidence in the record to meet this burden. We note that there is no

medical testimony at all in the record, and claimant's testimony does not establish that the "bills," submitted in his own handwriting, are either medical services claims or that they are related to his compensable low back injury. Therefore, we conclude that the disputed services, if rendered, have not been proven to be reasonable and necessary treatment related to claimant's compensable injury. Consequently, we affirm the Referee's order.

ORDER

The Referee's order dated October 20, 1987 is affirmed.

KENNETH R. NISBET, Claimant
VanValkenburgh, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 87-14232, 87-10918, 87-10919 & 87-11107
June 14, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Truck Insurance Exchange requests review of that portion of Referee Gary Peterson's order that set aside its denial of responsibility for claimant's right lateral epicondylitis. Claimant cross-requests review of that portion of the order that rejected his request for a carrier-paid attorney fee for services rendered through the hearing level. Claimant also argues that the Referee's order should be affirmed on the responsibility issue and requests a carrier-paid attorney fee for services rendered on Board review. We reverse on the responsibility issue, affirm the Referee's denial of a carrier-paid fee for the hearing level and, in view of our decision on the responsibility issue, reject claimant's request for a carrier-paid attorney fee on Board review.

ISSUES

1. Responsibility for claimant's right lateral epicondylitis.

2. Attorney fee for the hearing level.

3. Attorney fee for the Board level.

FINDINGS OF FACT

Claimant began working as a carpenter for Wasco Lumber Company (Wasco) in 1980. In July 1986, claimant nailed decking for an entire week and developed severe pain in his right elbow. He sought treatment from his family doctor, but the condition did not improve. Claimant left work and filed a claim with Truck Insurance Exchange (Truck), Wasco's insurer. Truck accepted the claim.

On October 15, 1986, claimant was examined by Dr. Schwartz, an orthopedic surgeon. Schwartz diagnosed lateral epicondylitis and injected the elbow with a steroid medication. The pain in claimant's elbow disappeared within a week of the injection and claimant was able to use it fully. The elbow still felt somewhat abnormal, however. Claimant described this abnormal feeling as being "just kind of numb inside."

Claimant returned to work in November 1986 as maintenance supervisor for Valley Vista Care Center (Valley Vista), a nursing

home insured by Liberty Northwest Insurance Corporation (Liberty Northwest). In this position, claimant performed a variety of odd jobs, including some light carpentry. During the period of about a week in May 1987, claimant removed and replaced a number of floor tiles. This work involved some chiseling which required light use of a hammer. Claimant began to experience pain in his right elbow a few days after beginning this task and the pain gradually increased. At the end of the week, the pain in claimant's elbow was as severe as it had been in October 1986. Claimant returned to Dr. Schwartz and Schwartz recommended surgery. This was carried out in June 1987.

Claimant filed an aggravation claim with Truck and a new injury claim with Liberty Northwest in early June 1987. Truck issued a responsibility denial on June 15, 1987 and filed a request for an order pursuant to former ORS 656.307. Liberty Northwest issued a denial of both compensability and responsibility on June 19, 1987. Before claimant retained an attorney or filed a request for hearing, Liberty Northwest withdrew its denial of compensability and acceded to the issuance of a .307 order. A .307 order issued on July 15, 1987 and was received by the Board the following day. The order designated Liberty Northwest as paying agent. Liberty Northwest's weekly temporary total disability rate is $205.97. Truck's is $254.03.

Claimant's attorney participated in a prehearing deposition and also appeared at the hearing. He took the position that claimant had sustained an aggravation rather than a new injury and questioned claimant on direct examination. The Referee concluded that claimant had sustained an aggravation and assigned responsibility to Truck. He awarded claimant's attorney a fee out of the increased temporary disability compensation accruing to claimant as a result of the difference between the temporary disability compensation rates of Truck and Liberty Northwest. Truck requested Board review and argues that the Referee should have assigned responsibility to Liberty Northwest. Claimant argues for the affirmation of the Referee's responsibility determination, but contends that the Referee erred in failing to award his attorney a carrier-paid fee. We reverse the Referee's responsibility determination and assign responsibility to Liberty Northwest.

Claimant has lateral epicondylitis. Lateral epicondylitis is an inflammation of the tendon of the extensor muscles of the forearm at the point of its attachment to the humerus. This inflammation results when some of the tendon fibers tear away from the humerus. Claimant's work at Valley Vista caused some additional tearing of the fibers of the tendon in his elbow. This tearing materially contributed to the exacerbation of claimant's right elbow condition in May 1987. The exacerbation resulted in disability and required medical services.

FINDINGS OF ULTIMATE FACT

1. Claimant's work activity at Valley Vista resulted in a slight worsening of his underlying lateral epicondylitis.

2. The amount of claimant's compensation was at issue at the hearing level; his entitlement to receive compensation was not.

3. The amount of claimant's compensation was reduced on Board review.

CONCLUSIONS OF LAW

1. Responsibility

The Referee concluded that Truck had the burden of proving an independent contribution by claimant's work activity at Valley Vista to the worsening of claimant's underlying condition to shift responsibility from itself to Liberty Northwest under the last injurious exposure rule and that Truck had failed to carry this burden. We conclude that the burden of proof was on Liberty Northwest and that Liberty Northwest failed to disprove that claimant's employment at Valley Vista independently contributed to a worsening of claimant's underlying condition.

The Referee's placement of the burden of proof was in accordance with our decision in Eva L. (Doner) Staley, 38 Van Natta 1280 (1986). Since the Referee issued his order, however, the Court of Appeals effectively overruled Staley in Champion International v. Castilleja, 91 Or App 556, rev den 306 Or 661 (1988). Castilleja was a successive injury case in which a .307 order had been issued. Under those circumstances, 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 proving responsibility in successive injury cases on the last carrier. Hence, absent sufficient proof by the last carrier of the lack of an independent contribution to a worsening of the claimant's underlying condition, responsibility is assigned to the last carrier. Donald D. Davis, 40 Van Natta 2000, 2002 (1988).

Dr. Schwartz has consistently opined that claimant's work activity at Valley Vista did not result in a "new injury" to claimant's elbow. In his deposition, however, he indicated that this activity was of a type which could cause or worsen epicondylitis and that it probably did result in some additional tearing of claimant's tendon fibers on a microscopic level. The only other medical professionals to offer an opinion regarding the effect of claimant's work activity at Valley Vista was a panel of the Western Medical Consultants. It opined that this activity "probably contributed very little to any pathological worsening of [claimant's] underlying condition and principally made it a bit more symptomatic." (Ex. 30-3).

The focus of the above opinions obviously was the relative contribution of the two periods of claimant's work activity. They clearly indicate that the great majority of the pathological damage to claimant's elbow occurred as a result of his work activity at Wasco in July 1986. They also reflect, however, that claimant's later work activity at Valley Vista independently contributed to a slight pathological worsening of the underlying condition. Such a contribution is sufficient to fix responsibility with the new injury carrier under the last injurious exposure rule. Mission Insurance Co. v. Dundon, 86 Or App 470, 473 (1987); Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986). Responsibility, therefore, will be assigned to Liberty Northwest.

2. Attorney Fee for the Hearing Level

The Referee awarded claimant's attorney a fee out of the

additional compensation accruing to claimant as a result of the Referee's responsibility determination. Claimant contends that his attorney should have been awarded a carrier-paid fee under ORS 656.386(1). Claimant's argument finds support in SAIF v. Phipps, 85 Or App 436 (1987). A majority of the Board has concluded, however, that Phipps was overruled sub silentio by later cases. Rhonda L. Bilodeau, 41 Van Natta 11, 15 (1989). In any event, claimant's attorney is not entitled to a carrier-paid fee even under Phipps because we reversed the Referee's responsibility determination and assigned responsibility to the carrier with the lower temporary disability compensation rate. Claimant, therefore, did not "prevail finally" against the carrier with the higher rate. See Greenslitt v. City of Lake Oswego, 305 Or 530, 533-35 (1988).

3. Attorney Fee for the Board Level

A claimant's attorney is entitled to a carrier-paid attorney fee for services rendered on Board review if a carrier requests Board review and the Board determines that the claimant's compensation "should not be disallowed or reduced." ORS 656.382(2). In the present case, Truck requested Board review on the issue of responsibility. Claimant's compensation was reduced by virtue of our assignment of responsibility to the insurer with the lower temporary disability compensation rate. Claimant's attorney, therefore, is not entitled to a carrier-paid fee on Board review.

ORDER

The Referee's order dated December 30, 1987 is reversed in part. The denial issued by Truck Insurance Exchange dated June 15, 1987 is reinstated and upheld. The denial issued by Liberty Northwest Insurance Corporation dated June 24, 1987 is set aside and the claim is remanded to Liberty Northwest for acceptance and processing according to law. Liberty Northwest shall reimburse Truck Insurance for its claim costs incurred to date. A client-paid fee, payable from Truck Insurance Exchange to its counsel, is approved, not to exceed $1,508. A client-paid fee, payable from Liberty Northwest to its counsel is approved, not to exceed #1,446. The remainder of the Referee's order is affirmed.

JESSE C. CAIN, Claimant
Rex Q. Smith, Claimant's Attorney
Williams, et al., Defense Attorneys
Bottini, et al., Defense Attorneys
Davis, et al., Defense Attorneys

WCB 87-07545, 85-08996 & 87-04224
June 15, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Farmers' Insurance Group requests, and claimant cross-requests, review of Referee Leahy's order that: (1) set aside Farmers' denial of claimant's "new injury" claim for his current low back condition; (2) upheld Fireman's Fund's denial of a "new injury" claim for the same condition; (3) upheld EBI Companies' denial of an aggravation claim for a previously accepted low back condition; and (4) awarded a reasonable attorney fee of $2,000. On review, the issues are compensability, responsibility, and attorney fees. We affirm.

On review, EBI moves to strike Farmers' reply brief on the grounds it was not timely filed. The motion is denied. We find that the brief was timely received within the modified briefing schedule.

FINDINGS OF FACT

Claimant compensably injured his low back in 1982 while working for EBI's insured. A July 14, 1982, Determination Order awarded 10 percent unscheduled permanent disability. This was later increased to a total of 20 percent by a stipulation dated February 7, 1984.

Claimant suffered waxing and waning back pain, but was able to participate in vocational rehabilitation. He entered a hairdressing school and was subsequently hired by Fireman's Fund's insured on June 24, 1985. Farmers Insurance Group replaced Fireman's Fund on the risk as of June 17, 1986.

Claimant was successful as a hairdresser and was promoted to manager. He continued to suffer waxing and waning of his back pain and continued to periodically treat with Dr. Noall, orthopedist. In September and October, 1986, claimant's back pain increased. Dr. Noall at first recommended part-time work only; he then recommended that claimant discontinue working as a hairdresser. Claimant left work on October 11, 1986.

Dr. Noall initially considered claimant's worsened condition to be further waxing and waning from the 1982 compensable injury. When claimant's condition did not improve in time, he subsequently opined that claimant's employment as a hairdresser had caused a worsening of his underlying condition.

EBI, Fireman's Fund and Farmers' all denied the claim; Farmers' denied compensability.

ULTIMATE FINDINGS OF FACT

Claimant's low back condition worsened after September, 1986.

Claimant's work activities as a hairdresser while Farmers was on the risk independently contributed to a worsening of his compensable low back condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

There was no testimony at hearing. The matter was submitted to the Referee on the medical record and Dr. Noall's deposition. The Referee found that the evidence established that claimant's work activities as a hairdresser independently contributed to a worsening of his condition. We agree.

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodard, 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). Claimant bears the burden of proving that a condition giving rise to a need for medical treatment or disability is materially related to a compensable claim. Grable v. Weyerhaeuser Company, 291 Or 397 (1981). We consider this to be a complex medical question requiring expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Noall has treated claimant since 1977, and was his treating physician at the time of the 1982 compensable injury. His reports over a period of years consistently show that claimant's low back symptoms would wax and wane, sometimes requiring medical services. Claimant was treated over a period of years intermittently with various modes of physical therapy and his condition generally improved.

Dr. Noall opined before claimant began work as a hairdresser that he felt claimant could physically perform the job, although it would require standing for long periods in one position with his arms extended. Claimant was successful as a hairdresser, although he suffered increased symptoms at various times.

In September, 1986, Dr. Noall recommended claimant consider doing some other line of work. He opined that the work involved too much standing with his arms extended. In his deposition, Dr. Noall indicated he was mistaken in his earlier belief that claimant could perform this work.

On January 28, 1987, Dr. Noall opined that, based on claimant's pattern of increased pain, and the fact that it had not been responsive to treatment as it had been in the past, he felt that claimant had suffered an aggravation of his underlying disease process, resulting in disability. In his deposition, he explained that prior to this time, he was of the opinion that claimant was continuing to suffer symptomatic waxing and waning as a result of his 1982 compensable injury. Because claimant's condition did not respond to treatment in September and October, 1986, he had changed his opinion and felt the work activities as a hairdresser had worsened the underlying condition.

The Orthopaedic Consultants examined claimant on July 1, 1987, and diagnosed chronic lumbar strain. The Consultants opined that the relationship of claimant's present complaints to his work activities was not clear. They felt that there was no independent contribution to a worsening of his condition by his hairdressing activities.

The final opinion of Dr. Noall and the report of the Orthopaedic Consultants, the only medical evidence in the record, are in some disagreement as to the contribution of claimant's hairdressing activities to his current condition. However, we do not consider the medical evidence to be in conflict over compensability. We find claimant has proved that his current condition is causally related to either his 1982 compensable injury or to his hairdressing activities. We therefore find his claims compensable.

Responsibility

EBI accepted claimant's low back injury claim in 1982 and was responsible for continued need for treatment for that condition. Responsibility remains with EBI unless and until subsequent work activities have independently contributed to a worsening of claimant's compensable condition. See Boise Cascade v. Starbuck, 296 Or 238 (1984); Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). If the medical evidence shows a new injury, responsibility should be with the insurer at the time of the new injury, even in the absence of a specific event or trauma. Home Insurance Company v. EBI Companies, 76 Or App 112 (1985).

The Referee found that claimant's work activities in

September and October of 1986 had independently caused a worsening of his low back condition. Farmers argues that the evidence establishes that claimant's work activities as a hairdresser only caused his condition to become symptomatic and did not result in a worsening of his underlying condition. In the alternative, Farmers argues that if claimant's condition was worsened by his activities as a hairdresser, this had already taken place by the time Farmers assumed the risk on June 17, 1986. This presents another complex medical issue, requiring competent medical testimony. Kassahn v. Publishers Paper Co., supra.

We often give greater weight to the opinion of a treating physician. Weiland v. SAIF, 64 Or App 810 (1983). In this case we find particular reason to do so. Dr. Noall has treated claimant for almost ten years and is quite familiar with claimant's condition and history. His explanation of his diagnosis of a worsening of the compensable condition, as opposed to his prior diagnosis of simply waxing and waning of symptoms, is complete and well reasoned.

The report of the Orthopaedic Consultants relates claimant's current condition to his 1982 compensable injury. However, in opining that it is not medically probable that claimant's hairdressing activities worsened the chronic back problem, the Consultants added a recommendation that further investigation might be needed on this point. We believe Dr. Noall was the most informed physician regarding claimant's condition and in the best position to determine the cause of his worsened condition. We therefore rely on Dr. Noall's opinion in finding that claimant's work activities as a hairdresser independently contributed to a worsening of his low back condition.

Claimant objects to the attorney fee awarded by the Referee. After reviewing factors such as experience, expertise, difficulty of the issues, and other factors relevant to the matter, such as the time record submitted by claimant's attorney, we find the Referee's award appropriate. See Barbara Wheeler, 37 Van Natta 122, (1985).

ORDER

The Referee's order dated July 28, 1987, is affirmed. A client-paid fee, payable from Farmers Insurance Group to its counsel, not to exceed $744.50, is approved. A client-paid fee, payable from EBI to its counsel, not to exceed $900, is approved. A client-paid fee, payable from Fireman's Fund to its counsel, not to exceed $595, is approved.

DARYL C. CRONEN, Claimant

Own Motion 89-0143M
June 15, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his June 5, 1981 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for the proposed left shoulder surgery and recommends that the claim be reopened for the payment of temporary disability benefits.

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.

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring further surgery. Claimant is currently receiving temporary disability benefits in his 1984 right shoulder claim. We conclude the 1981 claim should be reopened for the payment of temporary disability benefits to commence the date claimant is hospitalized for left shoulder surgery or the day immediately following the termination of benefits in the 1984 claim, whichever comes last, and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. 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.

NANCY C. EVENHUS, Claimant
Brian R. Whitehead, Claimant's Attorney
Cliff, Snarskis, et al., Defense Attorneys
Acker, et al., Defense Attorneys

WCB 87-04881, 87-03084 & 87-03085
June 15, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Black's order that: (1) set aside Liberty Northwest's "backup" denial of claimant's "new injury" claim for a left knee condition; and (2) upheld a denial by Industrial Indemnity of claimant's aggravation claim for the same condition. In her brief, claimant contends that the Referee erred in declining to assess a penalty and attorney fee against CIGNA/Insurance Company of North America for a failure to accept or deny claimant's "new injury" claim for the same condition. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant sustained a compensable left knee injury on August 25, 1980. This claim was accepted and processed by Industrial Indemnity. A Determination order issued on January 9, 1981, which awarded 5 percent scheduled permanent disability. By stipulation this award was increased to 12.33 percent permanent disability.

Claimant sustained a second left knee injury while working for her employer on September 15, 1986. This injury was reported to her employer on November 13, 1986, on a Form 801, which was referred to Liberty Northwest Insurance Corporation. The insurer on risk at the time of injury was CIGNA/Insurance Company of North America (CIGNA). One day later, on September 16, 1986, coverage shifted to Liberty Northwest.

On November 24, 1986, Liberty Northwest accepted and processed the claim. As a result, claimant was paid medical services, and temporary total disability from December 1, 1986, through February 1, 1987. On February 2, 1987, claimant returned to regular work. Sometime later, Liberty Northwest discovered that it was not on risk on the date of injury. Realizing benefits had mistakenly been paid, Liberty Northwest issued a "backup" denial on February 18, 1987.

On February 26, 1987, claimant filed a hearing request, contending that CIGNA had failed to timely accept or deny her claim and had not paid interim compensation. Claimant sought penalties and attorney fees.

In March 1987, claimant filed a report of injury with CIGNA. CIGNA indicated its receipt of this form on March 4, 1987. On March 10, 1987, CIGNA filed a response to claimant's hearing request. CIGNA denied claimant's contentions. However, it did not formally deny the claim within 60 days, or thereafter. On March 12, 1987, Industrial Indemnity denied the claim as an aggravation of the original 1980 injury. Claimant filed a request for hearing joining Industrial Indemnity, Liberty Northwest and CIGNA. CIGNA did not appear. Other than its response to claimant's hearing request, CIGNA never issued a formal denial, nor did it appear at hearing, or submit a brief on review.

CONCLUSIONS OF LAW

Responsibility

Despite the fact Liberty Northwest was not on the risk at the time of injury, the Referee found Liberty Northwest responsible for the September 15, 1986, left knee injury. Relying on Bauman v. SAIF, 295 Or 788 (1983), and Ebbtide Enterprises v. Tucker, 303 Or 459 (1987), the Referee set aside Liberty Northwest's "backup" denial. We agree, as supplemented below.

In Bauman, the Supreme Court announced the general prohibition against "backup" denials. The Court stated:

> "ORS 656.262(6) gives the insurer or self-insured employer 60 days after notice of the claim in which to accept or deny the claim. If, as in this case, the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days has elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. The insurer or self-insured employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability. We need not list all of the possible ramifications of such conduct but it is readily apparent that problems involving lapsed memories, missing witnesses, missing medical reports, and host of other difficulties would arise from the delayed litigation of the compensability of a claim. The statutory scheme in ORS 656.262 envisions a speedy resolution of workers' compensation claims....we hold that once a claim has been accepted the insurer or self-insured employer may not withdraw such acceptance."

Bauman, 295 Or at 793-4.

In Ebbtide Enterprises v. Tucker, 303 Or 459 (1987), the Supreme Court expanded the Bauman rule to include those cases where the only dispute was one of responsibility between insurers. The Court explained the underlying policy reasons for so holding:

> "In reaching the conclusion in Bauman that backup claim denials are impermissible under the Workers' Compensation Law, we relied not upon a perceived threat to claimant's benefits, but upon the institutional costs of permitting such denials. We identified problems of proof and the need for stability in the system and for speedy resolution of claims as policies advanced by the rule of finality imposed by the statutes. These considerations are as persuasive in disputes between insurers as they are in disputes between an insurer and a claimant."

Ebbtide, 303 Or at 463.

In between the Bauman and Ebbtide decisions, the Court of Appeals decided D. Maintenance v. Mischke, 84 Or App 218, rev den 303 Or 483 (1987). Mischke held that a "backup" denial issued by the first insurer is permissible, where the second insurer retroactively provides coverage, and that coverage included a previously accepted and processed claim. Mischke, 84 Or App at 221-222. In Mischke, when the second insurer contracted to provide coverage, the claim had already been accepted and processed by the first insurer. Unlike the case at bar, there was no mistake, the first insurer was actually on the risk at the time of injury. The second insurer simply contractually assumed the responsibilities of the first thereafter. Thus, compensability and responsibility were resolved to the extent of the acceptance. It was at that point in time that the Bauman principles attached to protect claimant from vacillation by her employer or its insurer. Mischke, 84 Or App at 221-222.

The principle enunciated by Mischke is to maintain the enforceability of guaranty contracts, while at the same time meeting the institutional needs announced in Bauman. This principle, which was subsequently followed in Ebbtide, is designed to ensure the stability of the workers' compensation system, the speedy resolution of claims, and the preclusion of evidentiary problems. We do not consider the institutional policy, as described in these decisions, permits insurers to vacillate and issue "backup" denials, when the insurers have by mistake accepted and processed a claim, only to discover as an afterthought they should not have done so.

Thus, we conclude that in order for the holding of Mischke to be applicable, the insurer must demonstrate the following elements: (1) the existence of a guaranty contract in accordance with ORS 656.419(1), which places another insurer on risk at the time of injury; and (2) the coverage assumed by the second insurer includes the previously accepted and processed claim at issue.

Turning to the case at hand, the first element of

Mischke is met. There exists a guaranty contract involving the employer and the two insurers as provided by law. The dates of this contract mandated that CIGNA was on risk through September 15, 1986, and that Liberty Northwest was on risk from September 16, 1986. Consequently, in terms of the contract, the insurer on risk at the time of the September 15, 1986 injury was CIGNA.

However, the second element is not met. Here, the second insurer had already entered into a contract before the injury arose. Therefore, there was no acceptance of the claim by operation of law, and hence, the issues of compensability and responsibility remained potentially viable and subject to litigation.

In addition, allowing a "backup" denial under these facts would defeat the need for stability and speedy resolution of a claim by placing claimant in a "holding pattern." Such a procedure would also give rise to evidentiary problems. For example, permitting the first insurer to "backup" and deny long after the initial acceptance, would require the second insurer to defend against a stale claim. Further, such a procedure would permit the issue of compensability to be raised at a later date, potentially resulting in surprise and prejudice to the second insurer in its attempt to thoroughly investigate the claim. For these policy reasons, we do not find the holding of Mischke to be applicable. See Beverly A. Bond, 41 Van Natta 975 (June 12, 1989).

In conclusion, Liberty Northwest's "backup" denial was invalid. Therefore, Liberty Northwest's acceptance continued in force and was legally binding, and the duty to pay benefits continued to run. Georgia Pacific Corp. v. Piwowar, 305 Or 494, 502 (1988). See also, Knapp v. Weyerhaeuser Co., 93 Or App 629, 673-4 (1988).

Penalties and attorney fees

The Referee declined to assess penalties and attorney fees against CIGNA for an unreasonable delay in payment of compensation and/or unreasonable failure to accept or deny a claim under ORS 656.262. We disagree and reverse.

On September 15, 1986, claimant injured her left knee in an industrially-related accident. On that date, CIGNA was on the risk. Claimant filed an 801 form with her employer on November 13, 1986. Notice of this claim is legally attributable to its insurer. Nix v. SAIF, 80 Or App 656, 660 (1986), rev den 302 Or 158 (1987). On March 10, 1987, in responding to claimant's hearing request, CIGNA contested claimant's entitlement to interim compensation, penalties and attorney fees. However, CIGNA did not formally accept or deny the claim within 60 days of receiving the claim as required. ORS 656.262(6). Therefore, penalties and attorney fees are due for an untimely acceptance or denial based upon amounts then due. ORS 656.262(10); 656.382(1).

CIGNA was also obligated to pay interim compensation. Specifically, CIGNA was required to begin making interim compensation payments for those periods of time that claimant was off work due to the compensable injury, beginning no later than 14 days after the employer had notice or knowledge of the claim, and continuing until a formal denial issued. ORS 656.262(4); Bono v. SAIF, 298 Or 405 (1984); Roger G. Prusak, 40 Van Natta 2037 (1988). Furthermore, each potentially responsible insurer owed

claimant interim compensation for the period in which she was off work due to her industrial injury, unless it denied the claim within 14 days of notice of the injury. Stephen E. Pace, 38 Van Natta 139, 141 (1986). Thus, the fact Liberty Northwest paid claimant interim compensation during this period does not defeat claimant's right to receive interim compensation from CIGNA for the period she was off work due to the compensable injury.

CIGNA never issued a formal denial, nor did it appear at hearing and deny the claim. Therefore, the duty to pay interim compensation began no later than 14 days after the filing of the 801 form on November 13, 1986, and continued until claimant returned to regular work on February 2, 1987. Since CIGNA failed to pay interim compensation as required by law, penalties and attorney fees are awarded for unreasonable delay in the payment of compensation. ORS 656.262(4); 656.262(10); 656.382(1); See Nix, 80 Or App at 660. The penalty assessed against CIGNA is to be calculated based upon 25 percent of the the amount then due, that is, the interim compensation due and owing by CIGNA to claimant.

ORDER

The Referee's order dated November 13, 1987, is affirmed in part and reversed in part. That portion of the Referee's order which denied claimant's request for a penalty and attorney fee against CIGNA/ Insurance Company of North America (CIGNA) is reversed. CIGNA shall pay claimant temporary disability as interim compensation for the period when claimant was off work from November 13, 1986, until February 2, 1987. As a penalty for this unreasonable conduct, CIGNA shall pay to claimant an additional 25 percent of the aforementioned compensation. For services at the hearings level and on Board review concerning the penalty issue, claimant's attorney is awarded $500, to be paid by CIGNA. The remainder of the order is affirmed. A client-paid fee, not to exceed $612, payable from Liberty Northwest to its counsel, is approved.

RICHARD LUNA, Claimant
Black, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 88-00722
June 15, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Brown's order that denied his request for travel expenses to attend a prior hearing. Claimant filed no brief on review. The sole issue is reimbursement of travel expenses. We affirm.

FINDINGS OF FACT

Claimant suffered a compensable left shoulder and elbow injury on November 22, 1983. He subsequently underwent left shoulder surgery. The self-insured employer denied reimbursement for the costs of the surgery. Claimant requested a hearing on that denial.

A hearing was held on November 17, 1987, in Klamath Falls, Oregon. Claimant, who had since moved to California, traveled to Klamath Falls to attend the hearing. Following the hearing, a Referee entered an order upholding the employer's denial. Claimant requested Board review. On review, we affirmed.

In the interim, claimant sought reimbursement from the

employer for travel from his home in California to the hearing. The employer denied the request. Claimant requested a hearing on the denial. A hearing was held by telephone on February 11, 1988. Claimant was not present. Following the hearing, the Referee issued an order upholding the employer's travel reimbursement denial. Claimant requested Board review.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion as our own. See also Kenneth J. Graves, 40 Van Natta 1170, 1171-72 (1988).

ORDER

The Referee's order dated February 19, 1988 is affirmed. The Board approves a client-paid fee, payable from the self-insured employer to its counsel, not to exceed $450.

DELORES M. SHUTE, Claimant
William H. Summerfield, Claimant's Attorney
James E. Griffin, Assistant Attorney General

WCB TP-89012
June 15, 1989
Third Party Order

Claimant has petitioned the Board for resolution of a dispute concerning the "just and proper" distribution of proceeds from a proposed third party settlement. See ORS 656.593(3). Inasmuch as claimant has neither accepted the proposed settlement nor has she requested a determination as to whether the settlement offer is reasonable, we consider her petition to be premature. Accordingly, the petition is denied for lack of jurisdiction.

FINDINGS

In August 1987, while performing her employment duties as an assistant manager for a video store, claimant slipped and fell down a flight of stairs. Her condition was diagnosed as lumbar strain with sciatica. The claim was accepted.

Claimant, through legal counsel, brought suit against a third party, the owner/lessor of the building, for her injuries. The third party has offered to settle claimant's cause of action for $7,500.

SAIF's "third party" lien for its claim costs totals $5,205.33. The amount of this lien is not contested. Assuming that the $7,500 settlement offer was accepted, a balance of $3,748.88 would remain after deducting claimant's attorney fees, costs, and statutory 1/3 share.

SAIF has approved the settlement offer. However, claimant is currently considering the offer. Moreover, unless SAIF's lien is reduced, claimant "will likely reject [the offer]."

No dispute concerning the reasonableness of the settlement offer has been presented for the Board's resolution. There are no proceeds from a third party settlement from which the Board can determine a "just and proper" distribution to the paying agency.

CONCLUSIONS

If a worker receives 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. If the worker elects to pursue a third party action, any compromise by the worker of any right of action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the Board. ORS 656.587.

When the paying agency refuses to approve the proposed settlement, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986). In exercising this judgment, we will generally approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. John E. Headrick, 40 Van Natta 1153, 1641 (1988).

Here, claimant has not accepted the settlement offer from the third party. Therefore, no compromise between the worker and the third party currently exists. Moreover, even if there was a compromise, SAIF has not refused to approve it. Under such circumstances, we are without authority to proceed under ORS 656.587.

Furthermore, if the worker settles the third party claim with paying agency approval, the paying 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).

Here, claimant acknowledges that she has not settled her third party claim. In fact, she expressly concedes that she will likely not accept the settlement offer without a reduction in SAIF's asserted lien. Because no third party settlement has been reached, there are no proceeds from which we can determine a "just and proper" distribution to SAIF. See ORS 656.593(3).

Despite her decision to "table" the current settlement offer, claimant continues to seek a determination concerning a "just and proper" distribution of the proposed settlement proceeds. Specifically, she asserts that she "will be bound by any decision of the Board should she choose to accept the settlement." (Emphasis added).

Considering the aforementioned conditional language, we interpret claimant's petition as, in effect, a request for an advisory opinion. We are not authorized to issue such opinions.

In conclusion, since claimant has not settled her third party claim and because SAIF does not refuse to approve the proposed settlement, we hold that a determination regarding the "just and proper" distribution of proceeds from the proposed settlement would be premature. Accordingly, claimant's petition for relief is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

JOHN TUCKER, Claimant
Bischoff, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 88-18687
June 15, 1989
Order of Dismissal

Claimant has moved for an order dismissing the self-insured employer's request for review of a Referee's order that awarded a carrier-paid attorney fee for services rendered in reaching a settlement of a dispute concerning a claim without a hearing. Claimant contends that we lack jurisdiction to consider the attorney fee issue. We agree and grant the motion.

FINDINGS OF FACT

In June 1987 claimant suffered a compensable low back injury. A January 1988 Determination Order awarded 20 percent unscheduled permanent disability.

Pursuant to a July 1988 stipulation, the parties agreed that claimant would be referred for vocational assessment, as well as an assessment in the Injured Workers Program. The parties further stipulated that claimant would not receive temporary total disability during this assessment period.

On September 2, 1988, claimant's treating physician notified the employer that claimant was awaiting approval to enter the program. In addition, the physician reported that claimant was "incapacitated from many types of work due to what I perceive as a mixture of physiological and functional components."

On October 27, 1988, claimant requested a hearing. Contending that the employer had failed to pay temporary total disability pursuant to the physician's September 2, 1988 notification, claimant sought penalties and attorney fees. On November 15, 1988, claimant amended his hearing request to include the employer's November 8, 1988 aggravation denial.

Prior to the scheduled hearing, a stipulation was reached. Claimant continued to be referred to the Injured Workers Program. Acknowledging that claimant's condition remained medically stationary and had not worsened, the parties further stipulated that claimant was not entitled to temporary total disability benefits as of the date of the stipulation. Finally, the parties agreed that "claimant's attorney shall receive as a reasonable attorney fee an amount to be determined by the Referee", with the employer reserving "the right to object and be heard as to the requested fee."

The Referee awarded a carrier-paid attorney fee of $1,400. The Referee's order indicated that, if either party was dissatisfied with the result, they could request Board review. The employer requested Board review and contends that the Referee's attorney fee award was excessive.

CONCLUSIONS

We have previously determined that we lack jurisdiction to consider requests for Board review where the sole issue is the amount of an attorney fee awarded under ORS 656.386(1). Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). In such cases, the appropriate avenue of appeal is to the circuit court under the provisions of ORS 656.388(2). See Greenslitt v. City of Lake Oswego, 305 Or 530 (1988).

Here, the only issue on review is the amount of the carrier-paid attorney fee awarded by the Referee. Under such circumstances, we lack jurisdiction to review the order. Arbra Williams, 40 Van Natta 506 (1988).

The insurer contends that it was misled by the statement concerning the parties' rights of appeal contained in the Referee's order. It is regrettable if the insurer was misled by the advisement of appellate rights provided in the order. Yet, our jurisdiction is statutory and incorrect statements of appeal rights cannot expand or contract that jurisdiction. See Gary O. Soderstrom, 35 Van Natta 1710 (1983). Accordingly, the request for Board review is dismissed.

Claimant seeks an attorney fee for services rendered at this level. The request is denied. Inasmuch as attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to attorney fees for successfully defending such an award on review. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

IT IS SO ORDERED.

GUNTHER H. JACOBI, Claimant
Francesconi & Cash, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-13798
June 16, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Fink's order which upheld the insurer's partial denial of claimant's medical services claim for his current bilateral shoulder, arm, wrist and hand condition. The sole issue on review is compensability of medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation.

In May 1986, following claimant's compensable injuries, his complaints related to the lumbosacral area, the mid-thoracic region, and the cervical spine.

Claimant's industrial injuries of April 10, 1986 and May 7, 1986 are not material contributing causes of his need for treatment for bilateral shoulder, arm, wrist and hand problems.

CONCLUSIONS OF LAW

At the hearing, claimant contended that medical treatment for his bilateral shoulder, arm, wrist and hand problems was causally related to the compensable injuries he sustained in April and May of 1986. On review, claimant advances, for the first time, the contention that the treatment is compensable on an occupational disease basis. The insurer submits that claimant cannot raise this theory, for the first time, at Board level. We agree.

Claimant's position could be characterized as merely a different theory of compensability, rather than a separate issue. However, we conclude that the insurer would be prejudiced if we resolved this case on an occupational disease basis. The

insurer's evidentiary showing at the hearing addressed the causal relationship between claimant's need for medical treatments and his compensable injuries. This was consistent with claimant's characterization of this issue at the time of hearing. Further, the claim was made in the form of medical reports which indicated a relationship to the previous compensable injuries, and referred to the claim numbers assigned those injuries. To now decide the case on a completely different basis would be fundamentally unfair, and we decline to do so. See McNett v. Roy-Ladd Construction Co., 46 Or App 601, 606 rev den 289 Or 588 (1980); Mavis v. SAIF, 45 Or App 1059 (1980).

The Referee concluded that claimant's current need for medical treatment for his bilateral shoulder, arm, wrist and hand condition was not compensably related to the accepted injuries. We agree based on the following reasoning.

The issue of whether claimant's current need for medical services is causally related to his industrial injuries of April and May 1986, is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Nelson, claimant's treating chiropractor, opined that claimant's thoracic outlet syndrome was not causally related to claimant's injuries of April 10, 1986 or May 7, 1986. Dr. Thompson, orthopedist, corroborated this conclusion and added that claimant's previous forearm industrial injuries and conditions caused thereby, had no bearing on claimants current bilateral arm problems. Dr. Bussanich, chiropractor, describes claimant's thoracic outlet syndrome as being work-related, but does not connect the condition specifically to the industrial injuries in question. In light of this, we are persuaded by the well-reasoned opinions of Drs. Nelson and Thompson. Somers v. SAIF, 77 Or App 259 (1986).

Following our de novo review of the medical and lay evidence, we conclude that claimant has not established that his current need for medical treatment for his bilateral shoulder, arm, wrist and hand condition is causally related to his industrial injuries of April 10, 1986 and May 7, 1986.

ORDER

The Referee's order of June 15, 1987 is affirmed. A client-paid fee, not to exceed $150, is approved.

CAROL K. MATTHEWS, Claimant
Vick & Gutzler, Claimant's Attorneys
Nancy Marque (SAIF), Defense Attorney

WCB 87-13211
June 16, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Paulus' order that: (1) declined to award her additional temporary total disability benefits; (2) found that the insurer had overpaid temporary total disability compensation and allowed an offset for that overpayment; and (3) affirmed an award by Determination Order of 10 percent (32 degrees) unscheduled permanent disability for a low back condition, for a total award of 20 percent (64 degrees). On

review, the issues are entitlement to additional temporary total disability compensation, offset and extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

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

The Referee found that "[t]here is no indication as to how close to March 1987 Dr. Helms actually evaluated claimant's status." We, instead, find that Dr. Helms evaluated claimant on at least two occasions in March 1987.

The Referee found that a September 9, 1985 Determination Order awarded claimant 10 percent unscheduled permanent disability for "an earlier injury to her back." We, instead, find that the September 1985 award was for the January 4, 1985 injury at issue on review.

The Referee found that claimant has received a total award of 10 percent unscheduled permanent disability for her January 4, 1985 injury. We, instead, find that she has received a total award of 20 percent permanent disability for that injury.

Finally, the Referee found that claimant has lost the ability to perform heavy work. We, instead, find that claimant is unable to perform either medium or heavy work.

FINDINGS OF ULTIMATE FACT

The Referee found that claimant was medically stationary in March 1987. We, instead, find that claimant became medically stationary on June 9, 1987.

We further find that claimant has sustained mild physical impairment as a result of her compensable injury in January 1985.

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability/Offset

Claimant contends that she was not medically stationary until August 1, 1987, and she seeks additional temporary total disability benefits through that date. A September 22, 1987 Determination Order found claimant medically stationary as of June 9, 1987 and awarded temporary disability benefits through that date. The Referee declined to award additional temporary disability compensation and affirmed the September 1987 Determination Order. She based that decision on her finding that claimant become medically stationary in March 1987. The Referee also approved an offset of temporary disability compensation paid for the period June 10, 1987 through September 22, 1987.

We do not entirely agree with the Referee's analysis on this issue. Nevertheless, we conclude that she was correct in affirming the September 1987 Determination Order and approving the requested offset.

Dr. Helms, the treating chiropractor, opined in December 1986 that claimant would be medically stationary in February or March 1987. At that time, Dr. Holmes, pain specialist, was anticipating an earlier January 1987 stationary date. However,

claimant had not reached stationary status when Dr. Holmes reexamined her in February 1987. Based on that examination, Dr. Holmes predicted a March 1987 medically stationary date. Dr. Helms disagreed, opining in May 1987 that claimant would not be stationary until the following November. Dr. Fechtel, subsequently conducted an independent chiropractic examination on June 9, 1987, and he opined that claimant was medically stationary at that time. Dr. Fechtel also reviewed the medically stationary predictions made by Drs. Holmes and Helms, and he noted that Dr. Holmes' March 1987 date was the more accurate. On July 31, 1987, Dr. Helms noted his disagreement with Dr. Fechtel's opinion and identified an alternative medically stationary date of August 1987.

The Referee relied on Dr. Holmes' opinion and found that claimant was medically stationary in March 1987. She discounted treating physician Helms' opinion based on her finding that "there is no indication as to how close to March 1987 Dr. Helms actually evaluated claimant's status."

We disagree with the Referee's reliance on Dr. Holmes' opinion. His March 1987 medically stationary date was a mere prediction of claimant's future status rather than an assessment of her current condition. We also disagree with the Referee's basis for discounting Dr. Helms' opinion. The record indicates that Dr. Helms has treated claimant at least once every two weeks since late 1985. This fact indicates that he examined claimant on at least two occasions in March 1987. Nevertheless, we discount his opinion because he provides no support for his contention that claimant was not medically stationary at the time of Dr. Fechtel's examination.

We, instead, rely on Dr. Fechtel's finding that claimant was medically stationary when he examined her on June 9, 1987. We defer to this medically stationary date because it is based on Dr. Fechtel's assessment of claimant's current condition, rather than a prediction of claimant's status at some future point in time. We, therefore, conclude that the September 1987 Determination Order correctly awarded temporary disability compensation through June 9, 1987. Accordingly, we adopt the Referee's ultimate ruling affirming that Determination Order and approving an offset of temporary total disability paid after that date.

Extent of Permanent Disability

The Referee assumed that, at the time of hearing, claimant had received a total of 10 percent unscheduled permanent disability for her January 1985 injury. After reviewing the relevant evidence, the Referee concluded that a 10 percent award adequately compensated clamant for her lost earning capacity from that injury. Accordingly, she declined to award additional scheduled disability.

On review, claimant contends that she has sustained greater lost earning capacity than the 10 percent identified by the Referee. The insurer responds with the argument that claimant has received a total of 20 percent unscheduled disability for her injury, rather than the 10 percent assumed by the Referee. The insurer further argues that the current award of 20 percent adequately compensates claimant for her lost earning capacity.

We first determine the extent of claimant's lost earning capacity. The Referee's 10 percent disability rating was based, in part, on her finding that claimant was limited to medium work. However, the medical experts identified minimal to mild impairment and a 20 pound lifting limitation. We, therefore, conclude that

claimant is limited to light or sedentary work and has sustained a mild degree of physical impairment as a result of her compensable injury. We also consider the relevant social and vocational factors identified in OAR 436-30-380, et seq. Claimant was 39-years old at the time of hearing, with a high school education and one term of business courses at a community college. She has work experience in restaurant management, bookkeeping, loan administration and office management. She has significant transferable skills for light and sedentary employment as a result of her college courses and work experience. After considering these factors and claimant's mild physical impairment, we conclude that an award of 20 percent unscheduled permanent disability would adequately compensate her for her lost earning capacity.

To date, claimant has received the following unscheduled permanent disability awards: 10 percent by Determination Order issued September 9, 1985; 5 percent by Determination Order issued November 10, 1986; and 5 percent by Determination Order issued September 22, 1987. When the initial September 1985 Determination Order issued, the insurer was processing claimant's January 1985 injury as an aggravation of an earlier injury in October 1983. As a result, the September 1985 award was credited to the October 1983 injury. Accordingly, the Referee assumed that the award was unrelated to claimant's January 1985 injury. However, a prior Referee subsequently ordered the insurer to process the January 1985 incident as a "new injury," and that order became final as a matter of law. The Evaluations Division, therefore, considered the initial September 1985 award when it awarded additional disability under the November 1986 and September 1987 Determination Orders.

Accordingly, at the time of hearing claimant had received a total award of 20 percent unscheduled permanent disability for her January 1985 injury. As discussed above, we are persuaded that an award of 20 percent adequately compensates claimant for her lost earning capacity as a result of that injury. For this reason, we conclude that the Referee properly declined to award additional permanent disability.

ORDER

The Referee's order dated January 13, 1988 is affirmed.

DUANE E. WALDRON, Claimant
David Smith (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 87-03073 & 86-13248
June 16, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant, pro se, requests review of Referee Leahy's order which: (1) upheld EBI Companies' denial of claimant's "new injury" claim for a low back and neck condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for his low back condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury to his low back in January 1981 while working for SAIF's insured. The injury was diagnosed as a mild lumbosacral strain. The claim was first closed by a Determination Order, dated May 11, 1981, which awarded claimant temporary disability benefits from January 29, 1981 through April 22, 1981.

