VAN NATTA'S WORKERS' COMPENSATION REPORTER

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

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Edited & published by:

Robert Coe and Merrily McCabe
1017 Parkway Drive NW
Salem, Oregon 97304
(503) 362-7336

CONTENTS

CITE AS

41 Van Natta ____ (1989)

JON S. BACH, Applicant
Dave Fowler, Assistant Attorney General
Gerri Christensen, Dept. of Justice

WCB CV-88004
November 30, 1988
Findings of Fact, Conclusions and Proposed Order (Crime Victim Act)

Pursuant to notice, a hearing was conducted and concluded by Roger C. Pearson, special hearings officer, on November 2, 1988 at Salem, Oregon. Applicant, Jon S. Bach, was present and not represented by counsel. The Department of Justice Crime Victims' Compensation Fund ("Department") was represented by Dave Fowler, Assistant Attorney General. The court reporter was Tina Duncan. The record was closed November 2, 1988.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated April 13, 1988. By its order, the Department accepted applicant's claim for compensation, filed pursuant to the Compensation of Crime Victims Act (Act). ORS 147.005 to 147.365. However, finding that applicant's actions and conduct contributed to his injuries, the Department awarded compensation equal to 50 percent of his unreimbursed medical and hospital expenses up to a maximum amount of $5,000.

ISSUES

Was applicant's injury substantially attributable to his own wrongful act or did applicant substantially provoke his assailant?

Did applicant's acts or conduct provoke or contribute to his injury? If so, to what degree or extent.

FINDINGS OF FACT

The following facts are not in dispute. On September 28, 1987, applicant timely filed an application for benefits with the Crime Victims' Compensation Program. Applicant claimed that he had been the victim of an assault and battery on September 7, 1987. As a result of this attack, he sustained fractures to his left cheekbone and nasal septum, which eventually required surgery to repair.

Law enforcement officials were notified of the alleged assault on September 8, 1987, which was within 72 hours of its perpetration. Officer Struble, a Linn County Deputy Sheriff, investigated the incident. Following the investigation, criminal charges for Assault IV were instituted against the alleged assailants, Will Peterson and Mickey Adams. Following a court trial, both individuals were acquitted of the charges.

Applicant returned to his work as a teaching assistant for the Oregon State University College of Pharmacy on September 21, 1987. He has incurred medical expenses in excess of the $250 statutory minimum.

On March 2, 1988, the Department accepted applicant's claim for benefits. However, the Department found that applicant was "intoxicated" and acting in an "obnoxious" manner at the time of the assault. Reasoning that a reasonable and prudent person would not have conducted himself in such a manner, the Department

concluded that applicant's actions and conduct had contributed to his injury. Consequently, the Department held that applicant was entitled to recover 50 percent of his unreimbursed medical and hospital expenses not to exceed $5,000.

Applicant requested reconsideration, contending that he had not contributed to the injuries he had sustained. The Department issued an Order on Reconsideration on April 13, 1988, adhering to its prior order. Thereafter, applicant timely requested review by the Workers' Compensation Board.

After reviewing the record and considering the testimony, I make the following findings concerning the facts which are in dispute.

The evening of the attack, applicant was at the "Buzzsaw" tavern drinking and dancing. He arrived around 9 p.m. and left at approximately 2 a.m. As the evening progressed, applicant became intoxicated and began annoying the female customers, particularly Teddi Rich. Peterson and Adams were "bouncers" at the Buzzsaw. Although they considered evicting applicant from the tavern for his behavior, he was not asked to leave.

While at the Buzzsaw, applicant met Frank Roles, who offered him a ride home. After leaving the tavern, applicant and Roles purchased two cases of beer and attended a party at Roles' residence. Many of the individuals from the tavern were at the party. While at the party, applicant continued to drink, his state of intoxication increased, and his behavior became disruptive.

With Roles' permission, Peterson told applicant to leave the party. Applicant eventually left, but returned, at least once, to recover "his beer." After his departure, he remained outside of the residence deciding how he would get home. Sometime thereafter, applicant was assaulted by Peterson and Adams. Following the attack, he ran to the residence of Teresa McKay, who eventually gave him a ride home.

ULTIMATE FINDINGS OF FACT

Applicant's injury was not substantially attributable to his own wrongful act nor did he substantially provoke his assailants. However, his inebriated conduct contributed to his injury.

CONCLUSIONS OF LAW

The standard of review for cases appealed to the Board under the Act is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

Pursuant to ORS 147.015, applicant is entitled to an award under the Act, if, among other requirements:

> "(5) The death or injury to the victim was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim."

The Department shall determine the degree or extent to which the victim's acts or conduct provoked or contributed to the injuries or death of the victim, and shall reduce or deny the award of compensation. ORS 147.125(3).

"Substantially attributable to his wrongful act" means attributable to an unlawful act voluntarily entered into from which there can be a reasonable inference that, had the act not been committed, the crime complained of would not have occurred. OAR 137-76-010(7). "Substantial provocation" means that a voluntary act or utterance which there can be a reasonable inference that, had it not have occurred, the crime would not have occurred. OAR 137-76-010(8).

Following my de novo review of the documentary and testimonial evidence, I find that applicant was the victim of an assault which was not substantially attributable to any wrongful act nor substantial provocation on his part. Consequently, I conclude that he is entitled to benefits from the Crime Victims' Compensation Fund. However, I am persuaded that applicant's conduct contributed to his injury. Accordingly, I hold that the Department was justified in reducing applicant's award of compensation.

Applicant categorically denies that he was either intoxicated or obnoxious or that he contributed, in any manner, to the injuries he sustained. Other than being requested to leave the party, he was unaware of any confrontation, altercation, dispute, or disagreement of any kind with any individual. When asked to explain why the assault had occurred, applicant surmised that it was because the assailants were "bullys," as exemplified by "their job as bouncers."

After closely and carefully observing applicant's attitude and demeanor while testifying about undisputed matters concerning his claim, I detected nothing which would cause me to doubt his credibility as a witness. However, when questioned about his consumption of alcohol and his state of mind and behavior that night, applicant's voice rose and his responses became evasive. These observations prompt me to question his credibility.

My suspicions are further enhanced by comparing the content of applicant's testimony with the record. Specifically, in initially relating the events leading up to the attack, applicant testified that he went to Roles' home only because Roles intended to meet other people there to give them rides home. He subsequently admitted that he and Roles had purchased two cases of beer on the way to the house. However, applicant continued to maintain that the get-together was not a "party." Furthermore, when questioned about his state of mind and alcohol consumption that night, applicant insisted that he had "only 4 or 5" drinks and remembered everything that happened. Yet, other than terming them "mixed drinks," applicant was unable to identify any of the drinks he consumed during his 5-hour stay at the tavern. Finally, and most important, applicant denied that any dispute with any individual, male or female, had occurred that evening. Inasmuch as this denial is directly contrary to the remainder of the record, which includes the opinions of an investigative officer, as well as the attorney who prosecuted the criminal case, I do not find it credible.

Considering the aforementioned concerns, I rely on the written record, rather than claimant's testimony, in resolving this dispute. The record primarily consists of reports from the investigating officer, Officer Struble, and a trial summary provided by Deputy District Attorney Gonzales.

After conducting his investigation, Officer Struble reported that applicant had almost been ejected from the Buzzsaw because he "was being a pain." Later that evening at the Roles' party, he had been asked to leave "because he was being a jerk toward the ladies." He left only after he got "his beer." It was Officer Struble's opinion that applicant had probably been beaten up. Struble further concluded that applicant had probably provoked the fight, stating as follows:

> "[H]e was extremely intoxicated. Everybody I interviewed said he was 'wasted.' He didn't even know where it happened. He probably doesn't really know what happened."

Although applicant acknowledges Officer Strubles' opinion, he discounts it because Strubles was "on [Peterson's and Adams'] side." Yet, applicant concedes that he, Strubles, Peterson, Adams, Roles, and others, testified at the "Assault IV" trial, where the judge acquitted the defendants of all charges. Applicant does not contend that the judge was "on their side," he only asserts that there was insufficient evidence to establish that they had assaulted him.

A recount of the trial, provided by Deputy District Attorney Gonzales, supports applicant's contention that he was assaulted. However, the recount does not support applicant's characterization of his conduct that night. In addition to setting forth a detailed summary of the trial, Gonzales presents a reasoned analysis of the case. Gonzales summarized as follows.

The testimony established that applicant was "real obnoxious toward the ladies" and "very intoxicated" at the Buzzsaw and at the party. He and Roles had purchased two cases of beer for the party. Applicant was asked to leave the party and, at one point, left. However, he later returned, insisting that he wouldn't leave without "his beer." When he received his case of beer, he left, but shortly returned. He was again asked to leave and, finally, did leave alone. Peterson and Adams left the party "quite awhile later," at which time most of the guests had already departed. Roles testified that applicant had invited himself to the party and, since he continued to drink and bother people, Roles had permitted Peterson to ask applicant to leave. Thereafter, Roles fell asleep and did not arise until the next morning.

Teddi Rich, a customer at the Buzzsaw and a guest at the party, testified that she had danced with applicant and had been touched by him "where he shouldn't." Other witnesses had testified that applicant had made advances toward Rich and was being a "jerk" towards her. On a "1 to 10" scale of intoxication (with 1 being low), Rich estimated that applicant was a 10. Rich characterized applicant's behavior as "obnoxious." She stated that applicant had been repeatedly asked to leave and only left after returning for his beer. Finally, she testified that Adams

left the party in his own truck and Peterson left in Roles' car, and Roles had not left the residence when she departed at 4:30 or 5:00 that morning.

Deputy District Attorney Gonzales concluded that the judge found that applicant had sustained injuries most likely caused from an assault. However, the judge considered the evidence insufficient to convict either Adams or Peterson. Gonzales suspected that the defendants had assaulted applicant, probably in Roles' yard rather than in the field, following a brief car ride, as applicant had contended. Yet, Gonzales also believed that applicant was "severely intoxicated and obnoxious."

Considering Gonzales' familiarity with the case and his unique opportunity to observe each participant and evaluate their testimony, his conclusions are given great weight. These conclusions further support the determination that applicant's conduct contributed to his injury.

Applicant presented his case in a very articulate and emphatic manner. I recognize his objections and appreciate his concerns. The actions of Peterson and Adams were beyond the norms of society, and were designed to, and unfortunately did, inflict physical injury. By no means should my decision be interpreted as sanctioning such conduct. Yet, as discussed above, the preponderance of the persuasive evidence establishes that applicant's conduct also contributed to this unfortunate incident. Consequently, I conclude that the Department was justified in reducing applicant's award of compensation. See ORS 147.125(3). Considering the circumstances described herein, I further conclude that a 50 percent reduction in benefits is appropriate.

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Fund dated April 13, 1988 be affirmed.

ROBERT D. RASMUSSEN, Applicant
Dave Fowler, Assistant Attorney General
Gerri L. Christensen, Dept. of Justice

WCB CV-88005
December 15, 1988
Findings of Fact, Conclusions, and Proposed Order (Crime Victim Act)

Pursuant to notice, a hearing was conducted and concluded by Roger C. Pearson, special hearings officer, on November 16, 1988 at Salem, Oregon. Applicant, Robert S. Rasmussen, was present and not represented by counsel. The Department of Justice Crime Victims' Compensation Fund ("Department") was represented by Dave Fowler, Assistant Attorney General. The court reporter was Peggy Walman. The record was closed November 16, 1988.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated July 26, 1988. By its order, the Department denied applicant's claim for compensation, filed pursuant to the Compensation of Crime Victims Act (Act). ORS 147.005 to 147.365. The Department based its denial on: (1) applicant's failure to cooperate fully in the

apprehension and prosecution of his assailant; and (2) evidence that established that applicant substantially contributed to his injury by provoking his assailant.

ISSUES

Did applicant cooperate fully with law enforcement officials in the apprehension and prosecution of the assailant? If not, has applicant established good cause for his failure to cooperate?

Was applicant's injury substantially attributable to his own wrongful act or did applicant substantially provoke his assailant?

Did applicant's acts or conduct provoke or contribute to his injury? If so, to what degree or extent.

FINDINGS OF FACT

The following facts are not in dispute. On December 14, 1987, applicant timely filed an application for benefits with the Crime Victims' Compensation Program. Applicant claimed that he had been the victim of an assault on December 6, 1987. As a result of this attack, he sustained several fractures to his left facial bones, which required surgery to repair.

Law enforcement officials were notified of the assault on the day it occurred. Officer Clarke, a Portland Police Officer, investigated the incident. Following the investigation, applicant decided to defer charges against his assailant, John Belleque.

Applicant returned to his work as a mechanic on December 14, 1987. He has incurred medical expenses in excess of the $250 statutory minimum.

On June 24, 1988, following its investigation, the Department found that applicant "did not follow through with the prosecution of this case." The Department further found that applicant had initially provoked his assailant by throwing gravel at the assailant's vehicle and then by punching the assailant through the window of his vehicle. Concluding that each of these findings represented a failure to comply with statutory requirements for benefits under the Crime Victims' Compensation Program, the Department denied applicant's claim.

Applicant requested reconsideration. He acknowledged that he had contributed to the "mutual combat" which occurred during the "first incident" between himself and the assailant. However, asserting that he had not contributed to the "second incident," which resulted in his injuries, applicant contended that he was entitled to benefits. Finally, applicant explained that he had not pressed charges against the assailant because he had concluded that it would not be "in the best intrest [sic] of [his] family."

The Department issued an Order on Reconsideration on July 26, 1988, adhering to its prior order. Thereafter, applicant timely requested review by the Workers' Compensation Board.

After reviewing the record and considering the testimony, I make the following findings concerning the facts which are in dispute.

On the afternoon of December 6, 1987, applicant and his mother were stringing Christmas lights in his front yard, when he heard "screeching tires." He turned to see a vehicle traveling down his residential street at a rapid rate. Speeding vehicles had been a recurring problem in the neighborhood. Recognizing the vehicle as one of the primary perpetrators of this speeding problem, applicant decided to intervene.

Applicant stepped into the middle of the street. When the vehicle did not decelerate, applicant moved toward the curb, picked up some gravel and made a throwing motion. However, he did not throw the gravel.

The vehicle locked its brakes. As it came to a stop, its 17-year-old driver, John Belleque, immediately disembarked and moved toward the front of the vehicle. Applicant met him near the front fender on the driver's side. An "animated discussion" began, which "rather rapidly" digressed into a shoving match, and, finally, a "brawl." Belleque initiated the physical contact.

During the battle, applicant attempted to get into the vehicle to drive it from the area. While attempting to do so, he noticed between 6 and 12 beer bottles. Belleque prevented applicant from starting the car. Thereafter, Belleque removed a club from the back seat of the car and began swinging it at applicant. They struggled with the club until applicant's mother "tapped" Belleque on the head with an empty beer bottle she had obtained from the back seat of the vehicle. This action marked the end of the struggle.

Applicant's mother witnessed the battle from its inception. A second car, carrying Dale Miller and Richard Carroll, arrived on the scene sometime after the melee bagan. Miller and Carroll did not witness the initial stages of the struggle.

As applicant and his mother returned to their house, Belleque made several threatening statements. These statements included: "You're a crazy man, I'll get you"; "I know where you live"; and "You better keep your kids inside."

Applicant went into the house to rest and calm down. At this point, he had no intention of reporting the incident. Within about 5 minutes, he heard Belleque's vehicle return. Applicant came outside to meet Belleque and an older man, Irv Spencer, who was the father of Belleque's girlfriend.

Spencer accused applicant of provoking an incident with a "child." Initially, their discussion was "rather animated." However, as applicant explained the surrounding circumstances, the exchange became more conversational in tone. Belleque became more agitated as Spencer began listening to applicant's explanation.

Spencer ordered Belleque to "shut up" and "get in the car." Although Belleque became quiet, he did not return to the vehicle. Shortly thereafter, as applicant looked up the street to point where he had first seen the vehicle, Belleque "blind-sided" him with a punch to the left side of his face. With that,

applicant announced that he was notifying the police. Belleque exclaimed that he "didn't care" and was "happy to get that one shot in." However, Belleque also warned applicant that if he pursued the matter, he had brothers who would "take care of him."

Although applicant contacted law enforcement officials that day, he advised the investigating officer that he would "defer charges at this time." His decision was prompted by the threats he had received from Belleque. Later that same day, Spencer returned to applicant's home. After describing Belleque's character and proclivity for violence, Spencer encouraged applicant to "let it alone" and "forget about it."

Following this conversation, applicant decided to seek compensation as a crime victim without first pressing criminal charges. He later reasoned that if his claim was denied for a failure to fully cooperate in bringing his assailant to justice, he still had until December 1989 to reinstitute charges against Belleque.

ULTIMATE FINDINGS OF FACT

Applicant did not fully cooperate in the apprehension and prosecution of his assailant. However, he has established good cause for his failure to fully cooperate.

Applicant's injury was not substantially attributable to his own wrongful act nor did he substantially provoke his assailant. Yet, his initial conduct did contribute to his injury.

CONCLUSIONS OF LAW

The standard of review for cases appealed to the Board under the Act is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

Pursuant to ORS 147.015, applicant is entitled to an award under the Act, if, among other requirements:

> "(3) The applicant has cooperated fully with law enforcement officials in the apprehension and prosecution of the assailant or the department has found that the applicant's failure to cooperate was for good cause;
>
> "(5) The death or injury to the victim was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim."

The Department shall determine the degree or extent to which the victim's acts or conduct provoked or contributed to the injuries or death of the victim, and shall reduce or deny the award of compensation. ORS 147.125(3).

"Substantially attributable to his wrongful act" means attributable to an unlawful act voluntarily entered into from which there can be a reasonable inference that, had the act not been committed, the crime complained of would not have occurred. OAR 137-76-010(7). "Substantial provocation" means that a voluntary act or utterance which there can be a reasonable inference that, had it not have occurred, the crime would not have occurred. OAR 137-76-010(8).

Applicant testified in a thoughtful, candid and forthright manner. After closely and carefully observing his attitude and demeanor while testifying, I find him to be an entirely credible witness.

Following my de novo review of the documentary and testimonial evidence, I find that although applicant did not fully cooperate in the apprehension and prosecution of the assailant, he had good cause for failing to do so. I am further persuaded that applicant was the victim of an assault which was not substantially attributable to any wrongful act nor substantial provocation on his part. Therefore, I conclude that he is entitled to benefits from the Crime Victims' Compensation Fund. Consequently, I conclude that the Department's order should be reversed. However, I find that applicant's initial conduct contributed to the events which resulted in his eventual injury. Accordingly, I recommend that his benefits be reduced by 25 percent.

The Department contends that applicant's claim does not qualify for benefits because he did not fully cooperate in the apprehension and prosecution of the assailant. See ORS 147.015(3). Applicant concedes that his application incorrectly indicates that he had cooperated to "apprehend/prosecute the assailant." Yet, he explains that he did not fully understand the extent to which his participation was required to satisfy this requirement. I find his explanation to be both unrebutted and reasonable. Therefore, I do not consider the inaccurate statement on his application fatal to his claim.

Furthermore, Belleque had directly threatened applicant and his children. When these threats are considered in conjunction with the assailant's character, as described by Spencer, I am persuaded that applicant had reason to fear for the safety and well-being of not only himself, but his family, if he proceeded with the criminal charges. Consequently, I conclude that applicant had good cause for failing to fully cooperate in the apprehension and prosecution of Belleque.

The Department does not attempt to justify the "sucker punch" which resulted in applicant's injury. However, it contends that applicant substantially provoked his assailant by stepping out into the street, appearing to throw gravel at the vehicle, and throwing the first punch while Belleque was still behind the steering wheel. Due to this conduct, the Department asserts that applicant's claim must be denied. See ORS 147.015(5).

The record supports the Department's contention that applicant stepped into the street, picked up some gravel, and made a throwing gesture. Yet, the preponderance of the persuasive evidence neither establishes that applicant threw the first punch nor initiated the physical violence. My conclusion is based on the following reasoning.

Support for the Department's assertion that applicant threw the first punch is found in Officer Clarke's investigation report. Officer Clarke interviewed Belleque, as well as Miller and Carroll, the two "passing motorists." These witnesses provided corroboration for Belleque's story that, after the car had stopped, applicant had run up to the car and punched Belleque through the driver's window.

Applicant admits that, "in all honesty", he cannot say who shoved first or threw the initial punch. However, he vigorously refutes the assertion that he punched Belleque while his assailant was still in the car. Instead, applicant insists that the struggle began while Belleque was outside of the vehicle. This account is persuasively supported by applicant's mother, who described the scene as follows: "[t]he car stopped in the middle of the street right in front of our house and the young driver was out of the car pounding and hitting my son."

In addition, applicant's mother provides information concerning the whereabouts of the "witnesses." She reported that while the fighting continued, "a car had pulled up behind the first car and stopped about 100 feet away." She further noted that the two occupants of the second car stated that they did not know the driver and would not help in stopping the battle.

Applicant's recollections also suggest that the "witnesses" arrived on the scene after the altercation had begun. He first noticed the other car after the "club swinging" incident. Although his attention would naturally be primarily focused on other more immediate matters, it is reasonable to expect him to have noticed a second vehicle had it been on the scene as he approached Belleque's vehicle. His lack of observation until the "club swinging" incident, plus his mother's account, leads me to conclude that the "passing motorists" were not in a position to have seen the fight from its inception. Consequently, their statements are accorded little probative weight.

Considering his character and aversion to violence, applicant does not believe that he threw the first punch. I find his credible testimony persuasive. Furthermore, subsequent events lend support to applicant's belief. Following the first incident, Belleque returned to the scene, accompanied by Spencer. As with the first incident, the exchange between Spencer and applicant was initially heated. Yet, unlike the first incident, this confrontation did not become physical. Instead, the discussion shortly became eminently civil as emotions eased. It was at this point that Belleque threw the "sucker punch." Inasmuch as Belleque injected the physical violence into this later exchange, it is reasonable to conclude that he also introduced this violent behavior during their first interlude.

The Department further contends that the two incidents are inextricably entwined and cannot be separated. Arguing that the altercation was initiated by applicant's provocative and aggressive behavior, the Department submits that he is foreclosed from receiving benefits as a crime victim. I agree that the two incidents are related. I further concur that applicant's conduct contributed to the altercation and, ultimately, his injury. However, the record does not establish that applicant's injury was substantially attributable to his wrongful act or substantial provocation of the assailant. Rather, as previously discussed, I am persuaded that it was the assailant who escalated the confrontation into physical violence.

Applicant's decision to cause the vehicle to stop was certainly ill-advised. Yet, the act was grounded upon a valid concern for the safety of his children, as well as his fellow neighbors, from speeding vehicles. Although one can question his

methods, his motives are understandable. I would regard his action as an impulsive self-help measure, designed to protect the neighborhood and to remind speeding motorists of the need to observe traffic limits. It is reasonable to assume that such conduct would result in a verbal exchange, but I do not consider it reasonably foreseeable that this behavior would cause an eruption of physical violence.

More important, the initial incident had already concluded and some five minutes had elapsed, when Belleque returned to the scene. During this interim period, the participants had an opportunity to regain their composure and proceed in a civil and emotionally mature manner. The record supports the conclusion that applicant availed himself of this opportunity, while the assailant did not.

With the benefit of hindsight, applicant wishes that he had merely written down the vehicle's license number and advised the appropriate authorities. I agree that this approach would have been preferable. Yet, applicant's impulsive behavior did not entitle Belleque to initially engage in physical violence or, eventually, to commit an assault. Consequently, I conclude that applicant is entitled to benefits as a victim of a crime. However, as discussed above, applicant's conduct also contributed to this unfortunate incident and, thereby, his injuries. Accordingly, after considering the circumstances described herein, I conclude that a 25 percent reduction in benefits is appropriate. See ORS 147.125(3).

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Fund dated July 26, 1988 be reversed. I further recommend that applicant's claim for benefits be remanded to the Department with instructions to accept and process the claim in accordance with law. However, I recommend that applicant's benefits be limited to 75 percent of his medical and hospital expenses, up to a maximum amount of $7,500.

RHONDA L. BILODEAU, Claimant
Lon N. Bryant, Claimant's Attorney
Kevin L. Mannix, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 86-11768 & 86-10223
January 4, 1989
Order on Review

Reviewed by the Board en banc.

Safeco Insurance Company requests review of Referee Neal's order which found it responsible for claimant's cervical/thoracic condition and ordered Safeco to pay claimant's attorney an insurer-paid fee of $1,400. We modify the Referee's order in part and also award claimant's attorney an insurer-paid fee for his services on Board review.

ISSUES

1. Whether responsibility for claimant's cervical/thoracic condition since early 1986 lies with Pony Express Courier and its insurer, AIAC, or Grimm's Fuel Company and its insurer, Safeco.

2. Whether claimant's attorney is entitled to an insurer-paid fee for his services at the hearing level.

3. Whether claimant's attorney is entitled to an insurer-paid attorney fee for his services on Board review.

FINDINGS OF FACT

Claimant, age 38 at the time of the May 29, 1987 hearing, has worked since high school primarily as a truck driver or heavy equipment operator. In 1980 she received chiropractic treatment for right shoulder blade pain, low back pain, headaches, neck pain and stiffness (Exs. A-2 and A-4).

Claimant began working for Pony Express Courier Corporation, AIAC's insured, as a courier guard in early 1984. She injured her neck/upper back on or about June 19, 1984 as a result of unloading boxes in the course of performing her duties at Pony Express (Exs. 3 & 4). She subsequently received chiropractic treatment from Dr. Dawson for a cervical/thoracic strain and right intercostal strain (Ex. 3). She was off work until early August 1984 (Exs. 3 & 6). She treated with Dr. Dawson through September 1984.

Dr. Dawson reported in December 1984 that claimant was medically stationary and had no permanent impairment, although she still experienced minor upper back discomfort when lifting her son too much (Ex. 9, page 1). Claimant's claim was closed by a January 11, 1985 Determination Order. She was awarded temporary total disability from June 20, 1984 through August 1, 1984. No permanent disability was awarded (Ex. 9, Page 2).

Claimant began working for Grimm's Fuel Company, Safeco's insured, as a truck driver in February 1985 (Ex. 9A, Page 8). In October 1985 she saw Dr. Dawson several times for a recurrence of the same symptoms that she had following her 1984 injury (Ex. 2, Page 3, and Ex 10).

In March 1986 claimant began driving a rougher truck at Grimm's. Over the next couple of months she experienced increased pain and numbness in the cervical/thoracic area. She received treatment from Dr. Dawson during this time period. In June 1986 she developed numbness and tingling in her hands. Dr. Dawson referred her to Dr. Bussanich, a chiropractor in Portland, in late June 1986. Dr. Bussanich prescribed physical rehabilitation treatment. Both Dr. Bussanich and Dr. Dawson took claimant off work in late June 1986 (Exs. 13, 14, and 16).

AIAC, the insurer for Pony Express, sent claimant a letter on July 1, 1986 denying reopening of her June 1984 injury claim as an aggravation. The basis for the denial was AIAC's contention that claimant's current neck/upper back condition was related to her work at Grimm's (Ex. 18).

On July 10, 1986, claimant's attorney sent a letter to Safeco, the insurer for Grimm's, making a claim for compensation regarding claimant's work at Grimm's. He also sent a copy of the letter to AIAC and requested AIAC's position regarding the designation of a paying agent pursuant to ORS 656.307 (Ex. 9A, Pages 9-10).

On July 18, 1986, claimant filed an 801 claim form with Grimm's (Ex. 19). On August 14, 1986, Safeco denied the claim. The denial was not limited, per its terms, to responsibility only (Ex. 21, Page 1).

Claimant's attorney subsequently requested that the Workers' Compensation Department issue an Order Designating a Paying Agent, as between AIAC and Safeco, pursuant to ORS 656.307. Both insurers thereafter advised the Department that responsibility was the only issue. On September 30, 1986, the Department issued an order designating AIAC as the paying agent pending resolution of the responsibility issue by the Hearings Division (Ex. 24).

In 1986 claimant experienced worsened symptoms and a worsening of her underlying cervical/thoracic condition/pathology as a result of her work at Grimm's.

Claimant took the position at the hearing level and on appeal to the Board that Grimm's was the responsible party regarding her neck/upper back condition and claimant's attorney actively participated at the hearing and Board levels regarding the responsibility issue.

Claimant's temporary disability compensation rate is higher if Grimm's, rather than Pony Express, is the responsible employer (Ex. 24, Page 1).

OPINION AND CONCLUSIONS

Responsibility

This is a case involving a specific traumatic injury during the first employment followed by a gradual worsening, with no specific traumatic event, during the second employment. In such a case, in order for responsibility to shift to the second employer the second employment must have caused a worsening of the claimant's underlying condition -- that is, a worsening of pathology. Worsened symptoms, even where they result in increased disability, are insufficient to shift responsibility to the second employer. If worsened symptoms were sufficient, the first employer would never be responsible. See Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986); Kienow's Food Stores v. Lyster, 79 Or App 416, 419, 421 (1986).

The evidence in the record clearly establishes that claimant suffered worsened symptoms regarding her cervical/thoracic condition as a result of her employment at Grimm's in 1986. The question is whether there was any worsening of her underlying condition/pathology. This is a medical question and requires an examination of the medical evidence in the record. Three physicians have offered opinions regarding the responsibility issue: Dr. Dawson, Dr. Bussanich, and Dr. Langston, an orthopedic surgeon who examined claimant in April 1987.

Dr. Bussanich's 1986 report (Ex. 14) and his deposition testimony (Ex. 48) support a finding that claimant experienced some pathological worsening in 1986 as a result of her work at Grimm's. Dr. Bussanich acknowledged that claimant had a chronic

cervical/thoracic strain and chronic long term nerve root inflammation at the cervical level as a result of the 1984 injury (Ex. 14, Pages 4-5 and Ex. 48, Page 13). But he also opined that the symptoms and clinical signs that claimant developed in the spring of 1986, which had not existed previously, were indicative of worsened pathology: irritation of the nerve trunks in the upper extremities (Ex. 14, Page 5 and Ex. 48, Page 19, Lines 22-25 and Page 20, Lines 1-10). Further, Dr. Bussanich reported that his radiographic findings indicated significant vertebral misalignment due to muscle spasms and fibrosis (Ex. 14, Page 5). No such findings were reported by Dr. Dawson following the June 1984 injury (Ex. 3).

Dr. Dawson opined in January 1987 that claimant did not suffer a new injury at Grimm's in 1986; rather he felt that claimant's work at Grimm's aggravated her symptoms from the 1984 injury (Ex. 34A). He reiterated that view in his May 18, 1987 report (Ex. 49, Page 2) and in his May 19, 1987 deposition (Ex. 50, Page 15, Lines 17-25, Page 16, Lines 1-2, and Page 21, Lines 6-11). The reason he gave for characterizing claimant's problems in 1986 as an aggravation rather than a new injury was that the problems were in the same area as in 1984 (Ex. 50, Page 21, Lines 12-14). However, Dr. Dawson acknowledged that some of claimant's symptoms in 1986 -- in the upper extremities -- were new. He added that the new symptoms were coming from the nerve root irritation location in the neck/upper back area that was bothering claimant since the 1984 injury (Ex. 50, Page 21, Lines 15-25, and Page 22, Lines 1-4). He then agreed that claimant's symptoms in 1986 reflected more nerve root irritation in the neck/upper back than there had ever been before (Ex. 50, Page 22, Lines 10-21). Dr. Dawson was then read what Dr. Bussanich said in his deposition (Ex. 48, Pages 19-20) about claimant having new clinical signs and symptoms in June 1986 which evidenced entrapment and irritation of the nerve trunks in the upper extremities. Dr. Dawson stated that he agreed with this testimony by Dr. Bussanich (Ex. 50, Page 22, Lines 22-25, and Page 23, Lines 1-19). Dr. Dawson subsequently added that claimant's upper extremity symptoms improved after a couple of weeks of treatment (Ex. 50, Page 24).

Dr. Langston opined, following his April 1987 examination of claimant, that she had suffered a new injury -- an upper torso musculoligamentous strain -- as a result of her work in 1986 (Ex. 47, Page 4). His opinion is not terribly helpful regarding the responsibility issue because he did not clearly address the question whether in 1986 claimant experienced only worsened symptoms or also a worsening, at least temporarily, of her underlying condition/pathology. The focus of Dr. Langston's report was on claimant's condition in April 1987 and he opined that claimant had no current objective evidence of impairment.

In sum, Dr. Bussanich's report and deposition testimony establish that claimant suffered a worsening, at least temporarily, of her underlying condition/pathology in 1986 as a result of her work at Grimm's. Dr. Dawson's statements in his deposition indicate his agreement with Dr. Bussanich in this regard and cause us to discount Dr. Dawson's other statements in the record, phrased in legal terminology, that claimant suffered an aggravation rather than a new injury. Dr. Langston's opinion is not very helpful regarding the responsibility question, but to the extent that it has any value it is more supportive of

responsibility being assigned to Grimm's than Pony Express. We conclude from the evidence and the applicable law that responsibility for claimant's cervical/thoracic condition beginning in 1986 lies with Grimm's and Safeco.

Attorney Fee for the Hearing Level

The Referee awarded claimant's attorney an attorney fee of $1,400, payable by Safeco, "for his active participation in overturning [Safeco's] denial." No authority was cited for this award, but the only potential authority was ORS 656.386(1). The attorney fee provision of ORS 656.307(5) did not become effective until January 1, 1988, see Or Laws 1987, ch 713, §§ 5, 8, and thus is inapplicable.

Under ORS 656.386(1), 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." Claimant's attorney took the position at the beginning of the hearing that Grimm's was the responsible party and actively participated in the hearing. That position prevailed. The question of whether the Referee correctly awarded claimant's attorney a carrier-paid fee for the hearing level, therefore, turns on whether this case may properly be characterized as 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); see Ohlig v. FMC Marine & Rail Equipment, 291 Or 586, 591-98 (1981); see also Shoulders v. SAIF, 300 Or 606, 611-16 (1986). Claimant's entitlement to receive compensation in the present case was resolved prior to the hearing through the issuance of an order pursuant to former 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, 40 Van Natta 1082, on recon, 40 Van Natta 1194 (1988). The only compensation issue remaining after the issuance of the .307 order was the amount of compensation claimant would receive. Grimm's had a higher temporary disability rate than Pony Express. If Grimm's was held responsible, claimant would receive more compensation than if Pony Express was held responsible. Whichever way the responsibility issue was decided, however, claimant's entitlement to receive compensation was not at risk. After the issuance of the .307 order, therefore, this case was not a "rejected case" within the meaning of ORS 656.386(1).

We note that the Court of Appeals appears to have ruled in SAIF v. Phipps, 85 Or App 436 (1987) that a claimant's attorney is entitled to a carrier-paid fee under ORS 656.386(1) when the claimant has a "stake in the outcome" of a .307 proceeding by virtue of a difference between the temporary disability compensation rates of the carriers. That decision is inconsistent with the Supreme Court's decisions in Ohlig and Short and has not been followed in subsequent Court of Appeals decisions. See Cascade Corp. v. Rose, 92 Or App 663, 667-68 (1988); Hunt v. Garrett Freightliners, 92 Or App 40, 42 (1988); Wilson v. Geddes, 90 Or App 64, 66 (1988); Anfora v. Liberty Communications, 88 Or App 30, 32-33 (1987). We conclude that Phipps has been overruled sub silentio.

Although claimant's attorney is not entitled to a

carrier-paid fee under ORS 656.386(1) for services rendered after the issuance of the .307 order, we conclude that the attorney is entitled to such a fee for services rendered before the issuance of the order. The denial issued by Safeco denied any causal relation between claimant's worsened condition and his work activity with Grimm's. The denial, therefore, was one of compensability as well as responsibility. Only after claimant's attorney filed a request for hearing on this denial and requested a .307 order did Safeco concede compensability and accede to the issuance of the order. The efforts of claimant's attorney were instrumental in overcoming Safeco's denial of compensability and in securing claimant's entitlement to receive compensation through the issuance of the .307 order. A fee payable by Safeco for the services leading to the issuance of the .307 order, therefore, is appropriate under ORS 656.386(1). See former OAR 438-47-015; Dennis S. Current, 38 Van Natta 858, 859 (1986).

We also conclude that claimant's attorney is entitled to a fee payable out of claimant's increased compensation under ORS 656.386(2) for services rendered after the issuance of the .307 order. Those services were instrumental in establishing that the carrier with the higher rate of temporary disability compensation was responsible and thus were instrumental in obtaining an increase in the amount of claimant's compensation. We award a fee of 25 percent of the increased compensation, not to exceed $750. See former OAR 438-47-030(1).

Attorney Fee for Board Review

Under ORS 656.382(2), 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." Safeco initiated Board review in this case and sought to shift responsibility to Pony Express. Had Safeco been successful, claimant's compensation would have been reduced because Grimm's had the higher rate of temporary disability compensation. Claimant participated on Board review and argued for the affirmation of the Referee's decision. Under these circumstances, claimant's attorney is entitled to a fee for the Board level under ORS 656.382(2), payable by Safeco.

ORDER

The Referee's order dated June 9, 1987 is modified in part. That portion of the order that awarded claimant's attorney an attorney fee of $1,400 payable by Safeco is modified. In lieu of the Referee's award, Safeco shall pay claimant's attorney a fee of $200 for services rendered before the issuance of the .307 order. For services rendered after the issuance of the .307 order, claimant's attorney is awarded a fee of 25 percent of the increased compensation resulting from the Referee's order, not to exceed $750. Safeco shall also pay claimant's attorney a fee of $700 for services rendered on Board review. Counsel for Safeco is authorized to charge a client-paid fee not to exceed $150. Counsel for Pony Express is authorized to charge a client-paid fee not to exceed $200.

Board Member Crider, concurring in part and dissenting in part:

I concur in those portions of the order assigning responsibility to Safeco and awarding claimant an attorney fee for services on Board review payable by Safeco. I dissent with

respect to that portion of the order which denies claimant a carrier-paid fee for services at hearing and substitutes a fee payable out of compensation for it.

The majority, in reversing the Referee's award of a fee for services at hearing, declares that under no circumstances in which a .307 order issued prior to hearing and compensability is not contested at hearing may a fee be awarded for services at hearing to overcome the denial of responsibility. It further declares that SAIF v. Phipps, 85 Or App 436 (1987), which is clearly to the contrary, has been overruled sub silentio. In so holding, the Board relies, in large part, on pre-Phipps case law and entirely on general pronouncements made in cases lacking in the essential factual ingredient which led the Court of Appeals to award a fee in Phipps, although it had refused to do so in Petshow v. Farm Bureau Insurance Co., 76 Or App 563 (1985). The Board has followed Phipps since it was issued. The majority too readily discards it.

Obviously, as the majority observes, claimant's attorney's entitlement to an insurer-paid fee for services at hearing is authorized, if at all, only by ORS 656.386(1). Clearly, also, such a fee is appropriate only if this case involved a dispute concerning a "rejected" or "denied" claim -- not a dispute over the amount of compensation due on an accepted claim. See e.g., Short v. SAIF, 305 Or 541 (1988). Nevertheless, it is not at all obvious that a responsibility case does not involve a rejected or denied claim. Indeed, as the Court of Appeals observed in declining to award a fee in a responsibility context, "it is literally true the claimant ultimately prevailed on a denied claim..." Petshow v. Farm Bureau Ins. Co., supra, 76 Or App at 562-563. The court, in Petshow, concluded that no .386(1) fee should be awarded -- not because the claim had not been denied and the denial overcome -- but because to award a fee to claimant for participating in a .307 hearing in every case in which a denial is set aside would be to award claimant a fee in every .307 case "regardless of their attorneys' efforts on the responsibility issue." Id. The court concluded that the legislature could not have intended to award a fee in every such case and began to establish limitations on the circumstances in which a fee would be awarded -- the language of ORS 656.386(1) notwithstanding.

In Petshow, itself, the court declined to award a fee, stating that an attorney fee award is generally inappropriate in a case where the claimant's role is merely that of a witness, as distinct from a case where the claimant takes a position concerning which of the insurers is responsible and actively litigates that point. See 76 Or App at 569. The court noted that claimant's attorney did not take a position as to which insurer was responsible. The court added that although claimant's attorney asked the claimant some questions at the hearing relevant to the responsibility issue, it was not necessary for him to do so because the insurers' attorneys were present to develop the facts regarding the responsibility issue. See 76 or App at 570.

Boyer v. Armstrong Buick, 81 Or App 505 (1986), presented the same situation as in Petshow and the present case: a hearing following the issuance of a "307" order where the only issue was responsibility. Claimant's attorney sought an insurer-paid fee. The court quoted Petshow at length and then

said: "As in Petshow, claimant did not take a position concerning which of the insurers was responsible and actively litigate that point; his participation at the hearing with respect to the responsibility issue was nominal." The court then denied an attorney fee award. See 81 Or App at 509.

The language used by the court in Petshow and Boyer suggests that the court felt that in a ".307" case -- where only responsibility, and not compensability, is at issue -- an insurer-paid fee is appropriate where the claimant takes a position as to which insurer is responsible and, through his attorney, actively litigates that point. That such was the court's view was made even clearer in SAIF v. Phipps, 85 Or App 436 (1987). Phipps also involved the issue of responsibility between two insurers. Prior to the hearing both insurers had conceded compensability and a ".307" order had been issued. See Stanley Phipps, 38 Van Natta 13 (1986). In Phipps the court cited Petshow and characterized it as a case where "we concluded that 'unless the claimant takes a position concerning which of the insurers is responsible and actively litigates that point' an award of attorney fees is inappropriate." After thus characterizing the Petshow decision, the court in Phipps noted that the claimant had taken the position at the hearing and on Board review that he had suffered an aggravation, not a new injury. The court further noted that the claimant's attorney participated at the hearing and filed a brief before the Board (claimant's attorney also filed a brief and argued the case before the Court of Appeals -- see 85 Or App at 437). Finally, the court noted that the claimant's stake in the outcome of the responsibility determination amounted to $120 more per week for time loss over a long period of time. Claimant did not prevail (in establishing an aggravation) at the hearing level, but he did prevail at the Board and the Court of Appeals levels. The court did not simply appear to hold, as the majority suggests, but did in fact hold that the claimant's attorney was entitled to a fee, pursuant to ORS 656.386, payable by the insurer who had been found responsible.

A different result regarding the attorney fee issue was reached by the Court of Appeals in Anfora v. Liberty Communications, 88 Or App 30 (1987), which was also a ".307" order/responsibility case. Claimant's attorney contended that he was entitled to a fee payable by the insurer found responsible by the Court of Appeals because he had participated in the proceeding on court review and had succeeded in establishing at the Court of Appeals level that the second employer was responsible. See 88 Or App at 32. The court disagreed. The court stated that no fee was due claimant's attorney pursuant to ORS 656.386 because the claimant's right to compensation had not been at stake. See 88 Or App at 32. The court noted that the fact that the claimant had succeeded in securing an extended aggravation rights period (by establishing a new injury) was insufficient to warrant an insurer-paid fee. See 88 Or App at 33. Although the court cited Petshow in its decision, it did not discuss or even cite Phipps or Boyer.

The same result was reached by the court in Wilson v. Geddes, 90 Or App 64 (1988), another "307" order/responsibility case. The court cited Petshow and Anfora and held that no insurer-paid attorney fee was due. In explaining its decision, the court stated that compensability had been conceded by all

insurers and claimant's right to compensation had not been in jeopardy. The court added that the claimant's attorney participated regarding the responsibility issue, at the request of the attorneys for the insurers, only because the factual background to be elicited through the claimant's answers to his attorney's questions would be identical to that required for claimant's permanent disability claim which was being considered in the same proceeding. The court did not view this as participating "meaningfully" regarding the responsibility issue. The court did not discuss or even cite Phipps or Boyer.

The most recent decision in the Petshow line of cases are Hunt v. Garrett Freightliners, 92 Or App 40 (1988) and Cascade Corporation v. Rose, 92 Or App 663 (1988). As in the previous cases, Hunt involved a case where a "307" order had been issued prior to the hearing and the only issue at hearing was responsibility between two insurers. The court noted that the claimant's attorney had participated at the hearing and taken a position that the second insurer was responsible and had prevailed. However, the court said that because claimant's right to compensation was never at risk his attorney was not entitled to an insurer-paid fee. The court cited Wilson, Anfora, and Petshow. The court did not discuss or even cite Phipps or Boyer. The court's opinion in Hunt does not indicate whether or not, as in Phipps , the claimant had a stake, in terms of a higher temporary disability compensation rate, in establishing that the second insurer was responsible. The facts recited as well as the opinion in Rose were virtually identical.

In sum, Phipps, read together with Petshow and Boyer, indicates that in a responsibility case -- where a ".307" order has been issued and responsibility is the only issue at hearing -- where claimant takes a position as to which insurer is responsible, actively litigates that point, prevails, and as a result becomes entitled to a greater amount of compensation than if he had not prevailed, then the claimant's attorney is entitled to a fee payable by the responsible insurer. The Wilson decision is not clearly inconsistent with this view of the applicable law. The court's language in Wilson indicates that the claimant's attorney did not meaningfully participate regarding the responsibility issue. There is no indication in the Wilson decision that the claimant took a position regarding which insurer was responsible or that a higher amount of compensation was at stake for the claimant depending upon the outcome of the responsibility issue.

Anfora, Hunt and Rose are more difficult to reconcile with Phipps. In each, the court's opinion indicates that the claimant's attorney took a position regarding which insurer was responsible, participated in the proceedings with regard to the responsibility issue, and prevailed. However, an insurer-paid fee was not awarded. I see two ways to approach this apparent case conflict. One approach is that chosen by the majority -- to treat Phipps as overruled by Anfora, Hunt and Rose. The other approach is to consider Anfora, Hunt and Rose to be factually distinguishable from Phipps. The latter approach is the better one, unless and until there is a future contrary indication by the Court of Appeals. The court did not discuss or even cite Phipps in the most recent cases. If the court felt that Phipps involved the same factual situation and that Phipps was erroneously decided, I believe that the court would have so stated. More

important, as far as I can determine from the court's opinions in the recent cases, the claimant, unlike the claimant in Phipps, had no stake, in terms of a higher rate of compensation, in the outcome of the responsibility issue -- that is, no immediate stake in which denial was set aside. I would conclude that Phipps has not been overruled by the Court of Appeals in subsequent decisions and that it applies in this case.

Here, it is not clear from the initial portion of the hearing transcript whether claimant was taking a position regarding which insurer was responsible (Tr., Pages 2-3). However, during the course of claimant's testimony, claimant's attorney did ask her some questions which were relevant to the responsibility issue and which seemed directed at establishing responsibility with Grimm's (Tr., Pages 51-53). I am persuaded, as is the majority, that claimant did take the position at hearing that Grimm's should be the responsible party and claimant's attorney actively participated with respect to the responsibility issue. Further, claimant "prevailed" and as a result is entitled to a higher rate of temporary disability compensation than if she had not prevailed. I conclude that the insurer-paid fee awarded by the Referee for claimant's attorney's services at the hearing should be affirmed.

Had the application of Phipps not led me to believe that claimant was entitled to an insurer-paid fee, I would have concurred in the majority's approach to the insurer-paid fee for services in obtaining a .307 order and the out of compensation fee for services in obtaining a higher rate of temporary total disability compensation.

Finally, I concur in the award of an insurer-paid fee for services on Board review and the majority's rationale for that award. The basis of the award is entirely different from the basis upon which I would award a fee for services at hearing. ORS 656.382(2) authorizes an insurer-paid fee if the insurer appeals the Referee's decision and the claimant's compensation is not "disallowed or reduced." In the context of a responsibility case, this statutory section supports an award of an insurer-paid fee if certain criteria are met: 1) the insurer found responsible by the Referee has an obligation to pay temporary disability at a higher rate than the other insurer; 2) the insurer found responsible appeals the Referee's decision to the Board; 3) on Board review the claimant argues in favor of the Referee's decision; and 4) the Board affirms the Referee's decision (that is, claimant prevails). In such a situation, the claimant's compensation has not been "reduced" in the face of the insurer-initiated appeal. These criteria are satisfied in this case and provide the basis for claimant's attorney's entitlement to a fee for his efforts on Board review.

GENE M. CLARKE, Claimant
Malagon & Moore, Claimant's Attorneys
Gleaves, et al., Defense Attorneys
Alan Ludwick (SAIF), Defense Attorney

WCB 85-14249 & 85-07940
January 5, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Clarke v. Little W Logging, 93 Or App 1 (1988). The court has found Blue Mountain responsible for claimant's back condition. Consequently, we have been instructed to "enter an order holding Blue Mountain and SAIF responsible."

Pursuant to the court's mandate, SAIF's October 30, 1985 denial is set aside and claimant's aggravation claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

BETTY L. EVANS, Claimant
Malagon & Moore, Claimant's Attorneys
Alice M. Bartelt, Defense Attorney
Beers, et al., Defense Attorneys

WCB 88-14514
January 5, 1989
Order Denying Motion to Dismiss

The insurer has requested Board review of Referee Miller's October 27, 1988 order that: (1) found that claimant was entitled to an insurer-paid attorney fee for unreasonable claims processing; and (2) awarded a $500 attorney fee. Claimant has moved for an order dismissing the insurer's request on the ground that we lack jurisdiction to consider the attorney fee issues. The motion is denied.

FINDINGS OF FACT

The Referee's Opinion and Order issued October 27, 1988. Reasoning that there was no compensation due, the Referee declined to assess a penalty for unreasonable claims processing. However, the Referee found that claimant's attorney was entitled to an attorney fee for services rendered in evoking the insurer's denial and for preparing to respond at hearing to potential issues involving a risk to claimant's compensation. Consequently, the Referee awarded an insurer-paid $500 attorney fee award.

On November 10, 1988, the insurer requested reconsideration, contending that claimant was not entitled to an attorney fee, or, in the alternative, that the fee should be reduced. Claimant responded on November 14, 1988. On November 16, 1988, the Referee denied the motion for reconsideration.

On November 23, 1988, the insurer requested Board review of the Referee's October 27, 1988 order. A certificate of personal service by mail, submitted with the request, indicated that copies of the request had been mailed to the parties to the proceeding on November 23, 1988.

ULTIMATE FINDINGS OF FACT

The Referee's order addressed the issues of penalties, as well as claimant's attorney's entitlement to, and the amount of, an insurer-paid attorney fee for unreasonable claims processing. The insurer requested Board review within 30 days of the Referee's order. All parties to the proceeding received notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance

with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the insurer's request for Board review, as well as the parties' notice of the request, were mailed within 30 days of the Referee's October 27, 1988 order. Consequently, both the request and copies are timely. See ORS 656.289(3); 656.295(2).

Claimant argues that we lack jurisdiction to consider the insurer's request because the request involves only attorney fee issues. We disagree.

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, on recon 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 Referee did not consider the amount of an attorney fee awarded under ORS 656.386(1). Rather, the issues addressed in the Referee's order concerned claimant's entitlement to, and the amount of, an attorney fee under ORS 656.262(10) and 656.382(1). In addition, the Referee considered the assessment of a penalty for alleged unreasonable claims processing. Inasmuch as the insurer has requested review of the Referee's order, and since that order addresses issues other than the amount of an attorney fee awarded under ORS 656.386(1), we conclude that we have jurisdiction. See Ronald L. Warner, 40 Van Natta 1082, 1084 (1988).

Accordingly, the motion to dismiss is denied. Once a transcript is obtained and copies are distributed to the parties, a briefing schedule will be implemented. Upon completion of the briefing schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

ROBERT A. GEBHARD, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Cliff, Snarskis, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 86-13771 & 86-08294
January 5, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Knapp's order that upheld denials of his occupational disease claim for a bilateral ankle condition, issued by Industrial Indemnity and Liberty Northwest Insurance Corporation. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following corrections and additions.

The Referee found that claimant estimated he jumped from his trailer on an average of 30-40 times a day. We, instead, find that claimant jumped from his trailer or the dock an average of 20-30 times a day, and as many as 40 times on some days.

The Referee found that claimant had fished commercially since 1982, whereas we find that claimant had been a part-time commercial fisherman since 1978.

Following his ankle sprains in 1964, claimant had no further problems with his ankles until 1982. At that time, he began to dislocate his ankles, and he experienced ankle pain on days he completed a greater than average number of deliveries at work. He also began having difficulty cross-country skiing because of ankle weakness.

Claimant's condition gradually worsened over the next three years and then began to degenerate more rapidly in 1985. He quit cross-country skiing because he was no longer able to use his ankles to control his movements. By 1986 he was experiencing weekly ankle dislocations and significant pain, swelling and ankle bruising after a particularly hard day at work.

Claimant received no treatment for his ankles prior to the time he commenced treatment with Dr. Cook in 1986.

Industrial Indemnity denied responsibility for claimant's left ankle condition and compensability and responsibility of the right ankle problem. Liberty denied compensability and responsibility for both ankles.

FINDINGS OF ULTIMATE FACT

It has not been established that claimant's work activities contributed more to the causation of his current bilateral ankle condition than all other activities combined.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the Referee erred in finding that his bilateral ankle condition was not compensable as an occupational disease. In order to prevail on his claim, claimant must prove that his work activity was the major contributing cause of the initial onset of his ankle condition or a worsening of the condition if it preexisted his employment. The Referee found that claimant had a preexisting bilateral ankle condition and must, therefore, demonstrate that his work activity was the major contributing cause of a worsening of that condition. The Referee ultimately concluded that claimant had not produced persuasive medical opinion satisfying his burden of proof.

We disagree with the Referee's conclusion that claimant's ankle condition was preexisting. We recognize that claimant twisted his ankles on several occasions in 1964. However, he had no treatment for those injuries or any further ankle problems until 1982. Furthermore, there is no medical evidence that claimant had a calcification and ligament insufficiency in his ankles prior to the time he went to work for the employer in 1980. In particular, the reports of Drs. Cook and Horniman do not establish a preexisting condition within the legal meaning of that term. We are not persuaded that their characterization of claimant's condition as "long-standing" was meant to infer that his current calcification and ligament insufficiency existed in 1964. Rather, we find they were just as likely referring to the fact that claimant's problems began four years previously in 1982. Accordingly, we do not agree that claimant had a preexisting ankle condition.

Notwithstanding our disagreement on this point, we agree with the Referee's decision that claimant has not carried his ultimate burden of proof in this case. As discussed above, claimant must demonstrate that his work activity was the major contributing cause of the onset of his ankle condition. In this context, "major contributing cause" means that claimant's work activities contributed more to the onset of his condition than all other activities combined.

Claimant relies on the opinion of treating physician Cook, who opined that "repetitive jumping with chronically unstable ankles would . . . be a major contributing factor to instability and degenerative involvement requiring treatment." The Referee rejected Dr. Cook's opinion because he had not opined that claimant's work activities were the major contributing cause of his condition. We are aware that it is not necessary for a physician to use magic words to demonstrate medical causation in an occupational disease claim. However, in this case Dr. Cook has never discussed the relative contribution of off-work activities. In light of this fact, we are not persuaded that he meant to opine that claimant's work activities contributed more to the onset of his ankle condition than all other activities combined.

Accordingly, we affirm the Referee's ultimate decision.

ORDER

The Referee's order dated May 4, 1987 is affirmed. A client-paid fee, payable from Liberty Northwest Insurance Corporation to its counsel, is approved, not to exceed $160.

EUSEBIO O. JUAREZ, Claimant
Michael B. Dye, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-07431
January 5, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Daron's order that: (1) upheld the insurer's partial denial of chiropractic treatments in excess of two times per month; and (2) declined to award penalties and attorney fees for the insurer's alleged unreasonable partial denial. We affirm.

ISSUES

1. Whether chiropractic treatments in excess of two times per month are reasonable and necessary medical services.

2. Whether claimant is entitled to penalties and attorney fees for the insurer's alleged unreasonable partial denial of medical services.

FINDINGS OF FACT

On May 30, 1985, claimant sustained a compensable back injury while lifting parts of sofas onto assembly tables. He began treating conservatively on a two to three times per week basis with Dr. Webb, chiropractor, who diagnosed acute moderate cervicodorsal and lumbar subluxations complicated by sprain/strain. Treatments consisted of specific chiropractic adjustments, soft tissue manipulation, physiotherapy, and specific spinal exercises performed at home.

On June 3, 1985, Dr. Webb released claimant to light duty work. On June 4, 1985, claimant attempted to return to work, but quit after four hours due to increased back pain. On June 12, 1985, claimant attempted to return to work, but again quit due to increased back pain.

On July 12, 1985, Dr. Jansen, chiropractor, examined claimant and diagnosed moderate acute cervico-thoracic sprain/ strain and mild acute thoraco-lumbar strain. He recommended that chiropractic care be continued on a less frequent basis than in the past.

On August 13, 1985, Dr. Webb referred claimant to the Northwood Rehabilitation Center where he was treated three days per week with aquatherapy and weight training designed to increase his spinal ranges of motion and strengthen the musculature supporting his lumbar spine.

On October 7, 1985, BBV Medical Services examined claimant, found no residual impairment, and recommended that he cease chiropractic treatments altogether and return to regular work.

On October 31, 1985, Dr. Webb explained that, as a result of the trigger point involvement in the left trapezius, supraspinatus, infraspinatus, teres minor and major muscles, claimant continued to need chiropractic treatments on an approximately two to four times per month basis in order to maintain his medically stationary status.

On April 18, 1986, a Determination Order awarded claimant 15 percent unscheduled permanent disability.

In July 1986 Dr. Webb attempted to reduce claimant's chiropractic treatments to one time per week, but claimant continued to return to his office approximately twice a week.

On August 19, 1986, Dr. Simpson, chiropractor, examined claimant on behalf of the insurer. He recommended that, although periodic manipulative care should be provided in the management of claimant's condition, routine manipulation was inappropriate.

On October 28, 1986, the insurer denied claimant's medical treatments in excess of two times per month.

On November 20, 1986, claimant began an on-the-job training program as an electronics assembler. Between January 6, 1987 and March 9, 1987, however, claimant was absent from work 47 percent of the time. Due to his poor attendance, claimant was fired. On March 4, 1987, claimant declined further vocational assistance.

On April 29, 1987, a Determination Order awarded claimant an additional 20 percent unscheduled permanent disability, for a total of 35 percent unscheduled disability.

On July 14, 1987, the Western Medical Consultants examined claimant on behalf of the insurer and found no evidence of permanent disability; they recommended no further medical treatment.

As of July 16, 1987, Dr. Webb did not have claimant on any fixed schedule for chiropractic treatments, but claimant continued to be seen on an as needed basis, usually about twice a week. The

treatments still consisted of chiropractic adjustments, soft tissue manipulation and physiotherapy to the left rotator cuff musculature and lower lumbar spine. They provided claimant with temporary relief of his pain for two to three hours following each session.

Claimant's symptoms at the time of hearing included low back pain with bilateral leg numbness, and left shoulder and arm pain.

The disputed chiropractic treatments were neither reasonable nor necessary. They did not appreciably relieve claimant's pain; nor did they enable him to work.

CONCLUSIONS OF LAW

Claimant contends that chiropractic treatments in excess of two per month are reasonable and necessary to maintain his current level of functioning. We agree with the Referee's conclusion that the treatments were not reasonable or necessary.

OAR 436-10-040(2)(a) provides the guideline of two treatments per month. The number of treatments may be limited to those shown to be reasonable and necessary to relieve pain and enable claimant to work. West v. SAIF, 74 Or App 317, 321 (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).

Dr. Webb, claimant's treating chiropractor, continued to provide palliative treatment for claimant on an as needed basis long after his condition became medically stationary. Although Dr. Webb encouraged claimant to limit the treatments to one time per week, claimant continued to treat at a rate of two to three times per week for continued pain. According to claimant's own testimony, these treatments provided relief from the pain for only two or three hours at a time. Palliative treatment which temporarily relieves pain for such a short period of time does not constitute significant palliative benefit. Reviewing claimant's poor attendance record at his on-the-job training program, it is also apparent that the treatments were not helping him stay on the job.

Claimant has presented no evidence to indicate that the chiropractic treatments in excess of two times per month were reasonable and necessary. On the contrary, the record is replete with persuasive evidence that claimant is in need of very limited treatment or no treatment at all. As early as July 1985 Dr. Jansen, on referral from Dr. Webb, believed that continued chiropractic care should be provided on a less frequent basis. Dr. Simpson found no indication for routine manipulation of claimant. Finally, Western Medical Consultants found no evidence of permanent disability and recommended no treatment at all.

We conclude that the level of chiropractic treatment claimant is receiving is not reasonable and necessary. ORS 656.245(1). All the medical experts, even Dr. Webb, favor palliative care on either a reduced or discontinued basis.

Under the circumstances, with claimant showing little improvement and the treatments clearly providing minimal palliative benefit, the insurer's denial of chiropractic treatments exceeding

two treatments per month was not an unreasonable action. Therefore, no penalties or attorney fees for unreasonable conduct will be assessed.

ORDER

The Referee's order dated September 4, 1987 is affirmed. A client-paid fee, not to exceed $878.90, is approved.

WILLIAM H. LINDSAY, Claimant
W.D. Bates, Jr., Claimant's Attorney
Beers, et al., Defense Attorneys

WCB 86-11263
January 5, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee Daron's order that granted the insurer permission to offset overpaid temporary disability benefits against permanent partial disability awarded under the Referee's order. On review, claimant contends that the insurer is barred from raising the offset issue as a result of a prior Disputed Claim Settlement. If the Board affirms the Referee's decision on the offset issue, claimant also requests review of those portions of the Referee's order that: (1) found that claimant's injury claim was not prematurely closed by a May 31, 1985 Determination Order; and (2) declined to award temporary disability compensation in addition to what was awarded under that Determination Order.

On review, the issues are offset, premature closure and temporary total disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact and ultimate fact, and we make the following additional findings.

Claimant filed a timely request for hearing on the May 1985 Determination Order and the insurer's August 1985 denial.

The May 1985 Determination Order created an overpayment of temporary total disability in the amount of $6,548.36. The insurer identified that overpayment in July 1985.

Under the terms of the June 11, 1986 Disputed Claim Settlement, claimant agreed to withdraw his hearing request as to the compensability of his alcoholism problem and to have his hearing request dismissed with prejudice on that issue. The Referee's order approving the settlement dismissed the hearing request "with prejudice as to all issues raised or which could have been raised."

The July 1986 Determination Order created an overpayment in the amount of $3,276.59.

On October 27, 1986 Claimant filed a hearing request following the issuance of the July 1986 Determination Order. Claimant's hearing request raised the issues of temporary total disability and unscheduled permanent partial disability. The insurer cross-petitioned, seeking offset of amounts overpaid under the May 1985 and July 1986 Determination Orders.

CONCLUSIONS OF LAW AND OPINION

Offset

We agree with the Referee's conclusion that the insurer is not barred from raising the offset issue as a result of the June 1986 Disputed Claim Settlement. Furthermore, we note that the insurer had no affirmative duty to raise the offset issue until the Referee issued his order awarding additional permanent partial disability. As a result, the insurer did not waive his right to offset by his failure to raise that issue within the one year period for seeking a hearing on that Determination Order. See Travis v. Liberty Mutual Ins., 79 Or App 126 (1986); Hicks v. Fred Meyer, Inc., 57 Or App 68, 71 (1982); Wilson v. SAIF, 48 Or App 993, 997 (1980); Donald W. Wilkinson, 37 Van Natta 937 (1985).

Premature Closure and Temporary Total Disability

As discussed above, a May 31, 1985 Determination Order closed claimant's injury claim and awarded him temporary total disability for the periods September 20, 1982 to October 11, 1983 and January 3, 1984 to February 11, 1985. Claimant contends that he was not medically stationary during the periods October 11, 1983 to January 2, 1984 and February 11, 1985 to August 20, 1985. Accordingly, he argues that the Referee erred in concluding that the claim was not prematurely closed and that claimant was not entitled to additional benefits for these periods.

The Referee's conclusion is based on his finding that claimant did not carry his burden of proving that he was not medically stationary during the periods in question. We affirm the Referee's ultimate decision, but for a different reason.

The temporary disability and premature closure issues raised by claimant did not arise out of the same aggregate of operative facts as the compensability issue decided by the June 1986 Disputed Claim Settlement. As a result, that settlement did not finally decide those issues. However, the order approving the settlement did effectively dismiss claimant's hearing request on the May 1985 Determination Order. Furthermore, claimant did not file a new hearing request within one year of the date of that order as required under ORS 656.268(6). As a result, the statute of limitations has run on the premature closure and temporary disability issues raised by claimant, and the Referee erred in addressing them.

For this reason alone, we affirm the Referee's order denying claimant's request for additional temporary disability.

ORDER

The Referee's order dated February 25, 1987 is affirmed.

JAMES L. PATTY, Claimant
Francesconi & Cash, Claimant's Attorneys
Mitchell, Lang & Smith, Defense Attorneys

WCB 86-14763
January 5, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer seeks review of those portions of Referee Fink's order that: (1) set aside its partial denial of claimant's medical services claim for inner ear concussion syndrome; and (2) set aside its partial denial of claimant's medical services claims for chiropractic treatment. On review, the issue is compensability of medical services. We affirm.

FINDING OF FACT

At hearing, claimant was a 42 year old trucker. He had a May 9, 1978 compensable injury to his left ulnar nerve, cervical spine and head. He had surgery for his ulnar nerve problem. He suffered recurring left eye, neck pain, and headaches. This proceeding involves a March 23, 1982 compensable injury where claimant injured his left shoulder, right side and head. The claim was closed by a Determination Order which awarded 5 percent unscheduled permanent disability and no temporary disability. Thereafter, an April 17, 1985 stipulation increased the award to 10 percent unscheduled permanent partial disability for his neck problems.

During 1985, claimant had frequent severe headaches, vertigo, dizziness, pain behind the left eye, memory loss, neck pain and lightheadedness. Claims for medical treatment for diagnoses made by Drs. Grimm, Black, and Hemenway, i.e. inner ear concussion syndrome, were denied by the employer on November 3, 1986 on the basis that it was not related to the compensable injury. It is more probable than not that claimant had inner ear concussion syndrome. It is more probable than not that the condition was caused by, or materially contributed to, claimant's disabling condition.

Between February 3, 1986 and August 27, 1986, claimant received palliative chiropractic treatment primarily for recurring neck pain. Claims for chiropractic treatment for this period were denied by the employer on November 3, 1986 on the grounds that it was not related to the compensable injury. The chiropractic treatment was related to his 1982 compensable injury.

OPINION AND CONCLUSIONS

When a claimant sustains a compensable injury, he is entitled to ongoing medical treatment "for conditions resulting from the injury for such a period as the nature of the injury or the process of recovery requires * * *." ORS 656.245(1). Further, a compensable injury need not be the sole cause of a claimant's continuing need for medical treatment; but rather, only a material contributing cause. Aguillon v. CNA Insurance, 60 Or App 231, 236 (1982).