In May 1982, a Referee issued an order, which denied reopening of claimant's claim on an aggravation basis, as well as affirming the Determination Order in its entirety. This order was affirmed by the Board in a March 1983 order.

Between May 1982 and February 1986, claimant continued to be treated for chronic back pain. Claimant requested a reopening of his claim in 1985 and the matter went to hearing in January 1986. In February 1986, a Referee issued an order upholding SAIF's aggravation denials of May and December 1985.

In September 1986, claimant filed a claim with EBI Companies' insured, alleging an on-the-job injury occurring in August 1986. EBI denied compensability and responsibility of the claim on the basis that no injury had occurred. Shortly thereafter, SAIF issued a denial of responsibility for claimant's aggravation claim on the basis that a "new injury" had occurred.

In October 1986, SAIF rescinded its aggravation denial as claimant's aggravation rights had expired in May of 1986 and suggested Own Motion processing. Claimant entered into a stipulation in December 1986 in which he acknowledged that after expiration of his aggravation rights, his relief was by Own Motion petition to the Board.

In February 1987, claimant's complaints were of neck and back pain.

FINDINGS OF ULTIMATE FACT

We are not persuaded that claimant was injured by slipping down a feeder belt at work on August 6, 1986.

We are not persuaded that claimant's compensable 1981 injury was worsened in August 1986.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had neither sustained an aggravation of his low back condition, nor a "new injury" to his back and neck. We agree.

The Referee found claimant was neither a credible nor a convincing witness. Inasmuch as claimant's testimony is riddled with inconsistencies, we agree with the Referee's finding that claimant is not credible. See Coastal Farm Supply v. Hultberg, 84 Or App 382 (1987).

In addition to claimant's lack of credibility, the medical evidence does not establish that either an aggravation or a "new injury" occurred. Dr. Hardiman, who treated claimant in February 1987, felt that he had nothing to offer claimant from a treatment standpoint. He noted a history of lumbar and cervical complaints which he felt was difficult to associate with claimant's present problem. Dr. Brown, who was relying on claimant's history alone, could not confirm either an aggravation or a new injury. Further, Dr. Mandiberg opines that claimant needed only minimal treatment and no medication as he felt that claimant would tend to fixate on his problem. Dr. Mandiberg, however, did feel that claimant had a lumbar strain, based on claimant's description of the August 1986 incident.

We note parenthetically that these opinions, particularly Dr. Mandiberg's, were offered under the assumption that claimant had sustained an injury in August 1986. As we have found to the contrary, the opinions are unpersuasive to the extent that the physicians relied on claimant's history. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Given claimant's lack of credibility, as well as the medical evidence, based on claimant's inaccurate histories, we conclude that claimant has not sustained his burden of establishing that his condition resulting from his 1981 injury with SAIF has worsened or that he sustained an injury while working for EBI's insured. Accordingly, claimant has neither proven an aggravation or a "new injury". As we have found the claims not compensable, the responsibility issue is moot.

ORDER

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

TIMOTHY DUGAN, Claimant
Malagon, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 88-0411M
June 12, 1989
Order Denying Request for Penalties and Attorney Fees

Claimant's attorney has requested that the Board grant a penalty and attorney fee for SAIF Corporation's failure to timely pay his attorney fee. The Board's August 11, 1988 Own Motion Order allowed a fee equal to 25 percent of the increased compensation, not to exceed $500. SAIF timely paid $125, but did not pay the remaining $375 until February 1989, after receipt of the attorney's request for penalties and fees.

SAIF has provided a reasonable explanation for its underpayment of attorney fees. Its initial failure to pay the entire fee was due to a clerical error. The attorney's request for a penalty and fee was SAIF's first notice of the underpayment. SAIF promptly paid the outstanding fee after receiving this notice. We are persuaded that SAIF would have immediately corrected its clerical error if the attorney had contacted SAIF before raising the issue with the Board. Under these circumstances, SAIF's initial underpayment was not unreasonable. Accordingly, we deny claimant's request for a penalty and attorney fee.

IT IS SO ORDERED.

LETA A. BASS, Claimant
Charles D. Maier, Claimant's Attorney
Rick Dawson (SAIF), Defense Attorney

WCB 86-14404
June 19, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of those portions of Referee Holtan's order that: (1) set aside its denial of claimant's aggravation claim relating to her compensable neck and right shoulder injury; and (2) directed it to pay temporary total disability until the claim was closed pursuant to law. On review, SAIF contends that the claim is not compensable and, in any event, claimant is not entitled to temporary disability compensation

because she left her employment for reasons unrelated to her injury. An alternative issue at hearing involved extent of permanent disability as awarded by a March 1986 Determination Order. This issue was rendered moot pursuant to the Referee's decision with regard to the aggravation claim. We affirm.

ISSUES

1. Aggravation.

2. Temporary Disability.

FINDINGS OF FACT

Claimant, a psychiatric aide, injured her neck and right shoulder in July 1985 while lifting a patient. Dr. Burr, orthopedist, became her treating physician. He treated her conservatively for a cervical and right shoulder strain. She was off work approximately eight months.

On February 11, 1986, Dr. Burr reported that claimant could return to modified work with no heavy lifting.

A March 27, 1986 Determination Order awarded claimant 15 percent unscheduled permanent partial disability. At the time, claimant's symptoms included a constant burning sensation in the neck area as well as an intermittent stabbing pain.

Claimant returned to light-duty work on March 31, 1986. She was then off work commencing April 15, 1986 due to an unrelated bronchitis condition. She returned to work on June 5, 1986 pursuant to a light-work release from Dr. Burr. On June 26, 1986, she returned to regular work pursuant to a full work release from Dr. Burr. She quit her employment one month later, on July 23, 1986, due to a combination of reasons including increased neck and shoulder symptoms, as well as non-injury related reasons. She subsequently filed her aggravation claim.

Claimant began treating with Dr. Warner, chiropractor, shortly after leaving her employment. He released her from work for more than 14 days effective July 30, 1987.

Claimant was 35 years old at the time of hearing. She has a tenth grade education. In addition to her work as a psychiatric aide, she also has experience working in a nursing home and as a waitress. She experiences recurring stabbing, burning pain in her neck. She also experiences headaches and pain and muscle spasm in her lower back with bending, standing and sitting or walking too long. These low back symptoms are unrelated to her compensable injury.

FINDINGS OF ULTIMATE FACT

Claimant experienced a worsening of her compensable neck and right shoulder symptoms following the March 1986 Determination Order rendering her more disabled than she had previously been.

Claimant has not withdrawn from the workforce.

Aggravation

In order to establish an aggravation claim, claimant must show "worsened conditions resulting from the original injury." ORS 656.273. In addition, claimant must establish that, as a result of such worsening, she is more disabled, meaning less able to work, either temporarily or permanently, then she was at the time of the last award or arrangement of compensation. Smith v. SAIF, 302 Or 396, 399 (1986). "Worsened conditions" may take the form of either a worsening of the underlying condition or a symptomatic worsening. Smith, supra.

Preliminarily, we note that claimant currently experiences low back symptoms which she was not experiencing prior to the last award of compensation. Both her own testimony and that of her husband suggests that these low back symptoms represent a significant portion of her current complaints. However, there is no medical evidence in the record as to the cause of this low back pain. We conclude that claimant has failed to establish a causal relationship between her low back complaints and her compensable injury. Consequently, we do not consider the low back complaints in determining whether claimant has established worsened conditions of her compensable injury.

Having so concluded, we now examine the medical evidence to determine whether claimant's underlying condition has worsened pathologically since the last award of compensation. Dr. Warner opined in this regard that claimant had indeed suffered a worsening of her underlying condition. He cited a number of objective findings in support of his conclusion, but he did not compare those findings with any pre-closure findings. Moreover, Dr. Warner began treating claimant subsequent to her alleged exacerbation. By contrast, Dr. Burr treated claimant both before and after she left work in July 1986. The Referee found that Dr. Burr was in the best position to judge claimant's medical condition. We agree.

Dr. Burr reported no worsening of the underlying condition. Rather, he reported that claimant's condition did not differ greatly from her condition reported after the Orthopaedic Consultant's examination in January 1986. We are persuaded by his opinion on this question. We conclude that claimant has not proven a pathological worsening of her underlying compensable condition since the March 1986 Determination Order.

Claimant can nevertheless prevail upon a showing of a symptomatic worsening. In this regard, subsequent to the Referee's order, the Court issued its decision in Gwynn v. SAIF, 304 Or 345 (1987). In Gwynn, the Court held that if a worsening involves a symptomatic flareup, and if the prior award contemplated symptomatic flareups, then the fact finder must determine whether the flareup was greater than that contemplated at the time of the last arrangement of compensation. Id. at 352-53. However, if a worsening is established, and if, as a result of that worsening, claimant is off work for more than 14 days, then claimant has proven an aggravation regardless of what is contemplated by the prior award. Perry v. SAIF, 307 Or 654 (1989).

Here, the last award of compensation was the March 27, 1987 Determination Order awarding claimant 15 percent unscheduled

permanent partial disability. Subsequent to that date, Dr. Warner released claimant from work for well over 14 days. Therefore, if claimant has proven that Dr. Warner's release from work resulted from an actual worsening of her compensable condition, then she has established entitlement to a reopening of her claim. Ybarra v. Castle & Cooke, Inc., 96 Or App 665 (May 24, 1989). We must therefore determine as a factual matter whether claimant has established a worsening of her condition since March 27, 1987. The Referee concluded that claimant had, in fact, suffered a temporary worsening of her symptoms such that she was more disabled than at the time of her prior Determination Order. We agree.

Again, we find the opinion of Dr. Burr persuasive on this issue. He reported, in response to a letter from SAIF's legal counsel, that claimant had experienced worsened symptoms in the fall of 1986. Moreover, this conclusion is supported by claimant's testimony that she suffered increased burning pain and more limited range of motion in her neck. In addition, her right shoulder pain and ability to raise her right arm became worse at the time of aggravation. The Referee found claimant to be credible; we find no reason to reject the Referee's conclusion. In sum, we find that claimant has established the requisite elements of a compensable aggravation claim.

Temporary Disability Compensation

The insurer contends that, even if claimant has suffered a compensensable aggravation, she is not entitled to payment of additional temporary disability benefits. The insurer reasons that claimant voluntarily left the workforce and, therefore, pursuant to the Court's decision in Cutright v. Weyerhaeuser, 299 Or 295 (1985), her right to temporary benefits has terminated. The Referee did not agree that claimant had withdrawn from the workforce. Neither do we.

Claimant credibly testified that she would like to work if she could find work within her physical limitations. See Chapel of Memories v. Davis, 91 Or App 232, rev den 306 Or 413 (1988). Moreover, we have previously found that her neck and shoulder condition worsened, supporting an inference that she was physically unable to continue her employment as of July 1986. Further support for this conclusion is found in Dr. Burr's October 28, 1986 report wherein he states that, at the time of her work release, he felt that claimant's condition required limitations on her lifting, pushing and pulling activities in order "to keep her on the work force." However, the evidence is uncontroverted that claimant returned to full, unrestricted job duties in June 1986, and that these job duties worsened her symptoms. We conclude that claimant has not withdrawn from the work force.

ORDER

The Referee's order dated February 11, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $600, to be paid by the SAIF Corporation

GORDON D. GARRETT, Claimant
Velure & Yates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-11631
June 19, 1989
Order Denying Request

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 23, 1989 Order on Review. The request is denied.

FINDINGS

On June 8, 1987, claimant requested Board review of a Referee's order. On August 27, 1987, claimant filed his appellant's brief. On September 24, 1987, the employer submitted its respondent's brief. This was the last brief filed.

On February 11, 1988, the administrator for the Board notified all practitioners with cases currently pending review that executed retainer agreements and statement of services would be required in all cases that involved the approval of an assessed, client-paid, or extraordinary fee. The practitioners were further advised that where the last brief in a case presently pending review had been filed more than 15 days from the date of the administrator's letter, the statement of services was due within 15 days.

On February 23, 1989, the Board issued its Order on Review. The order did not address the issue of a client-paid fee. This order has not been appealed, abated, stayed, or republished.

On June 6, 1989, the employer's counsel submitted a copy of an executed retainer agreement and statement of services. The Board received these materials on June 7, 1989.

CONCLUSIONS

When our order on the merits has become final by operation of law and has neither addressed the issue of the counsel's entitlement to, nor the amount of, an attorney fee, we have jurisdiction to consider a request for authorization of a client-paid fee. Jane E. Stanley, 40 Van Natta 831 (1988). However, when the request has been untimely submitted and our order on the merits has become final, we decline to authorize such requests for authorization. id. For those cases where the last brief was submitted prior to the effective date of our rules concerning the filing of statement of services, we have authorized fee requests that have been submitted within 15 days of the Administrator's February 11, 1988 directive. Harry N. Hunsley, 40 Van Natta 972 (1988).

Here, our February 23, 1989 order has not been appealed, abated, stayed, or republished. Therefore, the order has become final by operation of law. Yet, since the order did not address the issue of either the employer's counsel's entitlement to, or the amount of, a client-paid fee, we retain jurisdiction to consider the request for authorization of a client-paid fee. Consequently, we turn to our rules to determine whether the request was timely submitted.

A client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services and executed retainer agreement. OAR

438-15-010(1), (5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d), (Amended and renumbered OAR 438-15-028(1)(d), WCB Admin. Order 2-1989). These rules applied to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

Here, the employer's counsel has submitted a copy of an unsigned statement of services that indicates that it was mailed "5/4." In addition, counsel has included a February 24, 1989 letter to the Board, noting that a copy of a May 5, 1988 statement of services was enclosed. The Board has no record of receiving either of these submissions until June 7, 1989. Even assuming that the May 5, 1988 and February 24, 1989 submissions were received by the Board, each of the submissions were untimely under our rules, which applied to all cases pending before the Board on January 1, 1988. Even the earliest submission of May 5, 1988 exceeded the deadline provided in the Administrator's February 11, 1988 directive. See Hunsley, supra.

Had either the May 5, 1988 or February 24, 1989 submissions been received while we retained jurisdiction over the merits of the case, every effort would have been made to promptly process the requests. However, as discussed above, the aforementioned submissions were not received and the 30-day appeal period to further consider the merits of the case elapsed without Board action.

Inasmuch as the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and because our order on the merits of the case has become final by operation of law, we decline to authorize the employer's counsel's request. In reaching this conclusion, we wish to stress that we are neither questioning the employer's counsel's entitlement to, nor the amount of, a requested client-paid fee. We are only stating that, for the reasons discussed above, we are unable to approve the request.

IT IS SO ORDERED.

VIRGINIA J. BROWN, Claimant
Jack Ofelt, Claimant's Attorney
Meyer & Associates, Defense Attorneys

WCB 86-07243
June 21, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Menashe's order that awarded 10 percent (32 degrees) unscheduled permanent disability for a low back injury. The self-insured employer cross-requests review of the Referee's permanent partial disability award. The employer also cross-requests review of that portion of the order that set aside its denial of claimant's aggravation claim and awarded an assessed fee for prevailing on that issue.

On review, the issues are aggravation, attorney fees and extent of permanent partial disability.

We affirm the order of the Referee as supplemented below.

FINDINGS OF FACT

We adopt the Referee's findings of fact and make the following additional findings.

Claimant had a history of back problems and associated treatment prior to her compensable injury in November 1982. A CT scan performed shortly after her compensable injury demonstrated some degree of preexisting degenerative joint disease involving the lateral recess at the L4-5 level of the lumbar spine. (Ex. 40) It is not clear from the record whether claimant's injury permanently worsened her preexisting degenerative condition. (Ex. 43, 59).

X-rays taken in December 1983 demonstrated a small arthritic spur at the L5 level. Claimant's November 1982 injury did not materially contribute to the onset or worsening of her osteoarthritis.

Claimant's injury claim was reclosed after the November 1983 aggravation by a Determination Order issued on April 26, 1984. At that time, claimant had full lumbar range of motion and no disabling low back pain. As a precaution against future injury, she was restricted to medium level work defined as lifting frequently up to 25 pounds and occasionally over 25 pounds. This limitation was the result of the combined effect of her injury-related chronic strain and degenerative joint disease and osteoarthritis. (Ex. 49, 59)

Claimant's current low back and right leg symptoms are worse than they were in April 1984, and she is less able to do housework, cooking and other physical tasks than she was at that time. She is currently restricted to frequent lifting up to 10 pounds, occasional lifting up to 20 pounds, and no repetitive lifting, bending or squatting. Her current permanent impairment is the result of the combined effect of her injury-related chronic low back strain and underlying degenerative joint disease and osteoarthritis. (Ex. 31-18).

ULTIMATE FINDINGS OF FACT

We adopt the Referee's ultimate findings of fact and make the following additional findings.

Claimant was less able to work at the time of her symptomatic exacerbation in March 1986 than she was at the time of the April 1984 Determination Order.

Her decreased ability to work was attributable to chronic lumbar strain, superimposed on preexisting degenerative joint disease and osteoarthritis. Her November 1982 injury remained a material contributing factor of her chronic lumbar strain.

As a result of her March 1986 exacerbation, claimant is permanently less able to work than she was at the time of the April 1984 Determination Order. Her injury-related chronic strain materially contributes to her increased impairment.

CONCLUSIONS OF LAW AND OPINION

We affirm the Referee's order in its entirety.

Claimant is entitled to an assessed fee on Board review for prevailing against the insurer's cross-request on the aggravation issue. That issue would not have been before the Board absent the insurer's cross-request. ORS 656.382(2); former

OAR 438-15-070; Alfred Adent, 40 Van Natta 1677, 1819 (1988). Claimant is not entitled to an assessed fee on the extent issue, which was otherwise before the Board because of claimant's request for review seeking additional permanent partial disability. Id.

ORDER

The Referee's order dated March 6, 1987 is affirmed. Claimant's attorney is awarded a reasonaable assessed fee of $750 for prevailing against the insurer's cross-request on the aggravation issue.

CALVIN D. EDGAR, Claimant
Hayner, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 88-12979
June 21, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Bennett's order that affirmed a Determination Order that did not award unscheduled permanent disability for a low back injury. On review, claimant contends that he has suffered permanent impairment as a result of his compensable back injury and is entitled to an award of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant was 34 years of age at hearing. In January 1987 he suffered low back pain while pulling on a log choker. His condition was diagnosed as a lumbar sprain.

After three days, claimant returned to work, wearing a back support. However, because of increasing pain, he was released from work shortly thereafter. He again returned to work in April 1987, performing light duty activities. In July 1987, when those light duty jobs were no longer available, claimant stopped working for the employer.

Since his departure from the aforementioned employment, claimant has worked on a fishing boat. He worked for approximately nine weeks, performing "dragging" and "shrimping" duties. When he was informed by his employer that he would be required to perform the more physical task of "icing", claimant stopped working.

In April 1988 a closing examination was performed by the Western Medical Consultants. Range of motion findings were normal and were performed pain-free. Orthopedic and neurologic studies were likewise normal.

A July 6, 1988 Determination Order awarded approximately 10 days of temporary total disability and some four months of temporary partial disability. No permanent disability was awarded.

Claimant has a GED. He has taken vocational classes in painting, but has not received a certificate of completion. In addition to working as a choker setter and deckhand, claimant has been employed as a timber faller and rigger, as well as an engineer and hook tender on a fishing boat.

Claimant experiences a "slack feeling in [his] lower back," which is accompanied by some discomfort which varies with

his activities. He does not suffer disabling pain nor has he sustained permanent impairment as a result of his compensable low back injury.

CONCLUSIONS OF LAW

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of the July 6, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. id.

The Referee concluded that claimant was not entitled to a permanent disability award under the disability standards. In addition, the Referee held that claimant had not established by clear and convincing evidence that his degree of permanent disability was more than what the standards would indicate. Consequently, the Referee affirmed the Determination Order. We agree.

In determining whether claimant has sustained permanent impairment as a result of his compensable injury, we have considered his testimony concerning his complaints of pain, as well as the medical evidence. In so doing, we note that disabling pain can result in a loss of use or function and, when it does, it is rated based on the loss of use or function which results, and no additional value is allowed for the pain alone. Former OAR 436-35-320(1)(a). We further note that the former disability standards, which are applicable to this case, do not incorporate all the disabling effects attributable to pain within the impairment ratings for each specific body part. See Daniel M. Alire, 41 Van Natta 752 (April 6, 1989).

Here, claimant credibly testified that he experiences a "slack feeling in [his] lower back." He also complained of pain, which is "not constant", but rather, "annoying and disruptive." Claimant believed that these complaints limit him to activities with lifting requirements that do not exceed 50 pounds. His treating chiropractor, Dr. Soard, agreed that claimant should restrict his activities to jobs requiring less physical demands.

We do not find claimant's description of his limitations nor Dr. Soard's opinion persuasive when compared with the findings and report authored by the Western Medical Consultants. To begin, despite his subjective complaints, claimant conceded that, after leaving his at-injury employer, he was able to work for approximately nine weeks as a commercial fisherman, until he was informed that he would have to perform a job that he believed he could not tolerate. He also conceded that he had experienced no discomfort during the Western Medical Consultants' examination, although he attributed that finding to the Consultants' brief series of non-repetitive exercises. Claimant further admitted that he could have told the Consultants that he could probably return to work performing "his old job" as a choker setter.

Dr. Soard acknowledged that there was no need for further radiological studies. Yet, apparently based on claimant's subjective complaints, Dr. Soard recommended, in a conclusory manner, that claimant limit his employment activities to those requiring less physical demands.

Unlike Dr. Soard, the Consultants provided a detailed summary of their findings and explanations for their conclusions. Characterizing claimant's symptoms as scant and his functional capacity as excellent, the Consultants evaluated claimant's findings as normal without evidence of orthopedic or neurologic impairment. Consequently, they concluded that claimant could return to his previous employment, without limitations.

After considering the medical and lay evidence, we conclude that, since the range of motion findings concerning claimant's back were normal, there is no entitlement to an award of permanent disability under OAR 436-35-360. Furthermore, the record does not establish that the pain claimant described has resulted in any loss of use or function of his back. Therefore, we are not persuaded that the pain is disabling. See former OAR 436-35-320(1)(a). Accordingly, claimant is not entitled to an award under the disability standards.

Neither party is prevented or limited from establishing by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the Director under ORS 656.726. See ORS 656.283(7); 656.295(5). To be "clear and convincing," evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 402 (1987).

Here, claimant argues that his credible testimony concerning his back pain and physical limitations constitutes "clear and convincing" evidence that his permanent disability award under the standards is inadequate. See ORS 656.295(5). We disagree. Claimant's contentions are based on disabling pain and his 50 pound lifting restriction. We have previously concluded that claimant does not suffer disabling pain and that he is able to perform his former work activities without any limitation or restriction. Consequently, it follows that such evidence is insufficient to establish that it is "highly probable" that the award is inadequate.

ORDER

The Referee's order dated September 27, 1988 is affirmed.

WENDELL M. DELORME, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-06974 & 85-03372
June 23, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of that portion of Referee Smith's order that set aside its denial of claimant's occupational disease claim for a cervical condition. Because he found that the cervical condition was not medically stationary, the Referee declined to address claimant's challenge of a Determination Order that awarded 30 percent (96 degrees) unscheduled permanent disability for the low back and 5 percent (7.5 degrees) scheduled permanent disability for loss of use of the right leg. We affirm.

ISSUES

1. Compensability of claimant's cervical condition.

2. If compensable, then whether the Referee properly assigned responsibility for that condition to the insurer.

3. If not compensable, then extent of claimant's low back permanent disability.

FINDINGS OF FACT

Claimant, 57 years of age at hearing, has worked for most of his adult life as a truck driver. Prior to his employment with the insured, Muchmore Trucking, claimant was employed by Interstate Trucking. On February 17, 1983, while employed by Interstate, he suffered a compensable injury to his back diagnosed as a low back sprain. He filed a workers' compensation claim for a strained back. Treatment resulting from the February 1983 injury was conservative in nature.

Claimant had previously undergone two surgeries to his low back, including a fusion from L4 to the sacrum. One of these surgeries had resulted from an out-of-state work injury which culminated in a permanent disability award in an unknown amount.

In October 1983, claimant began treating with Dr. Overvold, chiropractor, for neck pain and headaches.

In February 1984, claimant commenced work for Muchmore. Claimant's job duties required that he periodically perform extensive bending and lifting activities while loading and unloading his truck. On April 24, 1984, these activities resulted in acute low back pain and stiffness. Claimant filed a claim for a lower back strain on April 27, 1984. The claim was accepted.

Claimant was taken off work by Dr. Overvold for several months. He returned to work with Muchmore in August 1984 and continued to work through November 1984. He continued to treat with Dr. Overvold through the remainder of 1984. Other than a brief note of cervical tension in a June 9, 1984 chart note and upper back tightness noted in an October 8, 1984 chart note, claimant's symptoms were confined to his lower back and legs.

Claimant last worked for Muchmore in November 1984. He then commenced work with a California trucking company in December 1984. He worked for that California company into April 1985. During the first few months of 1985, claimant was able to function reasonably well. However, in the spring of 1985, claimant experienced a recurrence of his low back symptoms and neck pain. Dr. Overvold took claimant off work as of April 27, 1985. Claimant had not returned to any work as of the date of hearing.

A July 8, 1985 Determination Order awarded claimant 25 percent unscheduled disability for the April 24, 1984 injury to his low back and a related award of 5 percent scheduled disability for loss of use of the right leg.

Claimant's neck symptoms progressively worsened during late 1985 and early 1986. He also continued to experience low back symptoms.

On March 18, 1986, claimant was examined by Dr. Berkeley, neurosurgeon, who recommended that claimant undergo a complete myelogram. The myelogram was performed on March 31, 1986, and

disclosed pathology of the lumbar spine as well as cervical osteoarthritis. Dr. Berkeley requested authorization to perform lumbar surgery first because claimant's symptoms were more severe in the lumbar region. However, he also proposed an anterior cervical discectomy and fusion at a later date.

Dr. Berkeley was granted authorization for the lumbar surgery and, on July 2, 1986, he performed such surgery.

A Determination Order issued July 9, 1987, awarding claimant a five percent increase in the low back disability award, for a total of 30 percent unscheduled permanent disability.

On August 7, 1986, the insurer for Interstate Trucking denied both the requested cervical surgery as well as compensability of the cervical osteoarthritis condition on the basis that the condition and/or need for surgery were not related to the February 17, 1983 injury. Claimant requested a hearing on the denial.

On January 21, 1987, the insurer for Muchmore Trucking also issued a denial on the grounds, inter alia, that claimant's cervical condition was not related to the accepted April 14, 1984 injury.

On January 23, 1987, claimant submitted an occupational disease claim to the insurer for Muchmore alleging that "[his] cervical area has become gradually more painful over the last several years due to the strain of [his] work as a truck driver."

On February 4, 1987, a disputed claims settlement was approved whereby claimant's request for hearing on Interstate's August 7, 1986 denial of claimant's cervical condition was dismissed with prejudice.

Claimant's occupational disease claim with Muchmore was denied by the insurer by letter dated February 26, 1987.

FINDINGS OF ULTIMATE FACT

Claimant's neck symptoms are caused by a degenerative osteoarthritis disease which preexisted his employment with Muchmore Trucking. We find that claimant's work activities, including those while employed by Muchmore Trucking, were the major cause of a worsening of that underlying degenerative disease.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant challenged both the insurer's January 21, 1987 denial and the February 26, 1987 denial. The Referee upheld the January denial on the basis that claimant failed to establish that his April 1984 injury while employed by Muchmore materially contributed to his neck problems. However, the Referee set aside the February denial on the basis that claimant had proven a compensable occupational disease. Moreover, citing Progress Quarries v. Vaandering, 80 Or App 160 (1986), the Referee concluded that Muchmore was responsible for the cervical condition. The insurer sought Board review of this latter determination. The insurer contends that, even if claimant's cervical condition is compensable, responsibility for that condition rests with either Interstate Trucking or the California trucking company for which claimant worked following his employment with Muchmore.

We must, therefore, first determine whether claimant has established a compensable occupational disease. If so, we must then

address whether responsibility for that condition was properly assigned to Muchmore Trucking. In order to establish a compensable occupational disease, claimant must prove that his work exposure was the major contributing cause of a worsening of his preexisting cervical osteoarthritic disease. Former ORS 656.802(1)(a); Devereaux v. North Pacific Ins. Co., 74 Or App 388, 391 (1985). A worsening of symptoms alone is not compensable. Rather, "worsening" in this 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).

However, it is not necessary that claimant prove that his employment with Muchmore in particular worsened his underlying degenerative disease. Because claimant has worked for several employers whose conditions of employment were capable of worsening his degenerative disease, it is sufficient for claimant to prove that his work activities in general resulted in the requisite worsening. Runft v. SAIF, 303 Or 493, 500 (1987). In this regard, the Referee found that Dr. Berkeley's opinions persuasively established that claimant's years as a truck driver were the major contributing cause of a worsening of his cervical disease. We agree. We adopt the Referee's discussion of this issue found on page 6 of his order.

In the alternative to its compensability argument, the insurer contends that the Referee improperly assigned to it responsibility for claimant's cervical condition. The insurer argues in this regard that the Referee should not have relied upon Progress Quarries v. Vaandering, 80 Or App 160 (1986), as authority for excluding consideration of claimant's California employment. The insurer asserts that claimant's California employment independently contributed to claimant's disabling condition. The insurer cites Miville v. SAIF, 76 Or App 603 (1985) and Olson v. EBI Companies, 78 Or App 261 (1986), as support for the proposition that, where a subsequent out-of-state employment has independently contributed to the claimant's disabling condition, and the claimant has not filed a claim in such state, then the Oregon insurer is absolved of responsibility.

If, as the insurer suggests, this case involved an initial compensable injury and subsequent increased disability of the same body part, we would agree with the insurer's reliance upon the court's decision in Miville. However, we have affirmed the Referee's conclusion that claimant did not experience a compensable neck injury while employed by Muchmore. Moreover, the disputed claims settlement entered into between claimant and Interstate Trucking does not establish a prior compensable neck injury. To the contrary, the effect of the disputed claims settlement is to continue the denied status of claimant's neck condition vis-a-vis International Trucking.

In sum, we have found that claimant's neck condition is compensable as an occupational disease under the last injurious exposure rule. Consequently, Progress Quarries v. Vaandering, rather than Miville v. SAIF, is controlling. The Referee's opinion is in accordance with that decision.

ORDER

The Referee's order dated October 27, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $900, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $1,237.50.

RICHARD R. D'OSTROPH, Claimant
Bottini, et al., Claimant's Attorneys
Cooney, Moscato & Crew, Defense Attorneys

WCB 86-18204
June 23, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Neal's order that: (1) declined to award additional temporary disability benefits; (2) declined to assess penalties and related attorney fees for an alleged unreasonable failure to pay temporary disability compensation; (3) upheld the insurer's denial of an aggravation claim; (4) declined to assess penalties and related attorney fees for an alleged unreasonable failure to process the aggravation claim; and (5) awarded 45 percent (67.5 degrees) scheduled permanent disability for loss of use or function of the leg, whereas a Determination Order had awarded 25 percent (37.5 degrees) scheduled permanent disability. We reverse those portions of the Referee's order that: (1) calculated the rate of claimant's temporary disability benefits based on his status as an "on-call" employe; and (2) upheld the insurer's aggravation denial.

ISSUES

1. Computation of temporary disability benefits.

2. Penalty and attorney fee for alleged unreasonable failure to properly calculate the rate of temporary disability benefits.

3. Whether claimant sustained a compensable aggravation claim. If so, whether claimant is entitled to temporary disability benefits for the period of that aggravation.

4. Penalty and attorney fee for alleged unreasonable failure to process the aggravation claim.

5. Extent of scheduled permanent disability benefits.

FINDINGS OF FACT

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

On May 5, 1981, claimant was hired as a full-time driver for the employer. He was required to be regularly available for work from 8 am to 5 pm, Monday through Friday, and he was available for work at those times. However, he was not assigned a fixed route; instead, he was assigned in a relief position to cover other drivers during vacations, holidays and other absenteeism. Between May 9, 1981 and the end of October 1981, he worked 387.71 hours during 26 weeks for a 14.91 hours per week average. This included several weeks when he called each day but did not work. He was paid hourly for his work. The hours per day and reporting and ending times of work varied depending on the employer's changing needs for his services. Claimant worked four days during the week of his accident, totaling 30.75 hours. Two days before his injury, on October 29, 1981, his permanent status was formalized by the employer. During his entire period of employment with the employer, claimant did not look for or engage in other work activities.

On December 7, 1986, the Western Medical Consultants

examined claimant on the insurer's behalf. The Consultants examined x-rays taken in 1984 and did not note any subluxation problems. No giveway symptoms were noted. Following the January 31, 1986 claim closure, claimant's right knee condition worsened. By October 3, 1986, he had chondromalacia of the right patella with lateral subluxation of the right patella. An x-ray examination showed that the patella had a prominent spur at the inferior pole and marked lateral subluxation. During the early part of 1986, claimant experienced increased pain, swelling, and giveway in his right knee. On October 3, 1986, the Western Medical Consultants again examined claimant and advised the insurer of claimant's condition. The Consultants also advised the insurer that claimant was not medically stationary and that further treatment was indicated. The October 3, 1986 letter was not processed as an aggravation claim and there was no acceptance or denial by the insurer.

CONCLUSIONS OF LAW

Computation of Temporary Disability Benefits

The Referee found that claimant was not "regularly employed" and, therefore, concluded that the rate of his temporary disability benefits should be calculated upon his average earnings for the 26 weeks prior to his compensable injury. We disagree and find that claimant was regularly employed.

ORS 656.210(2) provides:

> "For the purpose of this section, the weekly wage a worker shall be ascertained by multiplying the daily wage the worker was receiving at the time of injury:
> (c) By five, if the worker was regularly employed five days a week. As used in this subsection, "regularly employed" means actual employment or availability for such employment." (Emphasis added).

The above emphasized language makes it clear that a worker who is "available" for regular employment, is "regularly employed." See Charles M. Poole, 40 Van Natta 41 (1988).

The distinction between an on-call employe and a regular employe is that, whereas a regular employe must be available as scheduled, whether or not the employer takes advantage of his or her availability, an on-call employe's employment is "sporadic, unscheduled employment on-call by an employer with no right of reprisal if [the] employee is unavailable." Eldon Britt, 31 Van Natta 141, 142 (1981).

In Saiville v. EBI Companies, 81 Or App 469, 472 (1986), the court held that claimant was "regularly employed" within the meaning of ORS 656.210(2) regarding the computation of temporary total disability benefits where he worked 5 of 6 days between the date he was hired and the date on which he was injured, despite the fact that he did not work regular hours for an hourly wage. Id. In Charles M. Poole, supra, claimant was expected to be available to work for 42.5 hours per week, Monday through Friday. Therefore, the Board concluded that his rate of temporary disability benefits should be based on a regular 42.5 hour week. Id. In Eldon Britt, supra, claimant was also expected to be available to work up to 40

hours a week. Accordingly, the Board held that claimant was regularly employed as defined by ORS 656.210.

In the present case, claimant sought employment with the employer. He elected to work in Salem rather than Portland because he was advised that if he worked in Portland he would be on-call, whereas if he worked in Salem he would work more or less steadily since there was a great need for fill-in work. Claimant was hired by the Salem center as a replacement for an injured worker; he was hired as a full-time driver on an 8 to 5 shift, five days a week. Although he was required to be available in case he was needed, he was given no guarantee of work. Claimant was always available and did not attempt to seek other work. Since claimant was expected to be available from 8 am to 5 pm, Monday through Friday, we conclude that claimant was regularly employed within the meaning of ORS 656.210(2) and the rate of his temporary disability benefits should be based on a regular 40 hour week.

Penalty and Attorney Fee for Alleged Unreasonable Failure to properly calculate the rate of temporary disability benefits

The Referee declined to award claimant a penalty or attorney fee since she found that the insurer had correctly calculated the rate of his temporary disability benefits. Although we find that the rate was incorrectly calculated, we conclude that claimant is not entitled to a penalty or attorney fee.

ORS 656.262(10) provides that:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, . . . the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

In the present case, circumstances existed which could reasonably have led the insurer to believe that claimant was an on-call employee and the rate of his temporary disability benefits was not to be calculated on a regular 40 hour week. Therefore, we are unwilling to assess a penalty or attorney fee for unreasonable refusal to pay compensation.

Aggravation

The Referee concluded that claimant did not sustain an aggravation of his right knee condition. We disagree.

To establish a claim for aggravation, claimant has the burden of proving that his condition has worsened since the date of the last arrangement of compensation, and that the worsening was caused in material part by the compensable injury. ORS 656.273; Stepp v. SAIF, 78 Or App 438 (1986). To prove a worsening, claimant need only prove increased symptoms resulting in a greater loss of use of that body part or the need for additional medical treatment. Smith v. SAIF, 302 Or 109, 113-114 (1986).

On December 7, 1985, claimant was examined by the Western Medical Consultants. At that time, claimant was attending college courses without significant difficulty. He had a slight limp with an inability to fully extend the right knee when walking, but he

was able to squat and rise without difficulty. The Consultants opined that claimant had sustained a 25 percent permanent residual disability of the right lower extremity due to the work injury.

On January 31, 1986, claimant's claim was closed by Determination Order with an award of 25 percent scheduled permanent disability. Subsequently, claimant's knee condition worsened. Whereas prior to closure claimant had experienced only occasional swelling in the knee following heavy activity, after closure the swelling became a daily occurrence. The knee pain also increased to the extent that claimant began using a wheelchair on a full-time basis to get from class to class.

On July 21, 1986, Dr. Rusch advised the insurer that claimant's knee pain had aggravated due to his increased activity as a full-time student. He also recommended that claimant's use of a wheelchair on a more permanent basis would be appropriate given his level of complaints.

On October 3, 1986, the Western Medical Consultants examined claimant and informed the insurer that his condition was not medically stationary and noted that claimant's use of a wheelchair represented a very significant degree of disability. They further opined that claimant would benefit from at least an arthroscopic lateral release of the patella with the possibility of a more extensive patella procedure considered.

On November 17, 1986, Dr. Rusch opined that claimant's knee complaints "continue[d] (and perhaps [had] worsened), and may require a surgery in the future."

Based on our de novo review of the medical and lay evidence, we find that claimant's condition did worsen to the extent that he experienced an increase in the loss of use or function of of his right knee following the last arrangement of compensation. Therefore, claimant has proven an aggravation claim.

Penalty and Attorney Fee for Alleged Unreasonable Failure to Process Aggravation Claim

The Referee found that the October 3, 1986 letter from Western Medical Consultants did not constitute a claim for aggravation since it only suggested possible treatment. Therefore, she declined to assess a penalty and attorney fee. We find that the Consultants' report did constitute a claim for aggravation but that the insurer's failure to treat it as such was not unreasonable.

The October 3, 1986 report noted a worsened condition in the form of a marked lateral subluxation of the right patella. It recorded a history provided by claimant of swelling and frequent giveway of the right knee. The Consultants opined that claimant was not medically stationary and recommended at least an arthroscopic lateral release of the patella. Although this letter was sufficient to put the insurer on notice that there was a need for further medical services due to a worsened condition, we conclude that due to the source of the opinion, e.g., an independent medical consultant team, the insurer's failure to process the letter as a claim for aggravation was not unreasonable. Accordingly, claimant is not entitled to a penalty or attorney fee.

Extent of Scheduled Permanent Disability

The record does not support the conclusion that claimant's condition is medically stationary. Since a Determination concerning the extent of his permanent disability would be premature, the Referee's rating is set aside.

ORDER

The Referee's order dated June 18, 1987 is reversed in part. Claimant's temporary disability benefits shall be based on a regular 40-hour-work week. Claimant's attorney is awrded 25 percent of the increased compensation created by this order, not to exceed $3,800. The insurer's denial of claimant's aggravation claim is set aside. The claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning the aggravation issue, claimant's attorney is awarded a reasonable assessed fee of $1,750, to be paid by the insurer. The Referee's determination of the extent of claimant's permanent disability is set aside as premature. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $100.

RONALD L. MARSH, Claimant
Roll, et al., Claimant's Attorneys
Roy Miller (SAIF), Defense Attorney

WCB 86-09970
June 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Podnar's order which: (1) upheld the SAIF Corporation's partial denial of claimant's bilateral carpal tunnel syndrome; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable denial. On review, the issues are compensability and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back in January 1968. He underwent several surgeries to the low back and began to experience loss of stability in the legs which caused him to begin using crutches in 1971. He was found to be permanently and totally disabled by a May 1983 Referee's order.

In 1984, claimant began experiencing numbness, pain and tingling in his left hand and forearm. These symptoms eventually appeared in his right hand and forearm. In September 1985 claimant was seen by Dr. Tremaine, orthopedist, who diagnosed flexor and extensor tendinitis with possible median nerve compression and possible tardy ulnar nerve palsy. Claimant was also seen by Dr. Wilson, neurologist, who diagnosed early bilateral carpal tunnel syndrome as well as early polyneuropathy.

In June 1986, SAIF denied claimant's bilateral carpal tunnel syndrome on the basis that the condition was not related to his 1968 industrial injury.

Claimant has used crutches on a daily basis since 1971. The crutches are commonly referred to as "Canadian Crutches" and do not go up to the armpit, but rather have a wraparound on the forearm and a handle upon which one places his weight. Claimant

has attempted to use "Platform Crutches", but found them to be overbalanced which caused him to fall occasionally. He has discontinued use of "Platform Crutches."

FINDINGS OF ULTIMATE FACT

Claimant's use of crutches, as a result of his compensable injury, is not a material contributing factor of his bilateral carpal tunnel syndrome.

SAIF's denial of claimant's bilateral carpal tunnel syndrome was not unreasonable.

CONCLUSIONS OF LAW

The Referee concluded that claimant's use of crutches, as a result of his compensable injury, was not causally related to his bilateral carpal tunnel syndrome. We agree.

To establish compensability of his bilateral carpal tunnel syndrome, claimant must show, by a preponderance of the evidence, that his use of crutches, as a result of his compensable injury, was a material contributing cause of the condition. Grable v. Weyerhaeuser, 291 Or 387 (1981). The issue of whether claimant's bilateral carpal tunnel syndrome is causally related to his use of crutches is a complex medical question. Thus, although claimant's testimony is probative, the resolution of the issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Tremaine, claimant's treating physician, opines that claimant's use of crutches is causally related to his bilateral carpal tunnel syndrome. He initially diagnosed claimant's problem as tendinitis and median nerve compression. Subsequently, he diagnosed epicondylitis, secondary to crutch use. Dr. Tremaine then diagnosed polyneuropathy and felt it was the causal factor of claimant's condition. Finally, Dr. Tremaine opined that claimant's condition was directly related to crutch usage, which was related to the industrial injury. Therefore, he felt SAIF should be responsible. Given Dr. Tremaine's inconsistent positions, both as to diagnosis and causal relationship, we are not persuaded by his most recent opinion. Moreover, we consider the opinion to be both conclusory and unaccompanied by medical analysis. Moe v. Ceiling Systems, 44 Or App 429 (1980).

We are likewise not persuaded by Dr. Wilson's opinion that claimant's crutch usage was the likely cause of his condition. We consider his opinion also to be conclusory and lacking in medical analysis. Moe, supra.

We are instead persuaded by the well-reasoned opinions of Drs. Button, Nye, and Borman who find no causal relationship between claimant's crutch usage and the bilateral carpal tunnel syndrome. Both Drs. Button and Nye describe claimant's bilateral carpal tunnel syndrome as idiopathic in nature and note that extended crutch usage would not lead to the development of bilateral carpal tunnel syndrome. We find their well-reasoned opinions persuasive. Somers v. SAIF, 77 Or App 259 (1986). Consequently, we conclude that claimant has not established that his crutch usage is causally related to his bilateral carpal tunnel syndrome.

In light of the conflicting medical opinion as to causation of claimant's condition, as well as Dr. Tremaine's inconsistency in this regard, we do not find SAIF's denial to be unreasonable. Accordingly, penalties and related attorney fees are not warranted.