Inner ear concussion syndrome

The Referee found that claimant had inner ear concussion syndrome, diagnosed by Drs. Hemenway, Black, and Grimm, which was causally related to his industrial injury. He relied on the opinion of Dr. Hemenway, a consulting otolaryngologist, as the most plausible and logical explanation. Furthermore, the Referee considered

Dr. Hemenway's opinion to be buttressed by that of claimant's treating physician and other consultants. We agree.

The medical experts are divided concerning the cause of claimant's vertiginous problems between a diagnosis of inner ear concussion syndrome and anxiety-stress reaction with somatization disorder. The presentation by Dr. Hemenway that claimant suffers from inner ear concussion syndrome which was caused by the 1982 compensable injury, is adopted as being the most reasoned and persuasive evidence on diagnosis and causation. Somers v. SAIF, 77 Or App 259 (1986). In doing this, we considered the employer's argument that Dr. Hemenway's opinion is flawed because he did not know of the 1978 accident and the injury to claimant's head. However, we find that Dr. Hemenway knew of the 1978 accident at least when he reviewed the February 12, 1987 report prepared by Drs. Brown and Schleuning, otolaryngologists. Therefore, if the 1978 injury affected his opinion, Dr. Hemenway could have commented when he prepared his March 25, 1987 response. He did not. Finally, Dr. Hemenway's opinion is also consistent with that of Dr. Grimm, claimant's treating physician for both the 1978 and 1982 injuries. See Weiland v. SAIF, 64 Or App 810 (1983).

Chiropractic treatment

We agree with the Referee that claimant is entitled to payment for his medical service claims for palliative chiropractic treatment between February 3, 1986 and August 27, 1986. Here, no physician opined that claimant's need for chiropractic treatment was no longer related to his industrial injury. To the contrary, Dr. Powell, claimant's treating chiropractor, reported that the treatment was related to the industrial injury. Dr. Powell's opinion is corroborated by Dr. Grimm, who reported that claimant had chronic neck pain which he felt was related to the concussion syndrome sustained in the 1982 injury. Accordingly, we conclude that claimant has proven that his chiropractic treatment is causally related to his compensable injury. Aquillon, supra

ORDER

The Referee's order dated April 28, 1987 is affirmed. Claimant's attorney is awarded $750 for services on Board review, to be paid by the self-insured employer. A client-paid fee, not to exceed $1,436.50, is approved.

DEBRA J. ROBERTSON, Claimant
Hill & Schultz, Claimant's Attorneys
Barnhisel, et al., Defense Attorneys
William Blitz (SAIF), Defense Attorney

WCB 86-09623 & 86-09624
January 5, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of Referee Baker's order that: (1) set aside its denial of claimant's aggravation claim for her right carpal tunnel syndrome; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for the same condition. We reverse.

ISSUE

Whether claimant's right carpal tunnel syndrome is the responsibility of SAIF, on the basis of an aggravation, or Liberty Northwest, on the basis of a "new injury."

FINDINGS OF FACT

Claimant began to work for the employer in July 1983 as a poultry line worker. In October 1984, she sought treatment from Dr. Brooks, M.D., for pain in her right palm, thumb, and first finger. Dr. Brooks' examination showed negative Phalen and Tinel test results, and he diagnosed claimant's condition as early carpal tunnel syndrome and volar tendonitis. Dr. Brooks prescribed conservative treatment and recommended claimant wear a wrist splint. SAIF accepted claimant's right carpal tunnel syndrome and right volar tendonitis as a compensable occupational disease with an assigned injury date of October 22, 1984.

In April 1985, claimant returned to Dr. Brooks. His chart notes indicate that claimant's condition had been improving since October 1984 until her duties changed in late March 1985. New tests results showed negative Tinel test findings with positive Phalen's sign in claimant's right wrist and no thenar wasting.

In July 1985, Liberty Northwest became the employer's insurer.

In September 1985, claimant again sought treatment from Dr. Brooks. Subjective complaints at that time included numbness and tingling in the right thumb, index finger and middle finger. Objective findings included thenar wasting on the right, mild positive Tinel test findings, positive Phalen sign, and possible nerve damage. Nerve conduction studies showed mild sensory changes. Claimant's right wrist showed improvement while her left wrist began to develop symptoms of carpal tunnel syndrome. Dr. Brooks recommended that claimant begin wearing a splint on her left wrist.

In March 1986, claimant was again experiencing numbness in her index and middle fingers as well as pain in her wrists which at times extended up her forearm and into her shoulder. At that time, production at claimant's job had been increasing, while the number of workers on her line had been decreasing. Dr. Brooks examination results included: (1) negative Tinel's sign; (2) thenar wasting on the right and probable more marked hypothenar wasting; and (3) swelling over the right distal forearm.

In April 1986, Dr. Brooks reported that claimant's condition had become much worse. Claimant's right hand was falling asleep for up to 45 minutes, as compared with 5 minutes as was reported in October 1984. The pain in her left hand and wrist was extending up to the elbow and into the left deltoid region. Testing showed markedly positive Phalen's sign and some hypothenar wasting on the right compared to the left. Diagnoses at this time were right carpal tunnel syndrome and left tendonitis.

In a letter to SAIF, dated April 22, 1986, Dr. Brooks reported that claimant's conditions deteriorated whenever production increased. He further reported that claimant's most recent deterioration began in March 1986, at which time she suffered increased symptoms of numbness in her right hand and significant pain in both wrists.

In May 1986, SAIF denied responsibility for claimant's current right carpal tunnel condition. In June 1986, Liberty Northwest denied responsibility for the same condition. In October 1986, a ".307" order was issued with SAIF being designated as the paying agent.

Claimant's work activities, after July 1985, independently contributed to a worsening of her underlying right carpal tunnel condition.

CONCLUSIONS OF LAW

Based on a totality of the evidence, the Referee concluded that claimant had sustained an aggravation of her compensable right arm/hand condition. Accordingly, the Referee found that SAIF remained responsible for claimant's condition. We disagree based on the following reasoning.

The main issue involves responsibility for claimant's right arm/hand condition after July 1985, when Liberty Northwest came on the risk. In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court announced that unless work activities at the later employer/insurer independently contribute to the worker's disability (i.e. cause a worsening of the underlying condition) then the worker has sustained a mere recurrence of symptoms and the earlier employer/insurer remains responsible.

In October 1984, claimant's condition was diagnosed as early carpal tunnel syndrome and volar tendonitis. Her complaints at that time were pain in her right palm, thumb, and first finger and numbness in her right hand lasting for approximately 5 minutes. Phalen and Tinel test results were negative. In April 1985, claimant again had negative Tinel sign, positive Phalen sign, and no sign of thenar wasting.

In September 1985, after Liberty Northwest came on the risk, claimant's symptoms included numbness and tingling in her right middle finger for the first time. At this time, thenar wasting was observed, nerve conduction studies showed mild sensory changes, and mild positive Tinel's sign was found for the first time.

In March 1986, claimant experienced pain radiating up through her right shoulder for the first time. Thenar wasting on the right, with probable more marked hypothenar wasting, was again observed as well as swelling over the right distal forearm. Moreover, in April 1986 Dr. Brooks reported that claimant's condition had become much worse and noted that claimant's right hand was falling asleep for up to 45 minutes as compared with 5 minutes as reported in October 1984. Testing showed marked positive Phalen's sign and hypothenar wasting on the right.

An analysis of medical evidence establishes that after July 1985, when Liberty Northwest came on risk, claimant began experiencing new and more pronounced symptoms attributable to her right wrist/hand condition. In addition, new objective findings demonstrated a change in her condition. Finally, claimant's treating physician reported in April 1986, some 7 months after Liberty Northwest came on the risk, that claimant's condition had become "much worse" as compared to her condition in October 1984, while SAIF was on the risk. In light of this evidence, we conclude that claimant sustained a worsening of her underlying right carpal tunnel condition. We further conclude that claimant's work activities after July 1985 independently contributed to this worsening. Accordingly, Liberty Northwest is responsible for claimant's right carpal tunnel condition.

ORDER

The Referee's order dated April 28, 1987 is reversed. The denial issued by the SAIF Corporation is reinstated and upheld. Liberty Northwest Insurance Corporation's denial is set aside and the claim is remanded to Liberty Northwest for processing according to law. Liberty Northwest shall reimburse SAIF for its claim costs incurred to date.

The Beneficiaries of
MARIO SCARINO, (Deceased), Claimant
Pozzi, et al., Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney

WCB TP-87002
January 5, 1989
Third Party Distribution Order
on Remand

This matter is before the Board on remand from the Court of Appeals. Scarino v. SAIF, 91 Or App 350 (1988). The court has concluded that the deceased's adult children's shares of the third party judgment are not subject to SAIF's lien. Consequently, the court has remanded, with instructions to make the appropriate distribution determination.

After reviewing this matter, we conclude that the distribution scheme suggested by claimant comports favorably with the holding of the court. Therefore, we find claimant's proposed distribution to be appropriate.

Accordingly, we hold that the proceeds of the judgment should be distributed as follows. Following disbursements for claimant's attorney's fee ($97,230.86) and litigation costs ($16,648.76), the deceased's three adult children's shares ($48,615.42), and the surviving spouse's statutory 1/3 share ($32,538.89), a balance of $64,820.57 remains from the third party recovery. Inasmuch as SAIF's third party lien exceeds the remaining balance of the recovery, the $64,820.57 figure shall constitute SAIF's entire share of the recovery.

The record indicates that SAIF has already received the aforementioned sum, while the balance of the amount in dispute has been deposited in claimant's counsel's trust account pending final resolution of this matter. Since this dispute has now been resolved, claimant's attorney is directed to distribute the balance of the disputed amount in a manner consistent with the distribution scheme set forth herein.

IT IS SO ORDERED.

TERRY L. STARNES, Claimant
Coons & Cole, Claimant's Attorneys
Gary T. Wallmark (SAIF), Defense Attorney

WCB 86-08542
January 5, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Garaventa's order that affirmed a Determination Order award of temporary total disability compensation. On review, the sole issue is entitlement to additional temporary total disability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable neck and low back injury

in February 1985 while working as a highway maintenance man. He received conservative treatment from Dr. Nagel, orthopedic surgeon, who diagnosed acute cervical strain and mild degenerative changes in the lumber spine.

Claimant's injury claim was initially closed with 10 percent unscheduled permanent disability and reopened for aggravation in June 1986. At that time, Dr. Nagel provided further conservative treatment and released claimant to modified work on July 1, 1986.

On August 26, 1986, claimant informed Dr. Nagel that he wanted to try to return to his regular job with his employer. Dr. Nagel responded by prescribing a supervised physical therapy program directed at strengthening claimant's back muscles. Claimant's condition significantly improved as a result of his participation in this program. By October 9, 1986, his subjective symptoms and range of motion had resolved to their pre-aggravation status. Dr. Nagel released claimant to return to his regular work as of October 15, 1986.

Claimant's injury claim was reclosed by a November 28, 1986 Determination Order that awarded temporary disability benefits through July 30, 1986.

FINDINGS OF ULTIMATE FACT

Claimant did not become medically stationary until October 15, 1986.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the November 1986 Determination Order award of temporary total disability through July 30, 1986. On review, claimant contends that he is entitled to additional temporary total disability benefits through October 15, 1986, the date Dr. Nagel released him to return to his regular job. We agree.

A claimant is entitled to temporary disability benefits until he becomes "medically stationary." ORS 656.268. "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 affirming the Determination Order award of temporary total disability, the Referee relied on reports from Drs. Woolpert and Nagel. Specifically, Dr. Woolpert, orthopedist, performed an independent medical examination on July 30, 1986 and opined that claimant was medically stationary as of that date. On August 8, 1986, treating orthopedist Nagel opined that claimant "appear[ed] to be medically stable" at that time.

These reports do not persuade us that claimant had become medically stationary by July 30, 1986. Dr. Woolpert's medically stationary finding was rendered in the course of a report that was, in large measure, directed at claimant's ability to return to his regular work. Immediately after indicating that claimant was stationary, Dr. Woolpert stated that supervised physical therapy might produce some degree of improvement but would not enable claimant to return to his regular work. This suggests that Dr. Woolpert based his medically stationary finding on his view that further treatment would not enable claimant to return to his regular

work. As discussed above, the correct legal standard is whether further treatment would result in any degree of improvement in claimant's condition. See ORS 656.005(17).

Moreover, notwithstanding Dr. Nagel's initial opinion on August 8, 1986, he subsequently prescribed a supervised back strengthening program in response to claimant's decision to return to regular work. In addition, Dr. Nagel opined in October 1986 that claimant's back strengthening exercises had improved his condition to the extent that he was able to return to his regular job on October 15, 1986. Dr. Nagel's subsequent statements persuade us that he changed his initial opinion in light of claimant's significant improvement from physical therapy. The same statements also persuade us that claimant did not become medically stationary until Dr. Nagel released him to regular work on October 15, 1986.

Accordingly, we conclude that claimant is entitled to continuing temporary disability benefits for the period July 31 to October 15, 1986.

ORDER

The Referee's order dated July 9, 1987 is reversed in part and affirmed in part. That portion of the order that declined to award additional temporary total disability compensation is reversed. The SAIF Corporation is directed to pay temporary total disability benefits from July 31, 1984 to October 15, 1986. Claimant's attorney is awarded 25 percent of the increased compensation granted by this order, not to exceed $3,800, payable out of claimant's compensation. The remainder of the Referee's order is affirmed.

SHIRLEY STIGALL, Claimant
Roll, et al., Claimant's Attorneys
Stafford Hazelett, Defense Attorney

WCB 88-06162
January 5, 1989
Order of Dismissal

The insurer has moved the Board for an order dismissing claimant's request for review on the ground that her request for review was untimely. The motion is granted.

FINDINGS

The Referee's order issued July 14, 1988. On July 29, 1988, claimant mailed a copy of a request for Board review of the Referee's order to the employer, its insurer, and their legal counsel. The request for Board review was dated July 29, 1988.

On September 22, 1988, the Board received a copy of claimant's July 29, 1988 request for review. The request, which was neither mailed by registered nor certified mail, included a certificate of personal service upon the employer and its representatives. The certificate indicated that copies of the request had been mailed to the opposing parties on July 29, 1988. On September 26, 1988, the Board mailed a computer-generated letter to the parties acknowledging the request.

ULTIMATE FINDINGS

Claimant mailed copies of her request for Board review to all parties to the hearing within 30 days of the Referee's order. However, claimant's request for review was filed with the Board more than 30 days after 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).

If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. Id.

Here, we are persuaded that claimant mailed copies of her request to all parties to the proceeding within 30 days of the Referee's order. ORS 656.295(2). In reaching this conclusion, we rely upon the certificate of personal service by mail provided with claimant's request for review. See OAR 438-05-046(2)(b). We further note that neither the employer nor its representatives contend that they did not receive this notice.

However, the record fails to establish that claimant's request, which was dated July 29, 1988, was mailed to the Board within 30 days of the Referee's July 14, 1988 order. In this regard, we note that neither claimant's counsel's cover letter, the certificate of personal service accompanying the request for review, nor the request itself indicate that the July 29, 1988 request was mailed to the Board. Because the request was neither mailed by registered nor certified mail and since it was actually received by the Board on September 22, 1988, which is more than 30 days from the date of the Referee's order, it is presumed to be untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b).

Under these circumstances, we lack jurisdiction to review the Referee's order. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

MARVIN C. WRIGHT, Claimant
Vick & Gutzler, Claimant's Attorneys
James E. Griffin (SAIF), Defense Attorney

WCB TP-88016
January 5, 1989
Third Party Order

The SAIF Corporation, as paying agency, has petitioned the Board for resolution of a dispute concerning the proper distribution of proceeds from a purported third party settlement. Claimant contends that SAIF is not entitled to a share of the proceeds because, at the time of the settlement, his claim was in denied status. We agree with claimant's contention and conclude that SAIF is not entitled to a share of the settlement proceeds.

FINDINGS

In August 1984 claimant sustained injuries while driving to work with Theodore C. Bernards, when the car he was operating was struck by a vehicle driven by a third party. In December 1984, claimant filed workers' compensation claims with several alleged employers, including Bernards.

Bernards, as well as some of the other alleged employers, lacked workers' compensation coverage. Consequently, claims with those noncomplying employers were referred to the SAIF Corporation by the Workers' Compensation Division for processing. In June 1985 SAIF denied the claims, contending that claimant was not a subject worker. Claimant requested a hearing regarding the denials of his claim.

In January 1985, claimant engaged legal counsel to explore the possibility of bringing suit against the third party. Thereafter, an action was initiated. On January 20, 1986, claimant and the third party agreed to settle claimant's cause of action for $81,960.75. SAIF was unaware of the lawsuit and the settlement. From the settlement proceeds, claimant's counsel received $27,243.18 in attorney fees and $231.20 for litigation costs. The remaining balance, $54,486.37, was distributed as follows: (1) $24,616.65 for claimant's medical bills; and (2) $29,869.72 to claimant.

On January 30, 1986, the hearing concerning the denials of claimant's workers' compensation claims convened. Finding that no employer/employee relationship existed between claimant and the alleged employers, the Referee upheld all the denials. Claimant requested Board review. On March 10, 1987, the Board found that claimant was a subject worker of Theodore Bernards. Consequently, SAIF's denial was set aside and the claim was remanded to SAIF for processing on behalf of the noncomplying employer. Marvin C. Wright, 39 Van Natta 105 (1987). Thereafter, SAIF began processing the claim.

Bernards sought judicial review of the Board's order. On September 14, 1988, the Court of Appeals affirmed the Board's order. Bernards v. Wright, 93 Or App 192 (1988).

To date, SAIF has incurred actual claim costs totalling $43,418.82. These costs are comprised of $1,366.02 in medical expenses, $39,693.35 in temporary total disability compensation, and $2,359.45 in permanent disability awards. Inasmuch as its actual claim costs exceed what would be its share of the remaining balance of proceeds from the settlement had the statutory distribution scheme been followed, SAIF does not attempt to justify a lien for reasonably anticipated future expenses.

SAIF first learned of the settlement in April 1988. It was at this time that claimant sought reimbursement for the $24,616.65 in medical bills, which were paid directly to the providers at the time of the settlement. There is no evidence that SAIF had paid any benefits at the time of the distribution.

FINDINGS OF ULTIMATE FACTS

Claimant received a compensable injury in the course of his employment for a noncomplying employer. The proceeds from

claimant's settlement with the third party are attributable to his cause of action stemming from his compensable injury. However, at the time of the settlement and the distribution of proceeds, claimant's injury claim was in denied status and SAIF had not paid any benefits.

CONTENTIONS

Claimant contends that SAIF's lien should not apply to the settlement proceeds because the settlement was achieved prior to the date his claim was found compensable. Therefore, claimant asserts that SAIF was not a "paying agency" at the time the settlement proceeds were distributed and is not entitled to a share of the recovery. We agree.

CONCLUSIONS OF LAW

If a worker of a noncomplying employer receives a compensable injury in the course of employment, or if a worker receives a compensable injury due to the negligence or wrong of a third person, the worker shall elect whether to recover damages from such employer or third person. ORS 656.578. If the worker elects to recover damages from the employer or third person, notice of such election shall be given the paying agency by personal service or by registered or certified mail. ORS 656.593(1). The proceeds of any damages recovered from the employer or third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. Id.

"Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576. "Insurer" means SAIF or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state. ORS 656.005(14). A claim for compensation made by a worker of a noncomplying employer shall be processed by SAIF in the same manner as a claim made by a worker employed by a carrier-insured employer. ORS 656.054(1).

Here, claimant contended that he had sustained a compensable injury while working for a noncomplying employer. In accordance with ORS 656.054(1), SAIF processed the claim for the noncomplying employer in the same manner as it would any workers' compensation claim. Asserting that claimant was not a subject worker, SAIF denied the claim in June 1985. Claimant contested the denial, timely requesting a hearing.

In the meantime, claimant also continued to proceed against the third party. His perseverance eventually resulted in a January 1986 settlement, which was achieved some 10 days prior to the hearing concerning SAIF's denial and approximately 14 months before the Board found his claim to be compensable. Thus, at the time of the settlement, because claimant's injury claim was in denied status, SAIF was not "paying benefits to the worker." See ORS 656.576. Consequently, we conclude that SAIF was not a "paying agency" as defined by the aforementioned statute.

SAIF would not conclusively become a "paying agency" until the compensability of claimant's injury claim had been finally determined. See Raymond Steiner, 40 Van Natta 381, 382 (1988). This determination was not ultimately reached until the Court of Appeals decision became final, which occurred long after the settlement was achieved and its proceeds distributed.

In Steiner, we required the claimant's counsel to hold the remaining balance of a third party recovery in trust, pending a final determination concerning the compensability of the claim. However, there, in contrast to the present situation, at the time of the recovery and proposed distribution, the claim was considered compensable and the paying agency was providing benefits. We consider it a very different proposition to conclude that whenever a possibility remains that a claim in denied status will ultimately be found compensable, a claimant must hold a third party recovery in trust pending a final resolution of the compensability issue. To do so would require a claimant, who is not receiving workers' compensation benefits, to not only support himself, but also provide for his medical services, without the financial assistance available from the third party recovery.

In support of its contention that it is entitled to a share of the settlement proceeds, SAIF cites Schlecht v. SAIF, 60 Or App 449 (1982). In Schlecht, the claimant's injury claim was partially denied. When his third party action was settled, he tendered an amount to SAIF in satisfaction of its lien for actual claim costs. SAIF approved the settlement, but demanded that an additional amount from the settlement be held in trust, pending resolution of claimant's appeal from the partial denial. Thereafter, the denial was set aside, SAIF provided more benefits, and requested a larger share of the remaining balance of proceeds to offset these additional benefits and future anticipated costs. The Board approved SAIF's request for a greater share of the proceeds, but limited it to the extent of its actual claim costs.

The claimant appealed, contending that SAIF was required to make a claim at the time of the settlement and, having failed to do so, could not recover claim costs that actually accrued or were paid between the time of the settlement and the time of distribution. The court disagreed, reasoning that the paying agency need not make a claim "for the present value of its reasonably to be expected future expenditures for compensation" at the time of the third party recovery. Instead, the court construed the language of ORS 656.593(1)(c) concerning future claim costs to refer to compensation and expenditures anticipated at the time the third party recovery is distributed by agreement of the parties or ordered distributed by the Board.

SAIF interprets the Schlecht holding to be that "[m]atters concerning third party liens are to be determined as of the date of distribution to the paying agency." Since no distribution to the paying agency has yet occurred, SAIF submits that the date of distribution in this case is the date of the Board's third party order. SAIF's argument assumes that later findings of compensability, and its payment of benefits subsequent to the date of the settlement and distribution of proceeds, transforms it into the role of "paying agency" on the date the settlement was reached. We disagree with this contention, as well as SAIF's interpretation of the Schlecht holding.

We find the Schlecht decision to be readily distinguishable from the present situation. Specifically, in Schlecht, a portion of the claim had been accepted and SAIF had paid benefits at the time of the third party settlement. Consequently, there was no dispute concerning SAIF's status as a "paying agency." Since it was undisputed that SAIF, as paying agency, was entitled to a share of the third party settlement, the

court proceeded to conclude that the relevant date for determining a paying agency's future claim costs was the date the third party recovery is distributed either by agreement of the parties or as ordered by the Board.

Here, no portion of the claim had been accepted, voluntarily or otherwise, at the time of the settlement or the distribution of its proceeds. Thus, as previously discussed, SAIF was not a paying agency and, thereby, not entitled to a share of the settlement proceeds. Furthermore, because there was no "third party recovery" within the meaning of the third party statute, there is no need to establish a date for determining SAIF's future claim costs. Therefore, the Schlecht rationale is inapplicable.

Finally, claimant's counsel seeks an attorney fee for services rendered in this matter. We are unaware of any authority permitting us to grant such a request. Consequently, the request is denied. See Arlo W. Dunbar, 40 Van Natta 366, 491 (1988).

Accordingly, we hold that SAIF is not entitled to any portion of claimant's settlement.

JUDY C. YBARRA, Claimant
Vick & Gutzler, Claimant's Attorneys
John Motley (SAIF), Defense Attorney

WCB 86-11909
January 5, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of Referee Gary Peterson's order that set aside it's denial of claimant's aggravation claim. We reverse.

ISSUE

Whether the Referee erred by setting aside SAIF's denial of claimant's claim for aggravation.

FINDINGS OF FACT

Claimant compensably injured her low back in Oregon while employed by SAIF's insured in May 1981. After two surgeries, claimant's claim was ultimately closed. She received a total of 42.5 percent unscheduled permanent partial disability as a result of her 1981 injury. Claimant thereafter moved to the state of Washington, where she again became employed.

On September 19, 1985, claimant sprained her ankle at work in Washington. The injury required a cast and crutches, both of which affected claimant's gait. By early 1986, the ankle problem had begun to subside, but claimant experienced a marked return of low back pain. The increased low back symptoms arose from the altered gait and from a stretching of scar tissue over the L4-5 nerve root. Claimant filed a claim in Washington for the ankle injury and that claim was later closed. She did not file a claim for increased low back pain.

The 1981 Oregon injury remains a material contributing cause of claimant's current back condition.

The 1985 Washington injury independently contributed to a worsening of claimant's underlying low back condition.

CONCLUSIONS OF LAW

SAIF asserts that claimant was required to file a claim for compensation for low back pain in Washington before seeking benefits in Oregon. SAIF cites Miville v. SAIF, 76 Or App 603 (1985), in support of its argument. Claimant argues that Miville applies only if there has been a showing that the out-of-state injury independently contributed to a worsening of the underlying back condition. Claimant argues that there has been no such showing here.

In Miville, the claimant sustained a low back injury in Oregon, followed by a second low back injury in Washington. Ultimately, the claimant injured his back two more times in Indiana. Claimant filed an aggravation claim with the Oregon employer, which was denied, asserting that the later out-of-state injuries contributed to claimant's disability. The court held that where a claimant suffers an Oregon injury, followed by an out-of-state injury, the Oregon employer remains responsible if the Oregon injury remains a material cause of the claimant's condition and the claimant has applied for, but has been denied, compensation in the out-of-state jurisdiction. On the other hand, if the claimant has not applied for compensation or has done so and has received benefits in the out-of-state jurisdiction, the Oregon employer is no longer responsible. 76 Or App at 607.

In Harry W. Clark, 38 Van Natta 1371 (1986), the claimant suffered an Oregon injury, followed by an out-of-state injury to the same body part. The employer argued that the out-of-state injury was such that claimant was required to file for compensation in the foreign jurisdiction in order for the Oregon employer to remain responsible for an aggravation of the original injury. We found that on the facts of Clark that there had been no independent contribution to a worsening of the claimant's condition by the out-of-state injury and that, therefore, the claimant was not required to file a claim in the foreign jurisdiction before seeking benefits in Oregon. Id.

Here, by contrast, we find that the present claimant's out-of-state injury independently contributed to a worsening of her underlying low back condition. Our finding is based on the deposition testimony of Dr. Shanks, claimant's treating physician in Washington. Although Shanks testified that claimant's objective findings had remained essentially unchanged following the 1981 Oregon injury, he also stated that the most probable medical explanation for the flare-up of claimant's low back condition in late 1985 and early 1986 was a pathological change in her condition, i.e., a stretching of the L4-5 nerve root over scar tissue built up as a result of prior surgeries. Shanks further stated that this change would have occurred as a result of the 1985 Washington injury. As a result, claimant's residual capacity for work was reduced from medium to sedentary. We find that the pathological change in claimant's condition, coupled with a reduction in her capacity for work, represented an actual worsening of claimant's underlying condition, the cause of which was the 1985 Washington injury.

Because claimant's out-of-state injury independently contributed to a worsening of her condition, she was required under the principle of Miville to file for benefits in Washington before pursuing aggravation benefits in Oregon. She did not do so. Her Oregon claim is, therefore, precluded and SAIF's denial must be reinstated.

ORDER

The Referee's order dated August 4, 1987, as reconsidered August 21, 1987, is reversed. The SAIF Corporation's August 21, 1986 denial of claimant's aggravation claim is reinstated and upheld.

JOSEPH A. PETTIJOHN, Claimant
SAIF Corp, Insurance Carrier
SAFECO, Insurance Carrier

Own Motion 88-0406M
January 6, 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 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).

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. This consent authorizes an order from the Compliance Division which designates a paying agent for claimant's medical services only in this pre-1966 claim. If claimant desires further own motion relief, he should so advise. 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).

WILFRED L. SPECKMAN, Claimant
William G. Whitney, Claimant's Attorney
Steven Maher (SAIF), Defense Attorney
Scheminske & Lyons, Defense Attorneys
Carl M. Davis, Assistant Attorney General

WCB 85-05088, 85-02030 & 86-10233
January 6, 1989
Order on Reconsideration

Reviewed by Board Members Crider and Johnson.

Argonaut Insurance Company requests reconsideration of that portion of our order dated December 21, 1988 which assessed against it an attorney fee of $2,000. It also notes that our order consistently misidentifies one of the parties.

Regarding the attorney fee, Argonaut contends that the Board's order "does not contain any findings supporting either the amount of fees or entitlement thereto." We disagree, but add the following. Although Argonaut was not a party at the time of the first hearing, it ultimately was made a party to the proceeding.

Nothing in the language of ORS 656.386(1) prohibited the Referee from assessing all of claimant's attorney fee against Argonaut and nothing in the language of ORS 656.382(2) prohibited us from affirming that award. As for the amount of the fee, considering the factors set forth in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), since expanded and embodied in OAR 438-15-010(6), we concluded that the fee assessed by the Referee was reasonable. We continue to be of that opinion.

Regarding the misidentification of one of the parties, our order does indeed misidentify Dan Sheeley Construction as Dan Shebley Construction. This error was due to a clerical oversight. To correct this, our prior order is amended as follows. All references to "Kenneth D. Shebley," "Dan Shebley Construction" and "Shebley" (other than the references to Referee Shebley) are changed to "Kenneth D. Sheeley," "Dan Sheeley Construction" and "Sheeley."

Except as amplified or corrected herein, we adhere to our December 21, 1988 order in its entirety. The parties' rights of appeal shall continue to run from the date of our prior order.

IT IS SO ORDERED.

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

WCB 85-06272 & 86-01877
January 6, 1989
Order on Reconsideration

Claimant requests reconsideration of that portion of our December 7, 1988 Order on Review that declined to award an assessed fee for her attorney's services on review.

Claimant's counsel is statutorily entitled to an assessed fee for services rendered on Board review regarding the issues of: (1) premature closure of claimant's injury claim; and (2) compensability of her current sleep and mood disorder and neck, back, and upper extremity conditions. Our December 7, 1988 Order on Review declined to award an assessed fee because no statement of services had been submitted. See OAR 438-15-010(5). On reconsideration, claimant's counsel submits a copy of a statement of services mailed to the Board in February 1988. However, the submitted statement does not relate to the case decided in our December 7, 1988 order. Accordingly, we decline to award an assessed fee.

We note that our December 7, 1988 order stated that "claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review regarding compensabilty of claimant's sleep and mood disorder." As discussed above, claimant's counsel is also entitled to an assessed fee regarding compensability of claimant's neck, back and upper extremity conditions and premature closure of her claim.

Accordingly, our December 7, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our December 7, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

GLENN T. CALAWA, Claimant
Galton, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys
Reviewed by Board Members en banc.

WCB 86-16442 & 86-05078
January 11, 1989
Order on Review

The insurer requests review of that portion of Referee Lipton's order that set aside its partial denial of claimant's herniated disc and resulting need for medical treatment. We affirm.

ISSUE

1. Whether claimant's current herniated disc and resulting need for medical treatment are compensable.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in October 1983. He had previously compensably injured his back in 1975 and 1978, resulting in a total award of 12.5 percent unscheduled permanent disability.

Shortly after the October 1983 injury, claimant was examined by Dr. Wade, an orthopedist. Wade diagnosed a sacroiliac strain and found no sign of a disc herniation. In February 1984, claimant came under the care of Dr. Puziss, an orthopedist. Puziss diagnosed, inter alia, a cervical/dorsal strain and lumbosacral degenerative disc disease.

Claimant ceased treating with Dr. Puziss in May 1984. He sought no further medical treatment until after a motor vehicle accident in January 1985. The accident resulted in a strain to his neck and low back, which was treated conservatively by Dr. Banner, M.D.

In May 1985, claimant was examined by Dr. Atkinson, an orthopedist. Atkinson detected a minimal to mild posterior protrusion at L4-5.

In July 1985, the insurer closed claimant's claim with a Notice of Closure. A few days later, claimant returned to Dr. Atkinson with complaints of worsened low back pain. Atkinson diagnosed a possible bulging disc at L4-5 and recommended conservative treatment.

The insurer issued an aggravation denial in October 1985. Claimant appealed.

In November 1985, claimant was examined by Dr. Mandiberg, an orthopedist. Mandiberg diagnosed, inter alia, a low back strain and was unable to detect any objective findings.

Claimant's appeal of the insurer's aggravation denial proceeded to hearing on November 15 and December 13, 1985, before a prior Referee. In January 1986, the prior Referee issued his order, which, inter alia, set aside the insurer's aggravation denial.

Approximately one week prior to the hearing of December 13, 1985, claimant began to treat with Dr. Kam, a neurologist. Kam diagnosed, inter alia, a possible disc herniation at L4-5. On January 11, 1986, Kam performed a myelogram, which revealed a midline defect at L4-5.