ORDER

The Referee's order dated September 28, 1987 is affirmed.

JOHN A. PHARISS, Claimant
Coons & Cole, Claimant's Attorneys
David Force, Associate Attorney
Ray Heysell, Defense Attorney
Kevin Mannix, Defense Attorney

WCB 87-10729 & 87-07043
June 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Industrial Indemnity requests review of those portions of Referee Melum's order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld Farmers Insurance Companies' denial of claimant's "new injury" claim for the same condition. On review, the sole issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the "Findings" section of the Referee's order with the following correction.

The first sentence of "Finding (4)" should read November 1983 rather than October 1987.

FINDINGS OF ULTIMATE FACT

Claimant's work activities at Farmers' insured did not independently contribute to a worsening of his underlying back condition.

CONCLUSIONS OF LAW

We adopt the conclusions and reasoning set forth in the "Opinion" section of the Referee's order with the following comment.

The Referee concluded that Industrial Indemnity, as the first insurer, had the burden of going forward to prove independent contribution by the second insurer, Farmers. The Referee relied on Eva Doner (Staley), 38 Van Natta 1289 (1986). Since the Referee's order, we have disavowed Doner (Staley). Relying upon Champion International v. Castilleja, 91 Or App 556 (1988), we have held that in successive injury cases, the second insurer has the burden of proving that claimant's work, while at its insured, did not independently contribute to a worsening of claimant's underlying condition. See Donald D. Davis, 40 Van Natta 2000, 2002 (1988).

Although Davis, supra, requires this caveat, it does not require that we alter the result reached by the Referee. Although claimant's work with Farmers' insured may have worsened claimant's symptomatology, the evidence establishes that it did not independently

contribute to a worsening of claimant's underlying back condition. Accordingly, Industrial Indemnity remains responsible.

ORDER

The Referee's order dated November 13, 1987, is affirmed. A client-paid fee, not to exceed $877.50, is approved, payable by Farmers Insurance to its counsel. A client-paid fee, not to exceed $447, is approved, payable by Industrial Indemnity to its counsel.

RENE VAN WOESIK, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-09431
June 23, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Van Woesik v. Pacific Coca-Cola Co., 93 Or App 627 (1988). The court has concluded that claimant's compensable back condition has worsened since the last arrangement of compensation. Consequently, the court has held that claimant has established the compensability of his aggravation claim.

In accordance with the court's mandate, the carrier's August 23, 1984 denial is set aside and the claim is remanded to the carrier for processing according to law.

IT IS SO ORDERED.

CHARLES E. BARNEY, Claimant
Callahan, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

86-16419
June 27, 1989
Order on Review

Reviewed by the Board en banc.

The insurer requests review of those portions of Referee Lipton's order that: (1) increased claimant's unscheduled permanent disability award for a back injury from 5 percent (16 degrees), as awarded by a Determination Order, to 35 percent (112 degrees); and (2) set aside the Director's Review and Order, dated ebruary 19, 1987, which found claimant ineligible for vocational assistance. On review, the issues are extent of unscheduled permanent disability, and eligibility of vocational assistance.

We affirm and adopt the Referee's order, with the exception of the last paragraph of page 3, which we do not rely on for our findings. In addition, we make the following additional findings of fact and conclusions of law.

Concerning the extent of permanent disability issue, we provide these supplemental findings. As a result of the compensable injury, claimant has sustained permanent back impairment in the minimal range. Claimant is limited to occasional bending and twisting. He can only occasionally lift or carry 21-50 pound loads and can never lift in excess of 50 pounds. In reaching this conclusion, we rely upon the findings, evaluations, and opinions offered by claimant's treating physician, Dr. Dine. We do not rely on the falling episodes which claimant relates to the compensable injury, because the Referee's order upheld denial of that condition. We further conclude that claimant's permanent impairment, in combination with his social

and vocational factors, has resulted in a permanent loss of 35 percent earning capacity.

We turn to the vocational assistance issue. The Referee reversed the Director's order, finding that claimant was eligible for vocational assistance under the administrative rules. The Referee noted that, pursuant to former ORS 656.283(2), the Director's decision could only be modified if it violated a statute or rule; exceeded the statutory authority of the agency; was made under unlawful procedure; or was characterized by abuse of discretion. The Referee determined that the Director had relied upon incorrect information provided by the employer resulting in a decision which violated a statute or rule. We agree with the Referee's conclusion, as supplemented below.

Under former ORS 656.283(2), the standard for review is limited. However, the statute does not preclude examination and scrutiny of the underlying facts upon which the Director's decision is based by the Referee, and by the Board. See generally, Daniel T. Cobbin, 41 Van Natta 326 (February 23, 1989). Accordingly, we proceed to review, as a factual matter, the basis of the Director's decision in terms of former ORS 656.283(2).

To be eligible for vocational assistance, the worker must be in need of vocational assistance as a result of the compensable injury. Further, to maintain eligibility, none of the conditions under OAR 436-120-090 must exist. Former OAR 436-120-040(2) & (4). Former OAR 436-120-090(3) & (5) provides that the eligibility of vocational assistance will end if the worker's lack of suitable employment is no longer due to the injury, or if the worker's suitable employment after the injury ended for a reason unrelated to the injury.

The Director's decision of noneligibility was grounded on two critical findings of fact: (1) there were no permanent limitations resulting from claimant's compensable injury; and (2) claimant was able to return to work with the employer at injury without restriction, and would be so employed, but for claimant's termination with the employer at injury for reasons unrelated to the injury. Applying these facts to the rules, the Director concluded claimant was not eligible under former OAR 436-120-040 and 436-120-090.

At hearing, the Referee found, as a matter of law, that claimant had sustained permanent impairment, as represented by the Determination Order award of 5 percent unscheduled permanent disability, which had been granted prior to the Director's decision. The Referee further found that claimant would not have been hired back by the employer at injury due to his physical restrictions. As such, the Referee effectively held that it was a violation of former OAR 436-120-040, for the Director to conclude that claimant was not eligible for vocational assistance inasmuch as claimant had met all the requirements of that rule. As supplemented herein, we concur with the Referee's findings and conclusions.

ORDER

The Referee's order, dated August 27, 1987, is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $750, to be paid by the insurer. A client-paid fee not to exceed $240, is approved.

Board Member Ferris, dissenting:

I dissent.

To begin, I disagree with the majority's affirmance of the Referee's award of 35 percent unscheduled permanent disability. Claimant's initial treating physician agreed with the Orthopaedic Consultants' opinion that there was no objective physical findings to prevent claimant from returning to his previous type of work. Based on claimant's subjective complaints, the opinions of claimant's initial treating physician, as well as his current physician, indicate that claimant's permanent impairment due to the compensable injury is, at most, minimal. When claimant's relatively young age (40) and significant transferable vocational skills are combined with this minimal impairment, I suggest that a permanent disability award much less than 35 percent is appropriate.

I also disagree with the majority's agreement with the Referee that the Director abused his discretion in finding claimant ineligible for vocational assistance. Former OAR 436-120-090(3) provides that the eligibility of a worker for vocational assistance will end if the worker's lack of suitable employment is no longer due to the injury. In addition, such assistance will end if the worker's suitable employment after the injury ended for a reason unrelated to the injury. Former OAR 436-120-090(5).

Claimant returned to work for his employer at injury, performing modified duties. Shortly after his return, he was involved in an altercation with a coworker that prompted his termination. There is no indication that this altercation was connected to claimant's compensable injury. Because of this incident, claimant's employer at injury would not rehire him.

My review of the record persuades me that the Director did not abuse his discretion in concluding that claimant was not eligible for vocational assistance because his lack of suitable employment was not due to the injury. Consequently, I would reverse the Referee's order and affirm the Director's order.

WANDA J. LINGO, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-14253
June 27, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee McMurdo's order that declined to award her temporary disability compensation.

The Board affirms the order of the Referee.

ISSUE

Whether claimant had withdrawn from the work force prior to the worsening of her condition due to right carpal tunnel syndrome, thereby, precluding an award of temporary disability compensation.

FINDINGS OF FACT

Claimant sustained a compensable injury to her neck and right shoulder in September 1981. In late 1984 or early 1985, she began to develop right wrist pain. On January 8, 1986, her wrist pain was diagnosed as right carpal tunnel syndrome. Her wrist was splinted, and she was advised to reduce her activity. Shortly thereafter, she filed an aggravation claim for her right carpal tunnel syndrome. The self-insured employer denied her claim by a letter f April 10, 1986. Claimant appealed the employer's denial and, thereafter, underwent right carpal tunnel release surgery on October 15, 1986.

In March 1987, claimant contested the employer's aggravation denial in a hearing before a prior referee, Referee Foster. Referee Foster set aside the employer's denial and ordered it to accept claimant's right carpal tunnel syndrome. During the hearing before Referee Foster, claimant and her husband testified concerning whether she had withdrawn from the work force prior to the filing of her aggravation claim.

ULTIMATE FINDINGS OF FACT

Claimant withdrew from the work force beginning in approximately 1983. Since that date, she has neither worked nor sought work.

Claimant is not a credible witness based on the substance of her testimony.

CONCLUSIONS OF LAW

"Temporary disability is awarded for lost wages, see ORS 656.210(1), and a person who has withdrawn from the work force has lost no wages." Karr v. SAIF, 79 Or App 250, 253, rev den 301 Or 765 (1986).

Here, in the hearing before prior Referee Foster, claimant testified, inter alia:

> "Q. All right. You heard your husband's testimony that you hadn't worked nor apparently had you sought work since at least 1983. Is that correct?
>
> "A. That's correct.
>
> "Q. All right. Basically then, for the last three or four years essentially you haven't been employed nor have you sought employment.
>
> "A. Oh, I'd put in a few applications, and I had one interview.
>
> "Q. Back in '83?
>
> "A. Yes.
>
> "Q. All right. But I mean since then you haven't.

"A. No, I haven't."

In that same hearing before prior Referee Foster, claimant's husband testified, inter alia:

"Q. In fact, she [claimant] hasn't worked since about June of '82, has she?

"A. No, she hasn't.

"Q. Has she looked for work?

"A. No, she has not. I think she did put in a couple of applications.

"Q. When?

"A. I'm guessing, but I think 1983.

"Q. Okay. But would it be fair to say, Mr. Lingo [claimant's husband], that she has not looked for work or worked since '83?

"A. I think that's correct."

At the instant hearing before Referee McMurdo, claimant testified that she did not withdraw from the work force. Rather, she testified that between approximately 1984 and 1986 she undertook the following activities:

(1) applied for and received unemployment benefits and made the required three employer contacts per week;

(2) enrolled in a counseling program at the Employment Division and prepared a resume;

(3) looked for work on her own and applied for work with the State of Oregon, with her former employer, and with Kelly Services;

(4) contacted and enrolled at Salem Rehbilitation Services; and

(5) searched through the "jobs available" advertisements in the newspapers, while she was in the State of New York.

Claimant further testified that her present testimony before Referee McMurdo was more accurate than her former testimony before prior Referee Foster.

When a Referee's credibility finding is based on the substance of a witness' testimony, rather than on the witness' demeanor, we are as capable as the Referee in assessing credibility. Davies v. Hanel Lumber Co., 67 Or App 35 (1984). Here, Referee McMurdo made no express credibility finding. We, therefore, assess claimant's credibility based on the substance of her testimony.

In our view, claimant's prior testimony is not reconcilable with her present testimony. Before prior Referee Foster, both claimant and her husband unequivocally testified that

she had neither worked nor looked for work since 1983. Later, before Referee McMurdo, claimant testified that she was consistently looking for work between approximately 1984 and 1986. Given claimant's conflicting testimonies, we conclude that she is not a credible witness.

Accordingly, we agree with Referee McMurdo's conclusion that claimant withdrew from the work force prior to the date she became more disabled due to her carpal tunnel syndrome. She, therefore, is not entitled to an award of temporary disability compensation.

ORDER

The Referee's order, dated January 19, 1988, is affirmed. The Board approves a client-paid fee, payable from the self-insured employer to its attorney, not to exceed $2,655.50.

RONALD L. MATTHEWS, Claimant
Malagon & Moore, Claimant's Attorneys
E. Jay Perry, Defense Attorney

WCB 87-00939
June 27, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Quillinan's order that declined to assess penalties and associated attorney fees for an untimely payment of temporary disability benefits. On review, claimant contends that a penalty and attorney fee for unreasonable claims processing should be assessed. We agree and reverse.

FINDINGS OF FACT

The parties agree that the first time loss payment was due October 7, 1986, but was not paid until October 15, 1986 in the sum of $305.08 representing the first time loss payment.

CONCLUSIONS OF LAW

The first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. ORS 656.262(4). Timely payment of temporary disability benefit has been made when paid no later than the 14th day after the employer's notice or knowledge of the claim if temporary disability is immediate and payable. OAR 436-60-150(3)(a).

Here, it is undisputed that claimant's first payment of temporary disability was due October 7, 1986, but that the insurer did not make the payment until October 15, 1986. The insurer provided no explanation for this admittedly untimely payment. The Referee declined to assess a penalty and attorney fee, reasoning that the insurer was permitted a one-week grace period in the payment of temporary disability benefits and that an eight day delay was "de minimus."

In reaching this conclusion, the Referee relied on OAR 436-60-150(4), which provides that continuing temporary disability benefits shall be paid to within seven days of the date of payment at least once each fourteen days after the first payment of benefits. Because we consider another administrative rule controlling, we disagree.

Inasmuch as the payment in dispute was the insurer's first payment of temporary disability benefits, the payment was due 14 days after one of the triggering events enumerated in OAR 436-60-150(3). In any event, we have held, in a decision issued subsequent to the Referee's order, that OAR 436-60-150(4), does not permit a seven day "grace period" for the payment of either initial or continued temporary disability benefits. See Arlene Marshall, 40 Van Natta 1828, 1829 (1988).

Here, the parties agree that the due date for claimant's first and only installment of temporary disability benefits was October 7, 1986. Since this payment was actually made eight days later, on October 15, 1986, it was untimely.

We consider the insurer's failure to timely pay the aforementioned temporary disability benefits to represent an unreasonable delay in the payment of claimant's compensation. Under such circumstances, penalties and attorney fees are warranted. See ORS 656.262(10); 656.382(1).

Accordingly, the insurer is assessed a penalty equal to 25 percent of the temporary disability compensation paid on October 15, 1986. After review of claimant's counsel's statement of services and retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we conclude that a reasonable attorney fee for services at hearing and on Board review concerning this penalty issue is $750.

ORDER

The Referee's order dated August 28, 1987, as reconsidered September 29, 1987, is reversed in part. The insurer shall pay claimant a penalty equal to 25 percent of the temporary disability compensation paid on October 15, 1986. For services at hearing and on Board review concerning the penalty issue, claimant's attorney is awarded a reasonable fee of $750, to be paid by the insurer. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $509.

KENNETH S. WEDMORE, Claimant
Ackerman, et al., Claimant's Attorneys
Gleaves, et al., Defense Attorneys

WCB 87-15556
June 27, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of those portions of Referee Miller's order that: (1) increased claimant's rate of temporary disability compensation; and (2) assessed an associated penalty and attorney fee. Claimant cross-requests review of that portion of the order that increased his award of unscheduled permanent partial disability for his right shoulder from the 15 percent (48 degrees) granted by Determination Order to 25 percent (80 degrees). The issues are rate of temporary disability compensation, penalties and attorney fees and extent of permanent disability.

The Board affirms and adopts the order of the Referee with the following comment on the issue of the rate of claimant's temporary disability compensation.

The Referee calculated claimant's rate of temporary disability compensation according to the formula prescribed by

former OAR 436-60-020(4)(c). The employer contends that this was error because claimant was "regularly employed" within the meaning of ORS 656.210. It asserts, therefore, that claimant's rate of temporary disability compensation should have been calculated under that statute.

The employer would have a valid argument under the version of ORS 656.210 in force before January 1, 1986. See Saiville v. EBI Companies, 81 Or App 469, 472, rev den 302 Or 461 (1986); Eldon Britt, 31 Van Natta 141 (1981). Effective January 1, 1986, however, ORS 656.210 was amended to authorize the Director to promulgate rules for the calculation of temporary total disability benefits for any worker, regularly employed or irregularly employed, "whose remuneration is not based solely upon daily or weekly wages." Or Laws 1985, ch 507, §§ 3 & 4. The Director promulgated such rules in late 1985 and they became effective January 1, 1986. WCD Administrative Order 8-1985; see former OAR 436-60-003.

Claimant was injured on January 16, 1986. His wage rate varied prior to the injury depending upon which job he performed for the employer. The Referee correctly calculated the rate of claimant's temporary disability compensation, therefore, under former OAR 436-60-020(4)(c). See Donald E. Lowry, 40 Van Natta 1957, 1958 (1988).

ORDER

The Referee's order dated January 21, 1988 is affirmed. Claimant's attorney is awarded $427.50 for services on Board review, to be paid by the self-insured employer. A client-paid fee of up to $1,845 for services on Board review is approved.

PAULA K. ARMSTRONG, Claimant

Own Motion 89-0336M
June 29, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her September 19, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim for the payment of temporary disability benefits as claimant's current condition does not require hospitalization or surgery.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Claimant's current treatment includes exercises, medication, weight reduction and activity modification. There is no indication for surgery or hospitalization at this time. We conclude we are without authority to grant the relief claimant seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

JAMES R. CHENEY, Claimant
Welch, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 86-00195
June 29, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Champion International v. Cheney, 93 Or 780 (1989). The court has reversed our prior order that affirmed the Referee's conclusion that claimant's right knee condition was compensable. On remand, we have been instructed to reconsider this case in the light of Armstrong v. Asten-Hill Co., 90 Or App 200 (1988), as well as Wheeler v. Boise Cascade, 298 Or 452 (1985), and Weller v. Union Carbide, 288 Or 27 (1979). We have done so, and affirm the Referee.

ISSUE

Whether claimant's work activities were the major contributing cause of his right knee condition.

FINDINGS OF FACT

Claimant worked approximately two and a half years for a lumber mill, a self-insured employer, before he was laid off on January 28, 1985. The mill closed shortly thereafter.

Prior to his employment at the mill, claimant never experienced any pain or problems with his right knee. His work at the mill was strenuous and demanding. His duties included assignments as a board handler, an assistant sawyer, a sawyer, and a plate and screen repair person. He worked full time and was frequently required to work overtime.

While working as a sawyer in 1984, claimant heard and felt a cracking sensation in his right knee. His knee grew progressively more painful thereafter. During the last six months of his employment, it became somewhat of a problem. He missed no work as a result of his knee pain, however. Nor did he seek any medical treatment until several months after he was laid off.

Claimant was seen by Dr. Wymore, his family physician, in July, 1985. Wymore referred him to Dr. Spina, an orthopedic surgeon. Spina diagnosed chondromalacia of the right knee and recommended conservative treatment. In Spina's view, claimant's chondromalacia was "due to his hypermobile patella and it is a job-related illness."

In October, 1985, claimant filed an occupational disease claim for his right knee condition. The employer formally denied the claim two months later.

Claimant was examined by Dr. Duff, an orthopedic surgeon, in September, 1986. Duff corroborated Dr. Spina's diagnosis. However, based on an incorrect understanding that claimant's work at the mill did not require much kneeling, squatting, and climbing, Duff opined that claimant's right knee condition was probably not job-related.

In February, 1987, claimant's attorney deposed Dr. Post, an orthopedic surgeon. In Post's view, claimant's work at the mill could have caused an increase or worsening of his knee pain and symptoms, but probably had no effect upon his "preexisting condition" of chondromalacia patella. (Ex. 9, pp. 11, 12, & 18).

At the hearing, claimant and his father were the only two lay witnesses to testify. Their testimonies were completely candid and credible.

ULTIMATE FINDINGS OF FACT

Claimant did not have a preexisting "disease" or "condition" in his right knee. Chondromalacia patella is a universal degenerative phenomenon that occurs in all human beings. Some individuals will develop pain and symptoms as a result of the degeneration of the patella; others will not. Development of pain is often associated with repetitive activity.

Chondromalacia patella may vary in its severity and rapidity. There is no evidence that claimant's chondromalacia patella was of greater severity or rapidity than that of other males of like age.

Claimant suffered right knee pain as a result of his work activities. Although he missed no time from work, his right knee pain and symptoms reduced his ability to work and required medical treatment.

CONCLUSIONS OF LAW

To establish a claim for occupational disease, claimant must prove that his work activities were the major contributing cause of his right knee condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). If his knee condition preexisted his employment, he must also prove that his work activities caused a worsening of that condition. Devereaux v. North Pacific Ins. Co., 74 Or App 388, 392 (1985); Weller v. Union Carbide, supra; Wheeler v. Boise Cascade Corp., supra.

In our view, as we found above, claimant did not have a preexisting condition or disease in his right knee. Save for diagnostic studies performed after claimant began working at the mill, as well as the retrospective opinion of Dr. Post, which we find unpersuasive, there is no objective evidence that claimant had preexisting chrondomalacia patella. Moreover, claimant experienced no pain or symptoms in his knee, until after he had worked at the mill for several months.

As to Dr. Post, he testified that chondromalacia patella is a normal human "phenomenon" that most individuals begin to develop during adolescence. The severity and rapidity of chondromalacia patella varies among individuals. Yet, Post never testified, to a degree of reasonable medical probability, that claimant actually developed chondromalacia patella during adolescence or at any time prior to his employment at the mill. Rather, Post merely assumed that claimant's chondromalacia patella had begun to develop during adolescence because such is common in the general population.

In sum, we are not persuaded by Dr. Post's opinion, as applied to this claimant and on this record.

We turn to the remaining medical opinions. Dr. Spina opined that claimant's right knee condition was "a job-related illness." Dr. Duff's opinion to the contrary is not persuasive, inasmuch as we agree with the Referee's finding that Duff had an

incorrect understanding of claimant's work activities at the mill. Although Dr. Spina does not use precise "magic words", McClendon v. Nabisco Brands Inc., 77 Or App 412 (1986), the language he did use in the context of his entire opinion, as well as the other evidence in this case, is sufficient to establish that claimant's work activities were the major contributing cause of the onset of his disabling pain and chondromalacia patella.

Claimant's counsel is entitled to an assessed fee, to be paid by the employer. ORS 656.388(1). However, we cannot award such a 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 cannot presently be awarded.

ORDER

The self-insured employer's denial is set aside and the employer is directed to process claimant's claim according to law.

LOUISE BETTS COURY, Claimant
Lena M. Spalitta, dba,
MR. & MRS. HAIR DESIGN & BEAUTY Products, Emp.
Carney, Buckley, et al., Claimant's Attorneys
Richard C. Pearce, Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Assistant Attorney General

WCB 87-05458 & 87-05459
June 29, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The noncomplying employer requests review of Referee Schultz' order that: (1) found that claimant suffered a compensable injury; and (2) declined to set aside the SAIF Corporation's acceptance of claimant's injury claim, issued on behalf of the noncomplying employer. Claimant moves for dismissal of the employer's request for review, contending that no "justiciable controversy" currently exists. On review, the issues are jurisdiction and compensability. We deny the motion and affirm the Referee's order.

FINDINGS OF FACT

Claimant is a 50-year-old woman who broke her kneecap while walking from her car to work. She was injured on October 27, 1986.

She filed a claim on November 12, 1986. On January 16, 1987, the Compliance Division notified the SAIF Corporation that it had determined the employer to be a noncomplying employer. An order to this effect was signed January 20, 1987.

On February 5, 1987, the employer's attorney requested a hearing on that order. On March 24, 1987, SAIF notified claimant that it was accepting her claim as agent for the noncomplying employer. On April 10, 1987, the employer's attorney sent a new request for hearing to this Board. This letter states in relevant part:

> "The intent of the Application to Schedule and Request for hearing are to contest the issues of ... [the employer's] status as an employer and the compensability of the claimant's claim."

A copy of this letter was mailed to claimant. The letter did not advise claimant of her right to contest the denial at a hearing.

ULTIMATE FINDING OF FACT

The noncomplying employer did not deny the claim.

CONCLUSIONS OF LAW AND OPINION

Claimant has moved for dismissal on the grounds that no "justiciable controversy" currently exists before the Board. We disagree. The employer has timely requested review of a Referee's order addressing claimant's entitlement to compensation. Consequently, we have jurisdiction to address the questions raised in the employer's request. See ORS 656.289(3); 656.283(1); 656.704(3); 656.295(5).

The employer's letter of April 10, 1987, requesting a hearing is not the functional equivalent of a denial. It does not contain a statement of hearing rights. Therefore, the letter does not validly deny the claim. Derryberry v. Dokey, 91 Or App 533 (1988); Darrell E. Breymier, 40 Van Natta 1164 (1988). In Breymier, we noted that a denial letter must be mailed to claimant and must contain a statement of hearing rights as set forth in ORS 656.262(8). The denial letter in this case contains no statement of hearing rights. Therefore, claimant is entitled to compensation pursuant to SAIF's acceptance. In the alternative, were the compensability issue properly before us, we would affirm and adopt the Referee's opinion.

ORDER

The Referee's order dated October 13, 1987, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $718.75, to be paid by the SAIF Corporation, on behalf of the noncomplying employer. A client-paid fee, payable from the employer to its counsel, not to exceed $2,808, is approved.

MARY ANN JOHNSON, Claimant
EBI, Insurance Carrier

Own Motion 89-0197M
June 29, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her February 8, 1978 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim for the payment of temporary disability benefits as claimant's current condition does not require hospitalization or surgery at this time. Claimant contends she has been hospitalized several times since her injury.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Recent hospitalizations have been emergency room visits only. We do not find these visits satisfy the requirement that the injured worker be hospitalized for treatment. Physical therapy and work hardening have been recommended; however, no inpatient or outpatient surgery or hospitalization for treatment are necessary at this time. We conclude we are without authority to

grant the relief claimant seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

TARNA D. PALMER, Claimant
Quintin B. Estell, Claimant's Attorney
Roberts, et al., Defense Attorneys
John Motley (SAIF), Defense Attorney
Gary Jones, Attorney

WCB 88-06722, 88-06723 & 88-22498
June 29, 1989
Interim Order

Claimant has requested review of Referee Myers' order that: (1) affirmed a Determination Order that awarded 5 percent (16 degrees) unscheduled permanent disability for a low back, left shoulder and chest injury for which SAIF was responsible as insurer for the first employer; (2) affirmed a Determination Order that did not award permanent disability for a ribcage injury for which SAIF was also responsible as insurer for a second employer; (3) upheld SAIF's denials, on behalf of the two employers, of claimant's aggravation claims; (4) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for her current condition; and (5) authorized SAIF, on behalf of the second employer, to offset overpaid temporary disability payments against claimant's future permanent disability awards.

Claimant represents that during the closing arguments following the hearing, "one or more defense attorneys made statements in closing argument that constituted admissions." Closing arguments were recorded, but no party asked that they be transcribed. Claimant now requests that the closing arguments be ordered and transcribed at the Board's expense.

The request that the Board bear the expense of the transcription costs is denied. See Charles T. Brence, 39 Van Natta 422, 423 (1987). However, should claimant wish to obtain a transcript of the closing argument at her expense, the case will be remanded to the Referee for consideration of that document. If claimant chooses not to obtain such a transcription, review of this case will proceed in the normal course of business.

Accordingly, claimant is requested to inform the Board of her decision. If no response from claimant is received within 14 days from the date of this order, the Board will interpret claimant's silence as a decision to forego the costs of obtaining a transcript of the closing argument. Thereafter, copies of the hearing transcript shall be distributed and a briefing schedule implemented.

IT IS SO ORDERED.

LINDA WHIAT, Claimant
Jensen, et al., Claimant's Attorneys

Own Motion 89-0151M
June 29, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her December 1, 1969 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim as claimant's condition in October and November 1988 did not require hospitalization or surgery. SAIF also states that the time loss connected with the March 1987 surgery was paid in full by Liberty Northwest Insurance Corporation.

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 underwent left knee surgery in Marcy 1987 due to the compensable injury. Simultaneously, surgery was performed on her right knee. Temporary disability was paid in a more recent claim which is the responsibility of Liberty Northwest Insurance. Claimant contends that her need for treatment in the fall of 1988 is directly related to her March 1987 surgery. She states that the problems in her left knee have been ongoing since the surgery and her condition has never stabilized. Thus, she contends that she is entitled to temporary disability compensation for time lost from work due to left knee exacerbations in 1988.

We are not persuaded by claimant's arguments. Although she did continue to have some problems in her left knee, the evidence is clear that her condition became medically stationary in September 1987. Therefore, we consider claimant's condition in October and November 1988 to be a new and separate flare-up of symptoms requiring treatment. Because the treatment provided to her at that time did not include hospitalization or surgery, we are without authority to grant the relief claimant seeks. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

LINDA YOUNG, Claimant
Vick & Gutzler, Claimant's Attorneys
Cooney, Moscato & Crew, Defense Attorneys

WCB 88-14091
June 29, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Hoquet's order that affirmed a Determination Order award of 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the right forearm. On review, claimant contends that her award should be increased.

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

Claimant credibly testified that her wrist "hurts" when she twists it. These complaints have prompted her to periodically seek assistance from others while performing her duties as an audio-visual librarian. Claimant further asserts that her physical limitations are more consistent with the range of motion findings submitted by Dr. Mizrahi, chiropractor, than those from Dr. Puziss, orthopedist. Based on the measurements furnished by Dr. Mizrahi, claimant seeks an additional 15 percent scheduled permanent disability award under OAR 436-35-080(9).

The Referee declined to consider claimant's testimony, concluding that acceptance of such evidence would be inconsistent with former OAR 438-35-010(3), which provides that a movement in a joint is measured in active degrees of motion and is compared to the degrees of motion possible in the contralateral normal joint or to range of motions established by the American Medical

Association as normal. We disagree with the Referee's conclusion that claimant's testimony cannot be considered. The aforementioned rule does not preclude claimant from using her testimony as support for her contention that the findings rendered by Dr. Mizrahi, should be given greater weight. However, after considering claimant's credible testimony concerning her pain and physical limitations, we are not persuaded that Dr. Mizrahi's measurements are more accurate.

In reaching this conclusion, we agree with the Referee that the findings and conclusions offered by Dr. Puziss, are more persuasive than that from Dr. Mizrahi. In addition to the reasons enumerated by the Referee, we consider the well-reasoned opinion submitted by Dr. Puziss, the orthopedic specialist, to be of more assistance in gauging the loss of supination and pronation in claimant's right wrist. Finally, we find no persuasive support for claimant's contention that Dr. Puziss' findings should be discarded because they were purportedly based on passive, rather than active, degrees of motion. See former OAR 436-35-010(3).

ORDER

The Referee's order dated November 25, 1988 is affirmed. A client-paid fee, not to exceed $547.50, is approved.

LARRY E. FOURNIER, Claimant
Peter E. Baer, Claimant's Attorney
Cooney, Moscato & Crew, Defense Attorneys

WCB 86-04279
June 30, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Tenenbaum's order which: (1) upheld the self-insured employer's denial of claimant's aggrvation claim; and (2) found that claimant had failed to timely request a hearing concerning the employer's denial of a subsequent aggravation claim. We affirm in part and reverse in part.

ISSUES

1. Whether claimant's failure to timely appeal the August 8, 1986 denial precluded subsequent litigation of that issue.

2. Whether claimant's compensable low back injury was a material cause of any worsening of his psychological condition, or if the psychological condition predated the injury, whether the injury materially contributed to any worsening of the preexisting condition.

FINDINGS OF FACT

We adopt the "Findings" of the Referee. We also make the following additional findings.

On January 13, 1986, Dr. Manley, claimant's treating orthopedist, requested that claimant's low back claim be reopened due to what he thought was a physically worsened condition.

On January 30, 1986, claimant's claim for aggravation was denied. The employer stated that medical information did not support an objective material worsening of his compensable injury since March 1985, the last arrangement of compensation.

On June 17, 1986, Dr. Parvaresh, psychiatrist, performed a psychological evaluation. A report of that examination was submitted to the employer on June 26, 1986.

On August 8, 1986, the employer issued a second "formal aggravation denial." It advised claimant that the employer would not be reopening his claim for payment of time loss benefits since there was no evidence of a worsening nor medical authorization for time loss.

On March 16, 1987, Dr. Parvaresh was deposed. His statements were inconsistent. On the one hand, he stated that whatever psychiatric impairment claimant had during the period in question was not attributable to his compensable injury. On the other hand, he stated that back pain was one factor which contributed to claimant's psychological impairment. He did not feel, however, that the back pain, by itself, was sufficient to cause psychological problems. Also, Dr. Parvaresh could not answer the time loss question since he lacked sufficient information to assess whether claimant's psychological impairment became disabling.

CONCLUSIONS OF LAW

The Referee concluded that claimant's failure to timely appeal the August 8, 1986 denial, without a showing of good cause, rendered her without jurisdiction to address the issue. We disagree.

The Referee also upheld the January 30, 1986 denial of claimant's aggravation claim. She found that: (1) claimant's low back condition had not worsened since the last arrangement of compensation; and (2) the back pain had not caused a worsening of his preexisting psychological condition. We agree.

We do not sanction claims processing decisions which create situations in which multiple hearings concerning a single claimant could proceed simultaneously, each concerned with essentially the same issue. That neither contributes to the efficient operation of the workers' compensation system nor to the fairness of workers' compensation hearings. See Rater v. Pacific Motor Trucking Co., 77 Or App 418, 423 (1986); see also Vandehey v. Pumilite Glass & Building Co., 35 Or App 187, 192 (1978).

In Rater, claimant's treating physician reported to claimant's employer on September 29, 1982 that he had released claimant to return to work with a lifting restriction of 30 pounds. The employer responded to this letter as though it were an aggravation claim and issued a denial. At hearing, the parties agreed to keep the record open for supplemental evidence from the doctor. On April 8, 1983, the doctor indicated that claimant's condition had not worsened until November 29, 1982.

The court refused to treat the April 8 letter as a separate aggravation claim. It reasoned that neither party was prejudiced by allowing the claimant to base some or all of his claim on evidence regarding his condition that developed after his request for hearing. Therefore, it found that the April 8 letter was not intended as an assertion of a new claim but as evidence in the pending hearing on the denied claim. Id. at 424.

Here, on January 30, 1986, the employer denied

claimant's request to reopen his compensable low back claim due to an aggravation. Claimant's March 26, 1986 request for hearing specifically placed the aggravation denial at issue. On June 26, 1986, at the request of claimant's counsel, claimant was examined by Dr. Parvaresh, a psychiatrist. On August 8, 1986, the employer again denied claimant's aggravation claim. Claimant did not appeal this latter denial because he concluded that he had not made two separate aggravation claims.

The fact that the examination by Dr. Parvaresh in June 1986 raised a potential psychological component to claimant's alleged aggravation did not create a distinctly new aggravation claim which could be denied. If the employer wished to issue a partial denial of claimant's psychological condition, it was free to do so. It did not. The August 8, 1986 denial merely duplicated the January 30, 1986 denial which had previously been appealed by claimant in a timely fashion. Therefore, claimant was not precluded from raising the issue contained in the August 8, 1986 denial at hearing.

Alternatively, we find that claimant has shown good cause for his failure to file a request for hearing by the 60th day after notification of the August 8, 1986 denial.

ORS 656.319(1)(b) states that:

> "[w]ith respect to objection by a claimant to a 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 [t]he 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 January 30, 1986 and August 8, 1986 denials of aggravation were mirror images of each other. Claimant had no reason to believe that the denials related to separate claims for aggravation since he had not alleged separate claims for aggravation. Claimant had every reason to believe that the August 8, 1986 denial was simply a duplication of the first denial. Claimant appealed the August 8, 1986 denial within 180 days and has shown good cause.

We now turn to the merits of the case. ORS 656.273(1) provides that:

> "[a]fter the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury."

ORS 656.273(1) does not limit such conditions solely to physical aggravation of a worker's condition. Scheidemantel v. SAIF, 70 Or App 552, 555 (1984). An aggravation claim based on a psychological worsening should be compensable to the same extent that a physical aggravation is compensable. Id.

A claimant asserting the compensability of a psychiatric condition following an industrial injury must prove by a preponderance of the evidence that the work-related injury was a material cause of the condition, or, if claimant's mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen, Inc. v. Page, 73 Or App 136, 139 (1985) citing Partridge v. SAIF, 57 Or App 163, 167, rev den 293 Or 394 (1982).

Lay testimony may or may not carry claimant's burden of proving his aggravation claim; the law, however, does not mandate a medical report. Garbutt v. SAIF, 297 Or 148, 151 (1984).

Although Dr. Manley, claimant's treating physician, initially requested reopening claimant's claim as of December 13, 1985, he subsequently retracted that opinion. Based on the opinions of Drs. Franks, Paxton and Wilson (who all found no physical worsening of claimant's condition), Dr. Manley concurred that there had been no worsening of claimant's low back condition.

Claimant testified that his back pain increased with increased activity. However, no evidence was presented to support claimant's allegation that a worsening of his back condition had occurred since the last arrangement of compensation. Likewise, the record does not support claimant's allegation that his compensable low back condition caused a worsening of his underlying psychological condition to the extent that it caused disability or required medical services.

Claimant was 32 years of age at hearing. He had used cocaine regularly since he was 19. Prior to November 1984, his cocaine use had averaged three to four days per week. Following a head injury in November 1984, his cocaine use grew to seven days per week.

In 1985, claimant's behavior became increasingly erratic, including hallucinations, paranoid delusions, threats and acts of violence which eventually caused the dissolution of his marriage.

In March 1986 claimant was accused of, and charged with, the sexual abuse of his three-year-old daughter. This charge had a significant emotional effect on claimant. This crisis led to a religious awakening and drug free existence.

In June 1986 Dr. Parvaresh examined claimant. He opined that claimant's psychological impairment was not related to the 1980 injury. Due to insufficient information, however, he could not say whether claimant's psychological impairment was disabling.

Claimant alleged that his drug and alcohol abuse, which he claims was disabling, was a compensable result of back pain related to his industrial injury and its residuals. We agree with the Referee that this contention is not supported by the record.

Claimant was abusing drugs and alcohol in a progressive manner long before the time period in question. This conduct was neither caused nor worsened as a response to compensable back pain.

Finally, claimant's drug abuse was not disabling. He worked stripping concrete forms at least during the summer of

1985, and probably beyond. He would have worked thereafter if he had been called back.

The evidence does not support the contention that claimant's condition was caused or worsened in material part by the compensable injury.

ORDER

The Referee's order, dated August 28, 1987, is reversed in part and affirmed in part. That portion of the order that found that the Referee lacked jurisdiction to consider the merits of the self-insured employer's August 8, 1986 denial of claimant's aggravation claim is reversed. The employer's August 8, 1986 denial is upheld. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the self-insured employer to its counsel, is approved, not to exceed $628.

DORIS L. (CRIST) McCULLOUGH, Claimant
Michael B. Dye, Claimant's Attorney
Terrall & Miller, Defense Attorneys

WCB 87-01400
June 30, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Shebley's order which found that claimant was not entitled to temporary disability benefits after February 12, 1987 as awarded by Determination Order. On review, the issues are temporary disability and offset. We reverse.

FINDINGS OF FACT

We adopt the Referee's "findings of fact" as set forth in the first two pages of his order, with the following supplementation.

The insurer terminated temporary disability benefits as of February 17, 1987.

FINDINGS OF ULTIMATE FACT

Claimant was not medically stationary between February 2, 1987 and June 19, 1987.

Claimant was disabled from working until June 19, 1987.

CONCLUSIONS OF LAW

At the outset, we note that both the Referee and the parties have framed the issue as being premature closure. It is our understanding, however, that the question is whether claimant is entitled to temporary disability benefits between February 12, 1987 and June 19, 1987, the date claimant was found to be medically stationary. Accordingly, our discussion will proceed on that basis.

The Referee concluded that claimant was not entitled to temporary disability benefits after February 12, 1987, and accordingly, authorized an offset for amounts paid after that date. We disagree based on the following reasoning.

ORS 656.268 requires temporary disability benefits to be paid unless claimant is released to work, and medically stationary. See e.g. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 on recon, 93 Or App 103 (1988), rev den 307 Or 236 (1988). Accordingly, a claimant must be both released for work and medically stationary before temporary disability benefits can be terminated. Further, a worker's release to work on a "trial basis" does not warrant termination of temporary disability benefits prior to closure. Instead, the amount of benefits is subject to reduction for wages actually earned. Ronald W. Riding, 40 Van Natta 502, 504 (1988).

Dr. Srch, claimant's treating chiropractor, released claimant for work on a "trial basis" as of February 12, 1987. Although he imposed no restrictions on claimant, Dr. Srch had not yet found her to be medically stationary and anticipated further treatment. Dr. Srch did not find claimant medically stationary until June 19, 1987. We find Dr. Srch's opinion persuasive in regard to claimant's medically stationary date.

We find that claimant was not yet medically stationary at the time Dr. Srch released her for work on a "trial basis." Accordingly, she was entitled to temporary disability benefits between February 12, 1987 and June 19, 1987. Fazzolari, supra; Riding, supra.

We have found claimant procedurally entitled to temporary disability benefits through June 19, 1987. Nevertheless, if in fact claimant was able to work between February 12, 1987 and June 19, 1987 then the self-insured employer may be entitled to an offset for overpaid benefits.

The court in Fazzolari, supra, held that for carrier to be entitled to an offset, the evidence must show that a claimant was not actually disabled during the time period in which he/she was procedurally entitled to temporary disability benefits. Id at 595, 596. Applying this standard to the present case is a difficult question in that claimant was released to work on a "trial basis" by Dr. Srch on February 12, 1987, but did not return to work as it was not available.

Under these circumstances, we find that claimant was actually disabled until June 19, 1987 when Dr. Srch found her medically stationary and released her for work without restrictions. Accordingly, the employer is not entitled to an offset for temporary disability benefits payable during the time period from February 12, 1987 through June 19, 1987. Fazzolari, supra. In making this finding, we are aware that Dr. Dickson returned claimant to full work in December 1986. We do not find his opinion persuasive as to claimant's condition from January to June 1987, however, as he had not seen claimant since December 1986.

ORDER

The Referee's order dated September 30, 1987 is reversed in part and affirmed in part. That portion of the order which found claimant not entitled to temporary disability benefits after February 12, 1987 and authorized an offset for amounts paid after that date is reversed and the self-insured employer is directed to pay temporary disability benefits for a period beginning February 12, 1987 and ending June 19, 1987. The employer is permitted to offset these benefits by the temporary disability

benefits previously paid from February 12, 1987 until February 17, 1987. Claimant's attorney is awarded 25 percent of the increased compensation granted by this order, not exceed $3,800. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $610.50. The remainder of the Referee's order is affirmed.

RUDOLPH R. MLASKO, Claimant
Warren John West, Claimant's Attorney
Davis & Bostwick, Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 86-05674 & 85-06922
June 30, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of Referee Quillinan's order that set aside its denials of compensability and responsibility relating to claimant's low back. We affirm the Referee on the issue of compensability, but reverse on the issue of responsibility. Claimant has submitted a statment of services rendered at the hearing and Board levels and requests a carrier-paid fee for those services. Industrial Indemnity Company, the other carrier involved in this case, contends that claimant's attorney is not entitled to such a fee. We conclude that claimant is entitled to a carrier-paid fee.

ISSUES

1. The compensability of claimant's low back condition as to the self-insured employer.

2. Responsibility for the condition.

3. Carrier-paid attorney fee for services rendered at the hearing and Board levels.

FINDINGS OF FACT

Claimant sustained an acute lumbosacral strain in July 1971 while swinging a sledge hammer in the course of his employment with the self-insured employer. He was hospitalized for several days and was treated by Dr. Carroll, an orthopedic surgeon. Dr. Carroll released claimant to return to his regular work in August 1971, about three weeks after the injury. The employer accepted claimant's claim for the injury and the claim was closed by Determination Order in December 1971 with no award for permanent disability.

Between 1971 and 1975, claimant experienced minor flare-ups of low back pain about once per month on the average. Then, while lifting at work in August 1975, he experienced a severe exacerbation of low back pain accompanied by right thigh pain. At that time, the employer was insured by United Pacific Insurance Company. Claimant was hospitalized for several days and steadily improved thereafter with conservative treatment. Dr. Carroll released claimant to return to regular work about three weeks after the accident. United Pacific accepted the claim as a new injury and the claim was closed by Determination Order in March 1976 with no award for permanent disability.

Claimant continued to experience periodic flare-ups of low back pain between the 1976 claim closure and January 1978. In January 1978, he experienced another acute episode of low back pain after using an impact wrench at work. This episode was accompanied by left

hip and thigh pain. Claimant's condition was treated by Dr. Carroll and by Dr. Miller, a neurosurgeon. The 1978 episode was not as severe as that in 1975 and claimant was able to continue working. The employer was self-insured again in 1978 and it accepted the claim as a new, nondisabling injury. In accordance with the law in effect at the time, the claim was never closed.

Between 1978 and 1985, claimant continued to experience periodic nondisabling flare-ups of low back pain. Then, on March 1, 1985, claimant experienced another severe episode of low back pain at work after bending over to walk underneath a conveyor belt. The employer was insured by Industrial Indemnity at that time. Claimant left work on March 1, 1985 and received conservative treatment from Dr. Carroll shortly thereafter. Dr. Carroll released claimant to return to regular work on March 11, 1985.

Industrial Indemnity denied claimant's claim on responsibility grounds on May 21, 1985. The self-insured employer issued no formal denial, but indicated at the beginning of the hearing that it was denying any causal relation between the 1985 episode of low back pain and the 1971 low back injury as well as responsibility. Claimant's aggravation rights on the 1971 injury expired on December 16, 1976. United Pacific, the insurer at the time of the 1975 low back episode, was not made a party to the proceeding. No order pursuant to ORS 656.307 order was requested by any of the parties and none was issued.

Claimant's attorney took no position at the hearing regarding which of the carriers was responsible. He did question claimant and his wife on direct examination and Dr. Carroll on cross-examination. In an order dated April 20, 1987, the Referee affirmed Industrial Indemnity's denial, set aside the self-insured employer's denial and ordered the self-insured employer to pay claimant's attorney a fee of $1,100.

The self-insured employer requested Board review of the Rerferee's order. In its appellant's brief, the self-insured employer argued that the 1985 incident under Industrial Indemnity's coverage independently contributed to a worsening of claimant's underlying low back condition. In the alternative, it argued that there was no material causal relation between claimant's 1971 low back injury and the 1985 exacerbation. Claimant's attorney filed a one paragraph response in which he stated that he had reviewed the self-insured employer's brief and that claimant adopted the employer's primary argument as his own. Industrial Indemnity argued that the evidence failed to establish that the 1985 incident had independently contributed to a worsening of claimant's underlying condition. Claimant's attorney filed a statement of services reflecting a total of 15.2 hours of attorney time for the hearing and Board levels. We reverse the Referee's responsibility determination and assign responsibility to Industrial Indemnity.

FINDINGS OF ULTIMATE FACT

1. Claimant's 1971 low back injury was a material contributing cause of his worsened condition after the 1985 exacerbation.

2. Claimant's work activity for the employer at the time of the 1985 incident was capable of causing a worsening of his underlying low back condition. The evidence is inconclusive on the question of whether the incident which gave rise to the 1985 episode of low back pain actually worsened claimant's underlying low back condition.

3. Claimant's entitlement to receive compensation was at risk on Board review.

CONCLUSIONS OF LAW

1. Compensability

In order to establish the compensability of his 1985 episode of low back pain as to the self-insured employer, claimant must prove a material causal relation between that episode and his 1971 or 1978 low back injury. See Grable v. Weyerhaeuser Co., 291 Or 387, 400-01 (1981). This is a complex medical question requiring 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 only medical professional to offer an opinion regarding the causal relation between claimant's 1971, 1978 and 1985 episodes of low back pain was Dr. Carroll, claimant's treating orthopedic surgeon. He opined both in a report dated May 7, 1986 (Ex. 18) and in his testimony at the hearing (Tr. 36-42, 70-71) that claimant's 1971 low back injury caused a condition which persisted through the date of the hearing and was a material contributing cause of the 1985 episode of low back pain. We accept this opinion.

In view of our finding of a material causal relation between the 1971 low back injury and the 1985 episode of low back pain, we conclude that claimant has proven the compensability of his 1985 low back condition as to the self-insured employer.

2. Responsibility

Responsibility in successive injury cases is governed by the "last injurious exposure rule." Champion International v. Castilleja, 91 Or App 556, 560, rev den 306 Or 661 (1988). Under that rule, the last carrier whose employment independently 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). If compensability has been established and the last injurious event could have contributed to a worsening of the claimant's underlying condition, but the evidence on that point is inconclusive, responsibility rests with the last carrier. Champion International v. Castilleja, supra, 91 Or App at 560-61.

Dr. Carroll was the only medical professional to comment on the question of whether the March 1985 incident independently contributed to a worsening of claimant's underlying low back condition. He testified that the 1985 incident could have contributed independently to a worsening of claimant's underlying condition and that it did independently contribute to a worsening of the symptoms of claimant's condition and to the subsequent time loss and need for medical services. (Tr. 28-29, 51-52; see also Ex. 18). He also indicated that the level of claimant's chronic symptoms had increased since the March 1985 incident. (Tr. 65). Dr. Carroll further indicated, however, that claimant's back pain after the March 1985 incident was a "continuation" or "recurrence" of the condition caused by the 1971 injury. (Tr. 32-42, 55-59, 68-72). No one questioned Dr. Carroll directly concerning whether the 1985 incident actually contributed independently to a worsening of claimant's underlying condition. We are unable to decide that question, therefore, on this record.

Compensability has been established as to the self-insured employer and is not contested by Industrial Indemnity. The evidence concerning whether the 1985 incident contributed to a worsening of claimant's underlying condition is inconclusive. Under these circumstances, the new injury insurer, Industrial Indemnity, is responsible. Champion International v. Castilleja, supra.

3. Attorney Fees

A claimant's attorney is entitled to a carrier-paid fee under ORS 656.386(1) when 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 extent of disability) is at issue. Short v. SAIF, 305 Or 541, 545-46 (1988).

In the present case, claimant prevailed against Industrial Indemnity on Board review. Claimant's entitlement to receive compensation was at issue throughout this proceeding with regard to both insurers because no .307 order had issued. See Ronald L. Warner, 40 Van Natta 1082, 40 Van Natta 1194 (1988). Claimant's attorney, therefore, is entitled to a fee under ORS 656.386(1) for services rendered at the hearing and Board levels, payable by Industrial Indemnity.

ORDER

The Referee's order dated April 27, 1987 is affirmed in part and reversed in part. That portion of the order that set aside the self-insured employer's denial of compensability is affirmed. Those portions of the order that upheld Industrial Indemnity Company's denial of responsibility, set aside the self-insured employer's denial of responsibility and ordered the self-insured employer to pay claimant's attorney an attorney fee of $1,100 are reversed. The self-insured employer's denial of responsibility is reinstated and upheld. Industrial Indemnity's denial of responsibility is set aside and the claim is remanded to that insurer for processing according to law. Claimant's attorney is awarded an attorney fee of $1,520 for services rendered at the hearing and Board levels, to be paid by Industrial Indemnity. A client-paid fee, payable from Industrial Indemnity to its counsel, is approved, not to exceed $150.

RICKY J. PRICE, Claimant
Francesconi & Cash, Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 86-11481
June 30, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of those portions of Referee St. Martin's order that: (1) set aside its partial denial of future medical treatment; and (2) awarded claimant's attorney a fee of $1850. We affirm.

ISSUES

1. Whether claimant is entitled to medical services as a result of his compensable 1982 injury.

2. Whether the Referee's award of claimant's attorney fee for services rendered at hearing was excessive.

FINDINGS OF FACT

On August 16, 1982, claimant, a journeyman welder, compensably injured his neck and upper back as a result of working with his neck craned beneath trucks for long periods of time. He treated with Dr. Tyner, chiropractor, who diagnosed acute cervicodorsal sprain with attendant right brachial extension neuralgia.

On June 9, 1983, Dr. Tyner declared claimant medically stationary, released him to regular work without restriction, and found no permanent disability. Claimant's claim was subsequently closed with no permanent disability award. He has missed no time from work as a result of the compensable injury.

Since the date of injury, claimant has continued to receive chiropractic treatments from Dr. Tyner every two to three weeks for recurrent neck pain and stiffness. The increase in symptoms was caused by claimant holding his head unsupported off the ground while working beneath trucks, and lifting and carrying heavy steel. The symptoms are causally related to claimant's compensable injury. The treatments completely relieved claimant's symptoms, although the effect lasted anywhere from one day to two weeks. As a result of those treatments, claimant was able to move freely on the job without pain or limitations. Therefore, we find that the chiropractic treatments rendered were both reasonable and necessary medical services.

On August 6, 1986, the insurer issued a partial denial of "any further treatment as of 8/6/86."

The Referee awarded claimant's attorney an assessed fee of $1850 for her efforts in setting aside the denial at hearing.

CONCLUSIONS OF LAW

Medical Services

The Referee concluded that: (1) an absence of permanent disability did not prohibit claimant from receiving medical services resulting from his compensable 1982 injury; and (2) the medical services rendered were both reasonable and necessary. Therefore, he set aside the insurer's partial denial of medical treatment. We agree with the Referee's rationale for his decision and additionally find that the insurer's partial denial was procedurally improper.

Procedurally Improper Denial

The insurer's partial denial reads, in relevant part, as follows:

> "Based on the information we have received to date we must respectfully deny any further treatment as of 8/6/86."

The denial is entirely prospective in nature. It cannot be read any other way. It is addressed to no services rendered. It simply denies all future medical benefits. Even if services were not necessary at that time, a denial may not be used to cut off all future services.

A denial must be addressed to a claim for medical services. ORS 656.245(2). A claim for medical services is generally made in the form of a medical bill or a request for authorization of treatment. Billie J. Eubanks, 35 Van Natta 131 (1983). Here, the insurer has accepted all claims for medical services filed through August 6, 1986, the date of the denial. The denial purports to address all post-August 6, 1986 medical treatment. There having been no claim made for post-August 6, 1986 treatment, the denial can be read only as a denial of future medical benefits. Such a denial is void; and any denial of treatment in reliance on such a denial must be set aside. Thomas A. Beasley, 37 Van Natta 1514 (1985).

Entitlement to Medical Services

The insurer argues that: (1) claimant is not entitled to continued medical benefits pursuant to ORS 656.245 because he did not receive an award of permanent disability; and (2) if we find that the lack of permanent disability does not preclude entitlement to medical services, the chiropractic treatments rendered were not reasonable or necessary. Neither argument is well taken.

In Bowser v. Evans Product Company, 270 Or 841 (1974), the court clearly stated that a determination of permanent disability does not terminate the right of an injured workman to receive medical services for every compensable injury for such period as the nature of the injury or the process of the recovery requires. Id. at 843. Therefore, to establish entitlement to compensation for medical services under ORS 656.245(1), a claimant need not show that he has been awarded permanent disability for his compensable injury. He must prove the reasonableness and necessity of the medical services and a causal relation between the medical services and a compensable injury or disease. Jordan v. SAIF, 86 OR App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985). To prove the reasonableness and necessity of rendered medical services, a claimant must show that at the time the services were rendered they were likely to be of significant curative, palliative, preventive or restorative benefit. Id. at 320-21; Michael D. Barlow, 38 Van Natta 196, 197-8 (1986).

Claimant credibly testified at hearing that Dr. Tyner's chiropractic treatments completely relieved his neck pain. He stated that the relief was immediate and lasted anywhere from one day to two weeks. As a result of the treatments, claimant was able to work as a journeyman welder and move freely about the job environment without pain. Dr. Tyner also persuasively reported that claimant received immediate, significant relief of his neck pain following each treatment.

On the other hand, the Independent Chiropractic Consultants felt that Dr. Tyner's care was "at best, palliative and questionably related to his 1982 industrial exposure."

Dr. Simpson, in his March 6, 1987 report, stated that he did not believe that claimant's ongoing cervical symptoms were related to the 1982 compensable injury and did not comment on the reasonableness and necessity of continued medical treatment of claimant's neck condition. Therefore, his opinion is given little weight.

Based on the persuasive testimony of claimant and the opinions of his long-time treating chiropractor, we conclude that the chiropractic care constituted effective palliative medical treatment. Consequently, the medical services rendered were both reasonable and necessary, and therefore compensable.

Attorney Fee

The Referee awarded claimant's attorney an assessed fee of $1850 for services at hearing. In determining the reasonableness of attorney's fees, several factors must be considered: (1) time devoted to the case; (2) complexity of the issues involved; (3) value of the interest involved; (4) skill and standing of counsel; (5) nature of the proceedings; and (6) results secured. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Our review of the record, in light of the above factors, suggests that the attorney fee award made by the Referee was appropriate and should be affirmed.

ORDER

The Referee's order dated October 15, 1987 is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $300 for services rendered on Board review concerning the medical services issue, to be paid by the insurer. The Board approves a client paid fee not to exceed $1443.50.

KATHERINE A. RELPH, Claimant
Coons & Cole, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-03505
June 30, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of thoses portions of Referee Mulder's order that: (1) found that claimant had proved a compensable aggravation as of November 16, 1985; (2) upheld the insurer's denial of claimant's bilateral carpal tunnel condition; (3) upheld the insurer's denial of out-of-state medical services; and (4) denied claimant's request for penalties and attorney fees for the insurer's alleged unreasonable denial of medical services, alleged untimely acceptance or denial of claimant's aggravation claim and alleged untimely denial of claimant's claim for carpal tunnel syndrome. Claimant also moves to strike that portion of the insurer's respondent's brief asserting that time loss benefits effective December 5, 1984 should be characterized as an overpayment and that benefits should commence as of November 15, 1985. Finally, in her reply brief, claimant has submitted evidence not submitted to the Referee at hearing. Although the insurer has not formally cross-appealed, it seeks reversal of the Referee's finding that claimant's claim should have been reopened as of November 16, 1985. It also requests that the Referee's holding that temporary disability benefits subsequent to December 5, 1984 should not be characterized as an overpayment.

We consider claimant's submission of additional evidence in her reply brief to be a motion for remand to the Hearings Division for the taking of additional evidence. The motion is denied. We may remand a case to a Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). In this case, however, we find that the evidence sought to be admitted by

claimant was obtainable and available before the hearing. Remand, therefore, is not appropriate. See Bailey v. SAIF, 296 Or 41 (1983). The evidence submitted by claimant has not been considered on review.

Claimant's motion to strike a portion of the insurer's respondent's brief is also denied. Claimant asserts that the insurer may not address an issue not specifically raised by claimant in her appellant's brief without formally cross-requesting review of the Referee's order. We disagree. No formal cross-appeal is required in order for the Board to consider the arguments raised by the insurer on review. See Miller v. SAIF, 78 Or App 158 (1986); Gleason W. Rippey, 36 Van Natta 778 (1984);

ISSUES

1. Whether claimant sustained an aggravation of her compensable condition as of December 5, 1984.

2. In the alternative, whether claimant sustained a compensable aggravation as of November 16, 1985.

3. Whether the Referee erred in not characterizing temporary total disability benefits paid subsequent to December 5, 1984 as an overpayment.

4. The compensability of claimant's bilateral carpal tunnel syndrome, either as an accidental injury or an occupational disease.

5. Penalties and attorney fees for the insurer's alleged unreasonable refusal to provide out-of-state medical services.

6. Penalties and attorney fees for the insurer's alleged untimely denial of claimant's alleged December 1984 aggravation claim.

7. Penalties and attorney fees for the insurer's alleged untimely denial of claimant's claim for carpal tunnel syndrome.

FINDINGS OF FACT

Claimant sustained a compensable injury to her low back, neck, left arm and left shoulder in May 1982 while working as a nurse's aide. She was assisting in lifting a patient when she felt a pulling sensation in the areas affected. She initially treated with Dr. Thomas, who noted in June 1982 that claimant's pain had extended to the fingers of the left hand. By July 1982, claimant's physicians were recommending that she not return to her job at injury.

Claimant remained symptomatic throughout the remainder of 1982. She was seen in orthopedic consultation by Dr. Puziss in January 1983. Puziss suspected early carpal tunnel syndrome, although an EMG study the following month revealed no objective evidence of the disease. Claimant's claim was initially closed by Determination Order on March 7, 1984 with an award of 30 percent unscheduled disability for the low back and 5 percent scheduled disability for the left arm.

Claimant's symptoms continued. In April 1984 she was hospitalized for evaluation of her ongoing low back pain. Both a myelogram and CT scan proved essentially normal and further treatment was seen to be palliative only. Claimant was declared medically stationary. The claim was reclosed by Determination Order dated September 12, 1984 with an additional 15 percent unscheduled disability, bringing claimant's unscheduled award to 45 percent.

Claimant entered a vocational training program in accounting after claim closure and was paid temporary disability benefits during training. The training program required a great deal of sitting, which bothered claimant's low back. She returned to Dr. Berkeley, complaining of increasing symptoms. Berkeley referred her to Dr. Long, a physical medicine specialist who first examined claimant on December 5, 1984. Long diagnosed left shoulder pain of myofacial origin, right median compression neuropathy and chronic back pain. He was unable to determine the cause of claimant's complaints without first reviewing prior records. By January 5, 1985, however, Long reported that claimant's work as a nurses's aide contributed to the development of her left shoulder girdle and carpal tunnel conditions.

The insurer issued a denial of claimant's accidental injury claim for bilateral carpal tunnel syndrome on April 26, 1985. A second denial of the condition, based on a claim for occupational disease, issued on May 24, 1985.

In late 1985 claimant went with her husband to California in search of employment. In early November 1985 she contacted the insurer, seeking authorization for out-of-state treatment. The insurer gave her the name of a California physician. Claimant visited the doctor and was hospitalized on November 15, 1985 for observation, testing and medications. She was released after two days, but was re-hospitalized a few days later, complaining of severe pain. Claimant was hospitalized a third time on December 2, 1985, and she remained so for 14 days. She was ultimately discharged for failing to follow the advice of her attending physician.

On March 7, 1986, the insurer issued a denial of claimant's claim for an alleged aggravation of her 1982 compensable injury. Approximately a month later, claimant was hospitalized for evaluation of a possible disk herniation. Myelography and a repeat CT scan revealed a bilevel disk protrusion, which Dr. Rosenbaum ultimately related to claimant's 1982 injury. Surgery was performed on April 23, 1986.

Claimant's condition did not worsen on December 5, 1984. It did worsen, however, upon her inpatient hospitalization on November 16, 1985.

Claimant's 1982 injury was neither a material contributing nor major contributing cause of the development of her bilateral carpal tunnel syndrome. Claimant's bilateral carpal tunnel syndrome was not causally related to her work activities.

The insurer did not unreasonably fail to authorize out-of-state medical services.

The insurer unreasonably delayed acceptance or denial of claimant's 1984 aggravation claim.

The insurer unreasonably delayed acceptance or denial of claimant's carpal tunnel claim.

CONCLUSIONS OF LAW

1. Whether claimant sustained an aggravation of her compensable condition as of December 5, 1984.

Claimant asserts that she experienced a compensable worsening of her condition as of December 5, 1984, the date she was examined by Dr. Long for the first time. She argues that his statement that she should suspend her authorized training program until her symptoms subsided constituted not only a claim for aggravation, but a compensable aggravation, as well. The insurer argues that, at most, claimant experienced additional symptoms contemplated by her prior awards of permanent disability. It further asserts that Dr. Long was uncertain of the cause of claimant's condition at the time of the December 5, 1984 report.

In order to prove a compensable aggravation as of December 1984, claimant must establish that her compensable condition worsened at that time, such that she was more disabled, i.e., less able to work in the broad field of occupations, than at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). After reviewing the reports of Drs. Berkeley and Long, we conclude that claimant did not establish a compensable aggravation in December 1984.

Dr. Berkeley treated claimant for several months before referring her to Dr. Long. When he examined claimant on February 21, 1985, he found her condition to be unchanged from June 1984, except for possible carpal tunnel syndrome. In short, Berkeley did not think claimant had worsened.

Berkeley referred claimant to Dr. Long primarily for evaluation of claimant's upper extremity complaints. Long, however, took claimant's history of increased low back problems and on December 5, 1984, he opined that claimant should suspend her authorized training program until she became less symptomatic. He did not attribute claimant's symptomatic worsening to her 1982 injury, however, because he had not reviewed claimant's medical file.

Of Drs. Berkeley and Long, we find Berkeley to have been in the better position to assess whether claimant had suffered an aggravation of her compensable condition. He had treated her for several months before referring her to Long, and he was able to state with authority that her symptoms had simply increased during training, without rendering her more disabled. Long suggested a suspended training program based on a single examination and without benefit of claimant's complete medical file. We are more persuaded by Berkeley's opinion. Claimant has failed to prove a compensable aggravation as of December 5, 1984.

2. Whether claimant sustained a compensable aggravation as of November 16, 1985.

The Referee found that claimant suffered a compensable aggravation at the time she entered a California hospital on November 16, 1985. We agree. In Gwynn v. SAIF, 304 Or 345 (1987), the Court provided a "bright line" rule for determining

whether a compensable aggravation has been established for a worker who has received a prior award of permanent disability and has subsequently developed increased symptoms. The Court held that if the worker, as a result of a worsening of the compensable condition, becomes totally disabled for more than 14 consecutive days, or becomes an inpatient in a hospital for treatment of the compensable condition, the worker is at least entitled to compensation for temporary total disability. Gwynn, 304 Or at 353.

In the present case, claimant was directed to enter a California hospital by the physician to whom she was referred by the insurer. During her hospital stay, which began on November 16, 1985, she was evaluated and medicated for complaints of severe back pain. She ultimately spent approximately twenty days in three hospitals during November and December of 1985. We find that these series of increased pain complaints represents a symptomatic worsening of claimant's compenable condition which resulted in reduced earning capacity. Although treatment was ultimately unsuccessful, we conclude that claimant's inpatient hospitalization and total disability for more than 14 days for this symptomatic worsening of her compensable condition was sufficient, under Gwynn, supra, to establish a compensable aggravation as of the date she entered the hospital. Therefore, we agree with the Referee that claimant is entitled to the reopening of her claim, effective November 16, 1985.

3. Whether the Referee erred in not characterizing temporary total disability benefits paid subsequent to December 5, 1984 as an overpayment.

We adopt the Referee's opinion on this issue.

4. The compensability of claimant's bilateral carpal tunnel syndrome.

Claimant asserts that her bilateral carpal tunnel syndrome is the compensable result of her 1982 injury. In the alternative, she asserts that the combination of her injury and the work that preceded it, caused her condition to appear. It is claimant's burden to prove the compensability of her condition. If she pursues an accidental injury analysis, she must prove that her 1982 injury was a material contributing cause of her condition. Summit v. Weyerhaeuser Co., 25 Or App 851 (1976). If she seeks to establish that her condition arose from an occupational disease, she must prove that her employment was the major contributing cause of her condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). Claimant's case is of sufficient complexity that proof under either theory must come, at least in part, by way of expert medical analysis. See Kassahn v. Publisher's Paper Co., 76 Or App 105 (1985).

After reviewing this record, we find that claimant has failed to sustain her burden of proof under either theory she advances. The medical support for claimant's claim comes from Dr. Long, who first saw her on Dr. Berkeley's referral two and one-half years after her injury. Long was under the impression that claimant had suffered an "extraordinary strain" in 1982 and that her work involved regular, strenuous use of the hands and arms. He was also of the opinion that claimant exhibited carpal tunnel syndrome as early as a month after her 1982 injury.

We find the history upon which Dr. Long relied to be

flawed. First, there is no persuasive evidence that claimant's 1982 injury involved an "extraordinary strain." Claimant merely felt a pulling sensation while assisting in the lifting of a patient. Second, there is no persuasive evidence that claimant's work involved extraordinary use of the upper extremities on a regular basis. Last, there was no objective medical evidence that claimant had developed carpal tunnel syndrome until more than a year after her compensable injury. Based on this information, Dr. Button, a hand specialist, concluded that claimant's carpal tunnel condition was not the result of her employment. We find Button's opinion more persuasive than that of Long, because Button's was based on the more accurate history. See Moe v. Ceiling Systems, 45 Or App 429 (1980).

5. Penalties and attorney fees for the insurer's alleged refusal to authorize out-of-state medical services.

Claimant asserts that the insurer refused to provide certain California medical services to which she was entitled. She testified that she visited a physician to whom she was referred by the insurer, but was ultimately denied hospital care and further medical services. She argues that the insurer's failure to authorize further care was unreasonable and should be penalized.

On review, we are unpersuaded by claimant's argument. The insurer authorized claimant to visit a California physician, and it ultimately paid for all medical services for which billings were received. The California physicians ultimately determined, however, that further hospitalization would be inapproriate because of claimant's refusal to follow the physicians' recommendations regarding treatment. Under these circumstances, we find the insurer's actions reasonable. It was under no duty to provide care not recommended by its physicians.

6. Penalties and attorney fees for the insurer's alleged untimely denial of claimant's alleged December 1984 aggravation claim.

Claimant asserts that the insurer failed to timely accept or deny the aggravation claim she allegedly asserted by way of Dr. Long's December 5, 1984 report. The insurer argues that Long's report was insufficient to constitute a claim for aggravation.

A physician's report is an aggravation claim, so long as it, at a minimum, requests additional medical services resulting from the compensable injury. Haret v. SAIF, 72 Or App 668 (1985). Dr. Long's December 5, 1984 report requested additional medical services, but it did not definitively tie the need for those services to claimant's 1982 injury. Long was not prepared to make the causal connection until he reviewed other medical information. After reviewing that information, Long did relate claimant's need for treatment to her injury in a report dated January 3, 1985. We conclude that this report put the insurer on notice that claimant was asserting a claim for aggravation. It was then the insurer's responsibility to determine whether the claim was compensable as an aggravation. The insurer's failure to accept or deny claimant's claim until March 7, 1986 was unreasonable. A penalty and attorney fee are appropriate.

7. Penalties and attorney fees for the insurer's alleged untimely denial of claimant's claim for bilateral carpal tunnel syndrome.

Claimant asserts that the insurer failed to timely accept or deny her claim for bilateral carpal tunnel syndrome. She asserts that her claim was made as of Dr. Long's December 5, 1984 report. The insurer did not issue its first denial of claimant's condition until April 26, 1985, or more than 60 days after Long's report.

We agree with claimant that the insurer's denial was untimely, but we find that no claim was filed until January 3, 1985, when Dr. Long definitively opined that claimant's carpal tunnel syndrome was related to her 1982 injury. In the December 1984 report, Long could not state that claimant's condition was related to her compensable injury. It was not until he did so one month later that the insurer was presented with a claim for carpal tunnel syndrome. The insurer should have accepted or denied the claim within 60 days of January 3, 1985. Its failure to do so was unreasonable. Penalties and attorney fees are appropriate.

ORDER

The Referee's order dated February 12, 1987, as amended on March 16, 1987, is reversed in part and affirmed in part. Those portions of the order that denied claimant's request for penalties and attorney fees for untimely acceptance or denial of claimant's aggravation claim and claim for bilateral carpal tunnel condition are reversed.

For its untimely acceptance or denial of claimant's aggravation claim, the insurer is assessed a penalty equal to 25 percent of the compensation due, if any, between January 3, 1985 and March 7, 1986, the date of the insurer's denial. For prevailing on this issue, claimant's attorney is awarded a reasonable attorney fee of $300.

For its untimely acceptance or denial of claimant's claim for bilateral carpal tunnel syndrome, the insurer is assessed a penalty equal to 25 percent of the compensation due claimant, if any, for the period of January 3, 1985 and April 26, 1985, the date of its denial. For prevailing on this issue, claimant's attorney is awarded a reasonable attorney fee of $250, to be paid by the insurer. The remainder of the Referee's order is affirmed. A client-paid fee not to exceed $150 is approved.

PETE M. STRIDE, Claimant
Olson Law Firm, Claimant's Attorney
Charles Lisle (SAIF), Defense Attorney

WCB 86-12109
June 30, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Leahy's order that: (1) declined to grant permanent total disability; (2) affirmed Determination Orders that awarded no permanent or temporary disability for a cervical and right shoulder injury; and (3) declined to assess penalties and attorney fees for alleged unreasonable claims processing. The issues on review are temporary total disability, the extent of unscheduled permanent disability, including permanent total disability, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant was 63 years of age at hearing. He has a 12th grade education, and attended college for two terms. His work experience includes logging, driving delivery truck, firefighting, and automobile and real estate sales. His job at injury was as a maintenance worker at the employer's fairgrounds. He has a preexisting hearing loss in one ear.

Claimant compensably injured his right shoulder on April 8, 1985. The claim was accepted as an acute neuritis of the right shoulder. Claimant was treated conservatively and the pain resolved within 5 to 6 weeks. A Determination Order of January 9, 1986 granted no award for unscheduled permanent disability.

Claimant applied for Social Security retirement benefits in January, 1986. He started receiving benefits in February 1986 and voluntarily stopped working for his employer on February 27, 1986. He applied for unemployment benefits, but was disqualified. He continued to seek employment until his cervical condition flared up in May, 1986.

Claimant saw Dr. Klump on June 10, 1986 because he had had a recurrence of severe symptoms beginning three weeks previously. The next day claimant went to the SAIF office and asked to have his claim reopened. Claimant's recurrence of symptoms in May, 1986 was materially caused by his compensable injury. Claimant's symptoms are caused by a cervical radiculopathy which is also referred to as neuritis. Claimant also has degenerative changes which contribute to his symptoms.

On July 31, 1986, Dr. Klump wrote SAIF that claimant's symptoms at that time made him less able to work than he was before the flareup.

On August 5, 1986, SAIF wrote to claimant that it would not pay temporary disability benefits because he had retired. The letter indicated that SAIF was deferring the decision whether to accept or deny the aggravation claim. SAIF subsequently processed the aggravation claim to closure, but did not pay temporary total disability.

Claimant was medically stationary on November 19, 1986. Dr. Klump noted at that time that claimant had some atrophy in the muscles of his right hand, and some loss of grip strength. Claimant declined surgery. The prognosis for recovery of motor function was good. SAIF requested closure of the aggravation claim on December 24, 1986. A second Determination Order dated February 23, 1987 granted no award for permanent disability.

Claimant has progressive weakness in his right hand, atrophy in the right hand and right shoulder, pain when he extends his neck, pain in the right shoulder, across the parascapular area and down the right arm to his little finger. There is slowing of the ulnar motor fibers across the brachial plexus. Claimant's neck range of motion is limited to 30 percent of normal. His right shoulder range of motion is limited to 50 percent of normal. He has prominent spasms in the right trapezius. All these signs and symptoms are consistent with his compensable injury.

Claimant worked as a maintenance worker for 8 days in

October, 1986. He left for reasons unrelated to his compensable injury. He continued to seek work to the time of hearing.

ULTIMATE FINDINGS OF FACT

Claimant did not leave the workforce, voluntarily or involuntarily. On May 20, 1986, claimant's condition resulting from his compensable condition worsened and he was unable to work.

As a result of his compensable injury, claimant has suffered permanent impairment in the minimal range.

CONCLUSIONS OF LAW AND OPINION

Temporary total disability

The Referee concluded that claimant had retired as of February, 1986 and therefore had no "lost wages," relying on Cutright v. Weyerhaeuser, 299 Or 290 (1985). Claimant argues that he was still in the work force and still seeking work when his compensable condition flared up, and is therefore substantively entitled to temporary total disability. We agree.

In Chapel of Memories v. Davis, 91 Or App 232 (1988), the court was presented with a similar factual situation. There, claimant credibly testified that he was physically unable to seek work because of a flareup of his compensable condition. We find a similar situation here. Claimant was physically unable to seek work due to his compensable injury and therefore had neither voluntarily nor involuntarily left the workforce.

Here, we find the evidence establishes that claimant looked for work after voluntarily leaving his job with the employer, and but for his compensable injury, would have made reasonable efforts to obtain such employment during the period from May 20, 1986 through November 19, 1986. While the Referee did not make specific credibility findings regarding claimant's testimony, we find no basis to find claimant not a credible witness. He testified that he wanted to earn as much as social security rules allow before an offset against retirement benefits would be necessary. He was registered with the state placement service and worked for a period of 8 days in October 1986 when his condition improved. We conclude that claimant meets the criteria of "worker" as described in Chapel of Memories, supra, and therefore find that he is entitled to temporary total disability from May 20, 1986 to November 19, 1986, less the 8 days he worked during that period.

SAIF argues that claimant has never presented medical verification of inability to work, and is therefore not entitled to temporary total disability. We disagree. Claimant credibly testified that he was still in the workforce and that he was physically unable to seek work because of his medical condition. Moreover, Dr. Klump concluded that claimant's current level of symptoms rendered him less able to work than prior to his current flareup. Claimant may prove entitlement to temporary total disability by medical and lay evidence at hearing. See Botefur v. City of Creswell, 84 Or App 627 (1987). Here, we find that he has.

Penalty and attorney fees regarding temporary total disability

We find that SAIF's failulre to begin paying temporary total disability was not unreasonable. On July 31, 1986,

Dr. Klump provided medical verification of claimant's inability to work as a result of a worsening of his compensable injury. Thereafter, SAIF had 14 days to accept, deny, or begin paying interim compensation. ORS 656.273(4). We find that SAIF's failure to begin paying temporary total disability was not unreasonable. On August 5, 1986, SAIF refused to pay temporary total disability benefits, contending that claimant had retired from the work force. At the time, claimant had applied for a pension from his employer and was receiving Social Security benefits. SAIF never formally accepted or denied the claim, but did process it to closure without paying tempory total disability benefits. As previously noted, we are not persuaded that claimant retired from the work force. However, despite our ultimate conclusion, we do not consider SAIF's refusal to pay temporary disability benefits on that basis to be unreasonable conduct.

Failure to process the aggravation claim

Claimant made an aggravation claim when he asked SAIF to reopen his claim on June 11, 1986. This claim was bolstered by Dr. Klump's July 31, 1986 report that indicated that claimant was less able to work as a result of his compensable injury. SAIF did not deny the claim. Rather, it indicated that it would not pay time loss benefits because it did not believe it was obligated to do so. That letter was within 60 days of the initial aggravation claim. We infer, however, that SAIF accepted the aggravation claim at some point because it referred the claim for closure and the aggravation claim was, in fact, closed. Claimant has the burden of proving that the acceptance was late. He has failed to introduce any evidence that the acceptance was late. Accordingly, he is entitled to no penalty for late acceptance or denial.

Permanent total disability

Claimant does not contend, and the evidence does not establish that he is completely physically disabled.

We also review claimant under the "odd lot" doctrine. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). We consider the factors of age, education, adaptability to other labor, mental condition, and emotional status. If a combination of these factors make it improbable that claimant could ever enter the work force, we may find him permanently totally disabled. Claimant has the burden of proving that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

The Referee gave little weight to the testimony of Dr. Beggs, family physician. Dr. Beggs saw claimant once, shortly before hearing, and opined that claimant was unemployable. He did not take specific measurements, but testified that claimant had moderate loss of range of motion in his right shoulder and some muscle atrophy in his right arm and hand. He attributed this to cervical nerve root compression.

Dr. Klump, claimant's treating physician, did not report any permanent disability, although he indicated to claimant that surgery to relieve nerve root compression was indicated. Claimant declined surgery, and Dr. Klump then reported that claimant would have to live with a certain amount of disabling pain in his right shoulder.

Claimant also relies on his preexisting hearing loss to support a conclusion that he is permanently and totally disabled under the "odd lot" doctrine. The Referee found that claimant exaggerated the extent of his hearing difficulties, based on his observation of claimant's ability to hear. We defer to the Referee's finding, which is based on his ability to observe claimant and give little consideration to claimant's preexisting hearing condition.

A vocational provider testified that claimant was unemployable. This opinion was apparently based on a review of the medical record and one interview, without administering aptitude tests or physical performance appraisals. The lack of thorough vocational evaluations diminishes the persuasiveness of the provider's testimony. Moreover, the vocational provider acknowledged that claimant reained transferable skills in the automobile and truck sales/estimation area.

After reviewing the medical, vocational and lay testimony, we find that claimant is capable of obtaining gainful employment. He has some transferable skills and is not precluded by either his compensable condition or noncompensable hearing condition from working at a variety of jobs he has previously performed, particularly as a maintenance worker. We conclude that claimant is not permanently and totally disabled.

Unscheduled permanent disability

The Referee found that the evidence did not establish any degree of loss of earning capacity. Claimant argues that he is entitled to unscheduled permanent disability for his cervical condition and radiculopathy into the right arm. We agree.

The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at hearing, and all of there relevant social and vocational factors set forth in OAR 436-30-360, et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

The medical evidence does not clearly establish the range, if any, of claimant's permanent impairment. For the reasons expressed by the Referee, we give less weight to Dr. Beggs testimony. Dr. Klump, claimant's longtime treating physician, does indicate that claimant has a condition that will continue to cause disabling pain to some extent. Based on these observations, and claimant's descriptions of his limitations, we conclude that claimant has suffered permanent impairment, as a result of the compensable injury, in the minimal range.

After reviewing the medical and lay evidence, and considering the aforementioned social and vocational factors, we conclude that an award of 20 percent unscheduled permanent disability appropriately compensates claimant for his permanent loss of earning capacity resulting from the compensable injury.

ORDER

The Referee's order dated May 26, 1987 is reversed in part. Claimant is awarded 20 percent (64 degrees) unscheduled permanent disability for his right shoulder condition. Claimant is awarded temporary total disability from May 20, 1986 to November 19, 1986, less the 8 days claimant worked during that period. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
the Beneficiaries of Rockne Luckman,
Deceased, Claimant.

QUADEL INDUSTRIES et al,
Petitioners,

v.

LUCKMAN,
Respondent.

(WCB 85-12369, 86-04809; CA A48103)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 16, 1988.

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.

Martin J. McKeown, Eugene, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

SAIF seeks review of an order of the Workers' Compensation Board determining that claimant's deceased husband, Luckman, was a subject worker under ORS 656.039(4) and that she is, therefore, entitled to workers' compensation death benefits.

The facts are not in dispute. Luckman was employed by Quadel Industries, which had workers' compensation coverage through SAIF. He owned more than 10 percent of the outstanding shares of stock in the corporation and was also an officer and director; therefore, he would not ordinarily have been considered a subject worker, ORS 656.027(9), unless Quadel elected to provide coverage. ORS 656.039(4). He was killed on the job in August, 1985.

Quadel's office manager completed an application for workers' compensation insurance in March, 1984, but it did not elect coverage for corporate officers. The application form contained language stating that it did not include elective coverage for corporate officers who were also directors and had at least 10 percent ownership in the corporation. Following its acceptance of the application, SAIF sent a letter to Quadel notifying it that the application did not provide coverage for corporate officers and advising Quadel to contact SAIF if it desired such coverage. Later, in May, 1984, SAIF sent another letter to Quadel, specifically advising it that it had no coverage for Luckman and was not to consider his wages in

calculating premiums. Despite both notices, Quadel's office manager believed that corporate officers were covered by the policy, and he calculated and sent in premiums based on their wages as if they were covered. SAIF accepted them.

Luckman filed a claim for an eye injury in March, 1985. In the portion of the 801 form to be filled out by the employer, Quadel noted that Luckman was a corporate officer and that the injury happened during the course of his employment and left blank the space for indicating whether the employer doubted the validity of the claim and, if so, the reason for doubting. Quadel's authorized representative signed the employer's portion of the form on its behalf. SAIF accepted the claim, but paid no benefits, because the injury was non-disabling. On August 28, 1985, Luckman was killed on the job. SAIF denied claimant's claim for death benefits on the ground that Quadel had not elected to provide coverage for its officers.

The Board determined that the 801 form filed at the time of the March, 1985, eye injury provided written notice to SAIF of Quadel's election of coverage and that, pursuant to ORS 656.039(4), SAIF was required to provide coverage. That subsection provides:

> "Notwithstanding any other provision of this section, a person or employer not subject to this chapter who elects to become covered may apply to a guaranty contract insurer for coverage. An insurer other than the State Accident Insurance Fund Corporation may provide such coverage. However, the State Accident Insurance Fund Corporation shall accept any written notice filed and provide coverage as provided in this section if all subject workers of the employer will be insured with the State Accident Insurance Fund Corporation * * *."

We disagree with the Board's understanding that ORS 656.039(4) covers this situation. Its application is limited to "a person or employer not subject to" chapter 656 who elects to become covered. Quadel is subject to chapter 656, so the subsection does not apply to it. Luckman, as an officer of Quadel, was not a subject worker as defined by the act, ORS 656.027(9), and was not in a position to elect coverage for himself. That was the choice and responsibility of his employer. ORS 656.039(1). Quadel, as Luckman's employer, could have elected coverage for him, but, because Quadel is an employer subject to ORS chapter 656, that election would not be pursuant to ORS 656.039(4); it would be pursuant to ORS 656.039(1).[1]

ORS 656.419[2] governs contracts for workers' com-

[1] ORS 656.039(1) provides:

> "(1) An employer of one or more persons defined as nonsubject workers or not defined as subject workers may elect to make them subject workers. If the employer is or becomes a carrier-insured employer, the election shall be made by filing *written notice* thereof with the insurer with a copy to the director. The effective date of coverage is governed by ORS 656.419(3). If the employer is or becomes a self-insured employer, the election shall be made by filing written notice thereof with the director, the effective date of coverage to be the date specified in the notice." (Emphasis supplied.)

pensation insurance. Quadel's original coverage became effective when its application for insurance, together with any fees or premiums, were received and accepted by SAIF in 1984. ORS 656.419(3). It could have elected coverage for its officers at that time, but it chose not to. If it had, SAIF's contract would have included a statement that Luckman was covered "by reason of an election to be covered." ORS 656.419(2)(d).

SAIF contends that, in order to obtain coverage for Luckman, Quadel had to file a separate application. However, ORS 656.039(1) does not require an *application* to SAIF for coverage of officers; it requires only the filing of a *notice of an election* of coverage. Where, as here, there is an existing contract of insurance, the statutes do not appear to contemplate that the election of coverage must be "accepted" by the insurer, as is the case with an original application for insurance. ORS 656.419(3). It appears that the unilateral act of giving notice of election of coverage is all that is required.

Quadel's signing and filing the 801 form relating to Luckman's 1985 injury, which indicated that Luckman was a corporate officer and that there was no reason to doubt the validity of the claim, coupled with Quadel's having paid, from the outset, premiums on behalf of Luckman, *see* ORS 656.419(3), constituted sufficient notice to SAIF of Quadel's election of coverage for Luckman. We are aware of no basis on which SAIF could have refused coverage. We therefore affirm the Board's decision that Luckman was a subject worker and that SAIF is required to provide coverage.

Affirmed.

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[2] ORS 656.419 provides, in part:

"(2) A guaranty contract issued by a guaranty contract insurer shall be filed with the director by the insurer within 30 days after workers' compensation coverage of the employer is effective. The filing shall be in such form and manner as the director may prescribe. A guaranty contract shall contain:

"* * * * *

"(d) A specific statement that a named sole proprietor, partner or corporate officer is covered by the contract by reason of an election to be covered, if such is the case, and, if coverage extends to any other person by reason of an election of the employer of the person, a statement of that fact * * *

"* * * * *

"(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."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Thelma T. Smartt, Claimant.

SMARTT,
Petitioner,

v.

ADULT & FAMILY SERVICES et al,
Respondents.

(WCB 86-11704; CA A49051)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 6, 1989.

James L. Edmunson, Eugene, argued the cause for petitioner. On the brief were A. Sue Guthrie and Malagon, Moore & Johnson, 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 Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

Claimant seeks a determination reversing the Workers' Compensation Board and reinstating the referee's decision that the compensable mental stress condition from which she suffers is an injury, not an occupational disease. Claimant suffers from a compensable mental stress condition that she alleges began when she received a poor performance evaluation at work. She argues that her mental condition was unanticipated and came on suddenly and acutely as a result of a specific incident at work; therefore, she contends that it meets the classic criteria of an injury, *see James v. SAIF,* 290 Or 343, 624 P2d 565 (1981), and should be treated as an injury for the purpose of determining the wages on which to base benefits for temporary total disability.