Dr. Kam's medical reports were not in evidence before the prior Referee. After the prior Referee's order issued, the insurer requested the prior Referee to abate his order and to reopen the record for submission of Kam's then recent reports. In February 1986, the prior Referee issued an order denying the insurer's request.

Shortly thereafter, claimant returned to Dr. Kam with complaints of increased low back pain. Kam performed a discogram and diagnosed a disc herniation at L4-5.

In August 1986, Dr Puziss reviewed claimant's medical records. The next month, Dr. Kam reexamined claimant.

Claimant has never been symptom-free following his October 1983 injury. The January 1985 automobile accident was minor and did not contribute to claimant's current low back problem.

Claimant's October 1983 low back injury is a material contributing cause of his L4-5 disc herniation and resulting need for medical treatment.

CONCLUSIONS OF LAW

Collateral Estoppel

The Referee set aside the insurer's partial denial solely on procedural grounds. That is, the Referee found that the prior Referee's order "collaterally estopped" the insurer from litigating the issue of whether claimant's L4-5 disc herniation and resulting need for medical treatment are compensable. We agree in part.

In North Clackamas School Dist. v. White, 305 Or 48, on recon, 305 Or 468 (1988), the Court acknowledged the applicability of "res judicata" and "collateral estoppel" to workers' compensation cases. In so doing, the White Court referred to the preclusive effect on a claim as "claim preclusion" and the preclusive effect on an issue as "issue preclusion." 305 Or at 50-2. We conclude that issue preclusion is applicable to the instant case.

The rule of issue preclusion is, as stated in White: "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.

Here, in the hearing before the prior Referee, claimant sought to prove an aggravation of his October 1983 injury. Finding that claimant had met his burden of proof, the prior Referee stated, inter alia:

> "On August 1, 1985 claimant saw Dr. Atkinson complaining of a recurrence of back and right leg pain. Dr. Atkinson's impression following examination, which revealed some positive signs, was possible bulging disc at the L4-5 level. Claimant was directed to rest at home. On September 5, 1985 Dr. Atkinson recommended hospitalization. He attributed the low back condition that he was treating to the

> industrial injury. The evidence as a whole supports this conclusion. The motor vehicle accident may have initially affected the low back, but it was transitory and the ongoing low back complaints were referable to the industrial injury. (Emphasis added).
>
> "* * * * *.
>
> "I find claimant suffered a worsening under ORS 656.273(1) as of August 1, 1985."

In September 1986, the insurer issued a partial denial stating, inter alia:

> "Based on recent medical information, it would appear that your current medical condition regarding your lower back is not causally related to your 10-19-83 injury with our insured.
>
> "We are therefore denying current medical treatment and the disc surgery, which you have had, and all residuals related to that surgery and the condition which necessitated it."

As we view it, the rule of issue preclusion estops the insurer from arguing that claimant's condition prior to September 5, 1985, was not materially related to his October 1983 injury. The prior Referee specifically found that on that date Dr. Atkinson noted such a causal relationship. Considering the issue before the prior Referee (i.e., aggravation), his finding concerning causation was determinative. See ORS 656.273(1); Stepp v. SAIF, 78 Or App 438, 441 (1986). No appeal of the prior Referee's order was taken. We will, therefore, not disturb the prior Referee's finding.

Compensability

Claimant must prove that his current condition and resulting need for medical services are materially related to his October 1983 injury. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); ORS 656.245(1).

As we found above, the prior Referee's order found a causal relationship between claimant's low back condition on September 5, 1985, and his October 1983 injury. All of the medical opinions on which the insurer relies, however, run afoul of the prior Referee's finding.

First, Dr. Mandiberg reported that claimant had "no objective findings" or "impairment related to his 1983 injury." In short, Mandiberg found nothing wrong with claimant and recommended a psychiatric evaluation to address "significant functional" problems. Nothwithstanding Mandiberg's opinion, the prior Referee found that claimant's low back condition had worsened as a result of his October 1983 injury.

Second, Dr. Kam confirmed Dr. Atkinson's earlier diagnosis of a possible herniated disc. Kam added, inter alia:

"It was not until August 1985 that Dr. Atkinson noted recurrence of the pain and the problem became worse by September and October. Patient reported that he was going up steps in August 1985 when symptoms increased. * * * [T]he problem could not be attributed to one injury bending over and lifting up an aluminum ladder on 10/19/83." (Emphasis added).

We are not persuaded by Kam's opinion because it is irreconcilable with the prior Referee's finding of fact concerning the causation of claimant's worsened condition in August 1985. As we stated above, the prior Referee conclusively determined that claimant's worsened condition was causally related to his October 1983 injury.

Last, Dr. Puziss, opined that claimant's herniated disc at L4-5 was due to the January 1985 motor vehicle accident and a degenerative disc condition. Yet, in attributing claimant's worsened condition to the October 1983 injury, the prior Referee discounted the motor vehicle accident as the cause of claimant's worsened low back condition.

In sum, we are not persuaded by the medical opinions of Drs. Mandiberg, Kam, or Puziss. On this record, we find no evidence of a non-work superseding cause after September 5, 1985, in which to attribute claimant's current low back condition. His herniated disc at L4-5 was detected by Dr. Atkinson as early as August 1985. The prior Referee determined that claimant's worsened condition as of September 5, 1985, was causally related to his October 1983 injury.

Accordingly, we conclude that claimant has proven that his October 1983 injury materially contributed to his current low back condition, including his L4-5 disc herniation, and resulting need for medical services.

Claimant's counsel has not submitted a statement of services. We cannot authorize an attorney fee when a statement of services has not been filed. OAR 438-15-010(5). Because no statement of services has been filed to date, an assessed fee shall be authorized.

ORDER

The Referee's order dated March 20, 1987 is affirmed. A client-paid fee, not to exceed $2,337, is approved.

Board Member Ferris, dissenting:

I respectfully dissent and would reverse the Referee's order.

The majority reads too much into the prior Referee's order. No findings are contained in that order pertaining to claimant's disc herniation at L4-5. It could not have. Claimant's disc herniation was not diagnosed until after the Referee had issued his order. (Ex. 49 & 50-1).

The only evidence before the prior Referee that can be construed as concerning a disc herniation, is found in a report by

Dr. Atkinson. (Ex. 32). In August 1985, Atkinson diagnosed: "IMPRESSION: Possible bulging disc at the L4-5 level." On that evidence, which says nothing about a disc herniation, the majority concludes that the prior Referee's order procedurally "estops" the insurer from issuing a partial denial of claimant's current disc herniation and resulting need for medical treatment.

Unlike the medical evidence before the prior Referee, the present record consists of newly discovered medical findings concerning claimant's low back condition. As the majority acknowledged in its findings, none of Dr. Kam's medical reports were in evidence before the prior Referee. Kam was the first physician to diagnose an "L4-5 herniated disc." (Exs. 49 & 50). Accordingly, claimant's medical services claim should be decided as a matter of fact.

The majority opinion suffers from the same defect that the Supreme Court found to be reversible error in North Clackamas School District. v. White, 305 Or 48, on recon, 305 Or 468 (1988). In short, the majority fails to recognize that the instant issue, unlike the issue before the prior Referee, pertains to claimant's current low back condition and resulting need for medical services. 305 Or at 57-8. That issue was plainly not addressed by the prior Referee nor could it have been.

It is axiomatic that an insurer may deny the compensability of a worker's medical services. See ORS 656.245(1). The mere fact that a worker sustains a compensable injury or, as here, a reopening of his claim for an aggravation, does not forever obligate an insurer to compensate the worker for all his medical expenses. Id.

ORS 656.245(1) expressly states that an insurer is responsible only for those medical services "resulting from the injury for such period as the nature of the injury or the process of recovery requires . . . ." Nothing in the prior Referee's order addressed whether the condition denied by the insurer (i.e., claimant's current herniated disc) was causally related to his October 1983 injury.

In White, supra, the issues before the prior Referee were premature claim closure and extent of permanent disability. In deciding those issues, the prior Referee stated, inter alia:

> "The relationship of claimant's current disability to her industrial injury is a medical question, and claimant has not sustained her burden of showing a medical connection between her present condition and her industrial injury."

305 Or at 53.

After the prior Referee's order became final, the insurer in White, as here, issued a partial denial of the claimant's current medical services. The claimant requested a hearing. At the hearing, the insurer argued that the claimant's medical services claim was barred by the prior Referee's order. On judicial review, the Court of Appeals was erroneously persuaded by the insurer's argument, stating that the prior Referee had "already . . . determined" the underlying causation issue. 85 Or App at 564.

In reversing the Court of Appeals, the Supreme Court in White provided, inter alia:

> "The Court of Appeals' opinion seems to say that as a matter of law all of the claimant's claims, including the claim for medical expenses, are barred under the rules of res judicata. . . . If the later medical benefits claim is uncompensable, it is uncompensable because, as a matter of fact, medical evidence fails to show a causal relationship between the industrial accident and the present need for medical care." (Emphasis added).

305 Or at 470.

Similarly, here, the majority erroneously draws upon the prior Referee's statement concerning the causation of claimant's then present low back condition. However, consistent with the Supreme Court's analysis in White, the instant claim for medical services should be decided "as a matter of fact." Not as a matter of law, either in part or in whole.

Further troubling, is that the majority discounts all of the medical evidence. However, it is claimant's burden to prove his case; not the insurer's to disprove. See Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979); James v. Kemper Insurance Co., 81 Or App 80, 84 (1986); ORS 656.245(1). Even assuming arguendo that the majority is correct in its assessment of the medical evidence, claimant has not met his burden.

In November 1985, Dr. Mandiberg opined that claimant had no permanent impairment related to the October 1983 injury. In February 1986, claimant underwent x-rays, a CT scan, and a discogram. After reviewing the results of those tests, Dr. Kam diagnosed a herniated disc at L4-5. A few months later, Kam opined that it "would be hard to tell" if there was any causal connection between claimant's ongoing symptoms and the October 1983 injury. In so doing, Kam noted claimant's long period without medical care between 1983 and 1985. In August 1986, Dr. Puziss reviewed claimant's medical records and opined, inter alia:

> ". . . I finally conclude that the 10-19-83 work injury had no contribution whatsoever to the herniated disc condition treated in 1986 with surgical decompression."

Dr. Kam concurred with Puziss' opinion.

In sum, Drs. Mandiberg, Kam, and Puziss are all of the opinion that claimant's current low back condition and resulting need for medical services are not causally related to the October 1983 injury. I find their collective opinions persuasive. See Somers v. SAIF, 77 Or App 259, 263 (1986). Although the majority finds otherwise, there is no medical opinion in this record to support claimant's case. Dr. Atkinson offers no opinion concerning the etiology of either claimant's herniated disc or his current need for medical services.

I would, therefore, reverse the Referee and find claimant's current herniated disc at L4-5 and resulting need for medical services not compensable.

LUCIANO CARVALHO, Claimant
Joel Lieberman, Claimant's Attorney
Bottini, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 87-02171 & 87-02265
January 11, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Safeco Insurance Company seeks review of those portions of Referee Shebley's order that set aside its denial of responsibility for claimant's cervical and back condition. We affirm.

ISSUE

On review, the issue is responsibility.

FINDINGS OF FACT

Claimant, a 35 year old mechanic, sustained an injury to his back and neck, on June 26, 1986, while pushing a pickup truck. Maryland Casualty Company, the employer's workers' compensation insurance carrier on the date of injury, accepted the claim. Claimant sought treatment from Dr. Urban, chiropractor. Dr. Urban diagnosed moderate cervical, upper thoraco-costal and low back sprains and strains. Claimant was treated conservatively and continued to work without any time loss. He continued to receive occasional chiropractic treatments for intermittent low back, thoracic, and low cervical pain. This claim remains in an open status.

Safeco became the employer's workers' compensation insurer in July 1986.

On November 20, 1986, claimant sustained an injury to his neck and low back while pushing a car at work for the same employer. He immediately sought treatment from Dr. Herbst, a physician in an outpatient care center. Dr. Herbst diagnosed an acute neck strain. X-rays were negative. Claimant was treated conservatively. Dr. Herbst prescribed medication, a cervical collar, and physical therapy. Claimant was released from work.

One hour later, claimant sought treatment from Dr. Urban, who diagnosed severe neck pain. Claimant also complained of right sided low back pain. Claimant was treated conservatively and released from work.

A December 1986 MRI of the cervical spine revealed a slight bulging of the C5-6 disc with no evidence of nerve root or thecal sac compression.

On January 30, 1987, Safeco and Maryland Casualty Company each denied responsibility for claimant's cervical and back conditions. Neither carrier denied compensability of claimant's condition. On March 11, 1987, a .307 order issued, designating Safeco the paying agent.

On February 25, 1987, Dr. Urban reported that claimant was not medically stationary.

On March 30, 1987, Dr. Duncan, chiropractor, conducted an independent medical examination. Dr. Duncan diagnosed mild thoracocervical and lumbar musculoligamentous strains on June 26,

1986, with apparent aggravation by the November 20, 1986, incident by history, resolved, ongoing cervical complaints, secondary to documented postural distortion, by radiographic documentation, and slight bulging of the C5-6 disc, with no compromise of the thecal sac, or spinal nerves, probably of no clinical significance.

Claimant's June 1986 injury primarily involved his left lumbar, lumbosacral and sacroiliac regions of his spine, with secondary symptoms in the cervical and thoracic spines. His November 1986 injury primarily involved his cervical spine, with secondary complaints in the thoracic and right lumbar, lumbosacral and sacroiliac regions of his spine.

Claimant's neck pain resulting from the November 1986 injury causes him difficulty in sleeping. He has numbness and tingling in both arms and hands.

Claimant's injury on November 20, 1986 was an identifiable and traumatic event of a different nature and intensity than he had previously experienced in July 1986.

CONCLUSIONS OF LAW

Cases involving successive injuries and insurance carriers are decided under the "last injurious exposure" rule. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). Under this rule, responsibility rests with the carrier at risk at the time of the most recent injury that independently contributed to a worsening of claimant's underlying condition. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). Therefore, responsibility shifts from Maryland Casualty to Safeco if claimant's November 1986 injury contributed independently to a worsening of claimant's neck and low back conditions.

The assignment of responsibility for claimant's current back and cervical conditions is a complicated medical issue requiring expert medical opinion. See Uris v. Compensation Dept., 247 Or 420 (1967).

Safeco contends that claimant' November 1986 injury was a temporary exacerbation of his July 1986 injury. It relies on the medical report and testimony of Dr. Duncan. Dr. Duncan testified that the November 1986 incident did not independently contribute to claimant's condition or cause a new injury. Instead, claimant was merely experiencing cervical symptomatology resulting from his July 1986 injury. Because claimant was actively treating when the November 1986 incident occurred, Dr. Duncan opined that the incident was merely an aggravation of a preexisting condition. We do not find this opinion persuasive.

Dr. Urban, claimant's treating chiropractor, found that claimant's symptoms on November 20, 1986, constituted a new injury. Dr. Urban felt that claimant's symptomatolgy, both objectively and subjectively, was much more severe than it was previously. Additionally, after the November 1986 incident, claimant exhibited signs of disc injury which prompted Dr. Urban to refer him for an MRI evaluation. That evaluation revealed a bulging cervical disc. Dr. Urban opined that the November 1986 injury caused claimant's cervical disc injury and aggravated his previous cervical, upper thoraco-costal, and low back conditions. Further, Dr. Herbst, who treated claimant soon after his November

injury, observed tender right neck muscles with some degree of muscle spasm. He opined that claimant had a cervical strain.

We are persuaded that claimant's November 1986 injury was a result of a specific independent trauma to his cervical spine and low back and not a symptomatic exacerbation of his previous conditions. We rely on the well reasoned and persuasive medical reports of Dr. Urban. Dr. Duncan's opinion is unpersuasive and based upon inaccurate facts. Dr. Duncan testified that he discounted the MRI finding of a cervical bulging disc because claimant had demonstrated no radicular involvement, even though his medical report states that claimant reported numbness in both arms. Additionally, Dr. Duncan examined claimant only one time.

We conclude that responsibility for claimant's current condition lies with Safeco, the insurer at the time of the November 1986 injury.

Claimant requests an attorney fee from Safeco for participation on Board review. We decline to award an attorney fee as the compensation awarded to claimant would not have been disallowed or reduced had Safeco prevailed on review. ORS 656.382(2); Rhonda Bilodeau, 41 Van Natta 11 (January 4, 1989).

ORDER

The Referee's order dated April 27, 1987 is affirmed. The Board approves a client-paid fee for services on Board review for the attorney of Maryland Casualty Co., not to exceed $160.

SOLEDAD B. FLORES, Claimant
Olson Law Firm, Claimant's Attorney
Bottini, et al., Defense Attorneys

WCB 86-03728
January 11, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Danner's order that: (1) declined to award permanent disability for a left wrist condition; and (2) declined to assess penalties and associated attorney fees for the self-insured employer's alleged unreasonable failure to commence payment of interim compensation and otherwise process claimant's aggravation and medical services claims in a timely manner. The employer cross-requests review of that portion of the order that set aside its denial of claimant's aggravation claim.

On review, the issues are aggravation, penalties, attorney fees, and extent of scheduled permanent disability.

We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant is a seasonal cannery worker who compensably injured her left wrist in September 1984. Her condition was diagnosed as tendonitis, and she was released from work and treated conservatively. A Determination Order, issued January 18, 1985, closed her claim with no award of permanent partial disability. At that time, her compensable injury had predisposed her to symptomatic flare-ups with heavy or repetitive use of her left wrist. Claimant did not request a hearing on the January 1985 Determination Order.

Claimant resumed her seasonal employment in June 1985. The following month, she began experiencing left wrist pain which steadily worsened to the point that she consulted her family physician, Dr. Quijano, in late October 1985. He prescribed medication and advised claimant to rest her left arm for several weeks.

On October 30, 1985, the employer received a brief note from Dr. Quijano, which attributed claimant's condition to tenosynovitis, and stated that claimant should rest her left arm for one to two weeks, but could continue working as tolerated. The note did not comment on the need for medication or other treatment. Nor did it address whether claimant's current condition was related to her prior compensable injury. However, the employer added the notation "IAC, 9-14-84, left wrist," below its date stamp on the report. The employer uses the term "IAC" as an abbreviation for "industrial accident."

Claimant continued working through November 6, 1985. The employer received a follow-up report from Dr. Quijano on November 7, 1985. In that report, he noted that claimant was scheduled for further diagnostic tests and would continue to have restricted use of her left arm and wrist for two weeks. The employer added the notation "IAC, 9-14-84, left wrist," below its date stamp on that report.

On November 27, 1985, claimant was examined by Dr. Snider, orthopedist, on referral from Dr. Quijano. Dr. Snider had treated claimant following her compensable injury in 1984. On the day of Dr. Snider's examination, the employer received a note from him authorizing time loss from November 27, 1985 through December 20, 1985. The employer added the notation "IAC, right wrist," below its date stamp on this report.

On December 20, 1985, Dr. Snider released claimant to modified work not requiring heavy use of the left hand. At that time, claimant's left wrist condition was improving but still symptomatic. There is no evidence in the record that claimant received any further curative treatment after that time.

In late January 1986, claimant contacted the employer by phone concerning the status of her aggravation claim. Sometime prior to February 4, 1986, the employer received a report from Dr. Snider, dated January 31, 1986, clearly linking claimant's current left wrist condition to her prior compensable injury. On February 4, 1986, the employer formally denied claimant's aggravation claim and related temporary disability benefits. Claimant's left wrist condition was medically stationary at the time the denial was issued. Claimant requested a hearing on the denial.

Dr. Snider released claimant back to regular work in April 1986. She returned to her regular seasonal work in June 1986 and worked the entire season, which ended in November of the same year. She plans to return to that work when called in 1987.

At hearing, claimant requested a penalty and attorney fee for the employer's failure to timely pay medical bills. Specifically, claimant alleged that the employer had not paid $616.64 in overdue bills. The employer's attorney acknowledged that these bills were not paid and that a penalty and associated attorney fee were warranted.

FINDINGS OF ULTIMATE FACT

Claimant had experienced a symptomatic flare-up requiring additional medication when she consulted Dr. Quijano on October 29, 1985. Her left wrist symptoms caused her to leave work after November 6, 1985.

The employer had notice of claimant's aggravation claim by November 7, 1985. The employer had notice of claimant's medically verified inability to work by November 27, 1985.

The employer acted unreasonably in failing to process claimant's aggravation and medical services claims in a timely manner.

At the time of hearing, claimant's left wrist condition had returned to its pre-aggravation status.

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt the Referee's opinion on this issue.

Penalties and Attorney Fees for Failure to Timely Process Aggravation Claim

On review, claimant contends that the Referee erred in not awarding a penalty and attorney fee regarding the employer's failure to process her aggravation claim in a timely manner. We agree.

The Referee found that the employer had notice of claimant's aggravation claim as of October 30, 1985. We disagree and, instead, find that it had notice of claimant's aggravation claim as of November 7, 1985, the date it received Dr. Quijano's report authorizing further diagnostic tests. By that date, the employer had associated claimant's left wrist condition with her prior compensable injury and had notice that further medical treatment was necessary.

The Referee also found that the employer had medically verified notice of time loss as of November 27, 1985, the date it received Dr. Snider's report authorizing time loss through December 20, 1985. We agree with that finding.

The employer did not issue a denial of claimant's aggravation claim and associated temporary disability benefits until February 4, 1986. Moreover, it did not commence payment of interim compensation pending issuance of its denial.

The Referee offered no explanation for his decision not to award a penalty under these circumstances. We conclude that the employer acted unreasonably in failing to commence payment of interim compensation and process the aggravation claim in a timely manner. We further conclude that the employer's actions in this regard warrant the maximum penalty. Accordingly, we assess a 25 percent penalty against the temporary total disability benefits otherwise due under the Referee's order, and award an associated attorney fee.

Penalty and Attorney Fee for Failure to Timely Process Medical Services Claims

On review, claimant also contends that the Referee erred in rejecting her request for a penalty and attorney fee regarding the

employer's failure to timely deny or pay medical services claims in the amount of $616.64. We agree.

The Referee denied the requested penalty on the ground that the employer's February 1986 denial also denied claimant's medical services claims. However, the denial was only for claimant's aggravation claim and related temporary disability. It did not deny ongoing medical services related to her left wrist condition. Moreover, the employer's attorney acknowledged at hearing that these medical services claims were not paid and that a penalty and associated attorney fee were warranted.

Therefore, we conclude that the employer acted unreasonably in failing to timely process claimant's medical services claims. We further conclude that the employer's failure in this regard warrants the maximum penalty. Accordingly, we assess a 25 percent penalty against the outstanding medical services claims, and award an associated attorney fee.

Extent of Permanent Partial Disability

We adopt the Referee's opinion on this issue. Claimant has not shown that she is currently more disabled than she was at the time her claim was initially closed in January 1985. See Stepp v. SAIF, 304 Or 375 (1987).

ORDER

The Referee's order dated January 5, 1987, is affirmed in part and reversed in part. The self-insured employer is directed to pay claimant a penalty equal to 25 percent of the temporary total disability benefits due under the Referee's order. The employer is also directed to pay an additional penalty equal to 25 percent of the $616.64 in overdue medical services claims. For services at hearing and on review concerning the penalty issues, claimant's attorney is awarded a reasonable attorney fee of $450, to be paid by the self-insured employer. The remainder of the Referee's order is affirmed.

ARLENE T. FULKERSON, Claimant
SAIF Corp, Insurance Carrier

Own Motion 88-0377M
January 11, 1989
Own Motion Order

Claimant has requested that the Board exercise its Own Motion authority pursuant to ORS 656.278 and "remand [her] case 87-04271 to the Hearings Division so that [she] may have a fair hearing." We lack jurisdiction to grant the request.

FINDINGS OF FACT

In March 1987, claimant, through her then counsel, requested a hearing contesting the SAIF Corporation's denial of her injury claim. On June 29, 1987, the Hearings Division mailed a notice to the parties, scheduling claimant's hearing for September 23, 1987. Claimant's copy of the notice was mailed to her in care of her attorney. On June 30, 1987, claimant's attorney withdrew as her legal representative.

On September 23, 1987, a hearing convened as previously scheduled. Neither claimant nor any individual representing her interests was in attendance. The Referee noted that unsuccessful attempts had been made to contact claimant at her "message

telephone number." Concluding that there was a possibility that claimant had never received written notice of the hearing, the Referee denied SAIF's motion for dismissal.

On September 30, 1987, the Referee issued an order directing claimant to show "good cause" for her failure to appear at the hearing. A copy of this order was mailed to claimant at her most recent address by regular mail. No response was forthcoming.

On January 15, 1988, the Referee issued a second order to show cause. A copy of this order was mailed to claimant at her most recent address by certified mail. This notice was returned to the Hearings Division as "unclaimed."

On February 17, 1988, SAIF again moved for dismissal. On March 7, 1988, finding that more than 30 days had elapsed since his order to show cause, the Referee dismissed claimant's hearing request with prejudice. The dismissal order advised the parties that if they objected to the order, they could request Board review within 30 days.

On March 14, 1988, claimant responded to the Referee's March 7, 1988 dismissal order. She stated that she had been "in and out" of the Dammasch State Hospital for treatment for manic depression. Submitting that she had been unable to either appear at the hearing or reply to the Referee's correspondence, claimant requested a new hearing.

Claimant's response was received by the Hearings Division on March 15, 1988. However, it was not brought to the Referee's attention until April 18, 1988, more than 30 days after his March 7, 1988 dismissal order. The March 7, 1988 order has not been appealed, stayed, withdrawn, or republished.

On June 10, 1988, claimant requested that the Board exercise its Own Motion jurisdiction and remand her case to the Hearings Division. She reiterated her request for a new hearing.

CONCLUSIONS OF LAW

The Board may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified. ORS 656.278(1). This authority is limited to those cases in which there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization or there is need for medical services on a pre-1966 claim. ORS 656.278(1). The Board is not authorized to modify, change or terminate former findings or orders that a claimant incurred no injury or incurred a noncompensable injury. ORS 656.278(5)(a).

Here, claimant's petition does not concern a worsening of a compensable injury requiring either surgery or hospitalization or a claim for medical services on a pre-1966 claim. Moreover, inasmuch as SAIF's denial has not been set aside, claimant's injury claim has not been found compensable. Under these circumstances, we lack authority to grant claimant's request for Own Motion relief. See ORS 656.278(1), (5).

IT IS SO ORDERED.

GARY HESS, Claimant
Martin McKeown, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 86-06483
January 11, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Mongrain's order that: (1) upheld the self-insured employer's denial of his occupational disease claim for bilateral carpal tunnel syndrome; and (2) rejected his request for penalties and attorney fees for the employer's allegedly unreasonable delay in denying the claim. We reverse.

ISSUES

1. The compensability of claimant's bilateral carpal tunnel syndrome.

2. Penalties and attorney fees for late denial.

FINDINGS OF FACT

Claimant, 49 years old at the time of the hearing, worked as a crane operator for the employer from approximately 1975 to June 1986. From about 1975 to 1980, claimant operated a crane with three levers which moved forward and backward. From about 1980 to March 1986, claimant operated a crane with two levers which moved forward, backward and from side to side. The final three months of his employment, he operated a crane whose controls were not described in the record.

With respect to the second crane, both of the control levers had a rounded handle about the size of a billiard ball. There also were four buttons on the front lower portion of both handles. Claimant operated the crane by moving the handles and depressing the buttons. He had to manuver the right handle significantly more often than the left.

In approximately 1983, claimant began to notice numbness in his right wrist and hand. During the following two years, symptoms also appeared in his left hand and both hands gradually worsened. In January 1986, Dr. Bernstein, a neurologist, performed nerve conduction studies and diagnosed bilateral carpal tunnel syndrome, worse on the right.

We accept Dr. Bernstein's diagnosis. Carpal tunnel syndrome is a symptom complex involving the wrist and hand and is caused by compression of the median nerve within the carpal tunnel. This compression results from changes in the tissues within the carpal tunnel associated with acute trauma (Tr. 165), systemic or metabolic disorders or conditions (see Tr. 165), the aging process (Tr. 169-70), repetitive hand or wrist motions (Ex. 13A-1; Tr. 175-76), and other unknown causes. (See Ex. 13A-2; Tr. 182, 204). The severity of a carpal tunnel syndrome caused by repetitive hand or wrist motions is normally proportional to the intensity of hand or wrist use. (Tr. 164, 188). Bilateral carpal tunnel syndromes caused by systemic or metabolic disorders or conditions or the aging process are normally similar in severity on both sides. (Tr. 163).

Dr. Adams, an orthopedic surgeon, performed a surgical release of claimant's right carpal tunnel on June 2, 1986. During the surgery, Dr. Adams observed that the synovium of the flexor

tendons of the fingers was thickened and also performed a partial synovectomy. Synovium is a membrane which lines the tendons, lubricating and protecting them. (Tr. 175). The flexor tendons of the fingers and the associated synovial membranes pass through the carpal tunnel. (Tr. 177-78).

The wrist, hand and finger motions associated with claimant's employment as a crane operator contributed more to the thickening of the synovium of the flexor tendons of his fingers than all other potential causes. (Ex 13A-1 & 3). This thickening, in turn, caused the compression of the median nerves within claimant's carpal tunnels and resulted in carpal tunnel syndrome. (Ex. 13A-3).

Claimant filed his workers' compensation claim on January 6, 1986. The employer issued its denial of compensability 64 days later on March 11, 1986. Claimant missed no time from work due to his condition until June 2, 1986, when he underwent surgery.

OPINION AND CONCLUSIONS

Compensability

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

The record contains four opinions regarding the cause of claimant's bilateral carpal tunnel syndromes. Dr. Poage, claimant's family doctor, opined that the condition was work related by means of a check mark on a form. (Ex. 3). Dr. Adams, the treating orthopedist, noted that claimant had large hands and indicated that this made him susceptible to carpal tunnel syndrome. (Ex. 14). He also opined, however, that claimant's work activity had "precipitated his symptoms." (Ex. 14). Dr. Bernstein, the consulting neurologist, opined that the wrist, hand and finger motions associated with claimant's work as a crane operator had generated friction between the flexor tendons of claimant's fingers and his carpal ligaments, resulting in the synovial thickening observed by Dr. Adams. The synovial thickening, in turn, had compressed claimant's median nerves, resulting in the carpal tunnel syndromes. (Ex. 13A-1 & 3). Dr. Nathan, a consulting hand specialist, opined that the compression of claimant's median nerves was related to the aging process and thus was ideopathic. (Tr. 169-70). He thought that claimant's work activity had affected the symptoms of his condition, but not the underlying condition itself. (Tr. 170-71).

In making our findings of fact, we accepted the opinion of Dr. Bernstein. His opinion was based upon a complete and accurate history and provided an explanation for the presence of the synovial thickening observed by Dr. Adams and for the different degrees of

median nerve compression in claimant's wrists. The other opinions were inadequate for a variety of reasons.

The opinion of Dr. Poage was a bare, unexplained conclusion and thus was of little probative value. See Loehr v. Liberty Northwest Insurance Corp., 80 Or App 264, 267-68 (1986); Kenneth C. Snow, 39 Van Natta 743 (1987). Dr. Adams' opinion regarding the size of claimant's hands and the precipitation of symptoms by his work activity was so vague that in the absence of clarification we were unable to determine whether it supported or detracted from claimant's case. Dr. Nathan's opinion, although explained at some length, was not well reasoned.

Dr. Nathan provided no explanation for the synovial thickening observed by Dr. Adams during surgery; instead, he attempted to deny its existence. This denial was based on his reading of a pathology report regarding the synovial tissue, (Tr. 183-85), the fact that he had not noticed any synovial swelling during his examination of claimant, (Tr. 198), and special nerve conduction studies he had ordered which showed focal rather than generalized compression of the median nerves. (Tr. 178-79).

The pathology report cited by Dr. Nathan was very brief, stating simply "a piece of gray-tan fixed soft tissue consistent with synovial origin." (Ex. 11). Dr. Nathan indicated that inflamed synovial tissue is usually more brown in appearance. (Tr. 184-85). He readily acknowledged, however, that such is not always the case. (Tr. 185). Regarding Dr. Nathan's failure to notice synovial swelling, he acknowledged that such swelling may vary with time and activity and thus may not always be noticeable. (See Tr. 197). Regarding focal rather than generalized compression of claimant's median nerves, Dr. Nathan's testimony suggested that the locus of median nerve compression due to synovial swelling can vary depending on the extent of the swelling. (See Tr. 178-79). The location and extent of the compression, therefore, can vary with the waxing and waning of synovial swelling. After reviewing Dr. Nathan's reasoning regarding the presence or absence of synovial swelling, we found Dr. Adams' direct observations more convincing than Dr. Nathan's attempts to discredit them.

Another problem with Dr. Nathan's opinion was his failure to explain convincingly why claimant's right carpal tunnel syndrome was worse than his left. Under Dr. Nathan's theory, claimant's carpal tunnel syndromes were related to the natural aging process and should have been of approximately the same severity on both sides. Claimant's right syndrome, however, was significantly worse than his left. In an attempt to address this problem, Dr. Nathan speculated that claimant had sustained an acute trauma to his right wrist at some point in his life which had made that wrist more susceptible to the development of carpal tunnel syndrome. (Tr. 165). Claimant denied any such trauma, (Tr. 37, 79-80), and the record does not otherwise support Dr. Nathan's speculations.