If the condition is an injury, claimant argues that temporary total disability compensation should be calculated as a percentage of her wages on May 14, 1986, the date on which she received the poor performance evaluation, the incident that she alleges caused her "injury." *See former* ORS 656.210(2). If the condition is an occupational disease, temporary total disability benefits are a percentage of her wages on July 9, 1986, the date of disability and the date when claimant first sought medical services. *See SAIF v. Carey,* 63 Or App 68, 662 P2d 781 (1983); *see also* ORS 656.210(2)(b)(B). At that time, claimant's salary was $500 per month less than it had been at the time of the performance evaluation. In reversing the referee, the Board held that claimant had experienced an

occupational disease and calculated her temporary total disability compensation based on her wages on July 9, 1986.

Without deciding whether a mental stress condition may ever be treated as an "injury," *see* ORS 656.802(1)(b), we conclude that the Board's opinion that claimant's condition is an occupational disease is supported by substantial evidence. The Board found that claimant's disabling condition did not happen as a result of the single incident on May 14, 1986, but that her problem had started to develop before that and continued to develop over a period of seven weeks, culminating with her demotion on July 1 and her need for medical services on July 9, 1986. There is substantial evidence to support the Board's findings, and those findings support the Board's conclusion that claimant is suffering from an occupational disease. *See James v. SAIF, supra,* 290 Or at 348.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Tana L. Wilson, Claimant.

SAIF CORPORATION et al,
Petitioners,

v.

WILSON,
Respondent.

(WCB 87-16385; CA A48871)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 6, 1989.

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.

No appearance for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Reversed.

PER CURIAM

Employer seeks review of an order of the Workers' Compensation Board determining that claimant is entitled to

an award of attorney fees under ORS 656.262(10)[1] and ORS 656.382(1),[2] because employer failed to close claimant's nondisabling claim. Claimant was injured at work on January 8, 1981. Employer promptly accepted the claim as nondisabling and paid medical bills. However, employer never closed the claim as required by *former* ORS 656.268(3).

ORS 656.262(10) and ORS 656.382(1) authorize the assessment of penalties and attorney fees if an employer resists payment of compensation or otherwise unreasonably causes a delay in payment of compensation. There is no contention here that employer refused to pay or delayed the payment of compensation. In the two cases on which the Board relied, *Georgia Pacific v. Awmiller,* 64 Or App 56, 59, 666 P2d 1379 (1983), and *Lester v. Weyerhaeuser,* 70 Or App 307, 689 P2d 342, *rev den* 298 Or 427 (1984), holding that a penalty may be assessed for an employer's failure to seek claim closure, the failure resulted in a delayed payment of compensation. Here, there has been no delay in payment of compensation; accordingly, there is no statutory authority on which a penalty on attorney fees may be assessed.

Reversed.

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[1] ORS 656.262(10) provides:

"If the insurer or self-insured employer *unreasonably delays or unreasonably refuses to pay compensation,* or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382." (Emphasis supplied.)

[2] ORS 656.382(1) provides:

"If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Walter F. Drews II, Claimant.

DREWS,
Petitioner,

v.

EBI COMPANIES et al,
Respondents.

(WCB 85-12763; CA A43657)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 4, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. On the brief was Cash R. Perrine, Bend.

Craig A. Staples, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded for further proceedings.

RICHARDSON, P. J.

Claimant seeks review of an order of the Workers' Compensation Board that affirmed and adopted the referee's order on reconsideration. The referee and the Board held that claimant was barred by *res judicata* from challenging the amount of temporary total disability benefits. We reverse.

Claimant sustained a compensable injury in 1980 while working for Unity Construction, which was insured by EBI. Unity's owner reported claimant's wage as $8.50 per hour, and EBI paid temporary total disability benefits based on that wage rate. A determination order of September, 1981, awarded temporary total disability but no permanent disability benefits and closed the claim. In December, 1983, claimant requested a hearing on matters arising subsequent to the determination order. The hearing was held on June 13, 1984. There were several issues addressed at the hearing, but neither party discussed or raised any question about the wage rate base for temporary total disability. The claim was again closed by a determination order awarding temporary total disability and permanent partial disability.

In mid-1985, claimant discovered that the owner of Unity had incorrectly reported his wage rate on the original injury claim form. The correct rate was $10.50 per hour. That was later verified and reported by employer in an affidavit by the owner.

Claimant's counsel sent a letter to EBI regarding the mistake. The record is not clear when EBI received the information and whether it took any action in response to it. A hearing on other matters regarding the claim was scheduled for March 19, 1986, and claimant amended his hearing request to raise the issue of EBI's failure to correct the temporary total disability rate within fourteen days and sought penalties and attorney fees. The referee found that there was no evidence that EBI had corrected the mistake and awarded penalties and attorney fees, because EBI had not responded within a reasonable time.

EBI moved for reconsideration on the ground that claimant was barred by *res judicata.* The referee agreed. In her order on reconsideration she said:

"The evidence in this record indicates that the claimant's

> wage rate was in error on the 801. Time loss was paid in 1980 and the claim closed by a Determination Order in September 1981. If the rate was improper from the very beginning, it could have been corrected in the 1984 hearing.
>
> "* * * [T]he incorrect wage rate was an issue which could

> have been raised in the prior hearing and, since it was not, it was then waived."

In *North Clackamas School Dist. v. White*, 305 Or 48, 750 P2d 485, *modified* 305 Or 468, 752 P2d 1210 (1988), the court discussed the rules of *res judicata* in workers' compensation cases. The principles are applicable in workers' compensation proceedings "where they facilitate prompt, orderly and fair problem resolution." 305 Or at 52. The court said that the rules of *res judicata* involve two separate concepts: claim preclusion and issue preclusion. As in *White*, this case involves a question of issue preclusion. The court explained that concept:

> "If a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment." 305 Or at 53.

The 1984 hearing involved a number of issues concerning claimant's claim for compensation, but it did not involve temporary total disability. The amount of temporary total disability was not determined in the hearing and was not essential to the decision on the claim.

EBI argues, citing *Dean v. Exotic Veneers, Inc.*, 271 Or 188, 531 P2d 266 (1975), and *Million v. SAIF*, 45 Or App 1097, 610 P2d 285, *rev den* 289 Or 337 (1980), that temporary total disability was a separate claim that, under the aggregate of operative facts in existence before the 1984 hearing, could have been asserted and litigated. It follows, EBI contends, that, under the two cases cited, the claim cannot now be litigated. We do not agree that the issue that claimant now seeks to litigate is a claim as that term is used in *res judicata* parlance. EBI had been paying temporary total disability and, consequently, there was no need to raise an issue of entitlement to it. The narrow issue involved is the amount of temporary total disability. More particularly, the question is what was the correct wage rate; that is an issue of fact, not a claim.

It was not raised and was not necessarily determined at the 1984 hearing.

We conclude that claimant is not barred from raising the issue that he does, and the Board erred. Because the Board declined to address the merits of the issue of penalties and attorney fees, we remand for a determination of those issues.

Reversed and remanded for further proceedings.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Bryan D. Warrilow, Claimant.

WEYERHAEUSER COMPANY,
Petitioner,

v.

WARRILOW,
Respondent.

(WCB 86-09029; CA A49099)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 20, 1989.

Ridgway K. Foley, Portland, argued the cause for petitioner. On the brief were Mildred J. Carmack, William H. Replogle and Schwabe, Williamson & Wyatt, Portland.

J. Michael Casey, Portland, argued the cause for respondent. With him on the brief was Doblie & Associates, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded.

BUTTLER, P. J.

Employer seeks review of an order of the Workers' Compensation Board setting aside as inappropriate a partial denial of a claim for a work-related injury. We reverse and remand.

Claimant fell at work. The next day he sought chiropractic treatment for neck, shoulder, mid-back and left ankle pain. An x-ray revealed that he had mild degenerative changes in the cervical area with mild osteophytic spurring. He filed a claim, describing the injury as involving the ankle, neck and left shoulder. Employer first deferred acceptance of the claim. More than 60 days after the injury, it wrote a letter to claimant, stating:

> "We hereby accept that you did suffer an accident while engaged in your work activities * * *. We will be responsible for any treatment related to the effects of this incident. We are going ahead and processing for payment of the medical bills to date.
>
> "The x-rays taken at Mt. Hood Medical Center showed mild degenerative changes with mild osteophytic spurring. Currently we have no medical evidence that these changes are related to your current condition or to your accident * * *. Because these are not related to your injury, we must specifically deny responsibility for them.

> "This is a partial denial only, and does not affect the accepted portion of your claim. Again, we have paid the current medical bills, and will cover treatment related to the incident * * *."

Claimant requested a hearing, contesting the propriety of the denial.

The referee, in a statement at the hearing which he incorporated by reference in the written opinion, held that the denial was premature, because there was no evidence that claimant was contending that the degenerative condition was compensable, either by obtaining treatment or requesting payment of medical bills. At oral argument here, claimant relied in part on that rationale. We agree with employer that such a rule could put the employer in a precarious position. For example, in *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988), the claim was for a "sore back." The employer accepted it, and the medical evidence later showed that the sore back was the result of a noncompensable degenerative

condition. The employer then attempted to deny the degenerative condition, but the Supreme Court held that the employer's acceptance of the sore back claim encompassed all conditions that caused the sore back, including the noncompensable degenerative condition.

Here, employer's early denial of the degenerative cervical condition is intended to protect it from later finding itself in the position in which Georgia-Pacific found itself in *Piwowar*. To refuse to allow the partial denial would require the employer either to accept the claim and risk the result in *Piwowar*, or neither to accept nor deny the claim until all of the possible medical evidence concerning the cause of the condition is available, at which time the employer may be subject to a penalty for a late acceptance or denial. ORS 656.262(10). We reject the referee's rationale as a basis for setting aside the denial.

The Board affirmed the referee, but for a different reason. It set aside the denial on the ground that it did not satisfy the requirements of *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987), concerning what constitutes a partial denial. The Board quoted from that case:

> "The insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies. That specificity, which promotes timely closure of accepted conditions and prompt appeals of denied conditions, is the essence of a partial denial." 303 Or at 58.

It ruled that Weyerhaeuser's letter was not adequate, because it was not preceded by or contemporaneous with an acceptance of the claim and, therefore, did not specify what portion of the claim was accepted and what portion was denied.

We agree with the Board that the letter is vague as to what Weyerhaeuser has accepted, if anything. It expressly "accepts" all conditions "related to" the accident, but does not specify what those conditions are; it would appear to leave Weyerhaeuser the option later to deny other conditions not

specifically accepted on the ground that they are not related to the accident.

Despite its vagueness as to what it accepts, the letter is specific as to what it denies. "[W]e have no evidence that [mild degenerative changes with mild osteophytic spurring]

are related to your current condition or to your accident * * *. * * * [W]e must specifically deny responsibility for them." At a minimum, the letter constitutes a partial denial of the claim to the extent that it might be interpreted as seeking benefits for the degenerative cervical condition. We do not understand the language quoted from *Johnson v. Spectra Physics, supra,* to require that an employer be permitted to deny a portion of a claim only after or when it has accepted a portion of the claim. The significance of that language in context is that, if an employer denies a portion of a claim, it must do so with specificity.

Employer's partial denial protects it from the possibility that the degenerative condition, although perhaps not compensable itself, might later be determined to be encompassed in an acceptance of the claim involving claimant's ankle, neck and left shoulder injury. The partial denial does not, on the other hand, prevent claimant from later showing that the degenerative condition has been worsened or accelerated as a result of the injury. We know of no reason why an employer should not be permitted to deny the compensability of a condition that it reasonably interprets to be encompassed in a claim and which it believes to be noncompensable. Employer's letter specifies clearly the condition that it denies. That is sufficient to meet the requirement of *Johnson v. Spectra Physics, supra.*

Because the only issue that is involved here is the *propriety* of the partial denial, our decision that it is permissible does not mean that the denial is sustained on the merits. That question may be resolved at the appropriate time.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

WATSON,
Respondent,
v.
PUGET SOUND TUG & BARGE COMPANY et al,
Appellants.
(A8509-05722; CA A44520)

Appeal from Circuit Court, Multnomah County.

Clifford B. Olsen, Judge.

Argued and submitted July 13, 1988.

John R. Faust, Jr., Portland, argued the cause for appellants. With him on the briefs was Schwabe, Williamson & Wyatt, Portland.

Raymond J. Conboy, Portland, argued the cause for respondent. With him on the brief were Frank Pozzi and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Richardson, Presiding Judge, and Newman and Riggs, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Plaintiff[1] sued to recover for an occupational disease that he alleged that he had acquired during his work for defendants as a deckhand on tugboats and barges. The court submitted two bases of liability to the jury: negligence under the Jones Act, 46 USC § 688, and unseaworthiness under general maritime law. Defendants asserted the affirmative defense of contributory negligence. The jury found that defendants' vessels were "unseaworthy in a manner that was a substantial factor in causing plaintiff's injuries"; that defendants' negligence caused plaintiff's injuries; that plaintiff did not know and could not, with reasonable diligence, have known before September 16, 1982, "of the existence of the physical conditions which are the subject of this lawsuit and that such injuries were related to his employment"; and that plaintiff was not negligent "in a manner which contributed to his own injuries." Defendants appeal plaintiff's judgment and assign as errors that the court denied their motions for a directed verdict and that it instructed the jury on assumption of the risk. We affirm.

[1] Plaintiff Richard H. Watson died after we heard this case on appeal; Lyle A. Watson, his personal representative, was substituted as plaintiff. We refer to Richard Watson as "plaintiff."

We review the evidence to determine whether it was sufficient to support the jury's verdict. *Menke v. Bruce*, 88 Or App 107, 109, 744 P2d 291 (1987). Except for a brief period, plaintiff worked as a barge deckhand on the Columbia River from 1950 until 1984. The work was physically hard; it included pulling heavy lines, heavy lifting, handling heavy straps, working with cables and ropes and climbing. The work became more difficult during the course of his employment, because defendants reduced the number of deckhands assigned to each crew and towed larger barges. On the largest barges, plaintiff had to work with "superstraps," which were hard core metal wires one and one-half inches in diameter, 30 feet in length, weighing approximately 190 pounds. Defendants regarded him as one of their best deckhands, "a real mule."

Plaintiff often suffered injuries at work, but he recovered from them. In 1959, he hurt his back and went to a

chiropractor for treatment. He strained his back in 1960 and injured it again in 1976. He injured his foot in 1964 and his wrist in 1977. He injured an elbow and suffered a sprained finger in 1984. In July, 1984, he told the doctor that he had had trouble walking on a barge, and on December 5, 1984, he reported that he was unable to walk on a barge. That month, Dr. Skirving, plaintiff's physician, took x-rays of his back. They showed degeneration of his lumbar spine and hips. Skirving informed defendants that plaintiff had degenerative arthritic changes in his back and hips. Defendants then retired plaintiff.

Skirving testified that plaintiff's problems were a result of continued trauma of working. Dr. Thompson, an orthopedic physician who treated plaintiff after he had retired, testified that "repeated acts of having to handle lines and gear and doing heavy manual labor" caused "the injuries and what happened to him."

At the close of plaintiff's case, and at the close of all the evidence, defendants moved for a directed verdict on three grounds: (1) plaintiff had failed to introduce sufficient evidence to prove that defendants were liable due to negligence or unseaworthiness, because he did not identify a standard of care or of seaworthiness that defendants had violated; (2) plaintiff did not have an "occupational disease" for purposes of the Jones Act; and (3) the Statute of Limitations barred plaintiff's claim.

To prove a claim of negligence under the Jones Act, a plaintiff must show that the defendants failed to exercise reasonable or ordinary care under the circumstances.[2] *Carlson v. Wheeler-Hallock Co.*, 171 Or 349, 355, 137 P2d 1001 (1943). Although plaintiff's evidence showed that his work was physically hard and that defendants could have made it easier,

[2] We do not discuss defendants' arguments relating to unseaworthiness, because the finding for plaintiff on the negligence claim is sufficient to support the award. *See Veberes v. Knappton*, 92 Or App 378, 759 P2d 279 (1988); *Wells v. Home Purchasing Corp.*, 84 Or App 103, 106, 733 P2d 898 (1987).

defendants argue that he failed to produce evidence of a standard of care that they had breached. They assert that the jury "cannot unaided determine what equipment and manning are required to meet the legal standards of due care * * * on the particular operations of river tugs and barges." His evidence,

however, was sufficient. Plaintiff's witnesses testified that defendants did not employ enough crew members to complete the assigned tasks without injury to the crew and that the equipment that defendants provided to plaintiff, or authorized others to provide to him, was inadequate to avoid injury. There was also evidence from which the jury could find that defendants knew or should have known of equipment and manning deficiencies on vessels that they did not own, but on which they required plaintiff to work. Accordingly, the jury could find that defendants failed to exercise ordinary and reasonable care under the circumstances. Defendants' showing that the number of seamen assigned to each crew complied with the collective bargaining agreement or "community standards" did not require the court to direct a verdict for them.

The jury also could find from the evidence that defendants' negligence caused the work to be too heavy and could conclude from the medical evidence and plaintiff's testimony that the physical difficulty of the work caused his disease.

The three-year limitation period for a negligence claim under the Jones Act begins to run when the seaman knows, or should know, of the disease and that the work caused it. 45 USC § 56; 46 USC § 688. *Urie v. Thompson,* 337 US 163, 69 S Ct 1018, 93 L Ed 1282 (1949); *see Hutchinson v. Semler et al,* 227 Or 437, 446, 361 P2d 803, 362 P2d 704 (1961). Plaintiff filed his complaint on September 18, 1985. Defendants argue that the claim was barred, because his ailments began in 1959, and he knew, or should have known, before September, 1982, of a causal connection between his work and his condition. Although plaintiff had sustained injuries to various parts of his body, the jury could find from the evidence that he neither knew, nor should have known, before September, 1982, that he had a degenerative condition. Moreover, plaintiff testified that, when he started having serious physical problems in 1983, he did not know, and no doctor then told him, that they were caused by his work. The jury was entitled to believe him.

Defendants assign as error that the court instructed the jury:

> "You are instructed that under the law applicable to this case, the plaintiff cannot be charged with assuming the risk

> and dangers caused by the unseaworthiness, if any, of the vessel, or negligence of the defendant ship owner."

The court should not have instructed the jury on assumption of risk. It was not an issue in the case. *See Plourd v. Southern*

Pac. Transp. Co., 266 Or 666, 671, 513 P2d 1140 (1973). Defendants argue that the erroneous instruction was prejudicial in light of plaintiff's counsel's statement in his closing argument to the jury that it should take care to distinguish assumption of risk from contributory negligence. Defendants assert that, because of the erroneous instruction, this statement could "easily be understood as implying that defendants' arguments on contributory negligence will be contrary to the court's instructions." We have examined the record. Plaintiff's counsel's statement to the jury did not make prejudicial the court's error in its instructions. *See* ORCP 12B.

Affirmed.

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178 April 12, 1989 No. 228

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charles H. Whiddon, Claimant.

UNITED FOAM CORP.,
Petitioner - Cross-Respondent,

v.

WHIDDON,
Respondent - Cross-Petitioner,

BERTSECH MOBIL et al,
Respondents - Cross-Respondents.

(85-14106, 85-14081; CA A46136)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 10, 1989.

Patric J. Doherty, Portland, argued the cause for petitioner - cross-respondent. With him on the brief were E. Kimbark MacColl, Jr., and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Robert K. Udziela, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary and Conboy, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents - cross-respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Reversed on petition for review and remanded for proceedings not inconsistent with this opinion; affirmed on cross-petition.

PER CURIAM

In this Workers' Compensation case, employer seeks review of a Board decision that claimant's request for a hearing was timely.[1]

On August 29, 1985, employer issued a denial of claimant's aggravation claim and sent it by certified mail to claimant's correct address. The denial was returned unclaimed on September 15, 1985, and was re-sent by ordinary mail on November 7, 1985. The denial was appealed on November 14, 1985, more than 60 days from the date of the original mailing.

The Board held that claimant's request was timely because the denial was mailed and not "delivered." We held in *Cowart v. SAIF,* 86 Or App 748, 740 P2d 249 (1987) and *Giusti Wine Co. v. Adams,* 94 Or App 175, 764 P2d 620 (1988), that the date of mailing, not receipt, starts the running of the 60-day period under ORS 656.319. Because the denial was mailed by certified mail to claimant's address on August 29, 1985, the request was not timely. The only question remaining is whether claimant had good cause for filing a late request for hearing.[2]

Reversed on petition for review and remanded for proceedings not inconsistent with this opinion; affirmed on cross-petition.

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[1] We do not address petitioner's other assignment of error, because it was conceded at oral argument. Based on that concession, the cross-petition is moot.

[2] ORS 656.319(1)(b) allows a hearing request to be made more than 60 days from denial if:

> "[t]he 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."

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.

(WCB 85-11970; CA A42850)

Judicial Review from Workers' Compensation Board.

On respondents' petition for reconsideration filed February 1, 1989. Former opinion filed November 23, 1988, 94 Or App 127, 764 P2d 608.

Janet M. Schroer, Delbert J. Brenneman and Schwabe, Williamson & Wyatt, Portland, for petition.

Robert K. Udziela and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, for response.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Petition for reconsideration allowed; former opinion withdrawn; affirmed.

Rossman, J., dissenting.

BUTTLER, P. J.

Employer has filed a petition for reconsideration of our opinion in this case, 94 Or App 127, 764 P2d 608 (1988), in which we reversed the Workers' Compensation Board's decision affirming the referee's dismissal of the claim for failure to comply with a prehearing order requiring discovery. Because we believe that the petition is well taken, we allow reconsideration, ORAP 10.10, withdraw our former opinion and affirm the Board.

The facts are set out in our former opinion. Employer contends that we erred in failing to give proper deference to the Board's interpretation of OAR 438-06-085, which 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 concluded that claimant's continued refusal, over a period in excess of 90 days, to comply with three orders directing him to allow employer free access to claimant's doctor was a delay justifying dismissal under the rule. When claimant failed to respond after the referee gave him 10 days within which to do so, the referee dismissed the claim. The Board affirmed. It interprets the rule to provide that a prehearing delay in discovery occasioned by a claimant's failure to comply with an order allowing discovery is a ground for dismissal for want of prosecution.

We review the Board's decision to determine whether its interpretation is inconsistent with an agency rule, an officially stated agency position or a prior agency practice. *See* ORS 656.298(6); ORS 183.482(8)(a). If it is, we would remand the order to the Board. If it is not, we would affirm. The question to be resolved is a legal one for the court. The Board's interpretation is entitled to "some deference," however, *see Branscomb v. LCDC*, 297 Or 142, 145, 681 P2d 124 (1984), especially in light of the fact that the legislature has given to

the Board a broad mandate to promulgate rules for the performance of its duties, including the power to prescribe procedural rules for the conduct of hearings. ORS 656.727(4); *see*

1000 Friends of Oregon v. LCDC (Lane Co.), 305 Or 384, 390, 752 P2d 271 (1988).

In our former opinion, we substituted our interpretation for that of the Board and held that OAR 438-06-085 "is not a sanction for a failure to comply with discovery" and that the claim should not have been dismissed under that rule for want of prosecution. On reconsideration, we agree with employer that the Board's contrary interpretation is consistent with the wording of the rule and the purpose of the relevant statutes, *see, e.g.*, ORS 656.012; ORS 656.283(7); *see also Price v. Board of Parole*, 300 Or 283, 289, 709 P2d 1075 (1985), and we therefore accept that interpretation.

The Board also held that employer's access to medical information held by claimant's physician should be unrestricted and that claimant had improperly interfered with that access, thereby justifying dismissal of the claim. The Board relied on its opinion in *Alan W. Hayes*, 37 Van Natta 1179 (1985), where it explained its rationale for holding that an employer should have unrestricted *ex parte* access to the claimant's physician. In that opinion, it reasoned that, by filing a claim, the claimant waives any physician-patient privilege. It further held:

> "We find nothing in the statutes or rules requiring an insurer to give claimant prior notice of its intent to contact his or her physician. Further, we find that such a requirement is inconsistent with our stated policy of full, fair and expeditious disclosure of information between the parties. It is also inconsistent with the legislature's intent to create a compensation system that reduces litigation and minimizes the adversarial process." 37 Van Natta at 1182.

Again, we substituted our interpretation for that of the Board, basing our decision, in part, on OAR 436-10-030:

> "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."

We held:

> "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." 94 Or App at 131. (Emphasis in original.)

We held, further, that, in view of the availability of conventional methods of discovery in workers' compensation cases, those methods should be used in the event that a claimant refuses to make medical reports and information available.

We now conclude that we did not accord a proper degree of deference to the Board's interpretation of its own rule. The Board's view that OAR 436-10-630 constitutes an authorization by a claimant for the release of medical information relevant to the claim and that that information should be available without the formality of conventional discovery is consistent with the wording of the rule and the policy expressed in the statutes and rules favoring full and expeditious disclosure of information. *See* ORS 656.012; ORS 656.252(1)(d). The rule does not say, and the Board did not hold, that the doctor is *required* to talk to the employer or insurer. We conclude that the Board's interpretation is a proper one.

Petition for reconsideration allowed; former opinion withdrawn; affirmed.

ROSSMAN, J., dissenting.

I would deny the petition for the reasons I expressed in our former majority opinion. Accordingly, I dissent.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

GRIFFITH,
Appellant,
v.
HODES et al,
Respondents.

(A8702-01086; CA A48557)

Appeal from Circuit Court, Multnomah County.

John G. Crawford, Jr., Judge pro tempore.

Argued and submitted March 3, 1989.

Stephen L. Brischetto, Portland, argued the cause for appellant. With him on the briefs was Baldwin & Brischetto, Portland.

Lee M. Hess, Portland, argued the cause for respondents. With him on the brief was Swire, Riebe & Hess, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded.

RICHARDSON, P. J.

Plaintiff brought this action against his former employers for wrongful discharge, unlawful employment practices and breach of contract. He alleged that his discharge was motivated by discrimination and was based on his having a physical handicap and his having complained about the unsafe working conditions that allegedly produced the hand-

icap. ORS 654.062; ORS 659.425. He also alleged that the discharge was in retaliation for his having sought reasonable accommodation for the handicap and that the discharge violated defendants' personnel manual. Defendants moved for summary judgment on the general ground that there was no evidence demonstrating a genuine issue of material fact and on the additional ground that plaintiff's claims were barred by *res judicata* or collateral estoppel. The trial court granted the motion. Plaintiff appeals, and we reverse.

Plaintiff's employment duties included painting automobile transmissions. He developed physical symptoms, which he attributed to emissions from the paint and which he contends constitute a handicap. He complained to defendants and to the Accident Prevention Division about the perceived work safety problems relating to the emissions. Defendants supplied him with a respirator, which he regarded as inadequate. He refused to work unless they gave him a "functional" one. They ordered him to perform his job and, after his continued refusal, they fired him. After his discharge, plaintiff filed claims for workers' compensation and unemployment compensation. The Workers' Compensation Board and the Employment Appeals Board rejected the claims. Defendants base their *res judicata* and collateral estoppel contentions on the proceedings on the claims.[1]

Defendants' evidence about the two administrative proceedings consisted solely of the referees' decisions and the boards' decisions affirming them. Assuming that both of those

proceedings could otherwise give rise to *res judicata* or collateral estoppel in this action, *see Chavez v. Boise Cascade Corporation,* 307 Or 632, ___ P2d ___ (1989), we conclude that defendants' showing in support of their summary judgment motion did not demonstrate the relationship between the issues that were or could have been raised or decided in the earlier proceedings and in this one that is necessary to support their contentions.

The orders on the workers' compensation claim show that the referee and Board found that plaintiff had not established a right to compensation for "organic solvent encephalopathy." Defendants argue that the Board found that plaintiff's exposure to the solvents did not cause "encephalopathy *or any of his symptoms.*" (Emphasis supplied.) We do not agree that the Board so found. The quoted language was a summary of an expert's evidence, not a Board finding. It can have no barring or preclusive effect. *See Chavez v. Boise Cascade Corporation, supra.*

Defendants also appear to suggest that the Board's ultimate finding was equivalent to a determination that plaintiff was not harmed by the exposure at all and is not handicapped. We are unable to make that connection. We cannot

[1] The Bureau of Labor and Industries conducted an investigation on plaintiff's complaints and concluded that there was substantial evidence that defendants had violated ORS 654.062, by discharging him after he had "opposed unsafe working conditions," and ORS 659.425, by terminating him rather than accommodating a physical handicap. The parties make a number of arguments regarding the Bureau's determinations, which we need not address in view of the bases for our decision.

even determine from the face of the order what "organic solvent encephalopathy" is, let alone whether it is the only possible condition or handicap that can result from the events alleged by plaintiff in this action. Whether or not other portions of the workers' compensation record might substantiate defendants' arguments, the orders alone do not, and they are all that defendants offered. *See Shannon v. Moffett*, 43 Or App 723, 727, n 2, 604 P2d 407 (1979), *rev den* 288 Or 701 (1980).

The unemployment compensation claim proceeding also provides no basis for *res judicata* or collateral estoppel, insofar as the evidence in the record demonstrates. The referee's opinion, which EAB adopted, was that plaintiff's refusal to perform assigned work was misconduct that disqualified him from receiving benefits. The fact that plaintiff was guilty of work-connected misconduct and the underlying facts found by the referee are not decisive of, or even related to, the factual allegations of retaliatory and discriminatory conduct that he

makes against defendants here.[2] *See Chavez v. Boise Cascade Corporation, supra.*

The closer question is whether the ultimate finding in the unemployment compensation proceeding is related to plaintiff's allegations concerning defendants' violation of its personnel manual in any way that could give rise to *res judicata* or collateral estoppel. The manual provides that, under most circumstances, an employe cannot be discharged without having received three warnings in a one-year period. It also provides that some infractions will support termination without warning. Those include an "infraction of rules" and "serious bad behavior" (the listed examples of which are drinking or being drunk on the job, abusive language, fighting, stealing and deliberate destruction of property). Consequently, the referee's finding of misconduct does not actually or necessarily decide the same factual or legal question as the one presented by plaintiff's contract claim, because the manual *may* create a higher threshold for defendants to be able to discharge an employe than the unemployment insurance law creates for establishing that a discharge was based on work-connected misconduct. The unemployment compensation proceeding therefore does not have a collateral estoppel effect.

[2] In *Pintok v. Employment Division*, 32 Or App 273, 573 P2d 773 (1978), we held that there was substantial evidence to support EAB's finding of misconduct by an employe who was discharged for refusing to work with a welding machine. The employe's and the employer's testimony were directly contradictory concerning the adequacy of the ventilation in the work area and the availability of respirators. We also rejected the employe's contention that EAB's order was contrary to ORS 654.062, because

> "[t]his statute does not protect claimant under the facts of this case. ORS 654.062(5)(a) forbids termination of an employee for opposing forbidden practices and for instituting or participating in a proceeding against the employer under Chapter 654. Claimant here refused to do work requested of him. This does not constitute opposing a practice forbidden by Chapter 654." 32 Or App at 277.

Pintok was a direct review of an EAB decision. No question was presented about whether an employer's action can be discriminatory and be proscribed by ORS 654.062, even if the employe is guilty of misconduct. Clearly, an employer can be guilty of discriminating or retaliating against an employe for making a safety complaint at the same time that the employe improperly refuses to work because of an unfounded safety concern. The events are not mutually exclusive. Any suggestion to the contrary in *Pintok* is incorrect. Neither party cites or relies on *Pintok*.

It also does not give rise to *res judicata,* because the meaning and application of the discharge provisions of the manual were not and could not have been decided in the unemployment

compensation proceeding. We reject defendants' estoppel by judgment arguments.

Defendants also attempt to support the summary judgment by arguing that, in a number of respects, plaintiff's evidence fails to raise genuine and material factual issues concerning the reason for his firing, defendants' compliance with statutory and contractual obligations and the existence of a handicap. We do not agree with those arguments, and they require no specific comment. The court erred by entering the summary judgment.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Harlene A. Lloyd, Claimant.

LLOYD,
Petitioner,
v.
EMPLOYEE BENEFITS INSURANCE COMPANY et al,
Respondents.

(WCB 86-05744; CA A48990)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 10, 1989.

Darris K. Rowell, Salem, argued the cause for petitioner. On the brief were Kenneth P. Russell and Olson Law Firm, Salem.

Craig A. Staples, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

GRABER, P. J.

Affirmed.

GRABER, P. J.

Claimant seeks review of an order on reconsideration of the Workers' Compensation Board, arguing that the Board erred in not awarding certain penalties and attorney fees. We review for substantial evidence and errors of law and affirm.

The facts found by the Board are supported by substantial evidence in the record. Claimant injured her left knee

in 1979. That injury resulted in surgery but was not work related. In May, 1984, claimant compensably injured her right knee. In July, 1984, she had surgery on that knee, after which she was released to do light duty work. In January, 1985, additional surgery was performed on her left knee. Employee Benefits Insurance Company (EBI) denied compensability of the left knee condition. Claimant's private health insurance carrier, Bankers Life, paid the medical bills for that surgery while claimant pursued a determination of whether it was compensable. A referee eventually set aside EBI's denial and directed EBI to accept the left knee condition.[1] Neither party sought Board review of that decision.

Thereafter, a determination order awarded claimant temporary disability benefits, 15 percent scheduled permanent partial disability for loss of use of her right knee, and 20 percent scheduled permanent partial disability for loss of use of her left knee. Claimant requested a hearing. The parties entered into this stipulation:

> "On June 26, 1986, [EBI] received an itemization from [Bankers Life] for reimbursement of [Bankers Life's] costs. [EBI] did not provide reimbursement [to Bankers Life] until November 5, 1986."

The referee refused to assess a penalty against EBI (and in favor of claimant) for EBI's delay in reimbursing Bankers Life. Claimant asked for Board review. The Board concluded that it lacked jurisdiction to consider penalties for EBI's late reimbursement of Bankers Life, and that is the first issue presented on review.

The referee and the Board have jurisdiction over

"matters concerning a claim under ORS 656.001 to 656.794." ORS 656.708;[2] *see also* ORS 656.283; ORS 656.289(3); ORS 656.295; *SAIF v. Zorich*, 94 Or App 661, 664, 766 P2d 1053 (1989). ORS 656.704(3) provides:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under ORS 656.001 to 656.794, and for determining the procedure for the conduct and review thereof, matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue."

ORS 656.005(8), in turn, defines "compensation:"

> " 'Compensation' includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self insured employer pursuant to this chapter."

Claimant emphasizes the words "including medical services" and contends that "compensation" includes the payments from EBI to Bankers Life, because they were payments for medical services. Therefore, she says, those payments con-

[1] Claimant reinjured her left knee while trying to protect her compensably injured right knee. That apparently was the basis for the referee's conclusion that the left knee condition was compensable.

[2] Claimant does not assert that the penalty issue falls within the other categories of cases described in ORS 656.708.

cerned a claim. That construction ignores the limiting phrase, "to a subject worker." The payments by EBI to Bankers Life were not made to claimant and thus were not "compensation" within the meaning of ORS 656.005(8).[3] For that reason, the delayed payments to Bankers Life are not "matters concerning a claim" and do not fall within the referee's and the Board's jurisdiction.

Claimant argues that our holding is contrary to "the legislative intent to penalize insurance companies for late payments of bills to medical providers." She relies in particular on ORS 656.313(3) and ORS 656.262(10) and their legislative history to assert that "no logical distinction can be made between payment to a medical provider for services rendered [to an injured worker] and reimbursement of a private health carrier who paid for such services [while the compensability issue was pending]." Whether or not the distinction is "logical," it is one that the legislature has plainly drawn. Moreover, ORS 656.313(3) governs the right to reimbursement of

insurers. For purposes of that statute, "compensation" "does not include the payment of medical services." ORS 656.313(4). ORS 656.262(10) depends on the definition of "compensation" in ORS 656.005(8), which we discussed above. Neither the statutes nor their purposes persuade us that the Board has jurisdiction over what is, after all, a matter between EBI and Bankers Life that does not affect claimant. *See EBI Companies v. Kemper Group Insurance,* 92 Or App 319, 322, 758 P2d 406, *rev den* 307 Or 145 (1988).

In her second assignment of error, claimant argues that the Board erred in not awarding attorney fees for services before the Board. She relies on ORS 656.382(1), which authorizes attorney fees only when an employer refuses to pay "compensation" due or otherwise unreasonably resists the payment of "compensation." In the light of our holding that the payments are not compensation, claimant cannot recover attorney fees.[4]

Affirmed.

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[3] Bankers Life was not claimant's "beneficiary." *See* ORS 656.005(2).

[4] The referee had also assessed penalties against EBI for late payments to claimant. The Board modified the referee's order to increase those penalties, in addition to holding that it had no jurisdiction over the penalty issue that we discuss. Claimant cannot recover fees for prevailing as to the penalty. ORS 656.382(2); *Saxton v. SAIF,* 80 Or App 631, 723 P2d 355, *rev den* 302 Or 159 (1986).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Annette Preston, Claimant.

PRESTON,
Petitioner,

v.

WONDER BREAD et al,
Respondents.

(WCB 87-13133; CA A49098)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 10, 1989.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Allen W. Lyons, Portland, argued the cause for respondents. With him on the brief was Lyons & Scheminske, Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded for reconsideration.

RIGGS, J.

Claimant seeks review of an order of the Workers' Compensation Board that reversed the referee and upheld insurer's denial of her occupational disease claim. We review for substantial evidence and errors of law and remand for reconsideration. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

The Board found that claimant began working as a bakery worker for Wonder Bread in 1979. Since 1984, she had worked as a wrapper, which involved stacking buns on pallets and racks as they came off conveyor belts. Claimant also assisted in loading the ovens and cleaning equipment with an air hose. Her work exposed her to airborne flour dust. In mid-1983, she began experiencing hoarseness, frequent throat clearing, coughing, occasional loss of voice, excessive tearing of the right eye and nasal congestion and discharge. She filed an occupational disease claim in March, 1987. Allergy testing in May, 1987, revealed that claimant was highly allergic to many common inhalant allergens and also to numerous grains. The Board found that

> "claimant's exposure to flour dust in the course of her employment contributed more to the production of her eye, nose and throat symptoms than all other potentially contributing exposures combined."

Those findings are all supported by substantial evidence in the record.

The Board also "found" that claimant's symptoms were "due to" an atopic diathesis, which the Board defined as "a hereditary *predisposition* to react to certain allergens, including the substances to which claimant was exposed at work." (Emphasis supplied.) The Board concluded that "sensitivity to substances found in flour dust" was claimant's "disease" and that the allergic reactions claimant experienced were merely symptoms that did not demonstrate the worsening of her underlying condition necessary for a finding of compensability. *Weller v. Union Carbide Corp.*, 288 Or 27, 602 P2d 259 (1980).

The Board erred as a matter of law, because it applied its findings to the wrong standard by labeling a "predisposition" as the "condition" at issue. That is, its conclusion that

claimant's atopic diathesis is the disease or preexisting condition on which a compensation determination should be based is inconsistent with its definition of atopic diathesis as a *predisposition* to react to certain allergens. A predisposition is a "condition of special *susceptibility* to a disease" (emphasis supplied), not a disease in and of itself. *Stedman's Medical Dictionary* 1133 (23rd ed 1976). Therefore, the Board erred in concluding that claimant's predisposition is the condition to be evaluated.

The record indicates that the condition for which claimant sought compensation was "allergic rhinitis." Subsequent medical evaluations repeated that diagnosis. If, on remand, the Board finds that allergic rhinitis is the condition to be evaluated and that claimant's "eye, nose and throat symptoms" are consistent with that condition, the Board's finding that the major contributing cause of these symptoms is the work environment compels the conclusion that claimant's condition is compensable.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jose Ybarra, Claimant.

YBARRA,
Petitioner,

v.

CASTLE & COOKE, INC.,
Respondent.

(WCB 86-08841; CA A47325)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 23, 1988.

On petitioner's petition for reconsideration filed February 15, 1989, and respondent's motion for clarification filed January 25, 1989. Former opinion filed January 11, 1989. 94 Or App 746, 767 P2d 112 (1989).

Linda C. Love and Francesconi & Associates, PC, Portland, for petition.

Patric J. Doherty and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland, for motion.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Motion for clarification allowed; petition for reconsideration allowed; former opinion adhered to as clarified.

WARREN, J.

Respondent has filed a motion for clarification and claimant has filed a petition for review of our opinion in this case, 94 Or App 746, 767 P2d 112 (1989), in which we affirmed the Board's decision reversing the referee and denying an aggravation claim and payment for chiropractic care. We allow the motion and the petition, and adhere to our former opinion as clarified.

In our opinion, we stated:

> "Claimant contends that he has experienced an aggravation as a matter of law under the rule announced in *Gwynn v. SAIF,* 304 Or 345, 745 P2d 775 (1987), that a worker who is hospitalized or who returns to work after an award and then experiences total disability of 14 days or more has established an aggravation as a matter of law. In this case, claimant did not return to work after his original injury. We conclude, therefore, that the rule in *Gwynn* does not apply."

We agree with claimant that our statement of the holding in *Gwynn* was not precisely correct. Since our opinion in this case, the Supreme Court has decided *Perry v. SAIF,* 307 Or 654, 770 P2d 595 (1989), clarifying its opinion in *Gwynn.* As we understand *Gwynn* now, after *Perry,* in order to establish an aggravation, the claimant must prove an actual worsening of the compensable condition. If the last award contemplated a future worsening, including future periods of temporary total disability, a claimant is not entitled to additional compensation for the expected worsening, unless the period of temporary total disability exceeds 14 days. There is no indication that the Supreme Court intended to limit its holding in *Gwynn* to claimants who experience a worsening *after having returned to work.* To the extent that our quoted statement suggested that to be the case, it was wrong.[1]

Claimant contends that he has been totally disabled for at least 11 months. The medical evidence concerning his condition is in conflict. Dr. Anderson, claimant's treating chiropractor, first examined him in 1985, after the filing of this aggravation claim. In his opinion, claimant has experienced a "natural aggravation" and has been totally disabled for at

least 11 months. Dr. Rosenbaum, a neurosurgeon, examined claimant in 1982, before the last award of compensation, and in 1986. He concluded that claimant's condition has not

[1] We also erred in saying that *Gwynn* provides that a worsening occurs as a matter of law if a claimant is totally disabled *for 14 days or more.*

changed since the last award. Claimant testified that he is worse but admitted that his symptoms have been constant and unchanged since the last award of compensation. He has not worked since then.

The Board accepted Rosenbaum's opinion and concluded that claimant's condition has not worsened since the last award of compensation. That decision is supported by substantial evidence in the record. Claimant is not entitled to compensation for an aggravation under the rule announced in *Gwynn v. SAIF, supra.* Furthermore, we conclude that the Board's decision that further chiropractic treatments are not reasonable and necessary is supported by substantial evidence.

Motion for clarification allowed; petition for reconsideration allowed; former opinion adhered to as clarified.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Eleanor M. Thurston, Claimant.

COLUMBIA COUNTY SCHOOL DISTRICT #13/
LUMBERMEN'S UNDERWRITING ALLIANCE,
Petitioner,

v.

THURSTON et al,
Respondents.

(86-05028; 86-15156; CA A50069)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 14, 1989.

Eric R. Miller, Portland, argued the cause for petitioner. With him on the brief was Terrall and Miller, Portland.

Nancy J. Meserow, Beaverton, argued the cause and filed the brief for respondent Columbia County School District/ Wausau Insurance Companies.

Randy M. Elmer, Portland, waived appearance for respondent Eleanor M. Thurston.

Before Warren, Presiding Judge, and Joseph, Chief Judge, and Rossman, Judge.

WARREN, P. J.

Reversed and remanded with instructions to assign responsibility for disc condition to Wausau Insurance Companies.

WARREN, P. J.

Columbia County School District seeks review of an order of the Workers' Compensation Board determining that it, rather than its former insurer, is responsible for claimant's lumbar disc condition and for her bursitis. There is substantial evidence to support the Board's conclusion with regard to the bursitis. Because the Board applied an incorrect standard

for evaluating the responsibility question with respect to the lumbar disc condition, we reverse as to that condition only and remand.

Claimant began working for employer in 1976, when it was insured by Wausau Insurance Company. She suffered a lumbar disc injury in February, 1984, for which she was compensated by an award of five percent permanent partial disability. In July, 1985, employer became self-insured. In February, 1986, claimant again experienced low back pain. Dr. Mason, her treating physician, reported that her symptoms were due to bursitis, not to her original back problem. In his opinion, claimant's work in early 1986 brought on the bursitis and also "very likely" had an effect on the lumbar disc condition. However, there is substantial evidence to support the Board's finding, in accepting Masons's opinion, that claimant's symptoms are not caused by the disc condition but by the bursitis.

The Board held that, because Mason believed that claimant's employment in early 1986 had worsened the disc condition, that condition should be the responsibility of employer, who is now self-insured. Although there is evidence to support the Board's conclusion that claimant's disc condition has become objectively worse as a result of her employment, in order to shift responsibility to a subsequent employer or insurer the subsequent employment must contribute independently to disability or the need for treatment. *See Boise Cascade Corp. v. Starbuck,* 296 Or 238, 657 P2d 1044 (1984). Because claimant has not experienced disability or a need for treatment as a result of her worsened disc condition, there is no basis for shifting responsibility for that condition.

Reversed and remanded with instructions to assign responsibility for the disc condition to Wausau Insurance Companies.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Conrad N. Delanoy, Claimant.

DELANOY,
Petitioner,

v.

WESTERN SHAKE COMPANY et al,
Respondents.

(WCB 86-11549; CA A47790)

Judicial review from Workers' Compensation Board.

Argued and submitted October 17, 1988.

David C. Force, Eugene, argued the cause and submitted the briefs for petitioner.

Darrel E. Bewley, 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 Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded for reconsideration.

NEWMAN, J.

Claimant seeks review of a Workers' Compensation Board order that affirmed without opinion the referee's order denying a claim for permanent total disability.[1] Claimant asserts that the order is contrary to law and "is not supported by substantial evidence in the record." Because the order is inadequate for review, we reverse and remand.

The referee recited these facts as "evidence." Claimant, now age 42, injured his right knee in 1963 at his first job, shoveling oysters. Dr. Manley, an orthopedist, fused the knee in 1977, that shortened claimant's right leg. Claimant has also had low back problems since January, 1975, and a flare-up of back problems in 1978 that Manley attributed to the shortened leg. He has worked in the woods, driven a gravel truck, operated heavy equipment and, from 1966 until 1976, worked in a shake mill of which he was part owner. He is barely able to read and write but has good arithmetic skills.

In 1978, claimant began to work in one of employer's shake mills as a sawyer. In July, 1979, he twisted his left knee at work and filed a compensation claim. Manley diagnosed medial collateral ligament strain and performed arthroscopic examinations on the knee in September, 1979, and in May, 1980. He diagnosed chondromalacia and synovitis. In March, 1981, claimant returned to work in another of employer's shake mills. His claim was reopened in December, 1981, for more knee surgery. Dr. Degge examined him for employer in July, 1982, and found that he was medically stationary with "mildly moderate" left knee loss of function and inability to do work requiring prolonged standing, bending, walking, stooping or climbing. A determination order closed the claim on August 13, 1982, with no further award of permanent disability.

In November, 1982, claimant's left knee worsened and Manley referred him to Dr. Rusch, another orthopedist, who performed a major ligament reconstruction on January 21, 1983. In October, 1983, claimant stepped in a hole and

ruptured that reconstruction. On January 30, 1984, he underwent another major ligament reconstruction. On May 5, 1986, Orthopaedic Consultants examined him and concluded:

> "It is our recommendation that he can have a sedentary type job only, probably at home since he is unable to drive a car because of the right knee. Due to his inability to read or write his prognosis of returning to gainful employment is definitely guarded."

[1] The referee increased claimant's scheduled disability award for the loss of function of his left leg and increased his unscheduled permanent disability award for a low back condition.

Manley agreed with the recommendation but stated that claimant is "permanently disabled." A determination order closed the claim on August 11, 1986, and awarded claimant an additional 10 percent for loss of use of the left leg and 35 percent for unscheduled permanent partial disability.

The referee described some of claimant's vocational rehabilitation efforts. Manley recommended vocational assistance in October, 1980. Vocational services were suspended in June, 1982, until claimant was declared medically stationary. In August, 1982, after claimant underwent surgery, Manley again recommended vocational assistance. He participated in a number of counseling sessions from 1980 until May 9, 1986. According to the referee, vocational services were terminated on May 9, 1986, "as a result of claimant indicating that he had no desire to participate in training nor return to work." The referee concluded:

> "The evidence does not preponderate in favor of finding that claimant is incapable of employment on a physical basis alone. Dr. Manley has expressed his opinion numerous times that claimant is 'permanently disabled.' However, he has also indicated that claimant is capable of sedentary work where he can arise as needed, and it is apparent that he is including claimant's non-physical conditions in his conclusion. The latest examination by Orthopaedic Consultants found claimant physically capable of sedentary work as well. Claimant must therefore prove that he is incapable of employment as a result of a combination of his physical disabilities and non-physical factors. In this regard, *the evidence is undisputed that he is currently unemployable.* Although transferrable skills were identified, they were not felt to be sufficient without retraining, including improvement of his literacy.
>
> "Therein lies the problem in this case. Claimant has considered himself to be permanently disabled even before he returned to work as a sawyer for ten months in 1981. Granted, his knee worsened thereafter requiring reconstruction, and it is not disputed that he is no longer able to engage in that occupation, nor any other that he has previously performed. *He did finally participate in a vocational evaluation program, which found both physical and aptitudinal abilities to engage in sedentary work. However, claimant declined to participate further in vocational services. Although there is certainly no guarantee that participation therein would result in success in returning him to employment, his refusal to make the attempt has foreclosed the possibility.* As a result, claimant

[2] ORS 656.206(1)(a) provides:

> " 'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation. As used in this section, *a suitable occupation is one which the worker has the ability and the training or experience to perform, or an occupation which the worker is able to perform after rehabilitation.*" (Emphasis supplied.)

[3] We do not read the referee's statement that claimant refused to attempt to participate in vocational rehabilitation services and thereby "foreclosed the possibility" that he could return to employment to mean that the referee would deny PTD if he found that there was only a remote chance that claimant could be reemployed. A mere *possibility* that claimant might be reemployed at an unspecified time in the future is an insufficient basis on which to deny PTD. *See Welch v. Banister Pipeline,* 70 Or App 699, 702, 690 P2d 1080 (1984), *rev den* 298 Or 470 (1985).

has failed to establish that he is willing to make reasonable efforts to attempt to return to the labor market, and is therefore not entitled to an award of permanent total disability." (Emphasis supplied.)

The referee's findings that claimant is "currently unemployable" and that his skills "were not * * * sufficient without retraining"[2] are supported by substantial evidence in the record. He denied PTD, however, on the ground that claimant's refusal to participate in vocational services foreclosed the possibility of employment[3] and, therefore, that claimant has failed to show he was "willing to seek regular gainful employment and * * * ha[d] made reasonable efforts to obtain such employment." ORS 656.206(3).

In *Gettman v. SAIF,* 289 Or 609, 616 P2d 473 (1980), the court held that the Board cannot deny a PTD award "based upon a speculative future change in employment status" and that whether a claimant is permanently totally disabled "must be decided upon conditions existing at the time of the decision, and [the] award of compensation for [PTD] can be reduced only upon a specific finding that the claimant

presently is able to perform a gainful and suitable occupation." 289 Or at 614. *Gettman,* however, does not control the present case, because the court in that case declined to decide the effect on a PTD claim of "a claimant's unreasonable refusal to undertake or complete an offered course of vocational rehabilitation." 289 Or at 615 n 3. We interpret *Gettman* to mean that an unreasonable refusal to undertake or complete an offered course of vocational rehabilitation constitutes a failure to show that claimant was "willing to seek regular gainful employment and * * * ha[d] made reasonable efforts to obtain such employment."

The referee did not make the findings necessary to support his conclusion. He did not find who terminated claimant's vocational rehabilitation services or how or to whom claimant indicated "a desire to terminate services."[4] Moreover, although the referee recounted some of the vocational services offered to claimant, or in which he participated, he did not recount or resolve conflicts in the evidence of claimant's involvement. For example, he stated that, in January, 1986, claimant was evaluated at the Northwest Vocational Evaluation Center, after which Accra, a counselor, concluded that, although claimant did not have the skills to be employed immediately, there were several specific jobs that he could perform after on-the-job training and basic education. On the other hand, Dr. Fleming, a clinical psychologist who examined claimant on September 9, 1986, agreed with Accra's assessment of claimant's abilities and aptitudes but believed that claimant did not have the stamina and endurance to perform the described jobs. Fleming discussed at length Accra's job recommendations and why, in his opinion, claimant was disabled from performing them. The referee did not discuss, let alone weigh or resolve the conflict between Accra's and Fleming's conclusions. The referee did not find whether claimant

[4] The referee's statement that claimant desired to terminate services apparently rests on a letter to claimant from the department that states that his right to receive vocational rehabilitation services is revoked under *former* OAR 436-120-090(7). Other subsections of that rule, however, require that a claimant receive a written warning that his eligibility for vocational assistance will end because he has failed to cooperate. The file contains none.

was able to participate in on-the-job training in January, 1986, whether such training was available or whether it was offered to claimant and he unreasonably refused it.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Angela M. Stratis, Claimant.

STRATIS,
Petitioner,

v.

GEORGIA-PACIFIC CORPORATION,
Respondent.

(WCB 85-14407; CA A45884)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed February 22, 1989. Former decision filed January 18, 1989, 94 Or App 781, 767 P2d 934.

David C. Force, Eugene, for petition.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reconsideration allowed; former decision adhered to.

NEWMAN, J.

Claimant petitions for review of our decision that affirmed without opinion an order of the Workers' Compensation Board affirming and adopting the order of the referee that denied her claims for aggravation and medical services. 94 Or App 781, 767 P2d 934 (1989). We treat the petition as one for reconsideration, review for substantial evidence and errors of law and adhere to our previous decision.

In July, 1981, claimant injured her hands while working as a grader/dryer for employer. She continued to work but was laid off near the end of August. She has not worked since then. On September 4, 1981, Dr. Jefferson diagnosed "carpal tunnel syndrome." A few days later, claimant signed a report of injury on Form 801, in which she described her injury as a "strain" of the "fingers" of her left and right hand and gave the cause as the "continuous use of fingers on job, pulling wood off dryer." On September 25, 1981, employer accepted the claim as submitted and as a disabling injury. It also described the accident as "continued use of hands in performing work caused fingers on both hands to become painful." In October, 1981, Jefferson wrote to employer that, on September 4, 1981, he had seen the "signs and symptoms of carpal tunnel syndrome, which I felt was related to her employment at Georgia-Pacific," but that he "did not authorize time off."

Claimant continued to suffer pain and swelling in her wrists and, after further diagnoses in November and December, 1984, underwent a right carpal tunnel surgical release in March, 1985. She was diagnosed as medically stationary as of June 14, 1985. On September 23, 1985, a determination order awarded her temporary total disability and 10 percent permanent partial disability of the right wrist.

Claimant continued to suffer pain and numbness in her hands, as well as other symptoms, and consulted several doctors. About November 1, 1985, she filed an aggravation claim, which employer denied on January 13, 1986. Employer wrote:

> "This letter is to confirm that you have an accepted bilateral carpal tunnel condition, with no residuals.
>
> "It is now Georgia-Pacific's position that your current

> problems are not industrially caused, and we must respectfully deny your claim for aggravation.
>
> "Additionally, all medical bills will be reviewed on an individual basis, as to which will be accepted and which will be denied."

In March, 1986, employer denied a claim for $33.25 for diagnostic tests. The denial states that employer has

> "received a charge from Pathology Consultants totalling $33.25, and itemizing diagnostic tests for anti-nuclear antibodies and rheumatoid factor RA. These tests were recommended by Dr. John Mundall.
>
> "Please be advised that it is Georgia-Pacific's position [that] this bill is in no way related to the initial injury of July 1981, and we are, therefore, denying responsibility for the charge."

Claimant requested a hearing on the determination order, the denial of the aggravation claim and the denial of the medical bill.

The referee affirmed the determination order and claimant does not assign as error the Board's affirmance of the referee on that point. The referee also denied the aggravation claim. He stated:

> "Following claim closure claimant continued to treat with Dr. Jewell for hand pain, right worse than the left. Follow-up examination by Dr. Macritchie on September 30, 1985 on referral of Dr. Jewell found right hand pain, etiology unknown. She was unable to explain claimant's hand pain. Dr. Wasner in examination of August 28, 1985 likewise found non-specific hand pain, etiology unknown. While Dr. Jewell by letter dated October 16, 1985 to the employer found claimant suffering a recurrence of numbness, pain and swelling in her hands and not medically stationary, he made no specific relationship of this condition to her job, and Dr. Mundall, to whom Dr. Jewell had referred claimant, saw claimant on December 13, 1985 and found claimant with very little in the way of neurological abnormallities [sic] and concluded that a problem was musculoskeletal and Dr. Zivin who saw claimant on November 27, 1985 found no neurological grounds that would attribute her multitude of physical symptoms to the job exposure and found that none of her current symptoms could be explained by carpal tunnel problems."

The referee also stated that, after the surgery, "[claimant]

continued to treat with Dr. Jewell and repeat examination on February 5, 1986 found her condition unchanged." The referee also wrote that "since 1985 her condition has remained approximately the same." Furthermore, claimant testified that after the determination order, "the symptoms were the same * * *. It hasn't changed. * * * I don't think they were worse."

Claimant argues that the issue is the scope of employer's 1981 acceptance and that, under *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), and *Georgia-Pacific v. Piwowar,* 305 Or 494, 753 P2d 948 (1988), employer is liable for her "worsening." On the issue of aggravation, the question is not the scope of employer's initial acceptance, but whether claimant's condition worsened after the determination order of September 23, 1985. *See* ORS 656.273(1).[1] There is substantial evidence to support the Board's finding that it did not. The Board did not err when it affirmed the referee's denial of the aggravation claim.

The referee also upheld the March, 1986, denial of the $33.25 bill from Pathology Consultants for tests that it made for antinuclear antibodies and rheumatoid factor RA. He stated:

> "This matter was incompletely developed at hearing and it appears that all bills were received after the denial. There is no showing when the bills were incurred. A claimant has the burden of proving a claim. Consequently, the denial must be affirmed."

Although the bill from Pathology Consultants was received before, not after the denial, ORS 656.245(1) provides that "[f]or every compensable injury, the * * * employer shall cause to be provided medical services for conditions resulting from the injury." Claimant must show by a preponderance of the evidence that the medical services were provided for a condition "resulting from the [compensable] injury." *See Brooks v. D & R Timber,* 55 Or App 688, 691, 639 P2d 700 (1982).

Claimant asserts that Dr. Mundall ordered the diagnostic test to diagnose a previously accepted condition. On December 13, 1985, Mundall examined claimant and reported:

> "IMPRESSION: 1. Previous right carpal tunnel syndrome treated surgically.
>
> 2. Continued right arm pain, most likely secondary to a musculoskeletal cause such as tendinitis.
>
> "I doubt that the patient has a sensory or motor polyneuropathy. She has absolutely normal sensory and motor function in the feet and her symptoms are atypical for this illness. I can't so easily, however, rule out a multiple mononeuropathy as suggested by Dr. Macritchie's studies. However, I think that it is also unlikely based on my examination. She really has very little in the way of neurologic abnormalities and I think her problem is musculoskeletal now. She has had a definite

[1] Although the legislature amended ORS 656.273 by Or Laws 1987, ch 884, § 23, it did not amend subsection (1).

change in her symptoms from surgery and I think that there was most likely a successful decompression of her median nerve (I do not know what her preoperative electrical studies showed). Because of some functional aspects of her exam, (she seems to embellish her symptoms and has a functional giving away type motor exam. of the right arm) I wondered about 'fibrositis.' If she tolerates it and has not been already tried, I would suggest an antidepressant in managing her problems. I will send a copy of this note to Dr. Macritchie who is seeing her on an regular basis. The patient is going to get a copy of her blood tests. If she has not had a screen for the causes of a multiple mononeuropathy such as an ANA, RA and Sed rate and glucose, I am going to go ahead and order those."

The last sentence refers to the tests for which Pathology Consultants charged.[2]

In *Georgia Pacific v. Piwowar, supra,* the employer attempted to terminate the claimant's permanent partial disability payments after it had accepted her "sore back" condition. It learned after its acceptance that the condition might be caused by a disease—ankylosing spondylitis—that was unrelated to the claimant's work. The court, however, required the employer to continue to pay compensation for the previously accepted condition on the ground that an employer must continue to compensate a claimant for specific accepted conditions, regardless of the cause of that condition. *Piwowar* did not consider the compensability of medical services under ORS 656.245. Compensation, however, includes medical services resulting from the accepted condition. ORS 656.005(8).

Piwowar requires us to consider the scope of employer's original acceptance. If the medical services in dispute resulted from "strain" of the fingers of both hands or carpal tunnel syndrome, employer must pay for them.

Even if we give full scope to the language of the 1981 acceptance, there is substantial evidence to support the Board's determination that claimant's symptoms when Mundall ordered the diagnostic procedure were not results of the accepted conditions of "strain" of fingers or carpal tunnel syndrome. The Board did not err when it affirmed the referee's ruling that upheld denial of the $33.25 medical bill.

Reconsideration allowed; former decision adhered to.

[2] The results of the tests were negative.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of the Beneficiaries of Leon V. Liacos, Dec'd, Claimant.

LIACOS,
Petitioner,

v.

SAIF CORPORATION,
Respondent.

(TP-87030; CA A48158)

Judicial Review from Workers' Compensation Board.

Submitted on record and briefs April 3, 1989.

Michael D. Royce and Royce, Swanson & Thomas, Portland, filed the brief for petitioner.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Darrell E. Bewley, Assistant Attorney General, Salem, filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

PER CURIAM

Petitioner, the surviving spouse of a deceased worker, seeks review of the Workers' Compensation Board's amended third party distribution order. The underlying third party action was for the wrongful death of the worker, and the beneficiaries of that action include persons who are not beneficiaries for purposes of the Workers' Compensation Law. Petitioner argues that the Board erred by including the part of the settlement allocable to those persons in the third party distribution computation. After the Board issued its order, we decided *Scarino v. SAIF,* 91 Or App 350, 755 P2d 139, *rev den* 306 Or 660 (1988), which supports petitioner's argument. The Board must reconsider the order in the light of *Scarino.*

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
David T. Wright, Claimant.

WRIGHT,
Petitioner,

v.

BEKINS MOVING & STORAGE COMPANY et al,
Respondents.

(WCB 86-13710, 86-08766 & 86-13709; CA A46153)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted June 16, 1988; resubmitted in banc May 10, 1989.

James L. Edmunson, Eugene, argued the cause for petitioner. On the brief were Karen M. Werner, and Malagon & Moore, Eugene.

Catherine Riffe, Portland, argued the cause for respondents Bekins Moving & Storage Company and Pacific Marine Insurance Co. On the brief were Jay W. Beattie, and Lindsay, Hart, Neil & Weigler, Portland.

Michael G. Bostwick, Portland, waived appearance for respondent Argonaut Insurance Company.

Constance L. Wold, Beaverton, waived appearance for respondent Wausau Insurance Company.

RICHARDSON, J.

Affirmed.

Newman, J., dissenting.

RICHARDSON, J.

The issue in this workers' compensation case is whether claimant timely requested a hearing on employer's denial of his claim. The time for seeking review was specified in *former* ORS 656.262(8) and *former* ORS 656.319(1).[1] In essence, the request for hearing must be filed within 60 days after the claimant was notified of the denial or within 180 days, if he shows good cause for not filing the request before the 60th day. *Former* ORS 656.262(8) provided that, if the employer or its agent denies the claim, a notice of the denial shall be mailed to the worker. "The worker may request a hearing on the denial at any time *within 60 days after the mailing of the notice of denial.*" (Emphasis supplied.) *Former* ORS 656.319(1) provided:

> "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:

[1] Both statutes were amended in 1987 but the amendments do not relate to the provisions involved in this appeal.

"(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 a request by the 60th day after notification of denial." (Emphasis supplied.)

We review for substantial evidence, *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988), and the parties agree that there was substantial evidence to support the referee's findings. Claimant filed a claim on May 15, 1985, and notification that it was denied was mailed by employer to claimant on August 20, 1985. Claimant did not receive the letter and first learned of the denial on June 18, 1986. He filed a request for hearing on June 24, 1986. Claimant's request was well beyond the 60-day and the 180-day limitation if the time limitation commences on the date of the mailing of the notice.

Claimant's first argument that the request was timely is that the language of ORS 656.319(1)(a) means that the time begins to run from the date when he receives notice. He

focuses on the language of ORS 656.319(1)(a) that the request for hearing must be filed not later than the 60th day "after claimant was *notified* of the denial." The Supreme Court, in *Norton v. Compensation Department,* 252 Or 75, 448 P2d 382 (1968), construed notification to be when the notice of denial is mailed as specified in ORS 656.262(8). There is no question but that claimant did not request a hearing within 60 days after the date that employer mailed the notice of denial.

Claimant argues in the alternative that the fact that he did not receive the notice is an extenuating circumstance recognized by the court in *Norton* as a basis for relief from the time limitation. The court said in *Norton:*

"It is, of course, conceivable that the mailing of the notice of denial will not bring notice of the denial to the workman within 60 days after the denial or will not bring notice within a reasonably substantial time after the mailing, all through no fault of the workman. What relief can be granted to the workman in such event will have to depend upon the particular circumstances of each case." 252 Or at 78.

In *Burkholder v. SAIF,* 11 Or App 334, 502 P2d 1394 (1972), we held, on the basis of that statement in *Norton,* that there were extenuating circumstances and that the claimant's request, although filed more than 60 days after the notice was mailed, was nevertheless valid. The principal extenuating circumstance was the fact that the insurer had mailed the notice of denial to an address at which claimant had never lived or received mail, even though his correct address was known. Although mailing is a method reasonably calculated to give notice to a claimant, the notice must at least be correctly addressed. When it is not, as in *Burkholder,* the notice in effect has not been mailed.

In this case, the notice was correctly addressed and mailed but was not received by claimant. There is no indication that the fact that the notice was not received was due to

any fault of claimant or employer. The extenuating circumstance, claimant argues, is that he did not receive the notice. However, if that were considered one of the circumstances contemplated by the dicta in *Norton* and expanded as a principle of law in *Burkholder,* then the statutory period would in effect begin to run from the date that a claimant *received*

notice, which is directly contrary to the court's interpretation of the statute in *Norton.*

The workers' compensation system is purely a creature of statute and many of the provisions, such as filing deadlines and excuses for untimely filings, involve political accommodations of the competing interests of employers and claimants and the need for an orderly litigation system. Courts simply have no authority to add additional nuances to the legislative equation. The Supreme Court, in *Norton,* decided that the time limitation for contesting a denial begins when the denial is mailed. That is an interpretation of the statutory language. From that point, the statute provides clearly when the request for hearing must be filed to be on time—60 days, or 180 days if good cause can be shown. There is no statutory basis for adding a third category that excuses a request made after 180 days from the date of mailing, if there are "extenuating circumstances." Insofar as *Burkholder* suggests that a request filed after 180 days can ever be timely, it is disapproved.

Affirmed.

NEWMAN, J., dissenting.

The majority asserts that ORS 656.319(1) means, without exception, that the date of mailing is the date on which a claimant is "notified" of the insurer's denial. Both *Norton v. Compensation Department,* 252 Or 75, 448 P2d 382 (1968), and *Burkholder v. SAIF,* 11 Or App 334, 502 P2d 1394 (1972), repudiate that inflexible position. As *Norton* says:

> "It is, of course, conceivable that the mailing of the notice of denial will not bring notice of the denial to the workman within 60 days after the denial or will not bring notice within a reasonably substantial time after the mailing, all through no fault of the workman. What relief can be granted to the workman in such event will have to depend upon the particular circumstances of each case." 252 Or at 78.

The referee found, and the parties do not dispute, that claimant did *not* receive insurer's denial letter of August 20, 1985. He first learned of the denial after June 18, 1986. He had not changed his address. He had regularly received mailings from insurer at that address. Absolutely nothing happened to alert him to the denial until he received the

settlement letter from insurer that referred to it. Then he acted immediately and requested a hearing. What more could he have done? Yet, the majority says he is cut off. The legislature did not intend such a startling result.

Contrary to the majority's position, the issue is not

whether *the insurer* is at fault.[1] The majority misinterprets *Burkholder,* the point of which is *not* that the insurer was at fault because it misaddressed the envelope, but that the claimant, *through no fault of his own,* was not notified of the denial. It does not matter here that insurer correctly addressed the denial letter. The point is that claimant, through no fault of his own, was not notified of it.

The legislature never intended a Kafkaesque system that cuts off a claimant's remedy, even though he has no notice that he must act to preserve his rights. We decided *Burkholder* in 1972. ORS 656.319 *then* provided, *as it does today,* for a claimant to request a hearing within the 60-day and 180-day periods from the time when he is notified of the denial. Nonetheless, in *Burkholder* we applied *Norton* and ruled that the 60 day period did *not* begin to run on the date that the insurer mailed the denial letter, because the claimant, through no fault of his own, was not notified of the denial. The legislature has frequently amended the Workers' Compensation Law after 1972, but it has not amended ORS 656.319 to repudiate *Burkholder.*

Burkholder speaks to when a claimant is "notified" of a denial, as does *Norton. Burkholder* leaves undisturbed the 60-day and 180-day periods from the time of notification within which a claimant must request a hearing. Neither period begins to run until the claimant is notified of the denial; but, even if, as the majority asserts, my position creates a third time period, this is precisely what *Burkholder* allows in

"extenuating circumstances." It is precisely what the legislature has recognized by accepting that decision in the intervening years.

We should continue to construe the act in favor of the worker. In *Livingston v. State Ind. Acc. Com.,* 200 Or 468, 472, 266 P2d 684 (1954), the court stated:

> "This court has uniformly held that the provisions of the Workmen's Compensation Law should be interpreted liberally in favor of the workman, and particularly should this be so when we are confronted with a 'borderline' case. In the interests of justice, and to carry out the humane purposes of the Compensation Law, all reasonable doubts should be resolved in favor of the workman."

We need only follow our own precedents here to carry out the humane purposes of the act. The majority urges us to "disapprove" *Burkholder.* Why? It is consistent with a long tradition that an injured party should not lose his remedy because he is kept in ignorance of what he should do to gain redress.

I dissent.

Rossman, Deits and Riggs, JJ., join in this dissent.

[1] If insurer had acted in the manner then strongly advised by *former* OAR 438-05-065, it would have delivered the denial to claimant by "registered or certified mail with return receipt requested." Had the insurer used that form of mailing, it would then have had reason to believe that claimant had not received notice of the denial and it could have acted to see that he did receive it. The Board amended *former* OAR 438-05-065 after it heard this claimant's appeal to require that a notice of denial "*shall* be delivered by registered or certified mail with return receipt requested or by personal service * * *." (Emphasis supplied.)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

LUSK,
Appellant,
v.
MONACO MOTOR HOMES, INC.,
Respondent.

(16-87-06402; CA A49132)

Appeal from Circuit Court, Lane County.

Maurice K. Merten, Judge.

Argued and submitted February 13, 1989.

Leslie M. Swanson, Jr., Eugene, argued the cause for appellant. With him on the briefs was Swanson & Walters, P.C., Eugene.

Joel S. DeVore, Eugene, argued the cause for respondent. With him on the brief was Luvaas, Cobb, Richards & Fraser, P.C., Eugene.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

GRABER, P. J.

Reversed and remanded.

Riggs, J., specially concurring.

GRABER, P. J.

Plaintiff appeals from a summary judgment for defendant, his former employer,[1] in this personal injury case. The trial court held that plaintiff's exclusive remedy is under the Workers' Compensation Law. Plaintiff alleged that defendant deliberately intended to produce the injury that he suffered, but the trial court held that there was no genuine issue of material fact that would support that assertion. We reverse.

We state the facts most favorably to plaintiff, drawing all reasonable inferences in his favor. *State ex rel Redden v. Will. Recreation,* 54 Or App 156, 159, 634 P2d 286 (1981). Defendant builds mobile homes and, as part of the production process, paints portions of them. Before September, 1985, defendant subcontracted the painting, but at that time it installed two painting booths and hired defendant as one of its painters. The booths were designed to keep dirt and particles off the painted surfaces and to speed up drying; they were not designed to provide adequate ventilation for those using them. During spray painting, plaintiff worked in a cloud of paint mist and vapors.

Many of the paints that defendant used contained isocyanates. The product container labels warned that the

[1] The employer's workers' compensation insurer also was a defendant. It was dismissed from the action and is not a party to this appeal.

spray and vapors could cause lung injuries and allergic respiratory reactions and required that those working with the paints use supplied-air respirators. Defendant furnished only cartridge respirators whose labels warned against use with paints containing diisocyanates. Defendant did not warn plaintiff of the dangers to which he was exposed. He learned of them only by reading the warning labels.

In November, 1985, plaintiff began to get sick from the paint. He had headaches, felt dizzy and nauseous, became disoriented and irritable, and suffered memory loss. He asked his supervisor for a supplied-air respirator. Twice he told an inspector for defendant's workers' compensation insurer of the need; in the second conversation, the inspector expressed surprise that defendant had taken no action. A state inspector told defendant that supplied-air respirators would soon be required by the government. Plaintiff's supervisor asked

defendant to furnish a supplied-air system several times, including once in writing. In February or March, 1986, defendant brought in a supplied-air system for the painters to try out for a few days, but it refused to buy the system, because it did not wish to spend the necessary $2,000 per unit. Plaintiff's symptoms became worse and, on the advice of his physician, he quit as of June 4, 1986. He filed a workers' compensation claim and received benefits. Because of his sensitivity to hydrocarbons, which resulted from his exposure to the paint while working for defendant, plaintiff is permanently disabled from working as a painter.

ORS 656.018 provides, in pertinent part:

> "(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to 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 * * *.
>
> "* * * * *
>
> "(2) The rights given to a subject worker and the beneficiaries of the subject worker for compensable injuries under ORS 656.001 to 656.794 are in lieu of any remedies they might otherwise have for such injuries against the worker's employer * * * except to the extent the worker is expressly given the right under ORS 656.001 to 656.794 to bring suit against the employer of the worker for an injury."

Plaintiff recognizes that ORS 656.018 would normally foreclose him from seeking damages from defendant. He argues, however, that he is exempt from the normal rule under ORS 656.156(2), which provides:

> "If injury or death results to a worker from *the deliberate intention of the employer of the worker to produce such injury* or death, the worker, the widow, widower, child or dependent of the worker may take under ORS 656.001 to 656.794, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes." (Emphasis supplied.)[2]

[2] ORS 656.804 provides that an occupational disease "is considered an injury for employes of employers who have come under ORS 656.001 to 656.794." Therefore, both ORS 656.018 and ORS 656.156 apply, whether plaintiff suffered an injury or an occupational disease.

Plaintiff argues that a jury could find that defendant knew that the paint fumes were injuring him and that it made a conscious decision to continue to expose him to the hazard with that knowledge; from those facts, he states, a jury could infer that defendant deliberately intended to injure him. He points out that OEC 311(1)(a) creates a presumption that a "person intends the ordinary consequences of a voluntary act." Plaintiff insists that he can prove deliberate intent to produce the injury by showing that defendant desired "to cause the consequences of [its] act, or that [it] believe[d] that the consequences are substantially certain to result from it." *Restatement (Second) Torts,* § 8A. He contends, *quoting Restatement (Second) Torts,* § 8A, comment b, that if "[d]efendant knows [that] the consequences of his refusal to provide a fresh air supply to a painter using IMRON are 'substantially certain' to occur, yet he still refuses to provide one, 'he is treated by the law as if he had in fact desired to produce the result.' " Plaintiff, in short, assumes that the statutory phrase "deliberate intention * * * to produce such injury" establishes the same standard as does the term "intent" in the common law of intentional torts. If he were correct, we would have no difficulty in holding that he has shown enough to defeat defendant's motion for summary judgment. However, plaintiff wrongly interprets the statutory standard.

In *Jenkins v. Carman Mfg. Co,* 79 Or 448, 155 P 703 (1916), the plaintiff alleged that the defendant knew that one of the rolls in a lumber roller in its mill was defective and dangerous, had neglected to repair or replace it, and had required its employes to work near the roller with the deliberate intention of subjecting them to the risk of injury and to injury. On the basis of those allegations, the plaintiff sought damages for injuries that he suffered when the defective roll caught a piece of lumber and threw it against him. The trial court sustained the defendant's demurrer. 79 Or at 451-452. The Supreme Court treated the pleading as alleging negligence, recklessness, and a deliberate intent to subject the plaintiff to the risk of injury, but held that the complaint was insufficient to allege a deliberate intent to injure the plaintiff:

> "If defendant deliberately intended to wound plaintiff or his fellow-workmen and intentionally used this broken roll as he [*sic*] would have used an ax or a club to produce the intended

> injury, it is liable; otherwise it is not. *A deliberate act is one the consequences of which are weighed in the mind beforehand.* It is prolonged premeditation, and the word when used in connection with an injury to another denotes design and malignity of heart. * * *
>
> "We think by the words 'deliberate intention to produce the injury' that the lawmakers meant to imply that *the employer must have determined to injure an employee* and used some means appropriate to that end; that *there must be a specific intent,* and not merely carelessness or negligence, however gross." 79 Or at 453. (Emphasis supplied.)

In later cases, the court has adhered to the standard that it established in *Jenkins v. Carman Mfg. Co., supra. See*

Duk Hwan Chung v. Fred Meyer, Inc., 276 Or 809, 556 P2d 683 (1976); *Bakker v. Baza'r, Inc.*, 275 Or 245, 551 P2d 1269 (1976); *Caline v. Maede*, 239 Or 239, 396 P2d 694 (1964); *Weis v. Allen*, 147 Or 670, 35 P2d 478 (1934); *Heikkila v. Ewen Transfer Co.*, 135 Or 631, 297 P 373 (1931).[3] Only in *Weis v. Allen, supra,* did it hold that a plaintiff had satisfied the statutory criteria. There, the defendant had installed spring guns, which he knew to be illegal, at several places in his junk yards. The plaintiff knew of the guns and the way to disarm them. One evening, the defendant told the plaintiff that he would not set a particular gun that night. The next morning, the plaintiff opened the door that that gun protected without first disarming it and was injured when it fired. The court held that the jury could have found that the defendant, despite what he had told the plaintiff, had set the gun with the deliberate intention of injuring anyone who might inadvertently cause it to be discharged. That finding was sufficient to support the verdict for the plaintiff:

> "It was not necessary here to prove that the defendant had singled the plaintiff out and set the gun with the express purpose of injuring him and no one else. *The act which the defendant did was unlawful and was deliberately committed*

> *by him with the intention of inflicting injury.*" 147 Or at 681. (Emphasis supplied.)

As the cases show, ORS 656.156(2) does not permit an employe to avoid the exclusivity provision of ORS 656.018 simply by showing that the employer took actions the natural consequence of which was to produce the employe's injury. The statutory exemption applies only if the injury results "from the deliberate intention of the employer of the worker to produce such injury * * *." That phrase requires, in addition to the intent that will normally suffice to prove an intentional tort, that the injury be "deliberate," in the sense that the employer has had an opportunity to weigh the consequences and to make a conscious choice among possible courses of action, and also that the employer specifically intend "to produce * * * injury" to someone, although not necessarily to the particular employe who was injured. An employe does not satisfy those requirements by showing that the employer refused to provide safety equipment, even if injury is the necessary result of that failure. It is not enough for the employer to act with conscious indifference to whether its actions will produce injury; it must *intend* to produce injury.[4]

In this case, plaintiff alleged, in the words of the

[3] Other states follow similar standards, although the statutory phrasing varies:

> "Even if the alleged conduct goes beyond aggravated negligence, and includes such elements as knowingly permitting a hazardous work condition to exist, knowingly ordering claimant to perform an extremely dangerous job, wilfully failing to furnish a safe place to work, or even wilfully and unlawfully violating a safety statute, this still falls short of the kind of actual intention to injure that robs the injury of accidental character." 2A Larson, *Workmen's Compensation Law*, § 68.13. (Footnotes omitted.)

[4] The special concurrence focuses on the "certainty" of injury, that is, *whether* the employe will be hurt, rather than on the intent behind the injury, that is, *why* the employe will be hurt. An injury can result "certainly" from negligence or conscious indifference and thus not meet the statutory standard. Conversely, an employer can have the specific intent to produce an injury that was not "certain" to result from its acts, as in *Weis v. Allen, supra.* The special concurrence would read the word "deliberate" out of the statute. Moreover, it fails to address the other (and, in this case, more difficult) requirement of the statute: the specific intent "to produce [the] injury."

statute, that defendant acted "with [the] deliberate intention to produce [his] injury." The question is whether the evidence before the trial court at the time of summary judgment would permit a jury to find that he had proved that allegation. A jury could find that defendant knew that plaintiff was suffering injury from the paint, knew that he would continue to do so as long as he worked without a supplied-air respirator and, after deliberation, consciously decided not to provide such a respirator. It could, therefore, find that defendant's acts were "deliberate."

The more difficult question is whether it could find that defendant specifically intended "to produce [an] injury."

The affidavits suggest that defendant failed to provide the respirator because of the cost. Such a reason, while perhaps not laudable, is not a specific intent to produce an injury. However, the trial court on summary judgment, like a jury, need not accept defendant's proferred reason in isolation. Specific intent to injure may be inferred from the circumstances. *See State of Oregon v. Carver,* 22 Or 602, 603-04, 30 P 315 (1892).

Here, a jury could infer, from all of the circumstances, that defendant failed to provide the respirator *because* it wished to injure plaintiff: Defendant knew that the paint was highly toxic and that plaintiff's resulting injury was substantial and continuing; it did not follow the warnings of the paint manufacturer and the urging of its insurer to furnish a supplied-air respirator; plaintiff and his supervisor had complained about the problem repeatedly; and the cost of proper, available equipment (which defendant knew would soon be required by the state) was not prohibitive. A specific intent to produce injury is not the only permissible inference to be drawn from defendant's apparent obstinacy, but it is one that a jury should be permitted to consider.[5] *See State v. Livings,* 487 So 2d 475 (La App 1986). It is for the finder of fact, not the court on summary judgment, to determine what inferences to draw. *See Paulsen v. Continental Porsche Audi,* 49 Or App 793, 800, 620 P2d 1384 (1980). "Summary judgment is particularly inappropriate where 'the inferences which the parties seek to have drawn deal with questions of motive, intent and subjective feelings and reactions.' " *Cross v. United States,* 336 F2d 431, 433 (2nd Cir 1964), *quoting Empire Electronics Co. v. United States,* 311 F2d 175, 180 (2nd Cir 1962). The trial court erred, therefore, in granting defendant's motion for summary judgment.

Reversed and remanded.

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[5] Defendant retorts that "[p]laintiff's standard cuts both ways[,]" because, if its conduct met the criteria of ORS 656.156(2), then, by continuing to work under the conditions, plaintiff also deliberately intended to produce his injury under ORS 656.156(1). In an appropriate workers' compensation case, a factfinder might draw such an inference. However, ORS 656.156(1) is not directly pertinent here; plaintiff has already received workers' compensation benefits. Defendant has pleaded that plaintiff was negligent. Assuming that that theory is available when plaintiff alleges a deliberate intention to produce the injury, his comparative fault, if any, is not before us at this time.

RIGGS, J., specially concurring.

Although the majority reaches the correct result, it does so in a disingenuous manner that is contrary to sound public policy and is not required by precedent.

The majority attempts to draw a distinction between "intent" and "deliberate intent," but can do no better than to require "that the injury be 'deliberate,' in the sense that the employer has had an opportunity to weigh the consequences and to make a conscious choice among possible courses of action * * *." 97 Or App at ___. That analysis adds nothing to the meaning of "intent;" moreover, the majority's test is satisfied in this case. Plaintiff alleges that defendant was aware of the consequences of its actions, was aware of the existence of alternative courses of action and deliberately chose to inflict injury on plaintiff rather than adopt a different course. Neither statute nor policy requires that an employer be provided with an exemption from tort liability for having made such a choice. ORS 656.156(2); 2A Larson, *Workmen's Compensation Law,* 13-60 to 13-68, § 68.15 (1988).

This is not a case in which the pleadings allege a deliberate intent by the employer to subject the plaintiff to a *risk* of injury, but rather it is one in which the employer is alleged to have deliberately *injured* plaintiff through its actions in refusing to supply him with proper safety equipment. All, save one, of the Supreme Court's cases dealing with the exclusivity provision of the Worker's Compensation Law are of the first type and hold that a deliberate intent to subject a worker to a *risk* of injury is insufficient to establish tort liability. *See Duk Hwan Chung v. Fred Meyer, Inc.,* 276 Or 809, 556 P2d 683 (1976); *Caline v. Meade,* 239 Or 239, 396 P2d 694 (1964); *Heikkila v. Ewen Transfer Co.,* 135 Or 631, 297 P 373 (1931); *Jenkins v. Carman Mfg. Co.,* 79 Or 448, 155 P 703 (1916). This case is different. A jury could find that defendant deliberately compelled plaintiff to work in an environment certain to cause him injury, intending to cause that injury rather than modify the work environment. In that sense, the case is more like *Weis v. Allen,* 147 Or 670, 35 P2d 478 (1934), than it is like the other cited cases, even though the defendant in *Weis* was not shown to have intended to injure the plaintiff in particular. As in *Weis,* plaintiff alleges that defendant has

engaged in a course of conduct to which the Worker's Compensation Law does not lend its protection from tort liability. The trial court erred in ruling on a summary judgment motion that plaintiff's allegations failed to state the statutory requirement of intent.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Jack K. Kyle, Claimant.

TIMBERLINE LODGE et al,
Petitioners,

v.

KYLE,
Respondent.

(WCB 87-05239; CA A50117)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 7, 1989.

Paul L. Roess, Portland, argued the cause for petitioner. With him on the brief was Acker, Underwood & Smith, Portland.

Phil H. Ringle, Jr., Gladstone, argued the cause and filed the brief for respondent.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Remanded for reconsideration.

Riggs, J., dissenting.

EDMONDS, J.

Employer seeks review of an order of the Workers' Compensation Board reversing the referee and holding that claimant's injury arose out of his employment as a ski instructor with Timberline Lodge. We remand for further findings of fact.

Claimant injured his left knee while participating in a ski race at Timberline Lodge. He was employed as a ski instructor, which required him to remain on employer's premises from 8:30 a.m. to 4:30 p.m. On the day of the injury, claimant requested permission to participate in a ski race sponsored by a beverage company, but was asked to remain to see if his services would be needed. Later that morning, his supervisor gave him permission to participate in the race but instructed him to return immediately after he was finished racing to be available to give ski lessons if needed.

There is evidence in the record from which the Board could find that employer expected its ski instructors to improve their proficiency in skiing, that it considered racing to be beneficial in developing an instructor's teaching skills and that claimant had previously been encouraged by the ski school's assistant director to participate in races. However, the Board made no findings of fact regarding that evidence.

To be compensable, an injury must arise out of and in

the course of employment. ORS 656.005(7)(a). "If the injury has sufficient work relationship, then it arises out of and in the course of employment * * *." *Rogers v. SAIF,* 289 Or 633, 643, 616 P2d 485 (1980). An on-premises injury has sufficient work relationship if it occurs while the employe is "on-call" and is involved in an activity that is associated somehow with his employment. *Clark v. U.S. Plywood,* 288 Or 255, 260-261, 605 P2d 265 (1980).