The problems described above caused us to reject Dr. Nathan's opinion and to accept that of Dr. Bernstein. Dr. Bernstein indicated that claimant's work activity was the primary if not sole cause of the tissue changes within his carpal tunnels which resulted in the compression of his median nerves. (Ex. 13A-3). Claimant's work activity, therefore, contributed more to the tissue changes than all other causes combined and was the major contributing cause of his condition. Accordingly, claimant's condition is a compensable occupational disease.

Penalties and Attorney Fees

A carrier has 60 days from the date of notice or knowledge of a claim within which to accept or deny the claim. ORS 656.262(6). A penalty of up to 25 percent of any "amounts then due" may be assessed against a carrier which "unreasonably delays acceptance or denial of a claim." ORS 656.262(10). "Amounts then due" include costs of medical services rendered on a compensable claim before and during the period of unreasonable delay. See Whitman v. Industrial Indemnity Co., 73 Or App 73, 77-78 (1985).

The employer issued its denial 64 days after receiving notice or knowlege of the claim and thus exceeded the statutory time limit by four days. It offers no reasonable excuse for this delay and none is evident from the record. The delay, therefore, was unreasonable and a penalty will be assessed on any "amounts then due." Considering the circumstances and length of the delay, we conclude that a penalty of 5 percent is appropriate. See George J. Kovarik, 38 Van Natta 1381 (1986); Zelda M. Bahler, 33 Van Natta 478, 479 (1981), rev'd in part on other grounds, 60 Or App 90 (1982).

Claimant was able to work until he underwent surgery in June 1986. The employer issued its denial on March 11, 1986. No temporary disability compensation was due before the employer's denial, see Bono v. SAIF, 298 Or 405, 408-10 (1984), and no penalty can be assessed on that basis. However, medical services were rendered on claimant's claim before March 11, 1986 and we assess the 5 percent penalty on those expenses. Considering the statement of services submitted by claimant's attorney and the factors enumerated in OAR 438-15-010(6), we also assess an associated attorney fee of $200.

Claimant's attorney is entitled to an employer-paid attorney fee for services at the hearing level for prevailing against the employer's denial of claimant's occupational disease. See ORS 656.386(1). Such a fee is an assessed fee within the meaning of OAR 438-15-005(2). The Board may not award an assessed fee until it has received and considered a statement of services from the claimant's attorney. OAR 438-15-010(5). The statement of services submitted by claimant's attorney is for services on Board review only. No fee for services at the hearing level, therefore, can be awarded at this time.

ORDER

The Referee's order dated February 4, 1987 is reversed. The self-insured employer's denial dated March 11, 1986 is set aside and the claim is remanded to the employer for processing according to law. Claimant's attorney is awarded $1,000 for services on Board review on the compensability issue, to be paid by the self-insured employer. The employer shall pay claimant a penalty of 5 percent of the cost of all medical services rendered on the claim prior to March 11, 1986. In connection with the penalty issue, the employer shall pay claimant's attorney an attorney fee of $200. A client-paid fee, not to exceed $215, is approved.

WILLIAM HOOVER, Claimant
Robert E. Martin, Claimant's Attorney
James Griffin, Assistant Attorney General

WCB TP-88034
January 11, 1989
Third Party Distribution Order

The SAIF Corporation, as paying agency, has petitioned the Board to resolve a dispute concerning the just and proper distribution of proceeds from a third party settlement. See ORS 656.593(3). We conclude that the settlement proceeds are subject to SAIF's third party lien and that a distribution in accordance with ORS 656.593(1) is "just and proper." See ORS 656.593(3).

FINDINGS OF FACT

Claimant sustained a compensable injury. SAIF accepted the claim and has provided compensation. To date, SAIF has incurred actual claim costs totalling $42,364.96. SAIF projects no future claim expenditures.

Claimant engaged legal counsel to explore the possibility of bringing suit against a third party. Thereafter, an action was initiated. Claimant and the third party agreed to settle claimant's cause of action for $100,000.

The settlement was approved by SAIF, subject to the following condition. Claimant and SAIF agreed that a portion of the settlement proceeds sufficient to satisfy SAIF's contested third party lien would be held in trust pending a resolution of this dispute.

FINDINGS OF ULTIMATE FACT

Claimant sustained a compensable injury in the course of his employment. SAIF has paid benefits to claimant as a result of his compensable injury. The proceeds of claimant's settlement with the third party are attributable to his cause of action stemming from his compensable injury. Finally, a distribution of settlement proceeds in accordance with ORS 656.593(1) is just and proper.

CONCLUSIONS OF LAW

If a worker of a noncomplying employer receives a compensable injury in the course of employment, or 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 employer or third person. ORS 656.578. The proceeds of any damages recovered from the employer or third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

"Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576. "Insurer" means SAIF or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state. ORS 656.005(14). A claim for compensation made by a worker of a noncomplying employer shall be processed by SAIF in the same manner as a claim made by a worker employed by a carrier-insured employer. ORS 656.054(1).

Here, claimant sustained a compensable injury. SAIF

accepted the claim and has provided compensation. Inasmuch as SAIF has paid benefits to claimant as a result of a compensable injury, we conclude that it is a paying agency. See ORS 656.576; 656.005(14).

Furthermore, upon claimant's election to seek recovery against the third party, the provisions of ORS 656.593 became applicable. Consequently, portions of the third party settlement proceeds became subject to SAIF's lien, as paying agency, for its "just and proper" share. See ORS 656.593(3).

Having concluded that SAIF is entitled to a share of the settlement proceeds, we now determine what is a "just and proper" distribution.

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

Since 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). Thus, 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).

Here, the parties do not specify what portions of the proceeds have already been distributed for claimant's attorney's fee, litigation costs, and his statutory 1/3 share. See ORS 656.593(1)(a), (b), & (3). Yet, SAIF suggests that the balance of proceeds from the third party settlement remaining after the aforementioned deductions is sufficient to satisfy its lien. Moreover, claimant has not responded to SAIF's assertions concerning either its entitlement to, or the amount of, its third party lien.

Under these circumstances, we find that SAIF has established that it has incurred actual claim costs of $42,364.96. We further find no justification for departing from the general statutory formula concerning the distribution of

proceeds from a third party recovery. Consequently, we conclude that a distribution of $42,364.96 from the remaining balance of proceeds from the third party settlement to SAIF is "just and proper." See ORS 656.593(3); Robert L. Cavil, supra.

Accordingly, we hold that SAIF is a paying agency and, as such, is entitled to its statutory share of the proceeds from claimant's third party settlement. Therefore, claimant's attorney is directed to distribute the settlement proceeds in accordance with ORS 656.593(1). After the distribution of claimant's attorney's fee and litigation costs, claimant shall receive 1/3 of the remaining balance as his statutory share. See ORS 656.593(1)(a),(b). Thereafter, from the remaining balance of proceeds, claimant's attorney is directed to distribute $42,364.96 to the SAIF Corporation. See ORS 656.593(1)(c). Any remaining portion of the settlement proceeds should be distributed to claimant. See ORS 656.593(1)(d).

IT IS SO ORDERED.

JOYCE KING, Claimant
Art Stevens (SAIF), Defense Attorney

WCB 88-04722
January 11, 1989
Order of Dismissal

The SAIF Corporation has moved the Board for an order dismissing claimant's request for review on the ground that her request was untimely. The motion is granted.

FINDINGS OF FACT

The Referee's order issued October 7, 1988. On November 16, 1988, the Board received claimant's letter. The undated letter, which expressed dissatisfaction with the Referee's order, was filed by claimant's former attorney, who stated that he had received it the previous day from the SAIF Corporation. SAIF's date stamp indicates that it received claimant's letter on November 7, 1988. The envelope carrying the letter was postmarked November 3, 1988 and specified that it was for the Referee's attention. However, the envelope was addressed to SAIF's Post Office Box.

SAIF received notice of claimant's letter within 30 days of the Referee's order. Claimant's letter was not mailed to the Board within 30 days of the Referee's order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, claimant's letter was directed to the attention of the Referee, expressing her dissatisfaction with the Referee's order. Thus, the letter was apparently intended to be a request

for reconsideration of the Referee's order. However, assuming for the sake of argument that the letter was intended as a request for Board review, it was untimely.

The request was received by SAIF, a party to the proceeding, within 30 days of the Referee's order. Yet, the record fails to establish that the request was mailed to, or received by, the Board within the statutory 30-day period. Consequently, we lack jurisdiction to review the order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

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.

JEURINE E. MARSHALL, Claimant
Cosgrave & Kester, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-18131
January 11, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Danner's order that upheld the self-insured employer's denial of her claim for multiple injuries sustained in a motor vehicle accident. The issue on review is whether claimant's injuries arose out of the course and scope of her employment. We affirm.

FINDINGS OF FACT

Claimant is a media specialist for the self-insured employer, a school district. In addition to her work as a media specialist, she worked as an adult advisor to a group of students in a special advisory program. Her usual work hours are from 7:30 a.m. to 3:30 p.m., although she is not required to stay at school after 2:45 p.m. On September 21, 1987, claimant decided that she would bring some cupcakes to school the next morning in connection with meeting some of the goals of the advisory program. She sought and received approval of her plan from the counsellor in charge of the advisory program.

Claimant's school is located in southeast Portland. Claimant resides in west Portland. Her usual route to and from work causes her to cross the Sellwood Bridge over the Willamette River. Claimant intended to purchase the cupcakes at a market on the west side of the Sellwood Bridge in her neighborhood. She checked out of the school at approximately 3 p.m. on September 21, 1987. She had a personal appointment at 4 p.m. on the west side of the Willamette River. She intended to drive to the market, pick up the cupcakes, then drive to her personal appointment, then drive home. While crossing the Sellwood Bridge on her way to the market she was involved in a head-on motor vehicle accident and

received serious injuries. Later that evening, one of claimant's daughters, at claimant's request, called a teacher friend of claimant's and asked the friend if she would pick up a "treat" and take it to school the next morning. The friend did so. Neither the counsellor in charge of the advisory program nor the school principal would have ordered anyone to obtain a "treat" in lieu of the cupcakes claimant was unable to pick up.

CONCLUSIONS AND OPINION

This case involves the "dual purpose" exception to the "coming and going" doctrine. As a general rule, injuries sustained by a worker while travelling to and from the workplace are not considered to arise out of and occur in the course of employment. Philpott v. SIAC, 234 Or 37 (1963). One of the exceptions to this rule is the so-called "dual purpose" exception. This exception provides that if a trip to or from the workplace serves both personal and business purposes, it is a personal trip for purposes of the workers' compensation law, if the trip would have been made in the absence of a business purpose and would not have been made in the absence of the personal purpose notwithstanding the business purpose. On the other hand, the trip is a business trip if it would have been made notwithstanding the personal purpose and the employer would have caused the trip to be made by someone else had it not coincided with the worker's personal trip. See 1 Larson, Workers' Compensation Law, sec. 18.12 (1985); Brown v. SAIF, 43 Or App 447, 452-53 (1979); Gumbrecht v. SAIF, 21 Or App 389, 392-93 (1975).

We conclude that the injury causing event was the act of crossing the Sellwood Bridge into west Portland. We agree that the two questions posed by the employer's brief are the key to application of the "dual purpose" exception in this case. The first question is whether claimant would have crossed the Sellwood Bridge at approximately 3 p.m. on September 21, 1987 had she not planned to pick up the cupcakes. The evidence clearly establishes that claimant would have crossed the Sellwood Bridge, either to go home or to go to her personal appointment, and that she was able to do so any time after 2:45 p.m. on September 21, 1987.

The second question is whether the employer would have sent someone else to pick up cupcakes had claimant's trip not occurred. We conclude that the answer to this question is, "No." We do not attach significance to the fact that claimant was able to arrange for someone else to take a "treat" to school as a matter of friendship or professional courtesy. The question is whether the employer would have directed someone to make a trip for that purpose. The counsellor in charge of the advisory program and the school principal both testified that they did not have that authority and would not have done so.

Accordingly, we conclude that claimant's trip was personal under the application of the dual purpose exception to the coming and going doctrine and that her claim is not compensable.

ORDER

The Referee's order dated February 26, 1988 is affirmed. A client-paid fee, not to exceed $1,050, is approved.

Board Member Crider, dissenting:

I agree that this case involves the "dual purpose" exception to the "coming and going" doctrine. However, I do not agree with the majority's formulation of that exception. Moreover, I believe that application of the exception, properly formulated, leads to the conclusion that claimant was within the course and scope of her employment when injured in the motor vehicle accident. I, therefore, dissent.

My disagreement with the majority opinion centers around its statement that "[t]he question is whether the employer would have directed someone to make the trip for that purpose." The majority's formulation of the exception is far too restrictive. As applied here, it has the unwarranted effect of precluding recovery simply because claimant exercised discretion in the performance of her job duties.

Claimant had a responsible job that entailed the exercise of considerable discretion. She concluded, in the exercise of that discretion, that her student advisory group would benefit as a result of a sharing of refreshments. Although not strictly required of claimant, her employer agreed that the plan was an excellent one and authorized execution of the plan. The fact that claimant exceeded the minimum requirements of her employment, such that the employer would not have directed someone to pick up the refreshments, does not, and indeed should not, disqualify her from receiving benefits.

The relevant question is not whether the employer would have directed someone to make the trip, but rather whether the purpose of the trip was such that someone would have undertaken it if claimant had not been able to handle it in combination with her homeward journey. 1 Larson, Workers' Compensation Law, sec. 18.21 (1985). Stated otherwise, the relevant inquiry is whether the business purpose of the trip was important enough that claimant, or another employee, would have made the trip in the absence of the personal motive.

Claimant and her supervisor testified in this regard that the use of food was an important tool in furthering middle school goals. Further, the record establishes that claimant herself would have made the trip even had it not coincided with her homeward journey. Claimant had ordered the refreshments in advance. If she lacked sufficient time to pick them up before her personal appointment, then she would have made a special trip to get them later. It was sufficiently important that, as claimant awaited surgery following the accident, she arranged for a fellow employee to pick up the refreshments.

The "coming and going" rule is merely a shorthand method of dealing with a category of cases involving the "arising out of and in the course of employment" standard established by former ORS 656.005(8)(a) (now ORS 656.005(7)(a)). The ultimate inquiry under the statute remains whether "the relationship between the injury and the employment [is] sufficient that the injury should be compensable ***." Rogers v. SAIF, 289 Or 633, 642 (1980). The record here establishes such a relationship. I would, therefore, set aside the employer's denial.

JULIO R. OLIVEROS, Claimant
Charles D. Maier, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 85-08235
January 11, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of that portions of Referee Myers' order that: (1) increased claimant's unscheduled permanent disability award for a right shoulder condition from 5 percent (16 degrees), as awarded by Determination Order, to 15 percent (48 degrees); and (2) declined to award claimant's attorney a fee payable out of compensation. The insurer cross-requests review, seeking a reduction of the Referee's award of permanent partial disability.

On review, the issues are:

(1) Extent of unscheduled permanent disability; and

(2) Claimant's attorney's entitlement to a fee payable out of compensation for services at hearing.

We affirm the Referee's award of permanent disability and reverse on the issue of attorney fees.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact and findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

We adopt the Referee's opinion on this issue.

Attorney Fee for Services at Hearing

The Referee allowed the insurer to offset its prior overpayment of permanent partial disability against the additional 10 percent permanent partial disability awarded at hearing. As a result, no additional permanent partial disability was paid out under the Referee's order. Accordingly, the Referee reasoned that claimant's attorney was not entitled to an attorney fee for services at hearing because "claimant is receiving no compensation as a result of this Order." On review, claimant contends that the Referee erred in declining to award a fee. We agree.

Under the administrative rules in effect at the time of hearing, claimant's attorney was generally entitled to an attorney fee for "obtaining compensation or an increase" in compensation. See former OAR 438-47-010. In addition, former OAR 438-47-025 specifically authorized "a fee of 25 percent of any increase in permanent disability awarded by the Referee, but not more than $2,000 . . ." payable out of the increased compensation.

The Referee apparently concluded that claimant did not obtain an "increase" in compensation within the meaning of these rules because no additional permanent partial disability was actually paid out under the Referee's order. However, an award of attorney fees under the particular circumstances of this case was expressly

authorized under former OAR 438-47-085(2). That rule provides that an attorney fee approved under OAR 438-47-025 "shall not be subject to any set-off based on prior overpayment of compensation to claimant . . . The employer or carrier shall pay the approved attorney fee to the claimant's attorney." Accord Weyerhaeuser Company v. Sheldon, 86 Or App 46 (1987). (A decision which issued subsequesnt to the Referee's order). We conclude that this provision applies equally to attorney fees for "obtaining compensation or an increase" in compensation under former OAR 438-47-010.

The insurer is, therefore, obligated to pay the attorney fee authorized by former OAR 438-47-010 and 438-47-025. In reaching this decision, we reject the insurer's argument that a fee in the present case "directly flouts the clear mandate of former OAR 438-47-010(5)." That provision provides that a fee for a claimant's attorney "shall be paid out of the compensation award except as otherwise specifically provided.". The insurer argues that reducing its offset by the attorney fee approved under OAR 438-47-025 creates an insurer-paid fee not "specifically provided" under the rules. Assuming that our ruling does, in effect, create an insurer-paid fee, we conclude that it is specifically provided under former OAR 438-47-085(2), discussed above.

Accordingly, we reverse the Referee on this issue and conclude that the insurer is obligated to pay claimant's attorney a fee equal to 25 percent of the 10 percent increase in permanent disability awarded by the Referee, not to exceed $2,000.

Assessed Fee on Board Review

Finally, claimant has prevailed against the insurer's cross-request challanging the Referee's permanent partial disability award. He is, therefore, entitled to an assesssed fee on Board review if the insurer's cross-request raised an issue that otherwise would not have been before the Board. ORS 656.382(2); OAR 438-15-070; Alfred P. Adent, 40 Van Natta 1677, 1819 (1988). Accord Teel v. Weyerhaeuser Co., 294 Or 588, 590 (1983); Saiville v. EBI Companies, 81 Or App 469, 473 (1986); Travis v. Liberty Mutual Ins., 79 Or App 126 (1986).

Here, claimant requested review seeking an additional award of permanent partial disability. As a result, the issue raised by the insurer's cross-request, extent of permanent partial disability, was otherwise before the Board. Accordingly, claimant is not entitled to an assessed fee for prevailing against the insurer's cross-request.

ORDER

The Referee's order dated May 15, 1987 is affirmed in part and reversed in part. The insurer is ordered to pay claimant's attorney a fee equal to 25 percent of the 10 percent (32 degrees) increased permanent disability awarded by the Referee's order, not to exceed $2,000. The Referee's order is otherwise affirmed. The Board approves a client-paid fee, not to exceed $204.50.

LARRY K. ROSE, Claimant
Peter O. Hansen, Claimant's Attorney
Rankin, et al., Defense Attorneys
Terrall & Miller, Defense Attorneys

WCB 86-16120 & 86-03158
January 11, 1989
Order on Review

Reviewed by Board Members en banc.

EBI Companies requests review of that portion of Referee Podnar's order that set aside its denial of responsibility for claimant's low back condition. EBI also objects to the Referee's advisory opinion on the issue of extent of disability. Claimant cross-requests review of the order and contends that the Referee erred in not awarding his attorney a carrier-paid attorney fee. We reverse on the responsibility issue, affirm on the attorney fee issue and affirm the award of unscheduled permanent partial disability granted by Determination Order.

ISSUES

1. Responsibility for claimant's low back condition.

2. The entitlement of claimant's attorney to a carrier-paid attorney fee.

3. Extent of claimant's low back disability.

FINDINGS OF FACT

Claimant injured his low back in December 1984 in the course of his employment as a janitor with EBI's insured when he slipped and fell on his left hip and back. He treated with Dr. Gritzka, an orthopedic surgeon, with complaints of low back pain radiating into his left leg. A CT scan was negative for disc herniations. Dr. Gritzka diagnosed a lumbosacral sprain superimposed on a congenital defect of the facet joints at L5-S1 and prescribed conservative treatment. Physical therapy notes reveal that claimant experienced some symptoms in his right leg as well as his left. Dr. Gritzka declared claimant medically stationary in April 1985 and indicated that claimant had some limitation of spinal motion and chronic low back pain. He otherwise gave no impairment rating. The claim was closed by Determination Order in May 1985 with a 15 percent unscheduled award.

In January 1986, claimant sought treatment from Dr. Stephens, an orthopedic surgeon, with complaints of increased low back and bilateral leg pain, worse on the left. Dr. Stephens initially thought that claimant might have a herniated disc, but after a few visits he began to detect inconsistencies in claimant's symptoms and concluded that much of claimant's problem was functional in nature. This conclusion was later echoed by a panel of the Orthopaedic Consultants. Claimant's physical condition was the same in March 1986 as it was in April 1985. (Ex. 23-6). EBI issued an aggravation denial in February 1986. Claimant requested a hearing on the denial as well as the May 1985 Determination Order in March 1986. The request for hearing on the denial was later withdrawn. (See Tr. 2).

In June 1986, claimant returned to work as a painter's helper for an employer insured by Lumbermen's Underwriting Alliance (Lumbermen's). This job involved regularly lifting objects weighing 60 pounds or more. In July 1986, claimant attempted to lift a bucket full of sandblasting grit which weighed between 150 and 200 pounds.

He felt pain in his low back and put the bucket down. Claimant continued to work for the next two days and experienced an increase in low back pain and a feeling that his legs were going to sleep. He then left work and sought treatment from Dr. Sirounian, an osteopath. After his initial examination, Dr. Sirounian diagnosed "degenerative disc disease with acute lumbosacral strain."

A number of medical professionals have offered opinions on the aggravation/new injury question. All of the opinions are ambiguous and can be read to support either conclusion.

Claimant filed claims with Lumbermen's and EBI which were denied on responsibility grounds. An order pursuant to former ORS 656.307 was issued on January 15, 1987 at claimant's request. Claimant requested hearings on the denials which were consolidated with the hearing request on the May 1985 Determination Order. Lumbermen's weekly temporary disability rate is approximately $15 more than EBI's rate. (See Ex. 44).

At the hearing, claimant took the position that he had sustained a new injury. (Tr. 7-8). The Referee found that claimant had sustained an aggravation, rather than a new injury and assigned responsibility to EBI. Claimant was 26 years old in July 1986, had achieved a GED and had attended one year of college. His work history was varied.

ULTIMATE FINDINGS OF FACT

1. The evidence is inconclusive on the question of whether the July 1986 incident worsened claimant's underlying condition.

2. Claimant's entitlement to receive compensation was not at issue after the issuance of the .307 order in January 1987.

3. Claimant sustained impairment as a result of his original injury in December 1984 in the upper portion of the minimal range or the lower portion of the mild range.

CONCLUSIONS OF LAW

Responsibility

As indicated in our findings of fact, the evidence in this case on the aggravation/new injury question is inconclusive. Four medical professionals offered opinions which are relevant to the question. They are Dr. Sirounian, claimant's treating osteopath, Dr. Estin, an internist who participated in claimant's treatment, Dr. Burke, a consulting osteopath, and Dr. Hardiman, a consulting orthopedist.

Dr. Sirounian diagnosed claimant's condition after the July 1986 incident as "degenerative disc disease with acute lumbar strain." (Ex. 28-2). The word "strain" seems to indicate that the incident was a new injury rather than an aggravation. Later in the same report, however, Dr. Sirounian commented, "[Claimant's] symptoms are compatible with his disease process as given by history." This implies that claimant's symptoms represented simply a natural progression of his underlying condition. Dr. Estin's report is similarly inconclusive. He described claimant's condition as a "lumbar strain -- recurrent." (Ex. 38).

The opinions of Drs. Burke and Hardiman are no more

helpful. Dr. Burke opined: "My gut feeling is that the recent July 1986 low back strain was related to his 1984 injury -- the gun was loaded, the 1986 experience pulled the trigger." (Ex. 43). Dr. Hardiman opined:

> "The question here again is trying to determine whether this represents an aggravation or a new injury. Obviously, there is nothing in the physical examination that help [sic] us. However, in the history, we have to say that there is a patient here who has had for two years back discomfort, which did not completely abate after the first injury. Without an intervening period of wellness, one would be included [sic] to at least think of it in terms of an aggravation as a result of a new injury. Regardless, the treatment at this time is the same." (Ex. 35-3).

Turning from the medical evidence to claimant's testimony does not settle the question either. Claimant conceded that he continued to have back pain from the time of his 1984 injury through the time of the 1986 incident and flare-up. He also indicated, however, that the pain he experienced in 1986 was much worse than anything he had experienced previously and that he had never experienced pain in his right leg before the 1986 incident. Both of these latter assertions are contradicted by the medical record. The Referee found claimant not credible based on these discrepancies and we concur in his evaluation.

The question, therefore, is how responsibility should be assigned when compensability is conceded but the evidence on the responsibility issue is inconclusive. That question is answered in Champion International v. Castilleja, 91 Or App 556 (1988). There the court ruled that when the evidence on the responsibility issue is inconclusive, the last injurious exposure rule operates to place responsibility on the new injury carrier. Id. at 560. In accordance with Castilleja, therefore, we assign responsibility to Lumbermen's.

Attorney Fees for the Hearing Level

The Referee refused to award claimant's attorney a carrier-paid attorney fee for the hearing level because the issue of compensability had been determined before the hearing by the issuance of a .307 order and claimant's attorney had pursued the new injury theory which did not prevail before the Referee. We affirm the Referee on the first of the above grounds.

The only authority for an attorney fee award by the Referee was ORS 656.386(1). (The attorney fee provision of ORS 656.307(5) did not become effective until January 1, 1988, see Or Laws 1987, ch 713, §§ 5, 8, and thus was inapplicable.) 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); see Ohlig v. FMC Marine & Rail Equipment, 291 Or 586, 591-98 (1981); see also Shoulders v. SAIF, 300 Or 606, 611-16 (1986).

Claimant's entitlement to receive compensation in the present case was resolved prior to the hearing through the issuance of a .307 order. See Petshow v. Farm Bureau Insurance Co., 76 Or App 563, 569 (1985), rev den 300 Or 722 (1986); Ronald L. Warner, 40 Van Natta 1082, on reconsideration, 40 Van Natta 1194 (1988); Judy Witham, 40 Van Natta 1982 (December 7, 1988). The only compensation issue remaining after the issuance of the .307 order was the amount of compensation claimant would receive. The new injury carrier had a higher temporary disability rate than the aggravation carrier. If the former was held responsible claimant would receive more compensation than if the latter was held responsible. Whichever way the responsibility issue was decided, however, claimant's entitlement to receive compensation was not at risk. After the issuance of the .307 order, therefore, this case was not a "rejected case" within the meaning of ORS 656.386(1).

We note that the Court of Appeals appears to have ruled in SAIF v. Phipps, 85 Or App 436 (1987) that a claimant's attorney is entitled to a carrier-paid fee under ORS 656.386(1) when the claimant has a "stake in the outcome" of a .307 proceeding by virtue of a difference between the temporary disability compensation rates of the carriers. That decision is inconsistent with the Supreme Court's decisions in Ohlig and Short and has not been followed in subsequent Court of Appeals decisions. See Cascade Corp. v. Rose, 92 Or App 663, 667-68 (1988); Hunt v. Garrett Freightliners, 92 Or App 40, 42 (1988); Wilson v. Geddes, 90 Or App 64, 66 (1988); Anfora v. Liberty Communications, 88 Or App 30, 32-33 (1987). We conclude that Phipps has been overruled sub silentio. See Rhonda Bilodeau, 41 Van Natta 11 (January 4, 1989).

Although claimant's attorney is not entitled to a carrier-paid fee under ORS 656.386(1), we conclude that the attorney is entitled to a fee under ORS 656.386(2) out of claimant's increased compensation. The services rendered by claimant's attorney helped establish that the carrier with the higher rate of temporary disability compensation was responsible and thus helped obtain an increase in the amount of claimant's compensation. We award a fee of 25 percent of the increased compensation, not to exceed $750. See former OAR 438-47-030(1).

Extent of Low Back Disability

The Referee did not actually decide the issue of extent of disability because of his conclusion that claimant had sustained an aggravation rather than a new injury. He nonetheless stated that if he had reached the extent issue he would have awarded claimant an additional 10 percent unscheduled permanent partial disability. EBI objects to this advisory opinion. We agree with EBI that the opinion has no legal effect. In view of our conclusion that claimant sustained a new injury rather than an aggravation, however, we must decide the extent of claimant's disability for the original injury. We rate disability as of the time just prior to the new injury. See Mary V. Scholl, 38 Van Natta 1450, 1453 (1986); Pauline L. Travis, 37 Van Natta 194, 195-96 (1985), rev'd in part on other grounds, 79 Or App 126 (1986).

In evaluating the extent of unscheduled permanent partial disability for claimant's original low back injury, we consider the impairment due to the injury as reflected in the medical record and any credible testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply

these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

Considering the credible evidence regarding claimant's permanent impairment in light of the relevant social and vocational factors, we conclude that an award of 48 degrees for 15 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to his original injury. We therefore affirm the May 1985 Determination Order.

ORDER

The Referee's order dated January 27, 1987, as amended by the order dated February 9, 1987, is affirmed in part and reversed in part. Those portions of the order that set aside EBI's denial dated December 9, 1986 and upheld the denial dated November 3, 1986 issued by Fred S. James & Co. on behalf of Lumbermen's Underwriting Alliance are reversed. EBI's denial is reinstated and upheld. Lumbermen's denial is set aside and the claim is remanded to Fred S. James & Co. for processing according to law. That portion of the Referee's order requiring EBI to reimburse the new injury employer is also reversed. Lumbermen's shall reimburse EBI for its claim costs incurred to date. The remainder of the Referee's order, as well as the May 1985 Determination Order, are affirmed. Claimant's attorney is awarded 25 percent of the increased compensation resulting from this order, not to exceed $750. A client-paid fee, payable from Lumbermen's Underwriting Alliance and its adjusting agency, Fred S. James & Co., to its counsel, is approved, not to exceed 139. a client-paid fee, payable from EBI to its counsel, is approved, not to exceed $302.

Board Member Crider, concurring in part and dissenting in part.

I concur in that portion of the order dealing with responsibility. I disagree, however, with the majority's decision not to award an insurer-paid fee to claimant for services at hearing and on Board Review and, instead, to approve a fee out of claimant's compensation. I dissent for the reasons stated in my opinion in Rhonda Bilodeau, 41 Van Natta 11 (January 4, 1989).

DONNY R. RULE, Claimant
Flaxel, Todd, et al., Claimant's Attorneys
Tom Anderson (SAIF), Defense Attorney

WCB 87-00595
January 11, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Peterson's order that: (1) declined to award temporary disability benefits (TTD) during claimant's period of incarceration; and (2) declined to award a penalty and related attorney fee for the SAIF Corporation's alleged unreasonable unilateral termination of temporary disability benefits while claimant was incarcerated. We reverse.

ISSUES

1. Whether claimant is entitled to temporary total disability benefits for the period of his incarceration.

2. Whether SAIF was entitled to unilaterally terminate claimant's temporary disability benefits during his incarceration.

3. Whether claimant is entitled to a penalty and related attorney fee for unilateral termination of temporary total disability benefits.

FINDINGS OF FACT

We adopt the Referee's stipulated findings of fact.

CONCLUSIONS OF LAW

The Referee concluded that claimant was not entitled to temporary disability benefits during the period of incarceration because he is not substantively entitled to such benefits under Cutright v. Weyerhaueser Co., 299 Or 290 (1985), and because he is not procedurally entitled to continued payment of benefits until claim closure because payments never commenced. We disagree.

Entitlement to TTD

It is not necessary that we decide whether or not claimant is substantively entitled to temporary disability benefits for the period of incarceration because we conclude that SAIF should have paid benefits for the period commencing with claimant's first day off work and that SAIF's refusal to do so because claimant was later incarcerated was in effect a prohibited unilateral termination of benefits.

Unilateral termination of TTD

Claimant was disabled from work beginning November 18, 1986 and remained disabled fourteen days thereafter. Thus, claimant became entitled to temporary disability payments commencing the first day of the disability. ORS 656.210(3). SAIF was obligated to make temporary disability payments no later than December 7, 1986, that is, fourteen days after the employer's knowledge of the disability. ORS 656.262(4). Thereafter, SAIF was not permitted to terminate temporary disability payments until claimant was medically stationary and either had returned to regular work, was released to regular work, or the claim was closed. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988).

Since claimant's injury on November 18, 1986, he has been disabled from work and has not become medically stationary. His claim has not been closed nor has compensability of his claim been denied. Although SAIF had not, in fact, commenced the payment of TTD at the time of its "suspension" notice of December 8, 1986, the statute required that TTD be paid for the period beginning November 18, 1986 until claimant became stationary. SAIF's refusal to pay on the grounds of claimant's November 21, 1986 incarceration, therefore, was, in effect, a unilateral termination of further benefits.

SAIF was not entitled to unilaterally withhold benefits. Rather, it should have continued to pay until authorized to terminate such payments and/or to offset overpayments against future awards. SAIF, however, did not avail itself of its right to request a hearing under ORS 656.283(1), but instead resorted to self-help. This is impermissible. Northrup King & Company v. Fisher, 91 Or App 602, 606 (1988).

Penalties and attorney fees

The Referee concluded that claimant was only entitled to a

25 percent penalty and attorney fee based upon unpaid temporary disability from November 18, 1986 until November 21, 1986. We disagree.

ORS 656.262(10) states that:

> "If the insurer of 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."

As discussed above, claimant's entitlement to benefits during his period of incarceration and SAIF's request for an offset were issues that should be addressed at the time of claimant's claim closure. SAIF offered no reasonable explanation for its decision to ignore the ORS 656.268 procedures regarding the payment and termination of TTD. Its decision to terminate those benefits was based upon its belief that claimant was not entitled to TTD because he had removed himself from the labor force. Although that may be a reasonable position to take upon claim closure, SAIF could not bypass the clear statutory procedural safeguards. SAIF's decision, therefore, was unreasonable and claimant is entitled to a 25 percent penalty and related attorney fee based upon the entire period of unpaid TTD. Earl F. Childers, 40 Van Natta 481 (1988).

ORDER

The Referee's order dated April 1, 1987 is modified and reversed. In addition to the temporary disability awarded by the Referee's order, claimant is awarded temporary total disability benefits from November 21, 1986 until claim closure. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees payable out of claimant's compensation to be awarded by the Referee and Board orders shall not exceed $3,800. In addition, claimant is awarded a penalty equal to 25 percent of the compensation due as a result of this order. For Services at hearing and on Board review concerning the penatly issue, claimant's attorney is awarded a reasonable fee of $500, to be paid by the SAIF Corporation.

CHARLES L. SMITH, Claimant
CLAUDIA J. TORGESON & MICHAEL P. TORGESON, dba KING TORG'S DONUT SHOP & BAKERY, Employer
Ann B. Witte, Claimant's Attorney
Ann Kelley, Assistant Attorney General

WCB 86-12160 & 86-08550
January 11, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation, as claims processor for a noncomplying employer, requests review of those portions of Referee Lipton's order that: (1) set aside its denial of claimant's temporary total disability benefits (TTD) while incarcerated; and (2) awarded claimant a reasonable attorney fee of $750. We affirm in part and modify in part.

ISSUES

1. Whether SAIF was entitled to unilaterally terminate claimant's TTD during his period of incarceration.

2. Whether claimant's attorney was entitled to an assessed fee for his services at hearing, rather than a fee payable out of compensation.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

We adopt the Referee's conclusions regarding SAIF's improper unilateral termination of TTD, noting that the Referee's approach has been sustained by the Court of Appeals. Northrup King & Company v. Fisher, 91 Or App 602 (1988).

We reverse the Referee with regard to claimant's attorney fee. Claimant is not entitled to an ORS 656.386(1) attorney fee because such fees are awarded when claimant has prevailed over a decision rejecting a claim. See Virginia Wolf, 40 Van Natta 1725 (October 27, 1988). In this case the claim was accepted. The issue was what benefits he is entitled to under the accepted claim. Under these circumstances, an assessed fee is not within our authority to grant.

OAR 438-15-045 states that:

> "If, after a hearing requested by the claimant, the referee awards additional compensation for temporary disability, the referee shall approve a fee of 25 percent of the increased compensation, but not more than $1,050, to be paid out of the increased compensation."

Therefore, claimant's attorney was not entitled to an assessed fee for his services at hearing, but rather to 25 percent of the increased temporary disability compensation, but not more than $1,050.

ORDER

The Referee's order dated March 16, 1987 is affirmed in part and modified in part. That portion of the Referee's order that awarded claimant an assessed attorney fee for services rendered at hearing is modified. In lieu of the Referee's attorney fee award, claimant's attorney is awarded 25 percent of the increased compensation created by the Referee's order, not to exceed $1,050. For services on Board review concerning the temporary disability issue, claimant's attorney is awarded a reasonable fee of $400, to be paid by the SAIF Corporation on behalf of the noncomplying employer. The remainder of the Referee's order is affirmed.

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our September 30, 1988 Order of Dismissal. The request is denied.

FINDINGS

On December 8, 1987, the employer requested Board review of a Referee's November 24, 1987 order. On December 11, 1987, the Board acknowledged claimant's cross-request for review of the Referee's order. Neither party submitted a brief on review.

On February 11, 1988, the administrator for the Board notified all practitioners with cases currently pending review that executed retainer agreements or referral letters, 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 to receive such approval a statement of services should be filed within 15 days after the submission of stipulations and disputed claim settlements.

On July 26, 1988, the parties submitted a proposed "Stipulation and Order," which was designed to resolve all issues raised or raisable in their requests for review, as well as issues currently pending before the Hearings Division in WCB Case No. 88-02239.

On September 30, 1988, following Referee approval of the stipulation, the Board also approved the agreement and issued its Order of Dismissal. The Board's 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 October 5, 1988, the employer's counsel sought authorization of a client-paid fee for services rendered on Board review. The request included an attorney referral letter. This submission did not reach the Board's file until on or about December 7, 1988, after the employer's counsel sent a "third copy."

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 rules. Stanley, supra; Eyler, supra.

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

Here, the authorization request has been accompanied by an attorney referral letter. Such a submission constitutes an executed retainer agreement pursuant to the administrator's directive. However, the request was submitted approximately two months after the stipulation was filed with the Board and 15 days after the dismissal order. Based on the aforementioned authority, such a submission is untimely.

As previously noted, the October 5, 1988 attorney fee request was submitted while the Board still had jurisdiction to abate, amend, or reconsider its September 30, 1988 dismissal order. Under such circumstances, the Board makes every effort to promptly process such requests. Unfortunately, in this particular instance, the 30-day period to further consider the merits of the case elapsed without Board action. Consequently, the merits of the September 30, 1988 order have become final by operation of law. See Betty J. Eyler, supra.

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

Accordingly, because the request for a client-paid fee is untimely and since our order on the merits has become final by operation of law, we decline to authorize the employer's counsel's request. In so doing, 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.

ROBERT D. ARMSTRONG, Claimant
Brian R. Whitehead, Claimant's Attorney
Acker, et al., Defense Attorneys

WCB 86-02776
January 12, 1989
Order on Remand

By the Board en banc.

This matter is before the Board on remand from the Court of Appeals. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). The court held that the scope of its review in all workers' compensation cases in which petitions for review are filed after July 20, 1987, the date HB 2900 was approved by the Governor, shall be as provided in ORS 183.482(7) and (8). The court next held that ORS 183.482(8)(c) requires the court to set aside or remand a final order which is not supported by substantial evidence in the record. The court further reasoned that in order to conduct its "substantial evidence" review, it had to be able to know what the Board found as fact and why it believed that its findings led to the conclusions that it reached.

Because claimant filed his petition for review with the court on July 27, 1987, the court concluded that the scope of its review was as provided in ORS 183.482(7) and (8). Finding that the Board order was inadequate for judicial review, the court remanded for reconsideration. On remand, we conclude that claimant's occupational disease claim for chronic rhinitis is compensable. Therefore, our prior order is vacated and replaced by the following order.

FINDINGS OF FACT

Claimant is a former textile mill worker who, on January 24, 1986, filed a claim for nose bleeds and headaches, allegedly due to his exposure to textile dust and fibers while employed as a loom operator. The insurer issued a denial on February 7, 1986. Claimant does not challenge that portion of the denial which denied headaches. His claim proceeded to hearing on an occupational disease theory involving a diagnosed rhinitis condition.

Claimant had worked for the employer as a weaver for approximately seven years prior to the claim. During this time, he was exposed to dust and fibers resulting from the milling of asbestos, cotton, fiberglass, and acrylic materials. Use of asbestos and cotton fibers was discontinued by the employer in approximately 1980. As of December 1985, the employer primarily utilized synmesh, a monofilament fiber which results in no visible irritants. Consequently, milling of synmesh results in a less dusty work environment than asbestos and cotton materials. However, 20 to 50 percent of the material presently used is of a fiberglass or acrylic nature, and particles are released into the air from those substances.

An air quality study of the work place undertaken in May 1986 disclosed that the work place particulate values were approximately 1-10th of the threshold limit value allowed under OSHA standards. The workplace was nevertheless substantially more dusty than the average home environment. Claimant wore a dust mask briefly during 1985, but discontinued its use because it obstructed his vision.

Claimant last worked for the employer in December 1985. He was on vacation during the first two weeks of January 1986

during which time he pursued an out-of-state job opportunity. The job did not materialize. When he returned to Oregon in mid-January, claimant saw Dr. Minard, psychiatrist and neurologist, for severe headaches and chest pain.

Dr. Minard first examined claimant on January 13, 1986. On January 17th, Dr. Minard authorized a 30-day release from work due to severe headaches and the need for diagnostic tests and treatment. He subsequently referred claimant to Dr. Parosa, an internist and Board-eligible pulmonary specialist, for evaluation of his headaches as possibly related to sinusitis and his chest pains as possibly related to exposure to asbestos.

When claimant first saw Dr. Parosa on January 21, 1986, he complained of nasal bleeding, nasal obstruction with continuous secretion drainage, a low-grade sore throat, and a raspy voice. Among other things, Dr. Parosa diagnosed rhinosinusitis, with a probable mild secondary bronchitis. Treatment included antibiotics, nasal saline, intranasal corticosteroids, and topical vasoconstrictors.

Dr. Parosa reexamined claimant on January 27, 1986. Claimant's symptoms had gradually worsened since his last visit. He reported daily nasal bleeding.

Claimant was again examined by Dr. Parosa on February 11, 1986. When claimant's symptoms persisted, Dr. Parosa referred claimant to Dr. Eschelman, an ear, nose and throat specialist.

Dr. Eschelman examined claimant on February 17, 1986. Dr. Eschelman diagnosed a deviated septum and a mucosal cyst, but he found no evidence of sinusitis. He performed bilateral antral irrigations, which showed no evidence of chronic inflammatory changes. He recommended that claimant maintain good water intake, utilize nasal saline spray and irrigation, and use a vaporizer in his bedroom and substances such as sugarless gum to facilitate drainage. He recommended that claimant discontinue decongestants and other systemic medications.

Claimant's condition subsequently improved. As of the date of hearing, claimant's symptoms had resolved.

Claimant has a history of hay fever, allergic rhinitis, pneumonia, and bronchitis. He is allergic to house dust mites. He has seven children, one of whom has hay fever and one who has asthma. He has an increased tendency to be infected with colds and the flu because he has several children who bring home viruses from exposures outside the home. Claimant rides a bicycle for exercise throughout the year. Riding his bicycle in the cold weather aggravates his symptoms.

Claimant has heated his home with firewood for the last seven years. The home is quite drafty. During the winter, the air temperature in the home is maintained at approximately 60 degrees. Claimant has cut firewood for his own use for six to eight years. He cut firewood for commercial sale between October 1985 and January 1986. Claimant's use of a chain saw results in the formation of sawdust. He discontinued this business on the advice of one of his physicians.

Rhinitis is an inflammation of the nasal mucosa

characterized by post nasal drainage, sneezing, mild nasal itch and nasal congestion. Claimant suffers from chronic rhinitis. Claimant suffered a worsening of his chronic rhinitis in the latter portion of 1985 and early 1986. This worsening of claimant's rhinitis condition is related to his work activities. His work exposures, compared to his off-work exposures, were the greater cause of the worsening of his rhinitis.

Claimant was a credible witness, as were his other witnesses regarding the dust levels at the workplace.

CONCLUSIONS AND OPINION

This claim is one for occupational disease. To establish a compensable occupational disease, a worker must prove that his work exposure was the major contributing cause of either the onset or worsening of his condition. 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).

The record contains two expert opinions regarding the cause of claimant's condition and symptoms. One is that of Dr. Parosa, an internist and Board-eligible pulmonary specialist. The other is that of Dr. Montanaro, a Board-certified allergist and immunologist, who saw claimant on March 13, 1986, at the request of the insurer. Both Drs. Parosa and Montanaro diagnosed preexisting symptomatic rhinitis. Both physicians also acknowledge that claimant experienced a symptomatic aggravation. They disagree, however, as to whether claimant also experienced a worsening of his underlying condition.

Therefore, our first task is to determine whether claimant's preexisting rhinitis condition worsened, either temporarily or permanently. See Hutcheson v. Weyerhaeuser, 288 Or 51, 54-5 (1979). If so, we must then determine whether his work place exposure was the major contributing cause of that worsening.

Dr. Parosa opined that a worsening of symptoms reflects a worsening of the underlying rhinitis condition. He explained:

> "[W]hen I initially took the history from [claimant] we talked about loosely August being that time when it seemed to get worse....[I]t extended it in that it became a more severe irritative rhinosinusitis. He developed what he previously had not had, that is bleeding, that at times was a virtually daily occurrence in addition to worsening extension [sic] of increasing severity of the symptoms that were there prior to August. Now, to me, that is a worsening of the syndrome that he had prior to August, which I believe, again, was related to his work exposure....If the symptoms get worse, which are the correlation of the -- the symptomatic correlate of the signs that the physician sees, one must conclude that the process causing them also worsened."

Dr. Montanaro examined claimant on March 13, 1986, at the request of the insurer. His testimony regarding the correlation between an increase in symptoms and a worsening of the underlying condition is ambiguous. Early in his testimony he stated:

> "Well, I feel that ... irritant exposures, either in the workplace or away from the workplace, may result in a significant worsening of -- of symptoms. Symptoms do not imply that there are -- there are underlying significant pathologic changes. We have individuals who have runny noses, sneezing, who, if you go in and look at them have very little in the way of pathologic changes. If you biopsy that tissue, it would not show any significant pathologic changes." (Emphasis added).

Later in his testimony, Dr. Montanaro opined "that a change in a physiologic condition from minute to minute or day to day may not result in a long term change in a disease or a condition...." (Emphasis added).

The insurer cites Dr. Montanaro's testimony in support of the proposition that claimant suffered only an exacerbation of symptoms and not a worsening of his underlying rhinitis condition. We conclude, however, based upon the foregoing, that Dr. Montanaro was of the opinion claimant did suffer a worsening of his condition albeit a worsening that was neither "significant" nor "long term."

In Weller v. Union Carbide, supra, 288 Or at 36 (1980), the Supreme Court considered the question whether a worsening need be "significant" in order to be compensable. The Court concluded that it need not be "significant." Instead, the Court reasoned that a worsening was compensable if it either requires medical services or results in disability. See former ORS 656.005(8), 656.802(1)(a) and 656.804. Similarly, the Court concluded that a worsening need not be permanent in order to be compensable. Rather, a temporary worsening is compensable so long as it requires medical services or results in temporary disability. Id.

Claimant missed no work as a result of the worsening of his rhinitis. However, he did require the medical services of Drs. Parosa and Eschelman in order to treat his worsened condition. We conclude that claimant has proven a worsened condition requiring medical services.

We must next determine whether claimant's exposure to dust in the workplace was the major contributing cause of this worsened condition. Aware of all potential causes in claimant's case, Dr. Parosa is of the opinion that claimant's exposure to irritants at work is the major contributing cause of his rhinitis. He bases the causal connection on the history by claimant and the testimony of other witnesses of significant exposure to irritant particulates in the work place. He also relies, in part, on the resolution of the symptoms after claimant left that environment.

Dr. Montanaro disagrees with Dr. Parosa to the extent

that Dr. Parosa believes claimant's work exposure was the major contributing cause of claimant's chronic rhinitis condition. Dr. Montanaro opines that claimant's chronic condition was predominantly caused by nonwork exposures rather than work exposures. However, as earlier noted, Dr. Montanaro himself opines that claimant's work exposures resulted in an aggravation of his symptoms. While he further opines that those exposures did not result in a "significant" worsening of his underlying condition, his opinion nevertheless acknowledges a work-related worsening. We have previously concluded that the worsening was sufficient to require medical services. Consequently, Dr. Montanaro's testimony supports the conclusion that the worsening is compensable.

Even if we were to interpret Dr. Montanaro's testimony as not supporting workplace exposures as the major cause of a worsening of claimant's underlying rhinitis condition, we would nevertheless find Dr. Parosa's opinion on this issue more persuasive than that of Dr. Montanaro. We are influenced by several factors.

On reconsideration, we question the diagnostic advantage obtained by Dr. Montanaro's single visit to the work site. Like the Referee, we are unpersuaded that the conditions observed by Dr. Montanaro necessarily represented the work conditions under which claimant typically worked. The credible lay testimony of claimant and other mill employees describes conditions which are significantly more dusty than those observed by Dr. Montanaro.

We also attach little persuasive value to the fact that documented dust levels at the mill did not exceed the allowable limit. We first note that the workplace testing was undertaken several months following the date when claimant left his employment. In addition, the mere fact that dust levels were within legal limits does not mean that the dust did not cause an aggravation of claimant's rhinitis condition. See Palmer v. SAIF, 78 Or App 151, 155 n.4 (1986) (court unpersuaded by fact that sawdust levels only 7 to 13 percent of allowable Oregon limit). In this regard, both doctors agreed that some individuals are more sensitive to such substances and could show a reaction to particulates at the level shown on the test.

In addition, in the process of comparing work exposures with off-work exposures, Dr. Montanaro noted several off-work factors the significance of which we question. For example, Dr. Montanaro notes in a March 24, 1986 report that claimant maintains dogs and gerbils in his home and that he also has farm animals in his immediate environment. He subsequently testified that the presence of an allergy to animals would be a significant finding. However, Dr. Montanaro subjected claimant to a complete allergy profile which disclosed no evidence of allergy to animals.

Dr. Montanaro also noted that claimant heated his home with a woodstove. While Dr. Parosa agreed that a home heated by wood burning could be dry and that this dryness could aggravate an existing respiratory condition, he further opined that the most significant problem created by use of a wood-burning stove is a resultant indoor concentration of pollutants. However, he explained that the fact claimant resided in a very old, drafty house would mitigate this problem.

Moreover, in his March 24, 1986 report, Dr. Montanaro

noted a possible association between claimant's chronic rhinitis and both his nasal-septal deviation and his right antral mucosal cyst. However, he testified that very few people are free of a nasal-septal deviation. He suggested that a "pronounced" deviation would be required to produce symptoms, but he did not express an opinion as to the degree of claimant's deviation. Similarly, he testified that the significance of a mucosal cyst is limited and, in addition, that many individuals who have mucosal cysts experience absolutely no symptoms.

In sum, we conclude that Dr. Montanaro's testimony supports our determination that claimant's work exposure was the major contributing cause of at least a temporary worsening of his rhinitis condition. Alternatively, to the extent Dr. Montanaro might be interpreted as opposing such a determination, we conclude that his testimony is less persuasive than that of Dr. Parosa.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered in this matter. ORS 656.382(2); 656.386(1). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). Yet, we cannot award such a fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Inasmuch as no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Board's Order on Review dated June 30, 1987 is vacated. The Referee's order dated October 21, 1986, as amended on November 7, 1986, is affirmed. The insurer's denial dated February 7, 1986 is set aside and the claim is remanded to the insurer for processing according to law.

Board Member Ferris, dissenting:

Because I would conclude that claimant has failed to prove that work place exposure to dust was the major cause of a worsening of a preexisting rhinitis condition, I dissent.

The majority finds that Dr. Parosa is more persuasive than Dr. Montanaro. I would conclude otherwise. Dr. Montanaro is a Board-certified allergist and immunologist. Dr. Parosa is not Board-certified. Dr. Montanaro personally inspected claimant's work site. Dr. Parosa did not. Moreover, Dr. Parosa's impression that claimant's work place was consistently "very dusty" is at odds with documentary studies of the work site, as well as the personal observations of both Dr. Montanaro and Mr. Scott, an industrial hygienist. In addition, Dr. Parosa did not offer a persuasive explanation why he felt that claimant's work place was the major cause of his condition when he admitted that claimant was regularly exposed to a wide variety of irritants off the job.

Nor does the majority address the fact that claimant's symptoms continued for three months after he left the work site. In this regard, Dr. Montanaro stated that symptoms of irritant rhinitis will usually subside once exposure to the irritant is discontinued. By contrast, Dr. Parosa did not offer an explanation regarding why claimant's symptoms continued after he left the work site. Further, when his treatments proved ineffective, Dr. Parosa referred claimant to Dr. Eschelman, who diagnosed a deviated septum and a mucosal cyst. Dr. Eschelman

found no evidence of sinusitis. In light of his diagnosis, Dr. Eschelman discontinued the antibiotics claimant was taking and prescribed treatment which eventually effected a cure.

Based upon the foregoing, I would conclude that claimant has failed to sustain his burden of proof. The insurer's denial should be reinstated and upheld.

TORIA S. BENSON, Claimant
Jolles, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-14056 & 84-01712
January 12, 1989
Order on Reconsideration

The self-insured employer, claimant (pro se), and claimant's former attorney, have each requested reconsideration of the Board's Order on Review dated June 21, 1988, which, inter alia: (1) found claimant's neck, back, bilateral shoulder, and injury-related psychological stress conditions compensable; (2) found her occupational disease claim for an alleged chemical sensitivity condition not compensable; and (3) found her occupational disease claim for a psychological stress condition timely filed, but not compensable. On July 5, 1988, the Board abated its order. Thereafter, claimant requested the Board to deconsolidate and remand her chemical sensitivity claim to the Hearings Division.

Claimant's former attorney has requested an attorney fee for his services rendered at the hearing. Pursuant to ORS 656.005(19) and Adams v. Transamerica Insurance, 45 Or App 769, 774 (1980), we find that claimant's former attorney lacks standing to request reconsideration. Accordingly, we do not reach the merits of his request.

Claimant has requested deconsolidation and remand of her chemical sensitivity claim. We decline to grant her requests. ORS 656.295(5) & (6).

Accordingly, on reconsideration, the Board adheres to and republishes its former order as amended, effective this date.

IT IS SO ORDERED.

HUN J. KIM, Claimant
Welch, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 86-09851
January 12, 1989
Order Denying Request

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 19, 1988 Order on Review. The request is denied.

FINDINGS

On February 19, 1988, the Board affirmed the Referee's order that upheld the insurer's denial of claimant's injury claim. The Board's order did not address the issue of a client-paid fee.

On March 18, 1988, claimant appealed the Board's February 19, 1988 order to the Court of Appeals.

On May 31, 1988, the insurer's counsel sought authorization of a client-paid fee for services rendered on Board

review. The request did not include an executed retainer agreement.

CONCLUSIONS

Pursuant to ORS 656.295(8), a Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. The time within which to appeal an order continues to run, unless the order has been abated, stayed, or republished. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

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

Relying upon these authorities, we have previously held that we have jurisdiction to consider requests for authorization of client-paid fees where our final or appealed orders did not address the issue of either the counsel's entitlement to, or the amount of, a client-paid fee. Jane E. Stanley, 40 Van Natta 831 (1988); Franklin Brown, 40 Van Natta 786 (1988). However, we have concluded that to receive authorization, the request must be in compliance with Board rules. Stanley, supra; Brown, supra.

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

Here, the authorization request has been accompanied by a statement of service. However, neither an executed retainer agreement nor an attorney referral letter has been submitted. Under such circumstances, authorization cannot be given. See OAR 438-15-010(1). Even had acceptable documentation establishing legal representation been submitted, the request would still not receive our authorization. We reach this conclusion because the insurer's counsel's request has been submitted more than 3 months after the issuance of the Board's February 19, 1988 order. See Franklin Brown, supra.

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

Accordingly, because the request for a client-paid fee is untimely and since jurisdiction to consider the merits of the case presently rests with the Court of Appeals, we decline to authorize the insurer's counsel's request. In so doing, we wish to stress that we are neither questioning the insurer'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.

SUSAN K. COOK, Claimant
Kelley & Kelley, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-15817
January 13, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Huff's order that: (1) set aside its partial denial of chiropractic treatments in excess of the guidelines set forth in OAR 436-10-040(2)(a); and (2) assessed a penalty and associated attorney fee for the insurer's alleged unreasonable claims processing. Claimant failed to timely file her respondent's brief. We affirm on the medical services issue and reverse on the penalty and attorney fee issue.

ISSUES

1. Medical Services. Whether claimant has proven by a preponderance of the evidence that chiropractic treatments in excess of two per month are reasonable and necessary?

2. Penalty and Attorney Fee.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact as its own.

FINDINGS OF ULTIMATE FACT

Claimant's current chiropractic treatments in excess of two per month are reasonable and necessary as relates to her right arm condition.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The insurer argues on review that none of Dr. Durrant's reports contain any opinion justifying chiropractic treatments in excess of two per month. We do not agree. While Dr. Durrant's reports do not expressly defend a treatment frequency in excess of two per month, those reports do explain the need for claimant's current treatment regimen. That regimen involves treatments in excess of two per month. Therefore, by necessary inference, Dr. Durrant's reports do justify treatments in excess of two per month. Moreover, contrary to the insurer's assertion, Dr. Durrant did respond to Dr. Duncan's August 19, 1987 report. See Ex. 11a.

Subject to the foregoing supplementation, the Board adopts the Referee's opinion on the medical services issue.

Penalties and Attorney Fees

The Referee assessed a penalty and associated attorney fee for unreasonable denial. More specifically, the Referee found

that, on its face, the denial does not provide reasonable justification for denying or refusing to pay for the chiropractic treatment directed at claimant's right arm condition.

The insurer requested reconsideration. It argued that Dr. Duncan's August 19, 1987 report provided a reasonable basis for the denial.

On reconsideration, the Referee reaffirmed his prior decision with some clarification. The Referee explained that the penalty and attorney fee award were not imposed because of an "unreasonable denial" but, rather, were imposed for "unreasonable refusal to pay for treatment directed to the right arm in the absence of a formal denial."

We find that the award of a penalty and associated attorney fee is not proper under either theory. With regard to the "unreasonable denial" theory, we argee with the insurer that Dr. Duncan's August 19, 1987 report did provide a reasonable basis for the denial. With regard to the "unreasonable refusal to pay" theory, so far as the record discloses, claimant did not request a penalty or associated attorney fee for the insurer's failure to issue a formal denial of the right arm condition. Instead, claimant's argument, as evidenced by her response to the insurer's motion for reconsideration, was that the medical evidence was insufficient to support a denial. As stated above, we do not agree.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. ORS 656.382(2). Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, claimant's brief on review was not timely submitted. An untimely brief does not qualify as "legal representation...for the claimant...[upon] review on appeal." See 656.382(2). Therefore, the filing of an untimely brief does not create entitlement to an insurer-paid attorney fee. Shirley M. Brown, 40 Van Natta 879 (1988). We conclude that claimant's counsel is not entitled to award of an insurer-paid attorney fee on review.

ORDER

The Referee's order dated Janaury 6, 1988, as reconsidered February 2, 1988, is affirmed in part and reversed in part. That portion of the Referee's order that assessed a penalty and associated attorney fee for failure to issue a formal denial is reversed. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $806.

GROVER JOHNSON, Claimant
Jack Ofelt, Jr., Claimant's Attorney
Randolph Harris (SAIF), Defense Attorney

WCB 88-12065
January 13, 1989
Order Denying Motion to Dismiss

The SAIF Corporation has moved for an order dismissing claimant's request for Board review, contending that claimant has not timely filed a request for review in accordance with statutory requirements. We deny the motion.

FINDINGS

The Referee's order was dated November 4, 1988. The order was issued by Referee Barry Bennett. The Referee declined

to grant claimant's request for permanent total disability, but awarded 35 percent unscheduled permanent disability for a back condition.

On November 28, 1988, claimant mailed, by certified mail, a request for review to the Board. The request stated that claimant was asking the Board to review the "Opinion and Order of Referee Barry Bennett, dated November 4, 1988 in its entirety as the decision was contrary to medical evidence." The request indicated that copies had been provided to all parties to the proceeding before the Referee.

The request carried an inaccurate case number. Specifically, the request referred to "WCB Case No. 79-8210." Inasmuch as claimant had no other case numbers with the Board and because the request expressly referred to Referee Bennett's November 4, 1988 order, the request was processed as a request for review of the Referee's order in WCB Case No. 88-12065. On December 1, 1988, the Board mailed a computer-generated letter to the parties acknowledging the request for review in WCB Case No. 88-12065.

ULTIMATE FINDINGS

Claimant requested Board review of the Referee's November 4, 1988 order within 30 days of its issuance. All parties received notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). The necessary function of notice statutes is to inform the parties of the issues in sufficient time to prepare for an adjudication. Nollen v. SAIF, 23 Or App 420, 423 (1975) rev den (1976).

Here, SAIF asserts that claimant's request does not constitute a request for review because it does not refer to the correct WCB Case number. We disagree.

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(1). Claimant's request satisfies this statutory requirement. Admittedly, the request does not refer to the correct WCB case number. See OAR 438-11-005(3). Yet, claimant has no other case number with the Board.

This latter point distinguishes this case from the situation presented in Orville L. Carlson, 37 Van Natta 30 (1985), upon which SAIF relies. In Carlson, a Referee had issued two orders carrying separate WCB case numbers involving the same two

parties. The appellant mistakenly requested review of the wrong WCB case number and the wrong order. Since the appellant had prevailed in the order that it was appealing, the Board concluded that the appellant was not an aggrieved party. Therefore, the appellant's request for review was dismissed.

Here, in contrast, there was only one WCB case number involving these parties and only one Referee's order had issued. Moreover, claimant's intention was both clear and unambiguous. He sought Board review of Referee Bennett's November 4, 1988 order because "the decision was contrary to the medical evidence." Inasmuch as this request reflected claimant's desire to appeal, as an aggrieved party, a specific Referee's order, we consider it to be a request for Board review of that decision. See ORS 656.295(1). Consequently, we have jurisdiction to consider this matter. ORS 656.289(3); 656.295(2).

Finally, we note that the Board's acknowledgment letter carried the correct WCB case number. Since this acknowledgment was mailed to all parties to the hearing some 3 days before the expiration of the 30-day appeal period, we conclude that it is more probable than not that SAIF and its insured received timely actual notice of claimant's request for review under the correct WCB case number. See John D. Francisco, 39 Van Natta 332 (1987); James L. Sampson, 37 Van Natta 1549, 1550 (1985).

Accordingly, the motion to dismiss is denied. Once a transcript is obtained and copies are distributed to the parties, a briefing schedule will be implemented. Upon completion of the briefing schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

JAMES D. SHIRK, Claimant
David Hollander & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-08181
January 13, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee Knudsen's order that affirmed a Determination Order that awarded no unscheduled permanent disability for his two left arm injuries. The insurer cross-requests review of those portions of the Referee's order that: (1) declined to adjust claimant's medically stationary date as established by Determination Order; and (2) declined to authorize an offset of overpaid temporary disability benefits against future awards of permanent disability, if any. We affirm on the extent of disability issue, and reverse on the medically stationary date and offset issues.

ISSUES

1. Extent of permanent disability, if any, attributable to claimant's compensable injuries.

2. Medically stationary date.

3. Offset.

FINDINGS OF FACT

Claimant, a 54-year-old mill laborer, was involved in an off-work auto accident in February 1984. Following the accident, he reported headaches, neck pain, pain radiating to both shoulders and arms with paresthesia and a tendency to drop objects due to weakness, particularly in the right hand. A myelogram performed on July 2, 1984 disclosed severe arthritic changes resulting in compression of the nerve roots bilaterally at C4-5 and C5-6. In July 1984, Dr. Berkeley, neurosurgeon, performed a cervical diskectomy and interbody fusion at C4-5 and C5-6.

Following surgery, claimant reported significant right arm improvement. However, he continued to experience considerable weakness in the abduction and elevation of his left arm.

Claimant returned to work in early 1985. He was examined by Dr. Berkeley on February 4, 1985, at which time he reported pain upon lifting. Claimant was again examined by Dr. Berkeley on May 3, 1985, at which time he reported "some problems last month." These reported problems included headaches and spasms of the neck and shoulders.

On June 6, 1985, claimant suffered neck, left shoulder and left arm pain after lifting some planks at work. He missed no time from work following this incident. Claimant was again examined by Dr. Berkeley on June 21, 1985. Dr. Berkeley noted new symptoms and diagnosed either a "traction injury to his nerve roots in his neck" or "a small hemorrhage in the nerve root sleeves."

On July 3, 1985, claimant was tossing wood from a conveyer belt into the bed of a truck when a piece of wood, weighing approximately 45 pounds, caught on his glove yanking his left arm away from his body. He was pulled to the ground. He experienced pain in his neck and left arm.

Claimant did not immediately return to Dr. Berkeley. Instead, he saw Dr. Selvaggi, M.D., that same day. Dr. Selvaggi diagnosed an arm sprain and chronic neck pain. He reported that claimant was not released to work.

Claimant filed a claim on July 5, 1985 for "left neck, torn muscle." His claim was accepted by the insurer. Payment of temporary total disability benefits was commenced.

Dr. Berkeley examined claimant on August 1, 1985. He reported "[s]ome painful elevation-abduction of the left arm and proximal weakness in the left deltoid region as before." He advised that claimant consider either early retirement or retraining for a very sedentary job.

Claimant was examined by Dr. Howell, osteopath, on October 7, 1985. He reported on October 10, 1985 that claimant was medically stationary.

Claimant began treating with Dr. Rath, M.D., shortly before March 1986. Dr. Rath reported on March 17, 1986, that he concurred with Dr. Howell's report.

A Determination Order issued on April 25, 1986, awarding

temporary total disability but no permanent disability. A medically stationary date of March 17, 1986 was established. However, the insurer continued to pay temporary disability benefits through May 8, 1986.

Claimant was provided vocational rehabilitation assistance, through which he eventually returned to work in May 1986 as a security guard. This work placed few demands on his left arm.

Claimant moved to Arizona in August 1987, one month following receipt of a $115,000 third-party settlement of his automobile accident claim. He is not presently working.

Claimant attended school through the ninth grade. In addition to approximately five years employment as a mill laborer, claimant worked in a mobile home manufacturing plant for 18-1/2 years. Claimant is not physically capable of performing either of these jobs.