In *Mellis v. McEwen, Hanna, Gisvold,* 74 Or App 571, 575, 703 P2d 255, *rev den* 300 Or 249 (1985), we identified seven factors to determine whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employe; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employe was paid for the activity; (5) whether the activity was on the

employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employe was on a personal mission of his own. The Board recited those factors and made findings of fact relating to some of them, but it did not make specific findings of fact regarding all of them.[1]

Because the Board's opinion does not contain findings necessary to determine if claimant's injury has a "sufficient work relationship," we remand this matter to the Board for further findings of fact. ORS 183.482(8)(c).

Remanded for reconsideration.

RIGGS, J., dissenting.

Under the "unitary 'work-connection' " test, *Rogers v. SAIF,* 289 Or 633, 643, 616 P2d 485 (1980), claimant's injury is compensable if it has a "sufficient work relationship * * *." In *Mellis v. McEwen, Hanna, Gisvold,* 74 Or App 571, 573-74, 703 P2d 255, *rev den* 300 Or 249 (1985), we identified seven factors for the Board to consider in reaching conclusions under the *Rogers* test. Each of the factors identifies a consideration relevant to the Board's determination, but no one factor is determinative. *See* 74 Or App at 575. Other considerations may be relevant as well.

The Board found that the ski race took place on employer's premises, that claimant's participation in the race was acquiesced in by employer and that "[claimant's] activity while racing was work-connected." Each finding is supported by substantial evidence. *See* ORS 183.482(8)(c); *Armstrong v. Asten-Hill Co.,* 90 Or App 200, 206, 752 P2d 312 (1988). The Board concluded that "there was sufficient work connection to make the claim compensable." I would not hold, as the majority does, that the Board is required to make explicit

[1] The Board made findings that claimant was required to remain "on-call" on employer's premises, that permission was requested and given for claimant to enter the ski race, that the activity occurred on employer's premises and that claimant was injured while skiing in the race. On those facts the Board concluded:

> "Thus, when he was injured while skiing, he was engaged in an activity in which the employer expected him to engage, given the requirement that he remain on the employer's premises. We conclude that, under claimant's work conditions, there was sufficient work connection to make the claim compensable."

The finding that claimant was required to remain on the premises does not necessarily lead to the conclusion that claimant "was engaged in an activity in which the employer expected him to engage.

findings as to each of the *Mellis* factors. Because the Board's conclusion follows logically from the findings that it did make, I would affirm.

I dissent.

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276 June 21, 1989 No. 393

IN THE COURT OF APPEALS OF THE STATE OF OREGON

FORTNEY,
Appellant,
v.
CRAWFORD DOOR SALES CORP. OF OREGON,
Respondent.

(A8612-07927; CA A48611)

Appeal from Circuit Court, Multnomah County.

Clifford B. Olsen, Judge.

Argued and submitted May 22, 1989.

Wayne Mackeson, Portland, argued the cause for appellant. With him on the briefs was Des Connall and Dan Lorenz, P.C., Portland.

Larry A. Brisbee, Hillsboro, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

278 Fortney v. Crawford Door Sales Corp.

RICHARDSON, P. J.

Plaintiff suffered an on-the-job injury when an extension ladder fell and struck him. He alleges that an employe of defendant was negligent in connection with the accident and that defendant is his "indirect employer" for purposes of the Employer's Liability Act (ORS 654.305 *et seq*) (ELA). The trial court granted defendant's motion for a directed verdict on both claims. Plaintiff appeals and assigns error to that ruling. We affirm.

Plaintiff is an employe of Hoffman Construction, which was the general contractor for a building construction project. Hoffman contracted for defendant to supply overhead rolling steel doors and to deliver them to the project site. Plaintiff and Northam, also a Hoffman employe and plaintiff's foreman, were assigned by Hoffman to install the doors. They encountered difficulties, and Hoffman's project engineer contacted defendant's president and asked for help. Defendant sent Svir to assist. The injury occurred while plaintiff and Northam were working on a door near or against which Northam had placed the ladder. The ladder belonged to

Hoffman and was under the control of its personnel at all relevant times.[1] Svir was standing approximately 15 feet away from plaintiff at the time of the accident.

Plaintiff asserts that, because of defendant's employe's involvement in the installation project,[2] it was plaintiff's indirect employer and can be held liable to him under ELA. Plaintiff contends that defendant violated ELA because the ladder was not secured and because plaintiff had not been ordered by defendant to wear a hard hat. His negligence claim is based on the same particulars and on Svir's alleged failure to warn plaintiff that the ladder was falling.

The court said in *Miller v. Georgia-Pacific Corp.*, 294 Or 750, 662 P2d 718 (1983):

> "Before the ELA can be made the basis of a claim for relief by an injured worker suing a defendant other than an employer of the worker, however, the defendant must be in charge of or have responsibility for work involving risk or

> danger in either (a) a situation where defendant and plaintiff's employer are simultaneously engaged in carrying out work on a common enterprise, or (b) a situation in which the defendant retains a right to control or actually exercises control as to the manner or method in which the risk-producing activity is performed." 294 Or at 754.

Plaintiff contends that his evidence was sufficient to require the submission of his ELA claim on both a "common enterprise" and a "right or exercise of control" theory. His reliance on the second theory is two-pronged. He argues, first, that there was enough evidence to support a finding that Svir exercised actual control over the ladder. We disagree. *See* note 1, *supra.*

The second prong is that Svir had control over the door installation project and defendant thereby became the employer and was responsible for the job safety of all employes in connection with the installation work. Defendant responds that Northam and Hoffman were responsible for supervising plaintiff and were in charge of the work. Plaintiff notes that, although Svir's testimony was to the effect that his role was only advisory in nature, plaintiff testified that Svir was actively involved and, in effect, gave orders to the two Hoffman employes. Plaintiff concludes that, if the jury believed his testimony, it could find that Svir had a right of or exercised control over the installation activity.

We do not agree with plaintiff. Svir was sent to the work site in response to what amounted to a request to defendant by plaintiff's actual employer to tell the latter's employes how to install the doors. Svir's performance of that service necessarily entailed some instruction and direction, which, on occasion, might have been manifested through peremptory words or action. To treat that as the kind of "control" that can give rise to employer status for purposes of ELA would be akin to concluding that a supplier whose goods are accompanied by printed instructions is the employer of the workers who use the goods after delivery. Svir did not displace Hoffman's

[1] Plaintiff argues that there was evidence to allow an inference that Svir helped Northam carry and place the ladder. There was not.

[2] Defendant argues that Svir was an independent contractor. We need not address that argument, given the bases for our disposition.

supervisory authority over plaintiff and, more importantly, Hoffman retained and Svir never acquired actual responsibility for job safety. *See Wilson v. P.G.E. Company,* 252 Or 385, 448 P2d 562 (1968). Defendant was not plaintiff's indirect employer by virtue of any right or exercise of control.

Plaintiff also contends that defendant can be held accountable as an indirect employer, because it was engaged in

a common enterprise with his actual employer. That contention is defeated by the absence of a link between defendant and either the ladder specifically or job safety in general. The court said in *Wilson v. P.G.E. Company, supra:*

> "We do not construe the ELA to impose a duty upon each employer, engaged in a common enterprise with another, to make safe the equipment and method of work of the other, even though both have a measure of control over the activity in which they are jointly engaged. The injury must result by virtue of the commingling of the activities of the two employers and not be solely attributable to the activities or failures of the injured workman's employer." 252 Or at 391-92.

See also Sacher v. Bohemia, Inc., 302 Or 477, 731 P2d 434 (1987).

The trial court did not err in directing a verdict for defendant on plaintiff's ELA claim. The court was also correct in directing a verdict on the negligence claim. As discussed above, defendant and Svir had no responsibility for the safety of the equipment or for plaintiff's job safety. Given that, even assuming that there was evidence that Svir knew that the ladder could fall or was falling, plaintiff's failure to warn specification of negligence would appear to be based on an erroneous idea of bystander liability.

Plaintiff relies of *Fazzolari v. Portland School Dist. No. 1J,* 303 Or 1, 734 P2d 1326 (1987), and argues that he was not required to establish a duty on defendant's part in order to reach the jury. Defendant argues that plaintiff's theory necessarily presupposes the "special relationship" of employer and employe, "where 'duty' is still a factor not altered by the holding in *Fazzolari." See Budd v. American Savings & Loan,* 89 Or App 609, 750 P2d 513 (1988). Defendant also contends that plaintiff "would impose liability for a falling ladder where the defendant did not own it, did not use it and did not touch it." We agree with defendant's implicit suggestion that, although *Fazzolari* has changed the role of duty in negligence law, it has not eliminated the rule that a defendant must have *some* responsible involvement with an event in order to be found negligent for its occurrence. *See Fuhrer v. Gearhart By The Sea, Inc.,* 306 Or 434, 760 P2d 874 (1988). No involvement was established here.

Affirmed.

IN THE SUPREME COURT OF THE
STATE OF OREGON

CHAVEZ,
Respondent on Review,
v.
BOISE CASCADE CORPORATION,
Petitioner on Review.
(TC 86-0774-J-2; CA A43559; SC S35580)

On review from the Court of Appeals.*

Argued and submitted March 9, 1989.

H. Scott Plouse, of Cowling & Heysell, Medford, argued the cause and filed the petition for petitioner on review.

Daniel C. Thorndike, of Blackhurst, Hornecker, Hassen & Thorndike & Ervin B. Hogan, Medford, argued the cause and filed responses for respondent on review.

Scott P. Monfils, Nelson D. Atkin II, and Jeffrey S. Love, of Spears, Lubersky, Bledsoe, Anderson, Young & Hilliard, Portland, filed an *amicus curiae* brief on behalf of Associated Oregon Industries, Tri-County Metropolitan Transportation District of Oregon, Associated General Contractors, Roseburg Forest Products Co., RSG Forest Products, Inc., and Pacific Coast Association of Pulp and Paper Manufacturers.

Thomas M. Christ, of Mitchell, Lang & Smith, Portland, filed an *amicus curiae* brief on behalf of Oregon Self-Insurers Association and Oregon Association of Workers' Compensation Defense Attorneys.

Before Peterson, Chief Justice, and Linde, Carson, Jones, Gillette and Fadeley, Justices.

LINDE, J.

The decision of the Court of Appeals is affirmed, and the case is remanded to the circuit court.

Peterson, C. J., concurred and filed an opinion.

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* Appeal from judgment of Jackson County Circuit Court, L. L. Sawyer, Judge. 92 Or App 508, 759 P2d 297 (1988).

LINDE, J.

After suffering an industrial accident at defendant's plant, plaintiff obtained an award of 30 percent permanent partial disability from the Workers' Compensation Board. Defendant refused plaintiff's demand for reinstatement in his former position pursuant to ORS 659.415, which makes it an unlawful employment practice to deny reinstatement to a worker who has sustained a compensable injury if the position is available "and the worker is not disabled from performing the duties of such position." Defendant asserted that the Board's finding of disability precluded plaintiff from claiming that he was not disabled from returning to his former position, and the circuit court granted summary judgment on that basis.

The Court of Appeals reversed, holding that the Board's order did not necessarily establish plaintiff's inability to perform his previous job. *Chavez v. Boise Cascade Corporation,* 92 Or App 508, 759 P2d 297 (1988). We affirm the decision of the Court of Appeals.

The Court of Appeals followed this court's recent opinion in *North Clackamas School Dist. v. White,* 305 Or 48, 750 P2d 485, *modified on other grounds* 305 Or 468, 752 P2d 1210 (1988), "assuming," though with some uncertainty, "that an administrative determination can be used as a basis for collateral estoppel in a later civil judicial proceeding." 92 Or App at 510. The assumption is correct, at least for judicial proceedings like this case.[1]

North Clackamas School Dist. involved the effect of a prior ruling by the Workers' Compensation Board on a subsequent claim that claimant's condition had worsened. This court applied a rule earlier stated in *State Farm Fire and Casualty v. Reuter,* 299 Or 155, 158, 700 P2d 236 (1985), that "[i]f a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment." 305 Or at 53. The opinion quoted the statement in Restatement (Second) of Judgments

§ 83(1) that, with exceptions, a valid and final administrative adjudication has the same preclusive effects as a court's judgment. 305 Or at 52. The court did note that not only the quality of proceedings and opportunity to litigate were the same in both cases, but also the forum, making it unnecessary to consider the relative competence and responsibility of two different forums. *Compare State v. Ratliff,* 304 Or 254, 744 P2d 247 (1987) (motor vehicle department's license suspension procedure too informal for preclusive effect). But an identical forum is not essential for giving preclusive effect to necessary findings in a formal administrative adjudication if the parties had both a full opportunity and the incentive to contest the point at issue on a record that also was subject to judicial review. *Cf. Convalescent Ctr. v. Dept. of Income M.,* 208 Conn 187, 544 A2d 604 (1988). We therefore examine what the present Board order decided regarding plaintiff's ability to perform the work he previously had done.

In the compensation proceeding, plaintiff (claimant) appealed an order awarding him 15 percent unscheduled disability benefits. The extent of disability was the only issue. The referee's findings noted that claimant was employed as a grader offbearer when he sustained a low back injury. The findings then recited the medical history leading up to the treating physician's decision to release claimant for work, restricted to the extent of "never lifting or carrying over twenty pounds, occasionally bending, crouching, kneeling, crawling and climbing ladders, and never twisting at the waist." The next two findings stated:

[1] This case presents no claim of a right under Article VII, section 3, of the Oregon Constitution to a jury determination of disputed facts. *Cf. Parklane Hosiery Co. v. Shore,* 439 US 322, 99 S Ct 645, 58 L Ed 2d 552 (1979) (despite the federal Seventh Amendment, juries historically were precluded from retrying issues decided in prior equity proceedings); *id.,* 439 US at 337 (Rehnquist, J., dissenting).

"(4) At the employer's request, Drs. Yamodis and Morrison viewed a number of potential work activities in person and on video tape respectively. They indicated their agreement with Dr. Dunn's last stated restrictions, but indicated that all of the potential positions: dryer puller, dryer feeder, raiman operator, green chain puller and cleanup would place Mr. Chavez at risk for reinjury or incapacitation.

"(5) The personnel manager for Boise Cascade testified that his company has approximately 850 employees in three different divisions in Southern Oregon. The restrictions imposed on Mr. Chavez by Dr. Dunn preclude employment in any of the approximately 70 job classifications with his company. Reemployment has not been offered Mr. Chavez."

The referee further found that all examining and treating

physicians found claimant's physical condition to be normal and that claimant did not testify to any low back limitation and considered the treating physician's restrictions to be unrealistically limiting. The referee then stated, under the heading "Opinion," that claimant had no impairment within the agency's guidelines:

"What he has is a history of a rupture[d] disc and restrictions that have been imposed to prevent reinjury. Within those restrictions, he is precluded from returning to work in the wood products industry. He is retrainable, but has not been retrained. Even with the retraining that has been authorized by the employer, he will not be able to return to near the wage at time of injury level. He has a significant loss of earning capacity."

The opinion concluded that the resulting loss of earning capacity justified increasing the claimant's permanant partial disability benefits to 30 percent. Neither side appealed this award.

The questions in this action for reinstatement are whether the referee found as a fact that plaintiff is disabled from performing his previous work and if so, whether the finding was necessary to the compensation decision. The answer to the first question is somewhat obscured by the form of the referee's order. The so-called "Findings" mix recitals of the medical history and some facts found by the referee with recitals of testimony. Recitals of evidence, such as what was reported or "indicated" by the claimant, employer, or physicians, are not findings of fact. The referee's ultimate finding, that claimant had no "impairment as defined by the guidelines," but that within "restrictions that have been imposed to prevent reinjury * * * he is precluded from returning to work in the wood products industry," first appears under the heading "Opinion." In the context of the preceding paragraphs, it is unclear whether the referee found that claimant's return to work was "precluded" by his actual physical condition or by the employer's compliance with the restrictions stated by the treating physician and the occupational disqualifications inferred (in Finding (4)) by the physicians examining claimant on behalf of the employer.

In the present action, defendant argues that plaintiff's disability claim and acceptance of the referee's order

without appeal preclude him from denying that he is "disabled from performing the duties of [his former] position." Plaintiff maintains that neither his assertions in the compensation proceeding nor the referee's explanation for increasing the degree of his lost earning capacity is irreconcilable with his ability to return to his job. Our review of the record does not persuade us that defendant's position is correct. Plaintiff did not claim or concede that he could not perform his previous work, nor did he assent to all the restrictions prescribed by the physicians. The Court of Appeals held the referee's statements on which defendant relies unnecessary to the determination, probably because one may suffer a loss of earning capacity independent of an immediate loss of employment. ORS 656.214(5).[2] Perhaps a party who has contested a factual issue without objecting to its relevance should not later be able to deny the preclusive effect of express findings on that issue on grounds that they were unnecessary. But to make a claimant appeal an otherwise satisfactory award only to eliminate the preclusive effect of unrequested and nonessential findings would not further the procedural objectives of preclusion even had the referee's findings been clearer than they were. We affirm because the findings in this case were not essential and did not squarely establish plaintiff's inability to perform his previous work.

Doubtless, employers do not want to see injured workers jockeying to gain maximum disability benefits while retaining a right to reinstatement. Perhaps an injured worker similarly may perceive jockeying when an employer does not resist a claim for disability benefits in order to defeat a demand for reinstatement. The statutory scheme makes likely occasional tension between a claim to disability benefits for loss of earning capacity and a claim also to return to one's job, as in this case. The employer's recourse to the rules of preclusion depends on making a clear record in the compensation proceeding showing from what work the disability claimant

claims to be disabled and clear agency findings on that question. As already stated, we do not find such clarity in the record or the findings in this case.[3] The circuit court therefore should not have allowed defendant's motion for summary judgment, and the case must be remanded to that court for further proceedings.

The decision of the Court of Appeals is affirmed, and the case is remanded to the circuit court.

[2] ORS 656.214(5) provides in part:

"In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job."

[3] *Amici curiae* suggest that plaintiff's claim for reinstatement should be barred by "judicial estoppel," whether or not it is otherwise precluded, because plaintiff asserted a contrary position in the compensation proceeding. Because we do not find such clearly contradictory positions, this is not the case in which to address that legal proposition.

PETERSON, C. J., concurring.

I concur in the result.

I read the referee's opinion (quoting from his decision) to *find* that, because of "a rupture[d] disc" and "[work] restrictions that have been imposed to prevent reinjury," the claimant "is precluded from returning to work in the wood products industry." I do not share the majority's uncertainty concerning the quoted language.

I nonetheless would affirm the Court of Appeals because, as this court has stated, "the [referee's] determination was [not] essential to the judgment." *State Farm Fire and Casualty v. Reuter,* 299 Or 155, 158, 700 P2d 236 (1985). There is no statute or rule imposing the requirement that a worker be "precluded" from returning to his or her job in order to obtain an award of permanent partial disability. As the majority points out, 307 Or at ___, "[t]o make a claimant appeal an otherwise satisfactory award only to eliminate the preclusive effect of unrequested and nonessential findings would not further the procedural objectives of preclusion * * *."

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Cleo F. Perry, Claimant.

PERRY,
Respondent on Review,

v.

SAIF CORPORATION et al,
Petitioners on Review.

(WCB 85-07195; CA A44205; SC S35811)

In Banc

On review from the Court of Appeals.*

Argued and submitted April 5, 1989.

Christine Chute, Assistant Attorney General, Salem, argued the cause for petitioners on review. On the petition were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Darrell E. Bewley, Assistant Attorney General, Salem.

Leo R. Probst, Portland, argued the cause for respondent on review.

PER CURIAM

The decision of the Court of Appeals is reversed, and the case is remanded to the Court of Appeals to determine if claimant's condition had worsened within the definition set forth in *Gwynn v. SAIF,* 304 Or 345, 745 P2d 775 (1987).

* Judicial review from an order of the Workers' Compensation Board. 93 Or App 631, 763 P2d 736 (1988).

PER CURIAM

Claimant filed a claim alleging an aggravation under ORS 656.273(1), which provides:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury."

The issue in dispute is whether claimant has established "worsened conditions" within the aggravation period simply because he was hospitalized for treatment of the underlying condition. The referee, as the factfinder, found no worsening. The Workers' Compensation Board on *de novo* review found no worsening.

The Court of Appeals agreed with the finding of the Workers' Compensation Board and the referee that there had been no worsening as a matter of fact, but in reliance on *Gwynn v. SAIF*, 304 Or 345, 353, 745 P2d 775 (1987), decided that an "aggravation under ORS 676.273" had occurred. *Perry v. SAIF*, 93 Or App 631, 634, 763 P2d 736 (1988). The court erred in so applying *Gwynn v. SAIF*.

The Court of Appeals wrote:

> "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." 93 Or App at 634 (multi-word emphasis added).

In so holding, the Court of Appeals misapplied the *Gwynn* decision. The Court of Appeals read the above-quoted words "or becomes an inpatient at a hospital for treatment of that condition" to state an alternative test of aggravation independent of any worsening of the worker's "underlying condition." These words expressly referred to an alternative to total disability "as a result of worsening of the worker's condition from the original injury." As applied to this case, the *Gwynn* tests are whether the symptoms such as pain have caused loss of function of the body and resulted in loss of earning capacity. The mere fact that a claimant is hospitalized does not always signify a worsening. Worsening is a factual question.

The decision of the Court of Appeals is reversed, and the case is remanded to the Court of Appeals to determine if claimant's condition had worsened within the definition set forth in *Gwynn v. SAIF, supra.*

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Grace L. Stephen, Claimant.

SAIF CORPORATION et al,
Petitioners on Review,

v.

STEPHEN,
Respondent on Review.

(WCB 85-14678; CA A46435; SC S35680)

On review from the Court of Appeals.*

Argued and submitted March 9, 1989.

Christine Chute, Assistant Attorney General, Salem, argued the cause for petitioners on review. With her on the petition were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James L. Edmunson, of Malagon & Associates, Eugene, argued the cause for respondent on review.

Before Peterson, Chief Justice, and Linde, Carson, Jones, Gillette and Fadeley, Justices.

JONES, J.

The decision of the Court of Appeals and the order of the Workers' Compensation Board are reversed, and the case is remanded to the Board for further proceedings consistent with this opinion.

* Judicial review from order of Workers' Compensation Board. 93 Or App 217, 761 P2d 931 (1988).

JONES, J.

The issue in this workers' compensation case is whether a claimant who voluntarily leaves the work force and thereafter becomes totally disabled by a compensable injury is entitled to permanent total disability (PTD) benefits. We hold that, before a claimant is entitled to PTD benefits, the claimant must establish that, but for the compensable injury, she is or would be willing to seek regular gainful employment *and* has or would have made reasonable efforts to do so. We remand this case to the Workers' Compensation Board (Board) to make findings concerning whether, but for the compensable injury, the claimant would have returned to work.

We take the following facts from the Board's Order on Review:

> "Claimant worked as a welder for SAIF's insured from 1942 until 1945. During that period, she had significant exposure to asbestos. Since leaving work in 1945, claimant has neither sought nor obtained work other than raising her large family. Ultimately, claimant developed squamous cell carcinoma that resulted in a 1962 left vocal cord excision and a 1971 total laryngectomy."

We add the following from the parties' agreed statement of facts:

> "[REFEREE]: I understand that you have arranged for a formula to put words in claimant's mouth, both of you [because it is very difficult for claimant to talk].
>
> "[SAIF'S COUNSEL]: Yes. Counsel will indicate what she believes the claimant would testify if called, and I will presumably indicate my agreement or disagreement. And then I will indicate what I think she would say on cross examination and she will do the same.
>
> "* * * * *
>
> "[CLAIMANT'S COUNSEL]: Well, she'd testify that she is 73 years old. She has a fourth grade education. The only training that she had beyond just that schooling was the welding training that she had when she worked in the shipyards in the 1940's. She worked there until 1945 and hasn't worked since that time.
>
> "She never had definite plans to go back to work but she never had definite plans not to go back to work. She thinks

> that if she hadn't had the cancer that she could possibly have gone back to work as a welder. But she feels that she wasn't skilled and didn't have the education to go into any other kind of work.
>
> "She has had a heart condition for about the last five-and-a-half years. I can't really specify beyond that what the nature of that is or how severe it is or anything.
>
> "* * * * *
>
> "[REFEREE]: I suppose I would want to add one question. After the 1962 surgery after she healed up, did she consider herself able to return to welding work at that juncture?
>
> "[CLAIMANT'S COUNSEL]: No. In fact that's the one thing I forgot to say. She doesn't consider herself able to do

any kind of work after that 1962 surgery because of—just her weakness and her shortness of breath, combined with her lack of education and lack of skills and that sort of thing. She doesn't think she can go back and do the welding after 1962.

"* * * * *

"[SAIF'S COUNSEL]: I'll agree that she would so testify. In addition to that, she would testify to the following, that she is really not sure when her medical condition stabilized after any of her surgeries, that she hasn't looked for any work since 1945 and hasn't worked any place since 1945, that she has nine children which she raised, that she had no definite plans to return to work after her children grew up.

"On reflection now, she thinks she possibly would have looked for welding work at some indefinite time if she hadn't developed cancer, because welding was the only job she knew and she felt that she was not skilled or educated to do any other kind of work after leaving the shipyards.

"* * * * *

"She has been using the wheelchair for the last couple of months.

"* * * * *

"[CLAIMANT'S HUSBAND]: After she had her heart attack, she spent four months in bed, never got up for four months.

"[CLAIMANT'S COUNSEL]: Did she use a wheelchair before that?

"[CLAIMANT]: No.

"[SAIF'S COUNSEL]: She had a heart attack—let's add to this that she had a heart attack 12 to 14 months ago."

The Board's order further stated:

"In August 1982 claimant filed a claim for her cancer based on asbestos exposure. A May 1984 Referee's order found claimant's condition compensable. The Referee's order was affirmed by the Board in December 1984. *Grace Stephen,* 36 Van Natta 1881 (1984). In August 1985 a Determination Order issued awarding claimant 100 percent unscheduled permanent disability, but no temporary total disability. At hearing claimant sought permanent total disability and temporary disability compensation."

The referee concluded that claimant was totally disabled for the three months following both surgeries, and therefore awarded claimant temporary total disability (TTD).

The Board reversed the award of TTD on the basis of *Cutright v. Weyerhaeuser Co.,* 299 Or 290, 702 P2d 403 (1985), finding that claimant voluntarily left the labor market and thereafter "neither sought nor obtained work outside of her home again." The Board, however, affirmed the referee's award of PTD. SAIF Corporation (SAIF) appealed and the Court of Appeals affirmed per curiam. *SAIF Corp. v. Stephen,* 93 Or App 217, 761 P2d 931 (1988). We allowed review to determine whether, as a matter of law, a claimant who voluntarily withdrew from the labor force and subsequently became totally disabled by a compensable occupational disease is entitled to PTD, and if so, under what circumstances.

In *Cutright v. Weyerhaeuser Co., supra,* this court held that claimants who were voluntarily out of the labor force when their prior compensable conditions worsened and surgery became necessary were not entitled to additional compensation for TTD. *Cutright* noted that "[t]he thrust of the [workers' compensation] act is to restore injured workers to employment status." 299 Or at 297.

In this case, claimant essentially argues that PTD, unlike TTD, is based on lost earning capacity, rather than wage replacement. Claimant is wrong. That battle was fought in *Cutright*—PTD is based on wage replacement. The majority's reasoning in *Cutright* supports this conclusion; only the dissent supports claimant's position.

Cutright explains that the Workers' Compensation Law is grounded on wage replacement and medical treatment:

> "The entire scheme of Workers' Compensation Law is to compensate workers, who are active in the labor market, for *wages lost* because of inability (or reduced capacity) to work as a result of a compensable injury and to pay for medical expenses incurred in treatment of injury. * * *
>
> "* * * * *
>
> "That the legislature intended workers' compensation benefits to provide *wage replacement* is made clearer by the statutes providing for compensation for injured workers or their beneficiaries. * * *
>
> "Under ORS 656.206(2), the formula for calculating *permanent total disability* benefits is based on *wage replacement:*
>
> "'(2)(a) When permanent total disability results from the injury, the worker shall receive during the period of that disability compensation benefits equal to 66-2/3 percent of wages not to exceed 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50, whichever amount is lesser.
>
> "'(b) In addition, the worker shall receive $5 per week for each additional beneficiary not to exceed five. * * *'" 299 Or at 296-98 (emphasis in original deleted; emphasis added).

Moreover, *Cutright* indicates that lost earning capacity is not independently compensable:

> "Earning capacity only goes to the extent of disability. Loss of earning capacity can only be determined in the context of the claimant's ability to work; *it is not, by itself, an independent kind of injury for which compensation is provided." Id.* at 301 (emphasis added).

SAIF maintains that the award of PTD benefits should be reversed because claimant voluntarily removed herself from the labor market more than 40 years before she became totally disabled. The Workers' Compensation Law applies to "workers." *See* ORS 656.027. In part, ORS 656.005(27) defines a "worker" as

> "any person, including a minor whether lawfully or unlawfully employed, *who engages to furnish services for a remuneration,* subject to the discretion and control of an employer * * *." (Emphasis added).

A person who voluntarily withdraws from the work force is not entitled to PTD benefits for a subsequent disability because she or he is no longer a worker, that is, no longer one who "engages to furnish services for a remuneration." Such a person does not suffer lost wages as a result of a subsequent disability. As stated in *Cutright:*

> "There is not one word in [ORS 656.005(27)] that refers to a person who no longer engages in furnishing services for remuneration. Certainly, one who retires voluntarily from the work force is no longer a 'worker' as defined." *Id.* at 297 (emphasis in original).

Removal from the work force, however, is not necessarily a static state. A claimant may voluntarily leave the work force with a sincere hope of never having to return, but later decide that returning to the work force is desirable or necessary because of changed financial or personal circumstances. If such a claimant is unable to return to the work force because of a prior compensable injury, he or she would suffer lost wages at that point. Such a claimant is not barred from receiving PTD benefits solely because he or she earlier voluntarily left the work force.

A claimant who seeks to re-enter the work force after voluntary withdrawal, but is prevented from doing so by a compensable injury, may qualify as a worker although not presently engaged "to furnish services for a remuneration." ORS 656.003 provides that the statutory definitions apply "[e]xcept where the context otherwise requires." Because such a claimant suffers lost wages as a result of a compensable injury, the term "worker" as used in ORS 656.206 includes such a claimant. The inquiry concerning whether such a claimant is entitled to PTD benefits, however, does not end here.

ORS 656.206(3) provides:

> "The worker has the burden of proving permanent total disability status and must establish that the worker is *willing to seek regular gainful employment* and that the worker *has made reasonable efforts to obtain such employment.*" (Emphasis added.)

Thus, before a claimant is entitled to PTD he or she must establish that, but for the compensable injury, he or she (1) is or would be willing to seek regular gainful employment and (2)

has or would have made reasonable efforts to obtain such employment. A claimant who is so incapacitated that he or she cannot perform regular gainful employment need not establish that he or she "has made reasonable efforts to obtain such employment" because seeking such work would be futile. ORS 656.206(3) was not intended to require claimants to engage in such a useless act. *See Cutright v. Weyerhaeuser Co., supra,* 299 Or at 307 (Lent, J., dissenting). Such a claimant, however, must establish that he or she, but for the compensable injury, is or would be willing to seek regular gainful employment.

In the instant case the Board found:

> "[D]espite being a retired worker, the evidence supports the conclusion that any attempt by claimant to locate work would

have been futile. As a result, we find that claimant has satisfied the seek work requirement of ORS 656.206(3)." (Citation omitted.)

We agree that the findings justify the conclusion that any attempt by claimant to obtain regular gainful employment would have been futile. But that does not end the inquiry. Neither the Board nor the referee[1] made findings concerning whether, but for *the compensable injury,* the claimant would have returned to work. This determination is essential concerning claimant's eligibility for PTD. It is not sufficient, for example, to show only that she is prevented from returning by other, nonjob-related disabilities. Accordingly, we remand the case to the Board for further proceedings consistent with this opinion.

---

[1] In his September 12, 1989, Opinion and Order, the referee stated in part:

"At the hearing, the limited testimony of claimant and the testimony of the claimant's witnesses indicated that claimant was indeed permanently totally disabled. Dr. Morton indicated that after the 1971 surgery [claimant] became 100% disabled and this was related to the work-related cancer and not to the subsequent development of heart diseases. The Referee's observation of claimant during the course of the hearing also indicated that claimant was permanently totally disabled.

"I am of the opinion that claimant's status of permanent total disability was proved on the date of the hearing, July 9, 1986. The documentation indicates that claimant had a subsequent development of heart disease and what effect this had on claimant's present inability to work was not established until the date of the hearing. Conceivably, SAIF could have presented evidence that but for the heart disease the residuals from the work-related carcinoma would not have prevented her from employment."

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of John D. Ellis, Claimant.

ELLIS,
Petitioner on Review,

v.

McCALL INSULATION et al,
Respondent on Review.

(WCB No. 85-03981; CA A43948; SC S35650)

In Banc

On review from the Court of Appeals.*

Argued and submitted February 1, 1989.

Karsten H. Rasmussen, Eugene, argued the cause for petitioner on review. Also on the petition for review was Rasmussen & Henry, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent on review.

CARSON, J.

The decision of the Workers' Compensation Board is affirmed except as to the award of attorney fees, which is reversed.

* Appeal from an order of the Workers' Compensation Board of the State of Oregon. 93 Or App 188, 761 P2d 6 (1988).

CARSON, J.

In this workers' compensation proceeding, the primary issue is whether an insurer must pay chiropractic bills unrelated to a compensable injury absent the issuance of a formal denial. In the circumstances of this case, we conclude that payment is not required.

In 1979, claimant injured his back. He filed a workers' compensation claim, which the insurer accepted. Ultimately, an award of 10 percent unscheduled permanent partial disability was rendered.

Immediately upon injury, claimant began chiropractic treatments. The insurer paid for all the treatments until December 1984. The insurer then decreased the number of treatments for which it would pay. For example, in December, the insurer paid for only three of 12 treatments and, from January through June 1985, the insurer paid for only six of 56 treatments. When claimant changed chiropractors in July 1985, the insurer stopped payments altogether. The insurer did not issue any formal denial of an obligation to pay the bills or advise claimant that the bills would not be paid; it just stopped paying.

Claimant began this proceeding to compel payment of the unpaid bills. The insurer countered that the unpaid bills were unrelated to claimant's compensable back injury. After a hearing, the referee stated that he agreed with the insurer. Nevertheless, he ordered the insurer to pay the bills because the insurer did not timely deny them. He also ordered the insurer to pay a penalty and attorney fees.

Upon review, the Workers' Compensation Board concluded that the referee had erred in ordering the insurer to pay the unpaid bills. The Board determined that the bills were unrelated to the compensable injury. The Board also deleted the penalty and modified the attorney fees award.

The Court of Appeals affirmed the Board's decision.[1] *Ellis v. McCall Insulation*, 93 Or App 188, 761 P2d 6 (1988). We affirm the decision of the Court of Appeals.

At the outset, one matter should be made clear—claimant does not argue that the unpaid bills related to his compensable injury. That issue is not before us. Rather, claimant argues that the insurer must pay the bills because it did not timely deny them.

As claimant would have us do, we assume that his unpaid chiropractic bills were "claims" under ORS 656.262(6).[2] That statute requires an insurer to provide "[w]ritten notice of acceptance or denial of the claim" within 60 days after the employer has "notice or knowledge of the claim." If the insurer unreasonably delays acceptance or denial of the claim, the insurer is liable for "an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382." ORS 656.262(10).[3]

In *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987), the insurer did not accept or deny one aspect of a claim for medical, surgical, and time-loss benefits within the 60 days set by ORS 656.262(6). This court concluded that the failure to respond was "neither acceptance nor denial" and that inaction, in itself, did not render the insurer liable on the claim. *Johnson v. Spectra Physics, supra*, 303 Or at 58-59. This court also concluded, however, that the insurer might be liable for "penalties" under ORS 656.262(10) for delaying its response. *Id.*

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[1] In affirming the Board's decision, the Court of Appeals deleted the award of attorney fees. *Ellis v. McCall Insulation*, 93 Or App 188, 191, 761 P2d 6 (1988).

[2] ORS 656.262(6) provides, in part:

"Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. * * *"

[3] ORS 656.262(10) provides:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

Johnson governs this case. Here, the insurer also did not respond to "claims" for payment of chiropractic bills within the time set by ORS 656.262(6). The insurer simply stopped paying the chiropractic bills. As in *Johnson,* that inaction or failure to respond does not render the insurer liable for the unpaid bills or "claims."

In respect of an "additional amount" (or penalty) to be assessed under ORS 656.262(10), no amount was owed claimant for the unpaid bills. Consequently, there was no amount "then due" upon which to assess the additional amount.

In respect of attorney fees, the basis for an award of attorney fees, unlike the basis for an award of an "additional amount," is not hinged to "amounts then due." Instead, ORS 656.262(10) provides that attorney fees are to be assessed under ORS 656.382. ORS 656.382, in turn, is keyed to unreasonably resisting the payment of compensation. Here, the insurer did not unreasonably resist payment of compensation where the "claims" were unrelated to claimant's compensable injury and the insurer is not liable for the unpaid bills.

Claimant is not entitled to an "additional amount" or to attorney fees. The decision of the Workers' Compensation Board is affirmed except as to the award of attorney fees, which is reversed.

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The following orders issued by the Workers' Compensation Board are not published in this volume because they were judged to be of no precedental value. Copies may be ordered from the Board using the numbers provided.