Claimant continues to experience difficulty lifting objects with his left hand. At hearing, claimant demonstrated the weakness in his arm by lifting the hearing microphone 1/4 inch off the table and a box of tissues 5/8 of an inch from his thigh. He continues to take muscle relaxants in order to avoid left arm muscle spasms. He continues to drop objects from his left hand. He has difficulty putting on his clothes and driving a stick shift car. His symptoms worsened considerably during the eight months prior to hearing in December 1987.

FINDINGS OF ULTIMATE FACT

As of October 10, 1985, no further material improvement in claimant's condition would reasonably be expected from medical treatment, or the passage of time.

We are unable to find that claimant's current left arm complaints are materially related to his 1985 work injuries or that those injuries resulted in any permanent impairment.

Claimant is not a reliable witness.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability, if any, Attributable to 1985 Injuries

Claimant unquestionably suffers some permanent disability. The question, however, is whether that disability is attributable to his 1984 off-work traffic accident, his preexisting osteoarthritic condition, his 1985 work injuries, or a combination of these factors.

Claimant relies upon two factors to establish that at least a portion of his current disability is related to his 1985 work injuries. First, he relies upon the opinions of Dr. Berkeley. Second, he relies upon the fact that he was able to perform his mill work prior to the 1985 injuries and he was unable to perform those duties subsequent to his injuries.

Dr. Berkeley opined in a November 8, 1985 letter to claimant's attorney that claimant's June 1985 injury was an

aggravation of his preexisting cervical spondylosis. Dr. Berkeley attributed 75 percent of claimant's then disability to the 1984 traffic accident and 25 percent to the June 1985 work incident. Dr. Berkeley's reference to the June 1985 incident was apparently in error; the medical record and claimant's testimony establish that the July 1985 incident, not the June incident, was the more traumatic of the two injuries.

Opposing Dr. Berkeley's opinions are those of Dr. Howell. In his October 10, 1985 report, Dr. Howell listed his conclusions in the form of five "Impressions." He reported that there was not sufficient evidence to conclude that claimant's preexisting severe osteoarthritis was materially worsened by his occupational activities. He noted that claimant's current complaints were present prior to June 1985, and that prior to June 1985 claimant attributed those complaints to his 1984 motor vehicle accident. He further concluded that claimant exhibited no permanent disability attributable to his occupational activities.

Claimant argues that we should defer to Dr. Berkeley's November 8, 1985 report over Dr. Howell's October 10, 1985 report. Dr. Berkeley was claimant's treating physician. 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). We find several persuasive reasons to discount Dr. Berkeley's opinions.

Foremost among these is claimant's unreliability as a historian. Claimant testified that he could not recall whether he had sought further medical treatment between the time of his return to work in January 1985 and his first work incident in June 1985. Nor did he recall whether he had any problem lifting his arm during the same period. However, the record discloses that claimant continued to experience left arm difficulties during this period and, on at least two occasions, he sought further medical treatment from Dr. Berkeley for these problems.

Whereas claimant tended to underestimate his pre-June 1985 difficulties, he appeared to overstate his post-July 1985 problems. In this regard, Dr. Berkeley opined in November 1985 that claimant's impairment was moderately severe. However, in a contemporaneous vocational rehabilitation report, claimant's counselor reported that claimant was driving a full-sized school bus on Sundays for his church. Claimant also continued to go hunting, albeit in a less physically-demanding manner than prior to his 1984 traffic accident. Claimant's counselor also reported that claimant, with the aid of others, was loading scrap metal into a truck for resale.

There is no indication that Dr. Berkeley was aware of these activities on claimant's part. Dr. Berkeley's opinions regarding the causation of claimant's complaints rendering continued mill work impossible is necessarily dependent upon the information he receives from claimant. To the extent that information is unreliable, the persuasiveness of Dr. Berkeley's opinions is reduced.

By contrast, Dr. Howell's October 10, 1985 report contains a detailed and accurate history. In addition, Dr. Berkeley subsequently indicated that he "essentially" agreed with Dr. Howell's report. Claimant notes in this regard that Dr. Berkeley also stated:

"[I]t is my opinion that [claimant's] neckache and left arm pain have been aggravated by his [work] activities...and in fact, it is the result of these activities that prevented [claimant] from continuing with his work as his pain increased to an intolerable level and I had to take him off work."

It is unclear from this quote whether Dr. Berkeley felt that this "aggravation" represented a permanent worsening of claimant's condition caused by his work activities, or, in the alternative, whether claimant's work activities temporarily worsened claimant's symptoms so that he was unable to continue his duties as a laborer. We are unable to resolve the ambiguities in his opinion in claimant's favor.

Moreover, claimant began treating with Dr. Rath, M.D., in early 1986. Dr. Rath treated claimant more than ten times between June 1986 and July 1987. Dr. Rath reported that he was "in complete agreement" with Dr. Howell's report, "especially in regards to #1 - #5 impressions."

Claimant's second argument is that he was able to return to work following his 1984 traffic accident, but that he was unable to work following the June and July 1985 incidents. However, claimant suffers from severe degenerative osteoarthritis. Even prior to June 1985, Dr. Berkeley was skeptical of claimant's ability to return to his former employment. Subsequent to the 1985 work incidents, Dr. Berkeley felt that claimant, due to his preexisting condition, would continue to suffer symptomatic aggravations if he attempted to return to his former employment.

We conclude that claimant's work injuries rendered him temporarily disabled for which he received temporary disability benefits. However, the preponderance of the medical evidence does not support the proposition that claimant suffered permanent disability as a result of the 1985 work incidents. We conclude that claimant has failed to prove that his 1985 work injuries were a material contributing cause of a permanent worsening of his preexisting, symptomatic osteoarthritic condition. Claimant has also failed to prove that his June and July 1985 work injuries independently resulted in any permanent impairment. Consequently, he has failed to sustain his burden of proof of any permanent disability due to his compensable work injuries.

Medically Stationary Date

On November 8, 1985, Dr. Berkeley reported that claimant was medically stationary as of October 10, 1985. Dr. Howell reported on October 10, 1985 that claimant was medically stationary. Moreover, claimant concedes in his brief that he was medically stationary on October 10, 1985. We conclude that the April 25, 1986 Determination Order incorrectly established March 12, 1986 as the medically stationary date. Rather, claimant's condition as a result of his accepted 1985 injuries was medically stationary as of October 10, 1985.

Offset

At hearing, the insurer requested an offset against

permanent disability for overpaid temporary disability. The parties stipulated that claimant was overpaid temporary disability for the period from March 17, 1986 to May 8, 1986. Moreover, in light of our above discussion establishing an earlier medically stationary date, the insurer overpaid temporary disability for the period from October 10, 1985 through March 17, 1986. We conclude that the insurer is entitled to an offset of overpaid temporary disability during these periods against any future awards of permanent partial disability. See Berliner v. Weyerhaeuser Company, 92 Or App 264 (1988) (offset authorization continues in effect until revoked or overpayment wholly recovered).

ORDER

The Referee's order dated January 15, 1988 is affirmed in part and reversed in part. That portion of the Referee's order which upheld the April 25, 1986 Determination Order's award of no permanent disability is affirmed. However, that portion of the Determination Order which established a March 17, 1986 medically stationary date is set aside. The correct stationary date is established as October 10, 1985. The insurer is allowed an offset of temporary disability paid beyond that date against future awards of permanent disability on this claim, if any. A client-paid fee, not to exceed $756, is approved.

WILLIAM N. SUYDAM, Claimant
Velure & Yates, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney

WCB 86-03674
January 13, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Hettle's order that: (1) upheld the SAIF Corporation's denial of his reflux esophagitis and duodenal ulcer conditions as unrelated to his compensable injury; and (2) modified the medically stationary date established by Determination Order. On review, we affirm.

ISSUES

1. Compensability of claimant's stomach condition. Whether stress resulting from claimant's compensable 1981 injury was a material contributing cause to the development of his reflux esophagitis and duodenal ulcer conditions?

2. Medically stationary date.

(a) Whether the Referee had jurisdiction to modify the medically stationary date established by Determination Order?

(b) Whether, on the merits, the Referee's decision regarding the medically stationary date was correct?

FINDINGS OF FACT

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

Claimant's December 2, 1987 Request for Hearing specified premature claim closure resulting from a November 19, 1987 Determination Order as an issue to be decided at hearing. SAIF orally asserted at hearing that claimant was stationary prior to the date established in the Determination Order.

As of June 1, 1987, claimant's medical condition resulting from his accepted April 1981 injury was such that no further material improvement would reasonably be expected from medical treatment, or the passage of time.

Claimant's compensable 1981 injury was not a material contributing cause of the development of his stomach conditions.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

(a) Jurisdiction

Claimant argues that SAIF did not timely raise the issue of the date of claimant's medically stationary status, and, therefore, that the Referee lacked jurisdiction to modify the medically stationary date established by the November 19, 1987 Determination Order. We do not agree.

Claimant raised the issue of premature closure in his request for hearing. At hearing, the Referee stated that SAIF had raised a cross-issue, asserting that claimant was medically stationary prior to the date established by Determination Order. This statement apparently followed a prehearing discussion of the issues.

We conclude that the issue raised by SAIF was the same as that raised by claimant's Request for Hearing: When was claimant medically stationary? See Carl L. Bohrer, 39 Van Natta 108, 109 (1987). Consideration of the issue by the Referee was, therefore, proper.

Moreover, claimant raised no objection at hearing to the Referee's statement of the issues. In this regard, then-temporary rule OAR 438-06-037 provided that "[a] party may waive objection to lack of notice,..., of any issue raised at hearing." Following conclusion of the hearing, and prior to issuance of the Referee's order, OAR 438-06-037 became effective as a permanent rule of the Board. We conclude that, even assuming SAIF untimely raised the stationary date issue, claimant's failure to object at hearing to consideration of this issue amounts to a waiver of objection.

(b) Merits

Claimant argues on review that he was not medically stationary because he could not return to his former work. This is not a correct statement of the law. An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Pursuant to this standard, a worker's ability to return to his former employment is irrelevant.

Subject to the foregoing comment, we adopt the Referee's opinion regarding the merits of the medically stationary date issue.

Compensability

We adopt the Referee's opinion on this issue.

ORDER

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

ROBERT BARNES, Claimant
Malagon & Moore, Claimant's Attorneys
Nancy Marque (SAIF), Defense Attorney

WCB 87-04911
January 17, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of those portions of Referee Baker's order which: (1) set aside its denial of claimant's temporary total disability (TTD) benefits while he is incarcerated; and (2) awarded claimant an insurer-paid attorney fee for prevailing over the denial of TTD. In his brief, claimant cross-requests review of the remaining portion of the order which declined to assess a penalty and attorney fee for the allegedly unreasonable denial of TTD.

ISSUES

1. Unilateral termination of TTD benefits during incarceration.

2. Assessment of attorney fee for prevailing over denial of TTD.

3. Assessment of penalty and attorney fee for allegedly unreasonable denial of TTD.

We reverse on the penalty and related attorney fee issue, modify on the attorney fee issue, and affirm on the unilateral termination issue.

FINDINGS OF FACT

We adopt the Referee's findings of fact in the third and fourth paragraphs of his order, with the following supplementation. SAIF had no legitimate doubt of its liability for commencing and continuing payment of TTD benefits.

CONCLUSIONS OF LAW AND OPINION

Unilateral Termination of TTD

On review, SAIF contends that claimant is not entitled to TTD benefits during incarceration, because he is not substantively entitled to such benefits under Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). We need not consider that contention, however, because, like the Referee, we conclude that SAIF's denial of TTD was an impermissible unilateral termination of benefits.

It is undisputed that claimant was totally disabled beginning February 20, 1987 through more than 14 days thereafter. Consequently, claimant was entitled to TTD benefits for disability suffered beginning February 20, 1987, the first day of disability. ORS 656.210(3). SAIF was responsible for paying those benefits no later than the 14th day after the employer's notice or knowledge of the disability. ORS 656.262(4). Yet, SAIF refused to begin paying benefits, because claimant was incarcerated almost immediately after he was taken off work. SAIF's denial was, in effect, a unilateral termination of benefits.

Once claimant became entitled to TTD benefits, SAIF was not permitted to terminate those payments until claimant was medically stationary and either he returned to regular work, was released for regular work or the claim was closed. ORS 656.268(1), (2); Fazzolari

v. United Beer Distributors, 91 Or App 592, 595, 93 Or App 103, (1988) rev den 307 Or 236 (December 20, 1988). It is undisputed that claimant was not yet medically stationary when SAIF issued its denial of TTD. The claim, which SAIF accepted for a disabling injury, was not closed, and claimant neither returned to nor was released for regular work.

SAIF was not entitled to withhold benefits unilaterally. Rather, SAIF should have paid benefits until authorized to terminate such payments. SAIF did not avail itself of its right to request a hearing under ORS 656.283(1) and, instead, resorted to self-help. That is impermissible. Northrup King & Co. v. Fisher, 91 Or App 602, 606 (1988).

Attorney Fee

The Referee awarded claimant an insurer-paid attorney fee for prevailing on the denial of TTD. That is impermissible. Claimant is not entitled to an ORS 656.386(1) attorney fee, because those fees are assessed when claimant has prevailed over a decision rejecting a claim. Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988). In this case, claimant's disabling injury claim was accepted. The issue was what benefits he is entitled to under the accepted claim. Therefore, we have no authority to grant an assessed fee.

Because claimant was awarded TTD benefits after a hearing that he requested, the Referee should have approved a fee of 25 percent of the increased TTD compensation, but not more than $750. See former OAR 438-47-030(1). We modify accordingly.

Penalty and Attorney Fee

The Referee declined to assess a penalty and attorney fee, finding that SAIF acted reasonably because it had sufficient doubt of its obligation to pay TTD benefits under the circumstances. We disagree.

ORS 656.262(10) provides that an insurer is liable for a penalty and attorney fee, if the insurer unreasonably refuses to pay compensation. Here, SAIF's decision to withhold TTD benefits was based on its belief that claimant was not entitled to TTD because he had removed himself from the labor force. However, the issue of claimant's entitlement to TTD while incarcerated should be addressed at the time of claim closure. Claimant's disability began before he was incarcerated. Hence, he was clearly entitled to begin receiving TTD under ORS 656.210(3), and it could not be terminated except in accordance with the procedures in ORS 656.268. Yet, SAIF ignored these statutory procedural safeguards in withholding benefits. SAIF could not have had any legitimate doubt of its liability for commencing and continuing payment of TTD benefits; therefore, its unilateral refusal to pay compensation was unreasonable. Petersen v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986). Claimant is awarded a penalty of 25 percent of the entire amount of unpaid TTD benefits, and a related attorney fee.

ORDER

The Referee's order dated July 7, 1987 is reversed in part, modified in part, and affirmed in part. That portion of the order that awarded claimant an assessed fee of $1,400 is modified. Claimant's attorney is awarded 25 percent of the increased

compensation created by the Referee's order, not to exceed $750. Claimant is awarded a penalty of 25 percent of the unpaid temporary disability benefits due pursuant to the Referee's order, and his attorney is awarded a reasonable penalty-related attorney fee of $600. The remainder of the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $750, to be paid by the SAIF Corporation.

VIRGIL BROGAN, Claimant
Peter O. Hansen, Claimant's Attorney
Ruth Cinniger (SAIF), Defense Attorney

WCB 86-12575
January 17, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Tenenbaum's order that found the "fireman's presumption" inapplicable and upheld the SAIF Corporation's denial of claimant's occupational disease claim for coronary artery disease. We affirm.

ISSUES

1. Whether the "fireman's presumption," former ORS 656.802(2), applies in the present case.

2. Whether claimant's claim for coronary artery disease is compensable.

FINDINGS OF FACT

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

Claimant underwent a physical in February 1963. He became a volunteer firefighter for the City of Lake Oswego in 1964.

Claimant's work activities were not the major contributing cause of either his coronary disease or his angina pectoris.

CONCLUSIONS OF LAW

We adopt the Referee's opinion on the merits, with the following comment. The Referee found that the "fireman's presumption" of ORS 656.802(2) did not apply for two reasons: (1) that claimant's physical examination occurred "almost six years before claimant became a firefighter . . ." and (2) the report generated from that physical examination was "so brief and conclusive that it would be speculative to assume that claimant was in fact examined with respect to the conditions [i.e., cardiovascular disease] referred to in the statute."

While we agree with the Referee that the "fireman's presumption" does not apply, we disagree with her reasoning. We agree that claimant's physical examination occurred at least ten months before he became a firefighter. Thus, the "fireman's presumption," which requires that a worker's physical occur "upon becoming a firefighter or subsequently thereto," is not applicable. The Referee, however, found that claimant's physical had occurred almost six years before he became a firefighter. The Referee apparently concluded that claimant did not "become" a firefighter until he began earning a salary with the City of Lake Oswego. We find that claimant "became a firefighter" upon assuming his volunteer post in 1964. The statute, on its face, does not to require the worker to be a salaried employee in order for the presumption to apply, and we cannot require more than does the statute.

Second, the Referee found that the report generated from claimant's physical examination was too conclusory to meet the statute's requirements. The Referee found that it would be speculative to conclude that the report, which merely stated that claimant was "in good health," included information regarding claimant's cardiovascular fitness. We disagree. In fact, we find that it would be speculative to conclude that claimant's physical examination did not include an evaluation of his major health factors, such as cardiovascular functioning.

We adopt the Referee's opinion with regard to her conclusion that claimant's claim for occupational disease was not compensable.

ORDER

The Referee's order dated June 4, 1987 is affirmed.

STOKES R. CROTTS, Claimant
Myrick, Coulter, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 87-05525
January 17, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of that portion of Referee Seymour's order which set aside its denial of claimant's temporary total disability (TTD) benefits while he is incarcerated. We affirm.

ISSUE

Unilateral termination of claimant's TTD benefits while incarcerated.

FINDINGS OF FACT

We adopt the Referee's findings of fact in the first through fourth paragraphs of the "FINDINGS AND OPINION" portion of his order, with the additional finding that claimant was not yet medically stationary when his TTD benefits were terminated.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions of law and opinion in the fifth through seventh paragraphs of the "FINDINGS AND OPINION" portion of his order, with the following supplemental comment.

On review, the insurer relies on the Board's decision in Ted W. Peckham, 39 Van Natta 1037 (1987), which applied the analysis in Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), to an incarcerated claimant and concluded that the claimant did not qualify as a "worker" for the purpose of receiving TTD benefits during incarceration. However, we note that that decision was abated for possible reconsideration and remains under advisement; it is not effective. Ted W. Peckham, 39 Van Natta 1176 (1987). We further note that the Peckham decision was limited to the issue of claimant's substantive entitlement to TTD benefits during incarceration; it does not address the present issue of claimant's procedural entitlement to benefits. The Court of Appeals recently resolved this latter issue in claimant's favor, holding that an insurer may not unilaterally terminate TTD benefits, except under the circumstances prescribed in

ORS 656.268. Northrup King & Co. v. Fisher, 91 Or App 602, 606 (1988).

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

ORDER

The Referee's order dated June 29, 1987 is affirmed.

HELEN DODGE, Claimant
Allan Coons, Claimant's Attorney
Ronald Pomeroy (SAIF), Defense Attorney

WCB 86-14549
January 17, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Mongrain's order that affirmed an Order of the Director of the Workers' Compensation Department which held that claimant was not entitled to further vocational assistance. We reverse.

ISSUE

Entitlement to vocational assistance.

FINDINGS OF FACT

Claimant, 43 years old at the time of hearing, injured her low back in 1977 while employed as a nurse's aide. A herniated disk was diagnosed. Conservative treatment was provided. In addition to her low back condition, claimant also suffered from severe obesity.

Claimant returned to work at modified duties in June 1978, pursuant to a three-month work subsidy program.

An August 1978 Determination Order awarded claimant 10 percent unscheduled permanent disability for her low back.

Claimant remained at work for a little over one year before quitting her job due to a combination of personal reasons and continuing back complaints. A short while later, in November 1979, her treating physician reported that claimant was unable to continue working.

In the next several years following her injury, claimant made three aggravation claims. She eventually received a total award of 20 percent unscheduled permanent disability.

In January 1982, claimant was hospitalized due to an acute exacerbation of her low back symptoms. Claimant was discharged from the hospital at the end of February 1982. This hospitalization resulted in one of her aggravation claims.

In June 1982, claimant was examined by Dr. Radmore, psychiatrist, who diagnosed a work-related depression. She recommended psychotherapy and medication. Claimant began treating with Dr. Radmore.

Claimant suffered an additional exacerbation of her low back symptoms in July 1982. She was hospitalized for approximately three weeks. Again, an aggravation claim resulted.

A hearing was held in August 1982 to consider, among other things, compensability of claimant's January and June, 1982 aggravation claims and compensability of her psychological condition.

A few months earlier, on June 10, 1982, the SAIF Corporation had referred claimant to Field Services Division for vocational assistance. Due to several delays, the hearing that had originally been convened in August 1982 was reconvened over one year later. During the interim period, on August 19, 1982, Field Services notified claimant that she was ineligible for assistance because she had left her employment for reasons unrelated to her injury. Claimant did not appeal this decision.

A November 1983 Referee's order found, inter alia, that claimant's aggravation claims were not compensable but that her psychiatric treatment was compensable. On review, the Board affirmed on these issues.

In February 1984, claimant underwent a stomach stapling operation. Resulting weight loss improved her psychological condition. However, Dr. Radmore reported that claimant's psychological condition was not yet stationary.

Claimant subsequently requested a hearing involving delayed payment of medical bills. Prior to hearing, the parties settled their differences pursuant to a May 1985 stipulation regarding "all issues raised or raisable by the claimant's request for hearing."

Claimant filed an aggravation claim in 1985. The Board issued an Own Motion Order finding that there had been no material worsening of claimant's condition. The Board noted that even if there had been an aggravation, payment of temporary disability would not be approved because claimant had not been gainfully employed in several years and it appeared she had removed herself from the work force.

On October 30, 1985, Dr. Radmore reported that claimant had lost nearly 100 pounds. She further reported that claimant was not medically stationary. She requested that vocational assistance be provided. She repeated this request in a March 17, 1986 letter to SAIF. By letter dated April 14, 1986, SAIF refused to provide assistance on the grounds that: (1) claimant had left suitable work for reasons unrelated to her injury; (2) her claim had been closed since 1980; (3) all issues raised or raisable had been stipulated to in 1985 and vocational assistance was not raised; and (4) the Board had found that claimant had not aggravated and had removed herself from the labor market.

Claimant appealed the denial to the Director.

The Director found that claimant's termination from employment in 1979 was not a proper basis for denying vocational assistance. He noted, however, that claimant had failed to raise the vocational assistance issue during the course of three hearings, two Board reviews, and one stipulation. He further noted that claimant had never appealed the Field Services' 1982 denial of eligibility. He concluded that claimant was ineligible to receive vocational assistance.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the Director's order. He emphasized the fact that, in August 1982, claimant was advised of her ineligibility for vocational assistance and did not appeal that decision. The Referee further noted that, pursuant to former ORS 656.283(2), the Director's decision was subject to modification only 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's decision was subject to none of these conditions.

Claimant's obligation to appeal the Field Services Division's 1982 denial of eligibility is central to this case. The Director stated that it is incumbent on a worker who is dissatisfied with a denial of vocational assistance to appeal that decision "at the earliest opportunity." The Referee agreed with the Director's decision except that he would "more strongly emphasize" claimant's failure to appeal the 1982 denial of eligibility. He further concluded that none of the circumstances noted in OAR 436-120-095 for restoring eligibility were present. He, therefore, affirmed the Director's decision.

We disagree with the Director and the Referee. Nothing in the statute prior to January 1, 1988, or in the applicable administrative rules, required claimant to contest an insurer or departmental vocational assistance denial within any particular time.

We note in this regard that ORS 656.283(2) currently provides as follows:

> "If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must first apply to the director for administrative review of the matter before requesting a hearing on that matter. Such application must be made not later than the 60th day after the date the worker was notified of the action...." (Emphasis added).

In accordance with the emphasized portion of this provision, a worker is currently required to apply for administrative review of vocational assistance actions of the insurer or self-insured employer within 60 days after notification of the decision. However, when claimant received notification of Field Services' decision, in August 1982, ORS 656.283 did not contain a limitation period. Instead, this limiting language was added by the 1987 legislature. 1987 Or Laws ch 884 § 11. We conclude, based upon the absence of such a limitations period in 1982, that claimant was not required to apply to the Director for review of Field Services' denial of eligibility within a particular time period.

We note an alternative basis for our decision. Pursuant to a Referee's order dated November 8, 1983, claimant's psychiatric condition was found to be compensably related to her 1977 injury. Consequently, her psychiatric claim was remanded to SAIF for further processing until closure pursuant to ORS 656.268. By Order on Review dated September 21, 1984, we affirmed the Referee's decision on this issue.

Claimant's treating psychiatrist, Dr. Radmore, continued to report as of October 30, 1985 that claimant's psychological condition was not yet medically stationary. Dr. Radmore requested that claimant receive vocational assistance. This request eventually resulted in the Director's order which upheld SAIF's denial of assistance. It is, therefore, apparent that claimant's claim was reopened in November 1983 for acceptance of claimant's psychiatric condition. Moreover, Dr. Radmore's request for vocational assistance was generated while the claim remained reopened. We conclude that, even assuming claimant's right to eligibility for vocational assistance ended with her failure to appeal the 1982 denial, nevertheless her eligibility was restored when her claim was reopened for acceptance of her psychological condition. See former OAR 436-120-040; 436-120-090; and 436-120-095.

SAIF contends that claimant's appeal of the denial of vocational assistance is barred by application of the doctrine of res judicata. SAIF argues in this respect that claimant could have raised the issue of her eligibility at the time of the June 6, 1985 Stipulation. SAIF further argues that, because the Stipulation settled all issues "raised or raisable" between the parties, claimant is precluded from raising the vocational issue now. However, the vocational issue was not raisable at the time of the Stipulation because there was no order of the Director ripe for review. ORS 656.283(2). Thus, res judicata is not a bar to claimant's claim.

In sum, we find that claimant was not time barred from contesting the Field Services Division's August 1982 denial of vocational assistance. Assuming arguendo that she was so barred, her eligibility was nevertheless restored pursuant to a Referee's November 1983 order which had the effect of reopening her claim. Moreover, the doctrine of res judicata is not applicable under the facts of this case. We conclude that none of the grounds stated in the Director's order are sufficient to deny vocational assistance.

No determination has yet been made as to whether claimant meets the requirements for eligibility. We find that the record is sufficiently developed so that we may address this issue. See David L. Fleming, 38 Van Natta 1321 (1986), aff'd mem Fleming v. Daeuble Logging, 89 Or App 87 (1987).

The eligibility standards in effect at the time claimant's entitlement to vocational assistance was first denied were found at former OAR 436-61-100 (renumbered 436-120-040). That rule required that claimant reside in Oregon. Claimant did, and still does, reside in Oregon. In addition, Dr. Radmore has opined that claimant requires vocational assistance in order to obtain new employment. No contrary evidence exists in the record. We conclude that claimant is unable to return to regular, modified, or new employment because of the permanent residuals of her compensable injury, and that she lacks sufficient skills, aptitudes or abilities to obtain new gainful employment. See former OAR 436-61-100(6)(c). Consequently, claimant is eligible for vocational assistance.

ORDER

The Referee's order dated June 16, 1987 is reversed. The SAIF Corporation's April 14, 1986 denial of eligibility for vocational assistance is set aside and SAIF is ordered to provide such services. Claimant's attorney is awarded an assessed fee of $800, to be paid by the SAIF Corporation.

MARK F. GILLES, Claimant
Galton, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney
Kevin Mannix, Defense Attorney

WCB 87-02778 & 87-02777
January 17, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Neal's order that: (1) set aside its denial of responsibility for claimant's low back and neck condition; and (2) upheld Aetna Insurance Company's denial of responsibility for the same condition. We reverse.

ISSUE

Responsibility for claimant's neck and low back conditions.

FINDINGS OF FACT

Claimant was a delivery driver for a Eugene furniture company, insured by Aetna. He was originally injured on January 29, 1986, when a sofabed fell from the back of his furniture delivery truck, striking him on the back. His low back began hurting immediately; shortly thereafter he developed headaches as well.

Claimant sought treatment from Dr. Carlstrom, chiropractor, on February 8, 1986. He continued to work until February 28, 1986. At that point, the pain made it impossible for him to continue working and, because he did not understand that he could take time loss, he quit. While he was not working, and was receiving treatment, his condition improved. Dr. Carlstrom anticipated that claimant would be medically stationary and fully recovered in July 1986.

On April 1, 1986, claimant began doing part-time, on-call labor for a landscaper. His job primarily involved pushing a lawn mower, and occasionally required him to shovel bark dust. His back and neck continued to bother him throughout this period, but did not worsen.

In July 1986, claimant moved to Portland and began working for a dairy, his field of training. The dairy is insured by Liberty Northwest. He began working for the dairy in August 1986 as a cheesemaker. Two days a week, claimant was involved in the actual cheesemaking process. This involved stirring 10,000-gallon vats of milk with a ten-pound steel paddle as the cheese cooked. The stirring was done in a bent position. Once the cheese had set, he had to cut the cheese, bending over and exerting pressure on cutting screens while dragging them through the cheese blocks.

On the days that he did not make cheese, claimant was assigned various duties. He sometimes stacked milk cases, six in a stack, 2,000 cases in a day. He sometimes moved yogurt trays. These activities involved lifting from 30-60 pounds, and twisting. He also dragged stacks of milk cases across the floor with a pole. The stacking activities were heavier than the cheesemaking activities, but not as heavy as his furniture-moving duties.

When claimant began his job at the dairy, his back and neck pain had significantly resolved. He then received treatment only once a month for two months, as he was still driving to Eugene to see Dr. Carlstrom. Without treatment, his back and neck condition

worsened. Dr. Carlstrom referred him to Dr. Breitenstein, who became his treating chiropractor.

From August 1986, to January 1987, claimant's conditions gradually worsened until Dr. Breitenstein took him off of work. He was suffering from acute exacerbation of his chronic cervical strain. The dairy job aggravated the condition, causing a return of his original symptoms, but not a worsening of his underlying condition.

Claimant was examined by Dr. Howell, osteopath, in April 1987. At that time, he had mild to moderate muscle spasms in his neck, and mild muscle spasms in his thoracic spine. He also had limited range of motion in his cervical, thoracic and lumbar spine.

Claimant's underlying condition had not worsened as a result of his work activities for Liberty's insured.

CONCLUSIONS OF LAW AND OPINION

The insurer on the risk at the time of the compensable injury remains responsible for the injury unless work activity at a time when a subsequent insurer is on the risk independently contributes to a worsening of the underlying condition. Boise Cascade v. Starbuck, 296 Or 238 (1984). Responsibility will not shift if the work activity under the second insurer merely contributes to worsened symptoms of the injury. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

Claimant originally suffered strain and sprain of his cervical, thoracic and lumbar spine, when a sofabed fell off a truck and hit him in the back. Since then he has endured low back pain and neck pain which causes neck immobility and headaches. These symptoms abated significantly when he was not working and was receiving chiropractic treatment. However, they have never fully resolved.

When claimant has worked, either as a landscaper or as a cheesemaker, his symptoms have increased. There is no persuasive evidence, however, that his underlying condition has worsened. His last treating physician, Dr. Breitenstein, was hesitant to make a legal conclusion as to whether claimant had suffered a new injury or an aggravation. His consistent medical conclusion has been that the symptoms were, so far, an aggravation of the original injury. In January and February 1987, he said that it was too early to tell whether the cheesemaking job had led to new permanent residuals (i.e., a worsened underlying condition). The record does not contain a later opinion from Dr. Breitenstein altering his opinion that the symptoms remain an aggravation.

Claimant was examined once by Dr. Howell, who testified at hearing. Dr. Howell found objective evidence of injury, in the form of muscle spasms in claimant's neck and thoracic spine. Claimant also had decreased range of motion in his cervical, thoracic and lumbar spine. Dr. Howell opined that these were not ongoing effects of the 1986 injury, but were most probably the result of claimant's dairy work.

Dr. Howell's opinion fails to persuade, for two reasons. First, he examined claimant only once, for an hour that consisted primarily of questioning. He admitted at hearing that the tests he did conduct could not tell him whether claimant's pathological

condition was different from that which existed after the injury. Second, the doctor stated that he did not think that claimant had any ongoing strain or injury from either of his jobs. This conflicts both with the existence of muscle spasms and limited range of motion which objectively indicate injury, and with his own earlier opinion that these were caused by the second job. Dr. Howell's opinion does not provide persuasive reason to weigh it more heavily than that of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). We conclude that claimant's condition represents an aggravation claim and the responsibility of the compensable injury sustained while working for Aetna's insured.

ORDER

The Referee's order dated August 11, 1987 is affirmed in part and reversed in part. Liberty Northwest Insurance's denial of responsibility for claimant's back and neck conditions is reinstated and upheld. Aetna Insurance's denial of responsibility for the same condition is set aside, and the claim is remanded to Aetna for acceptance and processing. Aetna shall reimburse Liberty Northwest for its claim costs incurred to date. Claimant's attorney is not entitled to an insurer-paid fee. The Referee's order is otherwise affirmed. The Board approves a client-paid fee, not to exceed $455, for Aetna's counsel. The Board approves a client-paid fee, not to exceed $1,160, for Liberty Northwest's counsel.