UNPUBLISHED ORDERS 1989

Name	WCB Number	Date	Type of Order
Abel, Kenneth A.	88-0082M	5/31/89	Own Motion Order
Abou-Jamous, Ahmed	86-17937	3/89	Order on Review
Adams, Christie G.	87-12622	5/30/89	Order Denying Reconsideration
Adams, John	89-0077M	5/26/89	Order Approving Request
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Aldinger, Raymond	89-0334M	6/23/89	Own Motion Order
Aleman, Florentino	88-0445M	4/27/89	Own Motion Order
Allen, Joanne M.	88-18271	5/23/89	Order of Dismissal
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Amador, Ignacia	88-01526	5/23/89	Order of Dismissal
Ammons, Homer	89-0159M	4/5/89	Own Motion Order
Anglin, Joe L.	87-11078 etc.	5/12/89	Order on Review
Armstrong, Ruth	88-0803M	1/89	Own Motion
Arnold, Charles	89-0078M	3/89	Own Motion
Ashton-Stratemeyer, M.	88-16043	5/3/89	Order of Dismissal
Ashworth, Flora L.	87-0297M	3/89	Own Motion
Ayala, Roberto	86-11581	6/8/89	Order on Review
Ayers, James W.	89-0253M	6/16/89	Order Postponing Action
Ayhan, Eftihi	88-0805M	5/17/89	Own Motion Order of Dismissal
Baker, Anthony	89-0071M	2/89	Own Motion
Baker, David A.	87-16395	6/29/89	Order on Review
Baker, Lonny J.	86-12029	2/89	Order on Review
Baker, Steven C.	87-05886	3/89	Order on Review
Baldwin, Raymond	89-0265M	5/26/89	Own Motion Order
Ballweber, Faye L.	89-0107M	5/17/89	Order Postponing Action
Baney, Ruby	89-0201M	4/28/89	Own Motion Order
Bangs, Larry	88-16085	5/5/89	Order of Dismissal
Barber, Vivian	88-0209M	2/89	Own Motion
Barlow, Leroy E.	87-12281	6/13/89	Order on Review
Barton, Donna R.	86-09070	4/28/89	Order on Review
Bass, George	87-0632M	4/17/89	Own Motion Order
Bates, Stanley D.	86-17395 etc.	2/89	Order on Review
Batori, Michael C.	89-0288M	5/31/89	Own Motion Order
Beebe, Fred	88-0821	1/89	Own Motion
Bell, Allen	89-0149M	3/89	Own Motion
Benson, David	89-0300M	5/31/89	Own Motion Order
Berry, Gary L.	88-20675	5/31/89	Order of Dismissal
Berry, Gary L.	88-20675	6/14/89	Order on Reconsideration
Bielenberg, Darline M.	89-0010M	1/89	Own Motion
Binger, Lucille	89-0295M	5/31/89	Own Motion Order
Bird, Raymond R.	87-16838	4/19/89	Order Denying Reconsideration
Blair, Lee L.	87-00583	6/8/89	Order on Review
Blair, Michael	89-0214M	4/27/89	Own Motion Order
Bock, Janice	89-0192M	4/17/89	Own Motion Order
Bostock, Velora M.	89-0344M	6/29/89	Own Motion Order

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Name	WCB Number	Date	Type of Order
Boyd, Danny L.	87-0142M	3/89	Own Motion
Boyles, Kenneth	89-0069M	4/27/89	Own Motion Order
Braddock, Frank H.	89-0011M	2/89	Own Motion
Brandon, Jack A., Jr.	89-0251M	5/17/89	Own Motion Order
Bratton, John R.	89-0291M	5/31/89	Own Motion Order
Breshears, Kathy B.	87-12775	6/29/89	Order on Review
Brickner, William T.	86-12777	4/17/89	Order on Reconsideration
Brickner, William T.	86-12777	3/89	Order on Review
Briley, Carroll	88-0799M	1/89	Own Motion
Broadbent, Kenneth	89-0044M	2/89	Own Motion
Brooks, Glenda K.	89-0202M	4/28/89	Own Motion Order
Brown, Donie	89-0134M	3/89	Own Motion
Brown, Etta M.	86-08491	3/89	Order on Review
Brown, Gary D.	89-0199M	5/26/89	Order Postponing Action
Brown, Patrick B.	88-0016M	3/89	Own Motion
Brown, Rodney C.	87-08762 etc.	4/12/89	Order on Review
Brundidge, Clen A.	86-09372	3/89	Order on Review
Buchanan, Clark W.	86-0412M	3/89	Own Motion
Buckle, Jerry V.	86-00040	2/23/89	Order on Review
Burch, Dwane M.	86-0585M	3/89	Own Motion
Burgess, Edward	89-0017M	3/89	Own Motion
Bushbaum, Ronald J.	89-0345M	6/29/89	Own Motion Order
Campbell, Jess P.	87-0700M	4/7/89	Own Motion Order
Carmien, James	88-0333M	3/89	Own Motion
Carranza, Jose C.	88-03494	6/27/89	Order of Dismissal
Carroll, Elizabeth K.	86-10868	4/12/89	Order on Review
Castro, Stewart	87-11003	3/89	Order on Review
Catto, Dale	89-0105M	3/89	Own Motion
Cecil, Cathy	89-0191M	4/20/89	Own Motion Order
Center, Gary D.	87-0536M	6/23/89	Own Motion Order of Dismissal
Chase, Sharon	88-0777M	3/89	Own Motion
Chavez, Rudolfo	86-10990	3/89	Order on Review
Christensen, Jesse D.	88-0081M	5/17/89	Supplemental Own Motion Order
Christensen, Susan J.	88-19346	5/26/89	Order of Dismissal
Christiansen, Daniel	89-0089M	2/89	Own Motion
Christopher, Ohman E.	87-0746M	2/89	Own Motion
Clancy, Patrick	87-0348M	3/89	Own Motion
Clark, Ronald L.	87-06342	3/31/89	Order on Review
Clayton, Linda	89-0003M	3/89	Own Motion
Commella, Penny	89-0213M	4/27/89	Own Motion Order
Cook, Maureen	89-0096M	3/89	Own Motion
Coonrod, Kenneth L.	89-0050M	2/89	Own Motion
Cooper, David	88-0684M	1/89	Own Motion
Corbin, Dave	88-0410M	5/30/89	Own Motion Order on Recon
Cornell, Thomas D.	88-0452M	5/30/89	Own Motion Order
Cortez, Eric G.	87-03293	3/89	Order on Review
Couch, Billie D.	87-0322M	3/89	Own Motion
Crabtree, Ruth E.	87-14601	4/27/89	Order on Review
Crain, Carl W.	86-05256	4/17/89	Order on Reconsideration
Crenshaw, Carl	88-0816M	1/89	Own Motion
Cruzan, Herbert D.	88-0658M	3/89	Own Motion
Cummins, Richard	89-0273M	5/26/89	Own Motion Order
Cunial, Robert M.	87-16835	4/12/89	Order on Review
Curin, James A.	88-12206	6/8/89	Order of Dismissal
Cutler, Gary L.	89-0039M	2/89	Own Motion
Daley, Warren	89-0135M	3/89	Own Motion

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Name	WCB Number	Date	Type of Order
Dalton, Robert W.	88-0085M	1/89	Own Motion
David Hernandez, Isabel	88-0071M	1/89	Own Motion
David, (n/a)	87-06862	2/89	Order on Review
Davidson, Richard	85-0612M	1/89	Own Motion
Davis, Marvin R.	89-0337M	6/29/89	Own Motion Order
Dawson, Dennis L.	88-0812M	2/89	Own Motion
Deal, Joann M.	87-0355M	3/89	Own Motion
Dearmond, Gayford	87-0475M	3/89	Own Motion
Dearmore, Melodee A.	88-17533	6/21/89	Order of Dismissal
Delacruz, Reynaldo	89-0247M	5/17/89	Own Motion Order
Delany, Debra J.	86-11889	6/23/89	Order on Review
Denny, Carol	88-0766M	3/89	Own Motion
Derby, Richard	89-0051M	2/89	Own Motion
Diebel, Daniel	88-0544M	3/89	Own Motion
Diemer, Anita	89-0101M	3/89	Own Motion
Diemer, Anita	89-0101M	5/17/89	Own Motion Order of Dismissal
Dilley, Patrick	89-0033M	2/89	Own Motion
Dilworth, Jerry D.	86-16967	2/9/89	Order on Review
Dixon, Marlene	88-0828M	1/89	Own Motion
Dobbs, Michael	89-0187M	4/17/89	Own Motion Order
Dobyns, Kathleen M.	87-03976	3/89	Order on Review
Dooley, Stephen C.	84-0245M	6/19/89	Own Motion Order of Dismissal
Doran, Ron A.	87-09785	3/89	Order on Review
Dowers, Denton N.	87-05480	5/9/89	Order on Review
Downey, John L.	86-17785	3/89	Order on Review
Drago, Jeffery L.	89-0234M	5/17/89	Own Motion Order
Dupree, Derland A.	85-10471	3/89	Order on Review
Dvorak, Diane	89-0284M	5/31/89	Own Motion Order
Dyton, Norman G.	86-14661	5/11/89	Order Denying Abatement
Eagleton, Beulah M.	89-0002M	1/89	Own Motion
Eaton, Eleanor A.	87-0728M	5/31/89	Own Motion Order
Edens, Glen L.	84-07667 etc.	3/14/89	Order Denying Request
Efimoff, Nikolay	87-07192	5/12/89	Order on Review
Ellis, Gary	89-0025M	1/89	Own Motion
Ellis-Phillips, Jodey	88-0796M	1/89	Own Motion
Ellison, Jeanette M.	89-0180M	4/17/89	Order Postponing Action
Emerson, Phillip	89-0223M	4/28/89	Own Motion Order
Emmert, Marvin E.	89-0128M	3/89	Own Motion
Engleman, Gregory E.	88-13625 etc.	5/3/89	Order of Dismissal
English, James C.	88-0641M	2/89	Own Motion
Erickson, Dennis R.	88-0161M	5/30/89	Own Motion Order
Erickson, Lillian	87-0329M	3/89	Own Motion
Eyman, Ronald L.	88-0114M	3/89	Own Motion
Farmer, Charles A.	88-0243M	4/5/89	Own Motion Determination
Felton, Richard	89-0314M	6/15/89	Own Motion Order
Fenison, Richard L.	87-10955	6/27/89	Order on Review
Fenter, Roger G.	89-0095M	5/30/89	Own Motion Determination
Ferber, Gwynn	86-0417M	1/89	Own Motion
Fincher, Delores J.	89-0131M	3/89	Own Motion
Fischer, Richard	89-0271M	5/31/89	Own Motion Order
Fisher, Delmar E.	86-03939	3/28/89	Order on Review
Fite, Lige	89-0237M	5/31/89	Own Motion on Recon
Fite, Lige	89-0237M	5/12/89	Own Motion Order
Fitzgerald, John L.	89-0240M	5/12/89	Own Motion Order
Flannery, Leonard K.	89-0155M	3/89	Own Motion
Forrester, Harry	88-0814M	3/89	Own Motion

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Name	WCB Number	Date	Type of Order
Fourier, Shirley L.	86-0279M	4/17/89	Own Motion Order
Fouts, Leonard C.	88-0775M	3/89	Own Motion
Fouts, Leonard C.	88-0775M	5/17/89	Own Motion Order of Dismissal
Fowler, Leroy R.	89-0016M	1/89	Own Motion
Fowlkes, Richard E.	87-01920	5/17/89	Order on Review
Fox, Gary	89-0359M	6/19/89	Own Motion Order
Fox, Larry W.	88-20145	6/21/89	Order of Dismissal
Francoeur, Idalee E.	86-09705	3/8/89	Order on Review
Franks, Lou	89-0212M	4/27/89	Own Motion Order
Fraser, Brian P.	89-0015M	1/89	Own Motion
Frasieur, Wayne	89-0290M	5/31/89	Own Motion Order
Freed, John P.	88-0463M	3/89	Own Motion
Fuller, Virginia	89-0111M	3/89	Own Motion
Gandy, Kenneth	89-0079M	3/89	Own Motion
Garcia, Debra J.	86-07131	4/12/89	Order on Review
Garcia, Jesus	TP-88030	6/13/89	Amended Third Party Order
Garrison, Ken	87-09021	2/89	Order on Review
Gastaldi, Christopher	89-0163M	4/5/89	Own Motion Order
Gates, Mary L.	89-0323M	6/12/89	Own Motion Order
Gautier, Roberta B.	86-17739	5/17/89	Order on Review
Getty, Delbert	89-0219M	5/17/89	Own Motion Order
Gianella, Lorraine C.	88-07713	5/31/89	Order of Dismissal
Gibbs, Daniel	87-0134M	5/17/89	Own Motion Determination
Gibbs, Frank L.	86-0002M	3/89	Own Motion
Gill, William R.	86-10065	3/89	Order on Review
Girtman, Eldon L.	86-16358	4/12/89	Order on Review
Gitelson, Allan	89-0205M	6/19/89	Own Motion Order
Giumelli, Edwin W.	88-18033	5/23/89	Order of Dismissal
Glenn, Lester	88-0561M	2/89	Own Motion
Good, David	88-0408M	1/89	Own Motion
Goodman, Shirley J.	87-10531	5/12/89	Order on Review
Gorrell, Teresa M.	88-13453 etc.	6/21/89	Order of Dismissal
Graham, Anthony R.	86-18026	6/8/89	Order on Review
Graham, Lisa L.	87-07478	1/89	Order on Review
Graham, Robert	88-0783M	3/89	Own Motion
Graham, Robert J.	88-0783M	4/17/89	Order Approving Request
Green, Clarence	89-00830	4/21/89	Order of Dismissal
Green, Marvin	85-00521	4/12/89	Order on Review
Greene, Glenda J.	87-15696	6/27/89	Order on Review
Gregg (Freeman), Laurie	87-0180M	3/89	Own Motion
Gregory, Donald T.	87-18908 etc.	5/4/89	Order on Review
Greve, Everett	89-0164M	4/17/89	Own Motion Order
Griffith, Vernon	89-0139M	3/89	Own Motion
Grimes, Rebecca J.	87-12892	1/89	Order on Review
Grimm, James	89-0272M	5/26/89	Own Motion Order
Grimshaw, Edith	88-0701M	5/23/89	Own Motion Order
Grosdidier, Herbert L.	87-02216	4/18/89	Order on Review
Gullatt, Reta	88-0370M	6/6/89	Own Motion Order
Guttierrez, Maria T.	86-16076	6/29/89	Order of Dismissal
Hainey, Sarah	89-0316M	6/12/89	Order Postponing Action
Hall, Patricia N.	87-09563	1/89	Order on Review
Halliwell, Kenneth R.	89-0332M	6/23/89	Own Motion Order
Hamilton, Harold	88-0806M	1/89	Own Motion
Hammond, Duane E.	89-0052M	5/23/89	Own Motion Order
Hanson, Kathleen M.	89-0311M	6/15/89	Own Motion Order
Hargand, Charles H.	87-00715 etc.	3/89	Order on Review

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Name	WCB Number	Date	Type of Order
Harper, Betty L.	87-0763M	2/89	Own Motion
Hart, Michael W.	87-06547	4/18/89	Order on Review
Hartle, James	89-0260M	5/26/89	Own Motion Order
Hatfield, Wilma	87-0573M	2/89	Own Motion
Hawkins, Floyd	83-0382M	3/89	Own Motion
Hayes, Bobby J.	88-17438	5/23/89	Order of Dismissal
Hayes, Dorothy J.	89-0257M	5/17/89	Own Motion Order
Hayhurst, Landy J.	86-10957	3/8/89	Order on Review
Healy, Gene	89-0162M	4/5/89	Own Motion Order
Heater, William E.	89-0347M	6/29/89	Own Motion Order
Helm, Jacob M.	86-0112M	4/7/89	Own Motion Determination
Hembree, Donald E.	89-0014M	1/89	Own Motion
Hendershott, Kenneth A.	87-17525	6/6/89	Order on Review
Henry, John	88-0823M	2/89	Own Motion
Hernandez, Eustaquio A.	87-00505	4/7/89	Order on Review
Herrera, Raul	88-0774M	6/30/89	Own Motion Order
Hershey, Thomas E., Sr.	89-0062M	2/89	Own Motion
Hewit, Kenneth J.	88-0744M	5/30/89	Own Motion Order
Hickman, Darlene	88-0690M	5/31/89	Own Motion Order of Dismissal
Hicks, Mitchell	88-0705M	1/89	Own Motion
Higgins, James	88-0752M	1/89	Own Motion
Hilderbrand, James R.	85-15943	6/27/89	Order on Review
Hileman, Leroy V.	89-0186M	4/17/89	Own Motion Order
Hill, Ronald	87-07745	3/89	Order on Review
Hinson, Gayle	88-0730M	1/89	Own Motion
Hodgert, Thomas K.	87-02097 etc.	6/26/89	Order of Dismissal
Hodges, Charles V., Jr.	88-0785M	1/89	Own Motion
Hoffman, Colleen M.	89-0339M	6/29/89	Own Motion Order
Hofmann, Kevin	89-0286M	5/23/89	Consent to Issuance
Hoiting, Lawrence	88-0788M	4/17/89	Own Motion Order
Holifield, Jerry R.	86-16731	5/16/89	Order of Dismissal
Holifield, Kelly R.	87-14557	4/7/89	Order on Review
Holliday, William E.	89-0255M	5/17/89	Own Motion Order
Holst, Albert S.	87-0530M	1/89	Own Motion
Holsti, Hugo L.	88-0365M	6/29/89	Own Motion Order
Hookland, Richard	89-0073M	2/89	Own Motion
Howard, James E.	87-0747M	5/31/89	Own Motion on Recon
Howard, Richard	89-0074M	2/89	Own Motion
Howard, Ronald H.	87-06996	6/12/89	Order on Review
Howell, Darla J.	89-0026M	4/14/89	Own Motion Order
Howell, Donald	88-0357M	3/89	Own Motion
Howell, Steven	86-11800	4/12/89	Order on Review
Humphrey, Fay	89-01566M	4/5/89	Own Motion Order
Hunt, Clifford E.	89-0130M	3/89	Own Motion
Huntsucker, Clifford	89-0102M	3/89	Own Motion
Hyde, James	84-0419M	3/89	Own Motion
Irwin, Robert	89-0008M	2/89	Own Motion
Ivanoff, George S.	87-0673M	5/23/89	Amended Own Motion
Jackson, Donald	89-0036M	3/89	Own Motion
Jackson, Donald C.	89-0036M	5/31/89	Own Motion Order
Jacobs, Larry	89-0204M	4/27/89	Own Motion Order
Jacobson, Bert N.	85-0648M	3/89	Own Motion
Jaeger, Jon D.	87-04158 etc.	2/23/89	Order on Review
James, Amanda M.	87-04606	6/13/89	Order on Review
James, Gary J.	86-04564	4/20/89	Order Denying Reconsideration
James, Sharon L.	87-03748	4/18/89	Order on Review

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Name	WCB Number	Date	Type of Order
Johnson, Barbara L.	87-16924	6/13/89	Order of Dismissal
Johnson, Betty Lue	88-0311M	3/89	Own Motion
Johnson, Cordy	88-0736M	5/26/89	Own Motion Determination
Johnson, Edward	89-0158M	4/5/89	Own Motion Order
Johnson, Harry	88-0822M	2/89	Own Motion
Johnson, Leon	89-0280M	5/17/89	Own Motion Order
Johnson, Mark A.	87-02654	2/89	Order on Review
Johnson, Robert H.	87-06101 etc.	5/4/89	Order on Review
Johnson, Robert H.	87-06101 etc.	5/26/89	Order of Abatement
Johnson, Robert H.	87-06101 etc.	6/19/89	Order on Reconsideration
Johnson, Robert W.	87-13077	2/3/89	Order on Reconsideration
Johnson, Robert W.	87-13077	2/22/89	2nd Order on Reconsideration
Johnson, William D.	87-08530 etc.	3/89	Order on Review
Johnson-Schotz, Anita	86-10972	5/4/89	Order on Review
Johnson-Schotz, Anita	86-10972	5/23/89	Amended Order on Review
Johnston, Sheila	89-0072M	2/89	Own Motion
Jolley, Loretta A.	87-04307	5/17/89	Order on Review
Jones, Beverly J.	89-0161M	4/27/89	Own Motion Order
Jones, Margaret	89-0032M	1/89	Own Motion
Joseph, Elaine	87-0740M	1/89	Own Motion
Josi, Robert E.	89-0166M	4/5/89	Own Motion Order
Judd, Carl F.	88-0809M	6/16/89	Order Postponing Action
Judkins, David	88-0395M	3/89	Own Motion
Juker, Melvin E.	87-00983 etc.	5/17/89	Order on Review
Jungling, Lynn	89-0333M	6/12/89	Own Motion Order
Justen, Terry	88-0207M	3/89	Own Motion
Kaeo, Cornel D.	87-06274	2/16/89	Order on Review
Kaeo, Cornel D.	87-06274	3/20/89	Order on Reconsideration
Kartak, Michael	88-0656M	3/89	Own Motion
Keen, Gwendolyn	88-0498M	5/22/89	Own Motion Order
Kemhus, Evelyn E.	86-15806	2/23/89	Order on Review
Kennedy, Delaine	89-0021M	5/31/89	Own Motion Order
Kennedy, Delaine	89-0021M	6/27/89	Own Motion Order
Kennedy, Dewey	89-0188M	4/17/89	Own Motion Order
Kennedy, Richard	89-0113M	3/89	Own Motion
Kern, Calvin, Jr.	89-0243M	5/9/89	Own Motion Order
King, Janice M.	89-0136M	3/89	Own Motion
King, Judith	89-0068M	3/89	Own Motion
King, Walter F.	89-0117M	3/89	Own Motion
King, William R.	89-0012M	1/89	Own Motion
Kingsland, Alfred	89-0099M	3/89	Own Motion
Kintz, Keith J.	89-0196M	4/17/89	Own Motion Order
Kirk, Vona	87-16904	6/19/89	Order on Review
Kissee, Ted R.	87-17975 etc.	6/13/89	Order on Review
Kissee, Ted R.	87-0519M	6/13/89	Own Motion Order
Kitchin, Ronald	88-0810M	3/89	Own Motion
Knapp, Gerald	88-0672M	2/89	Own Motion
Knaub, Gary A.	89-0296M	5/31/89	Consent to Issuance Order
Knaub, Gary A.	89-0296M	5/31/89	Own Motion Order
Knodel, Carol	89-0065M	2/89	Own Motion
Kosel, Lucie Mae	88-0532M	1/89	Own Motion
Krening, Jack E.	89-0083M	3/89	Own Motion
Krueger, Harriett L.	87-02876	1/5/89	Order on Review
Krussell, Robert L.	87-16931	2,3/89	Order on Review
Lacy, George L.	86-09432	1/89	Order on Review
Lahodny, Beverly	89-0301M	6/15/89	Own Motion Order

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Name	WCB Number	Date	Type of Order
Lakey, Conrad	89-0055M	2/89	Own Motion
Lammon, Caleb	87-00911	6/15/89	Order on Review
Landeros, Jose L.	87-05498	6/13/89	Order on Review
Lang, Terry	89-0306M	6/12/89	Own Motion Order
Larsen, Teri L.	88-0780M	2,3/89	Own Motion
Larsen, Teri L.	88-0780M	5/3/89	Own Motion on Recon
Laur, Harold	89-0172M	5/31/89	Own Motion Order
Lausche, Eugene	89-0168M	4/17/89	Own Motion Order
LaVert, Bertha Barber	89-0369M	6/23/89	Denial of Consent
Leaton, Daniel	88-0583M	5/31/89	Own Motion Order
Lee, Robert E.	89-0094M	3/89	Own Motion
Lemons, Kim	89-0120M	3/89	Own Motion
Lenning, Mark L.	88-05282	5/30/89	Order of Dismissal
Leslie, Paul E.	87-0715M	2/89	Own Motion
Liday, Minor G.	88-0138M	4/5/89	Own Motion Order
Linday, Jeff	89-0177M	4/17/89	
Lindsay, William	89-0328M	6/26/89	Own Motion Order
Liverman, Jack	88-0490M	3/89	Own Motion
Lloyd, Audley, Jr.	89-0319M	6/26/89	Own Motion Order
Lockard, Earnestine	86-0076M	4/27/89	Own Motion Order of Dismissal
Lodeski, Carlene	89-0198M	4/19/89	Order Postponing Action
Logan, Richard	85-0591M	3/89	Own Motion
Lombardi, Linda L.	86-11315	2/89	Order on Review
Lotfi, Fred	89-0023M	3/89	Own Motion
Love, William	89-0054M	2/89	Own Motion
Lunsford, Herman	89-0263M	5/17/89	Own Motion Order
Lutz, Bryan	89-0360M	6/29/89	Own Motion Order
Lytton, Kenneth L.	88-0797M	5/17/89	Own Motion Order
Mack, Ronald G.	87-13647	6/13/89	Order on Review
MacKenzie, Eric W.	87-18256	4/18/89	Interim Order of Remand
Madsen, Melvin	89-0256M	5/17/89	Own Motion Order
Magnuson, Wesley	89-0309M	5/31/89	Consent to Issuance Order
Magoulas, Jim F.	89-0027M	2/89	Own Motion
Malar, Shirley E.	89-0315M	6/12/89	Own Motion Order
Mangun-Wolverton, B.	88-0147M	1/89	Own Motion
Mapes, Robert L.	87-04038	1/89	Order on Review
Marchuk, James M.	88-0673M	1/89	Own Motion
Marks, Norman	89-0254M	5/30/89	Own Motion Order
Marsh, Jackquline	89-0022M	2/89	Own Motion
Marshall, Arlene	86-06142	3/14/89	Order Denying Request
Martin, David	84-0207M	1/89	Own Motion
Martin, Elson	88-0152M	1/89	Own Motion
Martinez, Roberto C.	88-02787	5/17/89	Order of Dismissal
Martinez, Roberto C.	88-02787	5/23/89	Amended Order of Dismissal
Marugg, Darrell M.	87-12998	4/12/89	Order on Review
Marziano, Mario	88-12262	6/13/89	Order Withdrawing Dismissal
Marziano, Mario	88-12262	5/31/89	Order of Dismissal
Maugh, Floyd	89-0137M	3/89	Own Motion
Maul, Christopher	89-0331M	6/14/89	Own Motion Order
Maupin, Eddy V.	87-0122M	1/89	Own Motion
May, Ronald L.	88-0589M	1/89	Own Motion
Mayhew, Mark A.	89-00311	6/27/89	Order of Dismissal
McArthur, William L.	86-05236 etc.	3/2/89	Order on Review
McCullough, A.G.	87-08992	6/8/89	Order of Dismissal
McDaniel, Ronald L.	89-0171M	4/19/89	Own Motion Order
McDougald, Gene C.	89-0190M	4/17/89	Own Motion Order

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Name	WCB Number	Date	Type of Order
McFall, Dora	88-0453M	1/89	Own Motion
McKee, James L.	89-0193M	5/31/89	Own Motion Order
McKinney, Gerald	89-0246M	5/17/89	Own Motion Order
McKofka, Edward J.	89-0175M	5/17/89	Own Motion Order
McMillan, Patrick	89-0208M	4/27/89	Own Motion Order
McMillion, Joan R.	85-01540	2/89	Order on Review
McMullen, John M.	88-0216M	1/89	Own Motion
McPherson, Donald P.	89-0274M	5/31/89	Own Motion Order
McPherson, John C.	89-0123M	3,3/89	Own Motion
McRae, Billy	88-0768M	3/89	Own Motion
McRae, Billy	88-0768M	4/20/89	Own Motion Order on Recon
McSwain, Malcolm	88-0614M	1/89	Own Motion
Meadows, Betty	89-0059M	2/89	Own Motion
Meredith, Patricia A.	86-17614	3/8/89	Order on Review
Meyers, Robert J.	89-0121M	3/89	Own Motion
Michael, Philip G.	87-03834	5/30/89	Order on Review
Michael, Vernon	89-0075M	2/89	Own Motion
Miles, Donald R.	89-0169M	4/17/89	Own Motion Order
Miller, Barbara	88-0549M	6/15/89	Own Motion Order
Miller, Donald H.	87-14748	5/9/89	Order on Review
Miller, Gene P.	89-0182M	4/17/89	Own Motion Order
Miller, Guy A.	88-18516	6/21/89	Order of Dismissal
Mills, Donald R.	87-02797	2/23/89	Order on Review
Mills, Rosemary	87-01919	2/89	Order on Review
Millsap, Lawrence E.	88-0606M	1/89	Own Motion
Minear, Rodney J.	88-21246	5/17/89	Order of Dismissal
Mitchell, Charles P.	85-07024	4/25/89	Order Denying Reconsideration
Mlasko, Rudolph R.	85-0406M	6/30/89	Own Motion Order
Moffitt, Sterling	86-17346	5/3/89	Order of Dismissal
Montgomery, Robert E.	89-0283M	5/31/89	Own Motion Order
Moore, Daniel P.	89-0013M	1/89	Own Motion
Moore, Jack D.	86-0609M	3/89	Own Motion
Moorhead, Thomas L.	88-16906	4/14/89	Order of Dismissal
Morgan, Owen B.	88-0795M	1/89	Own Motion
Morris, Arthur	89-0063M	2/89	Own Motion
Mosley, Robert	89-0179M	4/17/89	Own Motion Order
Moyer, Phillip, Sr.	89-0209M	4/27/89	Own Motion Order
Mueller, Barbara	88-0596M	6/26/89	Own Motion Order
Mueller, Barbara	88-0596M	1/89	Own Motion
Mullins, Patrick H.	87-05324	6/8/89	Order on Review
Munch-Kearl, Peggy S.	86-01897	2/24/89	Order on Review
Munch-Kearl, Peggy S.	86-01897	3/16/89	Order on Reconsideration
Murphy, Shirley J.	88-13990 etc.	4/12/89	Order of Dismissal
Murphy, Shirley J.	88-13990 etc.	4/28/89	Amended Order of Dismissal
Murphy-Gelardi, P.	89-0170M	4/17/89	Own Motion Order
Murr, Marianne T.	87-19197	5/9/89	Order on Review
Murray, Vern	89-0349M	6/29/89	Own Motion Order
Myers, Donald	89-0035M	4/19/89	Own Motion Order
Myers, Kenneth W.	87-00812	5/17/89	Interim Order of Remand
Napier, Steven K.	86-13032	2/23/89	Order on Review
Neal, James	88-0137M	3/89	Own Motion
Nelson, Timothy J.	89-0267M	5/30/89	Own Motion Order
Nemec, Phillip	89-0092M	3/89	Own Motion
Newman, Sarah L.	87-0584M	3/89	Own Motion
Newton, Brian	89-0239M	5/9/89	Own Motion Order
Nicholson, Randy L.	86-01438 etc.	1/89	Order on Review

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Name	WCB Number	Date	Type of Order
Nicks, Edward	89-0053M	2/89	Own Motion
Nicks, Edward J.	89-0329M	6/30/89	Own Motion Order
Norris, Andrew C.	89-0350M	6/16/89	Own Motion Order
Norris, Thomas	89-0278M	5/30/89	Own Motion Order
North, Michael	88-0794M	1/89	Own Motion
Norvald, Gene H.	88-0817M	1/89	Own Motion
Norvald, Gene H.	89-0363M	6/16/89	Consent to Issuance
O'Mara, Richard A.	89-0129M	4/7/89	Own Motion Order
Ohman, Christopher	89-0250M	6/15/89	Own Motion Order
Olin, Homer	89-0009M	4/5/89	Own Motion Order
Orozco, Antonia C.	89-01780	6/26/89	Order of Dismissal
Orr, Newton W.	84-05108	5/12/89	Order on Review
Ougheltree, Marie	89-0097M	3/89	Own Motion
Owens, Linda D.	88-0685M	2/89	Own Motion
Pacheco, Williadeane	88-0585M	1/89	Own Motion
Padilla, Rosanna	89-0217M	5/17/89	Own Motion Order
Padilla, Victor	88-0725M	1/89	Own Motion
Padilla, Victor J.	87-11755	4/7/89	Order on Review
Parker, David L.	89-0085M	5/15/89	Own Motion Order
Parker, David L.	88-13890 etc.	5/15/89	Order on Review
Parker, David L.	88-13890 etc.	5/30/89	Amended Order on Review
Parker, David L.	88-13890 etc.	6/7/89	Order on Reconsideration
Parks, Duke	88-0181M	3/89	Own Motion
Parrish, Delano C.	89-0227M	5/17/89	Own Motion Order
Partridge, Edward H.	86-16459	2/13/89	Order on Review
Pavey, Henry W.	88-11925	5/3/89	Order of Dismissal
Payne, Thelma Purcell	88-0506M	5/30/89	Own Motion Order
Peacock, James	87-0062M	2/89	Own Motion
Peck, Robert D.	89-0233M	5/17/89	Own Motion Order
Pelto, Gene M.	87-04397	3/89	Order on Review
Pendergrass, David	88-0827M	1/89	Own Motion
Perkins, Jon H.	87-08594 etc.	5/11/89	Order on Review
Perry, Alan L.	89-0342M	6/29/89	Own Motion Order
Persinger, Christopher	88-0793M	1/89	Own Motion
Peterson, Master Don	89-0356M	6/19/89	Own Motion Order
Phibbs, Ross S.	87-07311	3/89	Order on Review
Philippi, Wesley	89-0056M	2/89	Own Motion
Phillips, Brian C.	89-0006M	1/89	Own Motion
Phillips, James E.	89-0090M	4/27/89	Own Motion Order
Phillips, Richard	89-0038M	4/27/89	Order Postponing Action
Phillips, Roger	89-0034M	2/89	Own Motion
Pittman, Gary D.	89-0325M	6/1/689	Own Motion Order
Plaschka, Robert E.	87-0372M	4/7/89	Own Motion Order
Plemmons, Loreen H.	87-15554	3/89	Order on Review
Poague, Robert	88-0129M	1/89	Own Motion
Pool, Naomi	88-0762M	1/89	Own Motion
Porras, Maria R.	87-07390	4/25/89	Order on Review
Porter, Harris	87-0244M	4/17/89	Own Motion Order of Dismissal
Porter, Richard	89-0241M	5/9/89	Own Motion Order
Powers, Roland	88-0247M	3/89	Own Motion
Price, David	86-0422M	3/89	Own Motion
Price, Ricky J.		3/89	Own Motion
Privatsky, Norman P.	89-0086M	3/89	Own Motion
Pullis, Wayne J.	88-17053	6/16/89	Order of Dismissal
Punneo, Claude Dean	89-0114M	3/89	Own Motion
Purdy, Rhonda E.	86-00412	3/16/89	Order on Review

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Name	WCB Number	Date	Type of Order
Purdy, Rhonda E.	86-00412	4/17/89	Amended Order on Review
Puttie, Steven	88-0791M	2/89	Own Motion
Pyle, Henry	89-0141M	3/89	Own Motion
Quadros, Barbara	86-12705 etc.	6/8/89	Order on Review
Quindt, Charleene L.	88-07988	1/89	Order on Review
Quinn, A.J.	88-0528M	6/16/89	Own Motion Order of Dismissal
Raines, Carroll E.	87-05696	4/5/89	Order on Review
Ramirez, Ricardo	89-0119M	3/89	Own Motion
Rard, John P.	89-0100M	3/89	Own Motion
Ray, Rodney	89-0165M	4/5/89	Own Motion Order
Ray, Sally	89-0142M	3/89	Own Motion
Rea, Linda	88-19811	5/31/89	Order of Dismissal
Reavis, Lawrence	87-14533	6/8/89	Order of Dismissal
Regehr, Richard A.	87-13757	5/30/89	Order on Review
Reich, Teri L.	87-03355	6/12/89	Order on Review
Reid, Kenneth	89-0308M	6/15/89	Own Motion Order
Reinertsen, Judith	89-0127M	4/17/89	Amended Denial of Consent
Reinertsen, Judith	89-0127M	3/89	Own Motion
Reiserer, Deanna	87-07026	4/18/89	Order on Review
Repp, William	89-0203M	4/27/89	Own Motion Order
Rhodes, Hoover	89-0108M	4/7/89	Own Motion Order
Richards, Stanley L.	88-0798M	1/89	Own Motion
Richardson, Phyllis	88-0471M	4/7/89	Own Motion Order
Richichi, Gary R.	87-09482	5/17/89	Order of Dismissal
Rictor, Donald A.	86-0244M	2/89	Own Motion
Riddell, Ray	89-0351M	6/29/89	Own Motion Order
Riley, John B., Sr.	87-0751M	1/89	Own Motion
Riley, Mary	88-15961	5/31/89	Order of Dismissal
Riley, Mary	88-15961	6/14/89	Amended Order of Dismissal
Rimer, Robert L.	89-0176M	4/17/89	Own Motion Order
Roberts, Bruce	88-0815M	1/89	Own Motion
Roberts, Donald	88-0529M	1/89	Own Motion
Robertson, Audrey A.	87-11417	1/89	Order on Review
Robertson, Robert	89-0019M	2/89	Own Motion
Robinson, Everett E.	89-0282M	6/19/89	Order Awarding Attorney Fees
Robinson, Everett E.	89-0282M	5/26/89	Own Motion Order
Rodriguez, Guadalupe	89-0118M	3/89	Own Motion
Rogers, Kenneth D.	87-08313 etc.	3/28/89	Order on Review
Rogers, Robert	89-0043M	5/17/89	Own Motion Order of Dismissal
Rosander, Ronald	89-0058M	4/27/89	Own Motion Order
Ross, Larry G.	89-0126M	3/89	Own Motion
Ross, Robert	89-0218M	5/17/89	Own Motion Order
Rossignol, Peggy	89-0275M	5/30/89	Own Motion Order
Rucker, Beverly J.	88-21016	6/16/89	Order of Dismissal
Rumpel, Billie	89-0754M	2/89	Own Motion
Runey, Stevan	89-0057M	2/89	Own Motion
Sabey, Jimmy	88-0813M	1/89	Own Motion
Sallee, Glen D.	85-08042	5/30/89	Order on Review
Sanchez, Arthur	89-0147M	4/20/89	Own Motion Order of Dismissal
Sanchez, Enrique M.	84-0435M	3/89	Own Motion
Sandberg, Steven J.	87-05254	6/13/89	Order on Review
Sandberg, Steven J.	87-05254	6/29/89	Order on Reconsideration
Sanders, Jeffrey	87-03378	5/31/89	Order on Review
Santibanez, Victor C.	87-15382	5/4/89	Order on Review
Saxton, Lawrence	89-0138M	6/6/89	Own Motion Order
Schaffner, Gerald L.	88-19673	5/31/89	Order of Dismissal

Name	WCB Number	Date	Type of Order
Schehen, Sherwood	88-0634M	4/20/89	Own Motion Order
Schmidt, Marlene G.	89-0173M	3/89	Own Motion
Schmidt, Myron A.	89-0040M	5/12/89	Own Motion Order
Schmidt, Myron A.	89-0040M	6/12/89	Own Motion Order on Recon
Schmidt, Myron A.	89-0040M	4/27/89	Order Postponing Action
Schneider, Richard	88-0804M	5/26/89	Own Motion Order
Schooling, Mary E.	86-14712	4/5/89	Order on Review
Schooling, Mary E.	86-10542	4/5/89	Order on Review
Schuster, Danny	89-0226M	5/17/89	Own Motion Order
Schwab, Donald F.	87-02450	6/8/89	Order on Review
Schwarz, Denise K.	86-16364	2/24/89	Order on Review
Scott, James H.	88-13949	5/23/89	Order of Dismissal
Self, Ira	88-0577M	3/89	Own Motion
Selman, Thomas	89-0167M	5/30/89	Own Motion Order on Recon
Sevey, Gene	89-0004M	1/89	Own Motion
Sharman, Donald R.	88-0778M	3/89	Own Motion
Shelliot, Delbert C.	87-05284	6/13/89	Order on Review
Sherman, Harvey L.	88-0566M	3/89	Own Motion
Sherman, James C.	87-0128M	5/30/89	Own Motion Order
Sherman, James C.	87-01094 etc.	5/30/89	Order on Review
Sherman, William L.	87-11797 etc.	3/23/89	Order on Review
Sherratt, Pamela L.	88-0526M	3/89	Own Motion
Shields, William T.	87-03693 etc.	1/5/89	Order on Review
Shiffer, John	88-0782M	3/89	Own Motion
Shuler, Susan E.	86-16034	2/23/89	Order on Review
Shuttlesworth, Larry D.	87-01710	3/89	Order on Review
Shuttlesworth, Larry D.	87-01710	4/17/89	Order on Reconsideration
Silvers, Orlan	86-0608M	2/89	Own Motion
Simmons, Roy D.	87-0696M	2/89	Own Motion
Simnitt, Nancy S.	86-0052M	3/89	Own Motion
Simon, Lyle	89-0307M	5/30/89	Own Motion Order
Simons, Scott M.	86-13725 etc.	4/21/89	Order on Review
Skaggs, Leah	89-0225M	5/17/89	Own Motion Order
Slater, Alice E.	86-11313	4/21/89	Order on Review
Slayton, Ellen	88-0519M	1/89	Own Motion
Slinger, Edward	89-0148M	3/89	Own Motion
Smith, Christine	89-0091M	3/89	Own Motion
Smith, Evelyn	89-0133M	3/89	Own Motion
Smith, John W.	89-0231M	5/17/89	Own Motion Order
Smith, Willard	87-0537M	1/89	Own Motion
Smouse, Judy	89-0087M	3/89	Own Motion
Solesbee, Keith	88-05751	5/4/89	Order of Dismissal
Sorrels, Michael A.	87-15688	1/89	Order on Review
Southworth, Everett	88-0502M	3/89	Own Motion
Spain, John K.	89-0313M	6/12/89	Own Motion Order
Spence, Paul E.	87-0373M	1/89	Own Motion
Spencer, Robert R.	89-0104M	3/89	Own Motion
Spivey, Harvey F.	85-0615M	3/89	Own Motion
Sportsman, Rex	89-0181M	4/27/89	Own Motion Order
Stark, Susan K.	86-05043	3/89	Order on Review
Stenzel, Ronald	89-0098M	3/89	Own Motion
Stephens, Williams	88-0820M	1/89	Own Motion
Stephenson, Beverly	89-0200M	4/13/89	Own Motion Order
Sterba, Gary	89-0067M	2/89	Own Motion
Stevenson, Barbara J.	87-14606 etc.	3/89	Order on Review
Steward, Richard	89-0252M	5/26/89	Own Motion Order

Name	WCB Number	Date	Type of Order
Stibik, David	88-0081M	2/89	Own Motion
Stines, Nancy	89-0232M	5/17/89	Own Motion Order
Stockebrand, Keith L.	88-0432M	3/89	Own Motion
Storms, Lenora	89-0305M	5/23/89	Denial of Consent
Strain, Patrick L.	86-09967	6/8/89	Order on Review
Strauss, Steven J.	89-0122M	3/89	Own Motion
Stuck, Elizabeth	89-0302M	6/15/89	Own Motion Order
Sturgis, Vi	87-05517	6/12/89	Order on Review
Sunderland, Wayne G.	86-0478M	4/4/89	Own Motion Order of Dismissal
Sundstrom, Leland R.	86-14782	3/89	Order on Review
Surface, Leland S.	87-01765	2/89	Order on Review
Sutton, Donna J.	86-16464	3/89	Order on Review
Sutton, Donna J.	86-16464	4/12/89	Order on Reconsideration
Swanberg, Betty J.	83-0281M	3/89	Own Motion
Swank, Donald L.	86-0261M	6/12/89	Own Motion Determination
Sweeney, Kathy A.	87-0571M	3/89	Own Motion
Tarpley, Gary	89-0132M	3/89	Own Motion
Taylor, David M.	88-15019 etc.	6/16/89	Order of Dismissal
Teague, Webster J.	85-06785	3/89	Order on Review
Thissell, John, Sr.	88-0727M	3/89	Own Motion
Thompson, Ernest E.	85-07828	3/8/89	Order on Remand
Thompson, Ernest E.	85-07828	3/16/89	2nd Order on Remand
Thompson, Jerome S.	87-01681	2/89	Order on Review
Thrasher, Ronald W.	86-0696M	3/89	Own Motion
Thurston, Lewis	87-0686M	3/89	Own Motion
Tila, Raimo	89-0018M	1/89	Own Motion
Tilton-Kidd, Doris	88-0166M	3/89	Own Motion
Timpy, Charles	84-0530M	3/89	Own Motion
Tindall, James	88-0095M	5/30/89	Own Motion Order
Tompkins, Nora A.	86-14921	6/21/89	Amended Order on Review
Tompkins, Nora A.	86-14921	6/8/89	Order on Review
Tovar, Seferino J.	88-16611 etc.	5/5/89	Order of Dismissal
Townsend, Rick T.	87-12762	6/13/89	Order on Review
Trafton, Leonard F.	86-13723	3/2/89	Order on Review
Trollope, Stephen W.	88-0146M	3/89	Own Motion
Turchy, Frank	88-0037M	3/89	Own Motion
Turner, Ronald J.	87-04630	4/19/89	Amended Order on Reconsideration
Turner, Ronald J.	87-04630	2/23/89	Order on Review
Turner, Ronald J.	87-04630	3/13/89	Order on Reconsideration
Tuttle, David	88-0746M	1/89	Own Motion
Ultsch, Bruce	89-0093M	3/89	Own Motion
Van Winkler, Joy	89-0211M	5/17/89	Own Motion Order
VanBurger, Earl D.	87-0520M	3/89	Own Motion
Vance, Robert E.	86-0260M	3/89	Own Motion
Vandehey, Joey R.	89-0195M	4/27/89	Own Motion Order
Vanderpool, William	88-0811M	1/89	Own Motion
VanHorn, Karen L.	89-04133	6/16/89	Order of Dismissal
Vanni, Lisa	88-14234	5/11/89	Order of Dismissal
Vanzant, Timothy R.	88-0631M	3/89	Own Motion
Vatland, Milnar	87-0603M	3/89	Own Motion
Vick, Linda	86-15972	2/24/89	Order on Review
Vilches, Alfonso	89-0258M	5/26/89	Own Motion Order
Waddell, Ralph	89-0160M	3/89	Own Motion
Wade, Bonnie	89-0324M	6/15/89	Own Motion Order
Wainwright, Charles	88-0548M	1/89	Own Motion
Wakeley, Alfred F.	86-17787	5/31/89	Order on Review

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Name	WCB Number	Date	Type of Order
Wall, Robert N.	89-0124M	3/89	Own Motion
Walsh, Marie C.	86-17420	3/20/89	Order on Reconsideration
Walsh, Marie C.	86-17420	3/8/89	Order on Review
Walsh, Marjorie R.	85-0680M	3/89	Own Motion
Warf, Steven	88-0213M	3/89	Own Motion
Warfel, Ermagene	87-05941	6/8/89	Order of Dismissal
Warnock, Keith	89-0279M	5/30/89	Own Motion Order
Warren, Guadalupe	86-13579	3/12/89	Order on Review
Warren, William V.	87-13829 etc.	6/21/89	Order on Review
Watkins, Paul	89-0249M	5/17/89	Own Motion Order
Watkins, Paul	89-0249M	5/30/89	Amended Own Motion Order
Watson, Michael A.	89-0229M	5/17/89	Own Motion Order
Watts, Shirley	89-0220M	5/3/89	Own Motion Order
Webb, Andy	88-0144M	1/89	Own Motion
Webber, Richard	88-0571M	3/89	Own Motion
Wells, Fred E.	87-02021 etc.	2/23/89	Amended Order on Review
Wells, Fred E.	87-02021 etc.	3/2/89	Order on Review
West, Alfred	87-0605M	4/17/89	Own Motion Order
West, Wesley	87-05649	6/16/89	Order on Review
Westfall, Marion	88-0819M	1/89	Own Motion
Wheeler, Charley A.	87-11106	6/8/89	Order on Review
Wheeler, Harriette	88-0046M	4/17/89	Own Motion Order
Wheeler, William B.	87-00392	5/26/89	Corrected Order on Review
Wheeler, William B.	87-00392	5/17/89	Order on Review
Whitaker, Gloria	89-0125M	3/89	Own Motion
Whitlow, David L.	86-14624	2/89	Order on Review
Wigle, Joseph	88-0588M	1,2/89	Own Motion
Wilbanks, Danny	88-0649M	3/89	Own Motion
Wilcox, Mary L.	87-01597	4/25/89	Order on Review
Wilcox, Shirley A.	87-09028 etc.	3/8/89	Order on Review
Wilder, William D.	84-11216	3/89	Order on Review
Wilding, Debbie A.	87-00184	2/89	Order on Review
Wilkerson, Barbara J.	86-07372	1/89	Order on Review
Williams, Arbra	88-0743M	2/89	Own Motion
Williams, Floyd	89-0266M	6/6/89	Own Motion Order
Williams, Mary E.	87-00078	1/5/89	Order on Review
Willman, Thomas	89-0144M	5/31/89	Own Motion Order
Wilson, David	89-0042M	2/89	Own Motion
Wilson, Ralph E.	87-07590	6/6/89	Order on Review
Wilson, William	89-0310M	6/12/89	Order Postponing Action
Windom, Walter	89-0088M	3/89	Own Motion
Winkle, Jerry	89-0030M	6/23/89	2nd Own Motion Order
Winkle, Jerry	89-0030M	6/12/89	Own Motion on Recon
Winters, Tom N.	89-0185M	4/17/89	Own Motion Order
Wolever, Arlene	89-0216M	5/17/89	Own Motion Order
Wood, Joan M.	89-0061M	2/89	Own Motion
Woods, Dorothy	89-0264M	5/23/89	Order Postponing Action
Wooldridge, Michael	89-0248M	5/17/89	Own Motion Order
Woolridge, Michael	87-0577M	3/89	Own Motion
Wright, Gary D.	86-11840	3/89	Order on Review
Wrinkle, Robert W.	89-0184M	5/17/89	Own Motion Order of Dismissal
Yakes, Audrey	88-0765M	1/89	Own Motion
Young, Gail	89-0020M	1/89	Own Motion
Yuille, Michael	89-0242M	5/9/89	Own Motion Order
Zable, Isabel	89-0294M	6/15/89	Own Motion Order
Zilkoski, Michael S.	87-09368	6/16/89	Order on Review

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