GREG A. HARSHA, Claimant
Pozzi, et al., Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney
Bottini & Bottini, Defense Attorneys

WCB 86-17621 & 86-07579
January 17, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Safeco Insurance Company requests review of those portions of Referee Podnar's order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition; and (3) set aside Safeco's partial denial of claimant's claim for an ulcer condition. We affirm.

ISSUES

1. Responsibility for claimant's low back condition.

2. Compensability of and responsibility for claimant's ulcer condition.

3. Claimant's entitlement to an assessed fee on Board review of the responsibility issue.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant compensably injured his low back in March 1985, while employed by Safeco's insured. Initially, claimant experienced low back pain and "shooting" pains in both legs. The leg pain resolved after a few weeks. An MRI scan in July 1985 revealed a small central disc herniation at L5-S1. In November 1985, he saw Dr. Thompson with an acute flare-up of severe low back pain radiating into the left thigh. After completion of the program at the Callahan Center, the claim was closed by Determination Order on May 23, 1986.

A few days after claim closure, claimant experienced another acute flare-up of symptoms in the low back, particularly on the left side. Dr. Thompson reported that claimant "may well be" developing further herniation of the disc. By June 2, 1986, however, claimant reported "feeling very good" and, with Thompson's approval, returned to sedentary work as a disk duplication operator for SAIF's insured. That job required prolonged sitting, which caused his back pain to worsen. In September 1986, claimant experienced a symptomatic flare-up after stacking 19-pound boxes at work. He had pain in the low back and right leg and numbness in the right foot. An MRI scan in October 1986 revealed that claimant's disc herniation at L5-S1 had increased in size since the last MRI scan was taken in July 1985. Claimant was taken off work.

Claimant filed claims for his low back condition with Safeco and SAIF. Safeco denied responsibility for the aggravation claim on October 27, 1986, while SAIF denied responsibility for the "new injury" claim on December 1, 1986. Because each insurer conceded that the condition was compensable, an order designating SAIF as paying agent issued on February 6, 1987, pursuant to former ORS 656.307.

In July 1986, claimant also developed an ulcer condition which resulted from his use of aspirin and other medication for relief from back pain and from stress and worry he experienced about his back condition and future employability. Safeco denied the ulcer claim on October 28, 1986.

The rate of claimant's temporary total disability compensation is higher for Safeco than it is for SAIF.

FINDINGS OF ULTIMATE FACT

Claimant's work activities with SAIF's insured did not independently contribute to any worsening of his low back condition. Claimant's low back condition and resulting treatment materially contributed to the onset of the ulcer condition.

CONCLUSIONS OF LAW AND OPINION

Low Back Condition

Under the last injury rule in successive injury cases, the first employer remains responsible if work activities with the second employer did not independently contribute to a worsening of claimant's underlying condition. Mission Insurance Co. v. Dundon, 86 Or App 470, 472-73 (1987); Hensel Phelps Const. v. Mirich, 81 Or App 290, 293-94 (1986). If, on the other hand, those activities independently contributed, however slightly, to a worsening of his condition, the second employer is solely responsible. Id. A worsening of symptoms alone will not shift responsibility to the second employer, even if the increased symptoms result in disability. Hensel Phelps Const. v. Mirich, supra, 81 Or App at 294. The assignment of responsibility for claimant's low back condition presents a complex medical question; therefore, resolution of this case turns largely on the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

the disc herniation at L5-S1. Rather, the issue is whether work activities during the second employment contributed to that worsening.

The medical evidence is divided. Dr. Thompson, the treating physician since May 1985, opined that claimant's work activity with the second employer, i.e., lifting boxes and prolonged sitting, contributed to the worsening. The Orthopaedic Consultants, on the other hand, concluded that the second employment was not a contributory factor. We ordinarily give greater weight to the treating physician's opinion, Weiland v. SAIF, 64 Or App 810, 814 (1983); however, we decline to do so here, because Thompson's reasoning is suspect.

When claimant saw Thompson for the symptomatic flare-up in October 1986, Thompson did not feel that work activities for the second employer were strenuous enough to cause significant problems, and he attributed the symptoms to the original 1985 injury. Thompson reversed himself only after an MRI scan revealed increased disc herniation since the previous scan in July 1985. However, the MRI scans alone do not establish that the worsening occurred during the second employment; they merely indicate that the worsening occurred sometime between July 1985 and October 1986. Therefore, Thompson's reliance on the scans is misplaced.

Thompson attempts to correlate the worsening with the sudden increase in claimant's pain after the lifting incident. We are not persuaded, however, because claimant has never been free from back pain since closure of the original claim in May 1986. Indeed, on May 28, 1986, a few days before accepting the second employment, claimant suffered an acute flare-up of symptoms after physical therapy, prompting Thompson to write that claimant "may well be" developing further herniation of his disc and that he was unable to return to work. Although claimant felt "very good" by June 2, 1986 and was released for work, his symptoms again increased upon his return to sedentary work.

The facts of this case are very similar to those in Mirich, supra. In that case, the claimant sustained a compensable back strain during the first employment, for which he received temporary disability benefits. He then performed a variety of jobs and experienced back discomfort during those activities. Later, he began working for the second employer. Work activities with that employer precipitated a second period of disability. The court assigned responsibility to the first employer, holding that the second employer did not independently contribute to a worsening of the underlying condition.

Like Mirich, claimant remained symptomatic after claim closure, indicating that the original condition persisted. The Orthopaedic Consultants noted the persistence of that condition and related the worsening to the original injury. They ruled out the second employment as a contributory factor. We are most persuaded by their well-reasoned opinion. Somers v. SAIF, 77 Or App 259, 263 (1986). Consequently, we do not find that work activities with the second employer -- SAIF's insured -- independently contributed to any worsening of claimant's underlying back condition. Accordingly, we conclude that Safeco is solely responsible for that condition.

Ulcer Condition

To establish compensability of the ulcer condition, claimant must prove by a preponderance of the evidence that the

compensable back injury materially contributed to his need for treatment of the ulcer condition. See Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987).

Dr. Lobitz, the treating gastroenterologist since September 1986, concurred with the opinion that claimant's use of aspirin and non-steroidal, anti-inflammatory medications for his back pain, in combination with stress and worry about his physical condition and future employability, all contribute materially to his need for treatment of his ulcer, gastritis, reflux and spasm. Lobitz agreed, therefore, that the compensable back injury was a material factor in the cause, exacerbation or aggravation of his gastrointestinal problems. Given the lack of contrary evidence, we find that the back injury was a material contributing cause of claimant's need for treatment of his ulcer condition, and conclude that the condition is compensable. As the insurer responsible for the back injury, Safeco is also responsible for the ulcer condition.

Attorney Fee

Claimant seeks an assessed fee for services rendered on Board review. His attorney is clearly entitled to an assessed fee for services rendered on Board review of the compensability issue. However, his statement of services includes services relating to the issue of responsibility for the low back condition. We must decide, therefore, whether claimant's attorney is entitled to an assessed fee for services rendered on Board review of the responsibility issue.

Claimant's attorney is entitled to an assessed fee when an insurer 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, Safeco initiated Board review of the Referee's decision to hold it responsible. Had Safeco prevailed, claimant's rate of temporary total disability (TTD) compensation would have been reduced because SAIF would have been liable for a lower TTD rate. On Board review, claimant defended the Referee's decision on responsibility. In affirming the Referee, the Board essentially found that claimant's TTD compensation should not be reduced. For that reason, claimant's attorney is entitled to an assessed fee on Board review of the responsibility issue, payable by Safeco. ORS 656.382(2); Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989).

ORDER

The Referee's order dated June 26, 1987 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed fee of $980, to be paid by Safeco Insurance Company.

BILLY J. HOLLEY, Claimant
Starr & Vinson, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
William Blitz (SAIF), Defense Attorney

WCB 87-03042 & 86-11418
January 17, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of Referee McCullough's order that: (1) set aside its denial of responsibility for claimant's aggravation claim for his right shoulder condition; and (2) upheld Employers of Wausau's denial of

claimant's "new injury" claim for the same condition. In its respondent's brief, Wausau contests that portion of the order which directed it to pay an $1,200 attorney fee for its denial of compensability of claimant's condition. We affirm.

ISSUES

(1) Responsibility for claimant's January 26, 1987 injury; and

(2) Liability for attorney fees for alleged denial of compensability.

FINDINGS OF FACT

Claimant, 44 at hearing, compensably injured his right shoulder on June 6, 1984, while working as a lumber grader for SAIF's insured. He received conservative treatment for over a year. On September 13, 1985, he had surgery, involving a distal clavicular resection.

Claimant worked until surgery, but thereafter did not return to work for SAIF's insured. In March 1986, he was referred to the Injured Workers Program at Sacred Heart Hospital in Eugene for evaluation. He went through three days of testing, at the end of which it was determined that he had significant permanent impairment as a result of the injury. It was recommended that he avoid repetitive use of the right shoulder, use of the arm away from the body, and use of the arm above shoulder level. He was also discouraged from frequent lifting. Claimant's treating physician, Dr. Filarski, imposed similar restrictions.

The claim was closed by Determination Order issued on August 14, 1986. Claimant was awarded temporary disability, and 15 percent unscheduled permanent partial disability.

Following this injury, claimant experienced pain on a daily basis. He could no longer throw a softball, swing a bowling ball or a golf club, or endure the pain of a rifle recoil.

In November 1986, claimant found a job with Wausau's insured as a lumber grader. This job was significantly lighter than the job with SAIF's insured. Claimant's physician did not approve the job, but claimant took it for economic reasons. The job bothered his shoulder from the start. He took painkillers, and occasionally a sleeping pill. He used the weekend to recuperate for the next week's work.

On January 26, 1987, claimant was temporarily assigned to different duties involving marking and grading lumber on the green chain. During the course of the workday, a jam-up occurred. While trying to pull on a board to straighten the jam-up, claimant felt a substantial increase in pain in his right shoulder, in the same area as the first injury. He grabbed his shoulder and fell to his knees. He then jumped back up, and bumped his shoulder on the boards. He continued to work until the lunch break, then sought out the company nurse, who immobilized his shoulder by taping his arm to his body. He continued the shift, but did not return to work the next day.

On January 27, 1987, claimant saw Dr. Cary, who gave him some medication and sent him to Dr. Filarski. Claimant was off work for two weeks. He then returned to work for one and a half weeks, before quitting because of the pain in his shoulder.

Following the January 1987 injury, claimant filed claims with both SAIF and Wausau. Both of these claims have been denied. Claimant's shoulder disability following the January 1987 incident was attributable to his work activities, but the incident did not independently contribute to a worsening of his underlying shoulder condition.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We affirm and adopt the Referee's conclusions of law beginning with the last full paragraph on page three and continuing through page four of the order.

Liability for attorney fees

No ".307" order was issued in this case. Claimant's attorney is therefore entitled to a carrier-paid fee for his services in setting aside a denial. ORS 656.386(1). Where a claimant overcomes an insurer's denial of compensability, even though another insurer is found responsible for compensation, the insurer that denied compensability is responsible for claimant's attorney fee. Karen J. Bates, 39 Van Natta 42 (1987). Applying this rule, the Referee assigned responsibility for the fee to Wausau.

SAIF issued its denial of responsibility, and suggested that claimant file a new injury claim with Wausau's insured. Wausau, in turn, denied responsibility, and suggested that claimant file an aggravation injury with SAIF. However, Wausau added the confusing language that: "[a]t this point, we do not have enough information to determine whether or not our denial should be of both compensability and responsibility."

The basic policy underlying Bates is to encourage carriers to seek or accede to the issuance of a .307 order (with the attendant continuation of compensation payments to injured workers) if they do not seriously contest claimant's entitlement to receive compensation. See Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). In this case, Wausau appeared to concede compensability of claimant's condition, but then confused matters by explicitly withholding such concession. However, it presented no evidence challenging the compensability of the condition. We find that it is appropriate, and in keeping with the policy of Bates, to assign liability for claimant's attorney fee to Wausau.

ORDER

The Referee's order dated May 12, 1987, reissued on June 18, 1987 and August 20, 1987, is affirmed. The Board approves a client-paid fee, not to exceed $459, for Employers of Wausau's counsel.

WILLIE J. HOLT, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-14588
January 17, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Neal's order that: (1) declined to grant permanent total disability; and (2) affirmed a Determination Order award of 25 percent (37.5) degrees) scheduled permanent disability for loss of use or function of the left leg, and 10 percent (32 degrees) unscheduled permanent disability for a psychiatric condition. On review, the issues are extent of scheduled and unscheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact and make the following additional findings.

Claimant is capable of performing modified work on a regular basis. He has not demonstrated his willingness to seek work or offered persuasive evidence that job search activity would be futile.

Claimant has sustained a mildly-moderate degree of permanent functional disability in his left knee as a result of his compensable injury. He has not demonstrated that he has sustained more than a minimal degree of disability as a result of his compensable psychiatric condition.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee concluded that claimant was not permanently and totally disabled. We adopt that decision with the following comment.

Claimant does have some degree of permanent functional disability as a result of his left knee condition and psychiatric disorder. Furthermore, we are aware that claimant's treating psychiatrist, Dr. Pidgeon, opined in July 1987 that claimant would be unable to work at any job for at least two years. However, we discount his opinion because it is based on an inaccurate picture of claimant's subjective limitations. Whereas claimant presented himself to Dr. Pidgeon as severely disabled, surveillance films presented at hearing demonstrate that claimant has significantly exaggerated his limitations. We further note that there is no medical evidence that claimant's exaggeration of his disability is unconscious and beyond his control.

Moreover, claimant has not demonstrated his willingness to be retrained and return to work. As noted by the Referee, claimant has continually maintained that he is unable to participate in retraining and work search activities because of his physical limitations. However, in light of our finding that claimant has significantly exaggerated his limitations, we are not persuaded that job search activity would be futile. Furthermore, the record contains no persuasive evidence that claimant's psychiatric disorder is so severe that his refusal to participate in vocational retraining and assistance is beyond his control.

Accordingly, we agree that claimant has not established that he is permanently and totally disabled, and we affirm the Referee on this issue.

Scheduled Permanent Partial Disability

We adopt the Referee's opinion regarding the extent of claimant's scheduled permanent disability for his left knee condition.

Unscheduled Permanent Partial Disability

The Referee concluded that claimant's Determination Order award of 10 percent unscheduled permanent disability adequately compensates him for his compensable psychiatric condition. We agree.

In reaching this decision, we are aware that treating psychiatrist Pidgeon opined that claimant had sustained a significant degree of permanent disability as a result of his depression and psychogenic pain disorder. However, as discussed above, we discount Dr. Pidgeon's opinion because it is based on claimant's exaggerated description of his limitations. In addition, after initially opining that claimant had sustained a 25 percent permanent psychiatric disability, Dr. Pidgeon increased that disability to 60 percent without explanation. This inconsistency is a further reason to discount his opinion.

Furthermore, in light of claimant's conscious exaggeration of his disability and the fact that he has been separately compensated for the functional loss in his left leg, we are not persuaded that he has sustained more than a minimal degree of additional impairment as a result of his psychiatric disorder. After considering this degree of impairment and the relevant social and vocational factors set forth in OAR 436-30-380, et seq., we conclude that claimant's current award of 10 percent unscheduled permanent partial disability adequately compensates him for his psychiatric condition. Accordingly, we affirm the Referee's opinion on this issue.

ORDER

The Referee's order dated July 30, 1987 is affirmed. A client-paid fee, not to exceed $652.50, is approved.

KAREN A. LONG, Claimant
Haugh & Foote, Claimant's Attorneys
Meyers & Associates, Defense Attorneys

WCB 87-00473
January 17, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Thye's order which upheld the self-insured employer's denial of her occupational disease claim for carpal tunnel syndrome. We affirm.

ISSUES

Claimant contends that the Referee abused his discretion by refusing to admit Exhibit 11.

Claimant also contends that she has a compensable occupational disease claim for carpal tunnel syndrome.

FINDINGS OF FACT

Claimant's doctor filed a claim on claimant's behalf for carpal tunnel syndrome on September 15, 1986. Claimant worked seasonally for this employer for three years. In the summer of 1985 she began noticing numbness in her fingertips. The numbness stopped during the off-season. During the 1986 season it returned.

Claimant's work activities are not the major cause of her carpal tunnel syndrome or of a worsening of a preexisting carpal tunnel syndrome.

The employer denied the compensability of the carpal tunnel syndrome on December 15, 1986.

Claimant requested a hearing on January 8, 1987. On January 15, 1987, a representative of the Hearings Division wrote to claimant acknowledging receipt of the request for hearing. The letter informed claimant of her right to representation by an attorney. It also indicated that an attorney would need time to prepare her case.

On May 19, 1987, the Hearings Division sent claimant notice of a hearing scheduled for September 9, 1987. On May 22, 1987, the Referee wrote to claimant urging her to obtain an attorney. Claimant did nothing to prepare for the hearing or to obtain an attorney until August 25, 1987, when she retained her present attorney. During the interval, she had moved out of state, but her mail was being sent to her mother-in-law. She returned to Oregon in late August 1987. It was upon her return to Oregon that she decided to obtain an attorney.

On August 28, 1987, claimant's attorney wrote the Referee requesting that he postpone the case or allow the record to remain open so that she could obtain an opinion from a doctor supporting claimant's case. She indicated that she had written the doctor on that date. On September 1, 1987, the Referee wrote to claimant's attorney denying the motion to postpone and the motion to leave the record open.

Claimant's attorney submitted Exhibit 11, a report supporting compensability, on September 4, 1987. The Hearings Division received the report on September 8, 1987. The report was not timely under the administrative rules in effect at that time.

The hearing took place on September 9, 1987. At hearing, the Referee concluded that claimant had failed to establish good cause for the late submission of Exhibit 11. He declined to admit it.

CONCLUSIONS

The administrative rule in effect at the time of hearing, OAR 438-07-005(3)(b) and (4) provided:

> "Not less than ten (10) days before the scheduled date of hearing, or within seven (7) days of mailing of a copy of the insurer's exhibit index, whichever occurs later, the claimant shall file with the assigned referee any additional exhibit which the claimant wishes to offer in evidence.

"At the hearing the referee may in his or her discretion allow admission of additional medical reports or other documentary evidence not filed as required by (3) above. In exercising this discretion, the referee shall determine if good cause has been shown for failure to file within the prescribed time limits."

The Referee found that claimant had not shown good cause. Under the circumstances of this case, we conclude that the Referee did not err in finding no good cause. He did not abuse his discretion in refusing to admit Exhibit 11 into evidence.

Turning to the merits, there is no evidence which supports compensability. Dr. Nathan states that claimant's work did not alter her preexisting carpal tunnel disease. Dr. Thiringer concurred. We rely on Dr. Nathan's opinion.

ORDER

The Referee's order of September 7, 1987 is affirmed. A client-paid fee, not to exceed $365.50, is approved.

THERON STIEHL, Claimant
Malagon & Moore, Claimant's Attorneys
Chuck Lisle (SAIF), Defense Attorney

WCB 87-01138
January 17, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of transportation expenses to obtain medical services and declined to assess a penalty and attorney fees for unreasonable denial. We reverse.

FINDINGS OF FACT

The material facts are not in dispute. Claimant has a compensable injury claim under which he requires medical services consisting of treatment of a condition of his hands. (The precise nature of the condition and type of treatment is not apparent from the record.) Claimant lives in Rogue River, Oregon. He initially was treated by Dr. Saez, a Medford neurosurgeon, who referred him to Dr. Peterson, a Medford orthopedic surgeon, for followup care.

Claimant became dissatisfied with Dr. Peterson's care and consulted Dr. Ross, a Medford plastic and reconstructive surgeon. Dr. Ross informed claimant that he had no treatment to offer and recommended that claimant seek treatment from either one of two surgeons in the Eugene metropolitan area. Claimant sought treatment from Dr. Jewell, plastic and reconstructive surgeon, one of the two recommended by Ross, in Springfield. When claimant notified the SAIF claim examiner that he had selected Dr. Jewell as his attending physician, SAIF issued a denial of further reimbursement for transportation expenses in excess of the reimbursement due for traveling the distance between Rogue River and Medford. SAIF also advised claimant that, in its opinion, claimant could receive like medical services in Medford and provided claimant with the names of five Medford physicians, including Dr. Ross, from whom claimant could receive like services.

SAIF based its denial on OAR 436-60-050(4), which provides:

> "The worker may choose an attending physician within the state of Oregon. Reimbursement to the worker of transportation costs to visit the attending physician, however, may be limited to within a city, or metropolitan area, or the distance to the nearest city or metropolitan area, from where the worker resides and where a physician providing like services is available. A worker who relocates within the state of Oregon may continue treating with the attending physician and be reimbursed transportation costs accordingly. If an insurer chooses to limit reimbursement to the nearest available city, or metropolitan area, a written explanation shall be provided to the worker along with a list of physicians who provide the like services within an acceptable distance of the worker. The worker shall be made aware of the fact treatment may continue with any attending physician within the state of Oregon of the worker's choice, but the reimbursement of transportation costs will be limited as described."

SAIF complied with the letter of the rule. Claimant argues that the rule is an invalid infringement of his right to medical care under ORS 656.245, or, if the rule is valid, that the evidence does not establish that any of the five physicians named by SAIF are capable of providing the same services provided by Dr. Jewell. Because we agree with claimant's second argument, we need not question the validity of OAR 436-60-050(4). See Cooper v. Eugene Sch. Dist. 4J, 301 Or 358, 365 (1986) ("An agency ordinarily can interpret a statute [rule] so as to exclude unconstitutional [statutorily impermissible] applications before it is forced to question the statute's [rule's] validity.").

The only evidence that any of the five physicians listed by SAIF is capable of providing services like those provided by Dr. Jewell is SAIF's bare assertion of the fact. We conclude that SAIF's assertion is negated by virtue of the undisputed fact that one of the physicians listed by SAIF, Dr. Ross, actually referred claimant to Dr. Jewell. We infer from the fact that, because Dr. Ross referred claimant to the Eugene area rather than to another physician in Medford, "like services" were not available in Medford. We do not believe any reasonable purpose would or could be served by requiring a lay person to exhaust all of the names on the list of physicians before seeking a physician whose name is not on the list. We conclude that referral out of the area by one physician is sufficient, especially when that one physician was one specifically recommended by SAIF. There is no other evidence that like services were available any nearer to Rogue River than the Eugene metropolitan area. We therefore conclude that claimant is entitled to full reimbursement of transportation costs incurred as a result of visits to his attending physician.

Although the Referee did not address the question, claimant sought a penalty and attorney fee at hearing and renews the request on review. We do not believe that SAIF's reliance on OAR 436-60-050 nor its assumption that like services were available in Medford were unreasonable. Claimant's counsel is statutorily entitled to an insurer-paid attorney fee. ORS 656.386(1). However, no statement of services has been submitted. Under such circumstances, an insurer-paid attorney fee cannot be awarded. OAR 438-15-010(5).

ORDER

The Referee's order dated August 14, 1987 is reversed. The SAIF Corporation's January 16, 1987 denial of full reimbursement for transportation expenses between Rogue River and Springfield is set aside. The expense claim is remanded to SAIF for processing according to law.

ROY M. JOHNSTON, Claimant
Malagon & Moore, Claimant's Attorneys
Brian Pocock, Defense Attorney

WCB 85-13546
January 18, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Johnston v. James River Corp., 91 Or App 721 (1988). We have been instructed to reconsider this case in light of the court's decisions in Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) and George v. Richard's Food Center, 90 Or App 639 (1988). In accordance with the court's instructions, we issue the following order.

The self-insured employer requests review of that portion of Referee Foster's order that set aside its denials of claimant's occupational disease claim for a respiratory disorder. We reverse. The employer also requests that the Board reimburse it for costs it incurred in claimant's appeal to the Court of Appeals which resulted in the court's decision to remand the case to the Board. We deny this request.

ISSUE

1. Compensability of claimant's respiratory condition.

2. Responsibility for the condition.

3. Whether the Board should reimburse the employer for costs it incurred in an appeal by claimant which resulted in a decision by the Court of Appeals to remand the case to the Board on the ground that the Board's initial Order on Review was insufficient for judicial review.

FINDINGS OF FACT

Claimant began working for American Can Company in September 1972 on a paper products line. Machines in claimant's work area made rolls of toilet tissue and paper towels from larger rolls of paper material composed of cellulose derived from douglas fir, hemlock and alder sawdust and wood chips. Claimant operated a machine which wrapped the finished rolls in cellophane. This whole process gave rise to a considerable amount of fine paper dust in the air, although the amounts were well within governmental safety standards.

Claimant experienced periodic respiratory difficulties throughout the 1970's for which he sought treatment on a number of occasions. In 1981, claimant sought treatment for breathing difficulty and nasal congestion from Dr. Hartman, a family practitioner. Dr. Hartman diagnosed acute bronchitis and recommended that claimant work in a less dusty environment. The employer was unable to accommodate this recommendation, but did provide claimant with a dust mask. Claimant wore the mask for a short period of time, but then quit using it because he found it to be uncomfortable.

On July 2, 1982, the plant where claimant worked was purchased by James River Corporation, the self-insured employer in this case. Claimant continued to work on the paper products line and continued to experience periodic breathing difficulty. His symptoms improved temporarily during weekends and other periods off work.

In March 1985, Dr. Hartman referred claimant to Dr. Rapp, an allergy specialist. Dr. Rapp diagnosed asthma and allergic rhinitis and indicated that they were related to claimant's exposure to "wood dust" at work. A few months later, claimant left work because of breathing difficulty and nasal congestion. His symptoms improved while he was off work.

Claimant returned to work in mid-May 1985 and within a few days his symptoms worsened. Claimant left work again and his symptoms improved. In June 1985, he was examined by Dr. Lakin, a lung specialist. Based upon his examination of claimant and review of claimant's medical records, Dr. Lakin did not think that claimant had work-related asthma. Instead, he indicated that claimant had a "hypersensitivity pneumonitis type of problem." Dr. Hartman released claimant to return to work on July 29, 1985 with the restriction that claimant not be exposed to paper dust. The employer could not place claimant in a position which did not involve such exposure and so claimant remained off work. Claimant filed a claim with James River Corporation in August 1985, which was denied.

Claimant remained off work from May 1985 until April 1986. During this period, his symptoms totally resolved. Just before returning to work, claimant was examined by Dr. Wilson, an allergy specialist. Dr. Wilson conducted tests which led him to the conclusion that claimant's problem was not allergic in etiology. He diagnosed a hereditary condition called "hyperreactive airways disease." People with this condition have an abnormal bronchial sensitivity which causes bronchial spasm, tightness, wheezing, coughing and excess mucus production with exposure to nonspecific irritants. Hyperreactive airways disease may worsen and become irreversible with continued exposure to irritants over a long period of time. In view of the fact that claimant's symptoms had totally resolved during the period he was off work, however, Dr. Wilson opined that claimant's exposure to paper dust at work had not worsened his underlying condition. Claimant returned to work in late April 1986 with a respirator and continued to work through the time of the hearing in July 1986.

Claimant filed no claim with his prior employer, American Can Company. Prior to the hearing, counsel for James River Corporation filed a motion to join American Can Company and its insurer as parties to the proceeding. This motion was denied

by the Hearings Division on July 18, 1986 on the ground that James River Corporation could assert responsibility as a defense regardless of whether other potentially responsible carriers were joined. The Referee issued his order finding claimant's condition compensable on August 22, 1986. The employer requested Board review and the Board reversed the Referee's order by an Order on Review dated October 8, 1987. Claimant appealed the Board's order to the Court of Appeals and the court reversed and remanded on the ground that the Board's order was not sufficient for judicial review. The employer incurred costs totalling $266 in connection with claimant's court appeal.

FINDINGS OF ULTIMATE FACT

Claimant has hereditary hyperreactive airways disease. Claimant's exposure to paper dust after July 2, 1982 caused claimant to experience bronchial and nasal symptoms, but did not worsen his underlying condition.

CONCLUSIONS OF LAW

Compensability

To establish a compensable occupational disease against the employer, claimant has the burden of proving that his exposure to paper dust after July 2, 1982 was the major contributing cause of a worsening of his underlying hyperreactive airways disease. See Weller v. Union Carbide Corp., 288 Or 27, 35 (1979); Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983). The Referee concluded that claimant had carried this burden. We disagree.

Several doctors have given opinions regarding the nature and etiology of claimant's condition or its symptoms. Dr. Hartman, claimant's treating general practitioner, opined that "[claimant's] symptoms were directly related to the exposure of paper dust at his place of work." (Ex. 11-1). He gave no opinion regarding the etiology of claimant's underlying condition. Dr. Rapp, one of the consulting allergy specialists, opined that claimant's condition was allergic in etiology based upon tests which indicated that claimant was allergic to cedar dust and his assumption that claimant was exposed to such dust at work. (See Ex. 1A). He also confirmed by spirometric testing that claimant's symptoms were increased by exposure to dust at work. Dr. Lakin, the consulting lung specialist, indicated that claimant's condition was not allergic in etiology and indicated instead that claimant had a "hypersensitivity pneumonitis type of problem." (Ex. 16). The only other opinion admitted into the record was by Dr. Wilson. In a detailed report and testimony, he opined that claimant had a hereditary condition called "hyperreactive airways disease." (Ex. 10-5; Tr. 24-25). He also opined that this condition had been affected symptomatically by exposure to paper dust, but had not been pathologically worsened. (See e.g., Ex. 10-5; Tr. 26-33, 44-46).

In evaluating medical opinions, we give the greatest weight to those that are well-reasoned and are based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Gauging the above opinions under this standard, we conclude that the opinion of Dr. Wilson is due the greatest weight. His opinion was based upon complete and accurate information and was thoroughly explained. The opinion of Dr. Lakin, although cursory, reinforces Dr. Wilson's diagnosis and thus tends to support his conclusions.

The opinion of Dr. Rapp was based upon the erroneous assumption that claimant was exposed to cedar dust at work. It, therefore, cannot be relied upon. Dr. Hartman states that claimant's symptoms were increased by his exposure to paper dust. He does not opine that there was a worsening of claimant's underlying condition. On this record, we conclude that claimant has failed to prove that his hereditary hyperreactive airways disease was pathologically worsened by his work exposure and thus has failed to prove a compensable occupational disease. See Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Annette Preston, 40 Van Natta 589 (1988).

Responsibility

In view of our conclusion on the compensability issue, we need not address the employer's responsibility argument.

Reimbursement of Costs

The employer has cited no statute, administrative rule or court case which would authorize the Board to reimburse it for the costs it incurred in claimant's appeal of our prior Order on Review. We know of no such authority. The employer's request, therefore, is denied.

ORDER

The Referee's order dated August 22, 1986 is reversed. The self-insured employer's denials dated September 25, 1985 and October 4, 1985 are reinstated and upheld.

Board Member Crider, dissenting:

Claimant suffers from breathing difficulty, coughing, wheezing, phlegm, running nose and other respiratory symptoms when he is working. His condition improves with the use of a mask while at work. His symptoms disappear altogether when he has been off work for extended periods of time. Tr. 78. Dr. Wilson, the examining physician relied upon by the employer, diagnosed claimant's condition as "hyperreactive airways disease" but indicated that this "disease" alone does not cause claimant's symptoms. In the absence of irritants, "he has propensity, but he doesn't have the clinical pattern" which led him to seek treatment. Tr. 40. Indeed, were claimant not exposed to irritants such as the paper or wood dust at work, he would be entirely asymptomatic hereafter. Tr. 46. Nevertheless, the majority concludes that claimant has not established a compensable occupational disease. I could not disagree more.

Preliminarily, I note that I agree with the Board's findings of fact, in the main. I observe, however, that the majority's finding that "claimant experienced periodic respiratory difficulties throughout the 1970's for which he sought treatment..." is a bit exaggerated. The record suggests that claimant sought treatment in 1973 and again in 1975; there is no detailed information about his difficulties on those occasions; however, he was diagnosed on one occasion as suffering from "chest pains, productive cough", on another, as suffering from an "upper respiratory infection" for what was diagnosed as "chest pains,

productive cough", and, on another, of suffering from "allergic bronchitis." There is certainly insufficient evidence to suggest claimant suffered from a chronic problem, what it was, or why he suffered from it on any of these occasions.

I also note that the majority fails to make some critical findings. For example, the record unequivocally establishes not only that claimant's respiratory ailments were associated with exposure to wood dust at work, but also that exposure to other possible irritants, including tobacco smoke, dirt, various grasses and the like, is not associated with the ailments. In other words, it establishes that occupational exposure, compared to nonoccupational exposure, is the major contributing cause of claimant's ailments.

Instead of making these findings concerning the clinical condition that required treatment, the majority has postulated that claimant's disease is "hyperreactive airways disease." Because that condition is congenital, the majority finds the entire claim noncompensable.

Claimant is not seeking treatment for hyperreactive airways disease. He is seeking treatment for the bronchial spasm, inflammation, and reduction in airflow that make him miserable. Those problems are the occupational disease, i.e., the condition "requiring medical services" within the meaning of the statute.

The majority errs in treating the congenital hypersensitivity as the "underlying disease" and the clinical condition that is generated by the occupational irritant as but "symptoms." In Tucker v. Liberty Mutual Ins. Co., 87 Or App 607 (1987), the Court of Appeals corrected an analogous error. The claimant therein had high arches. Due to his high arches, he suffered more than most employes would from a job which involved a great deal of standing. His physician diagnosed high arches and foot strain. The Board concluded that the disease was the high arches and that the claimant's job activities had not worsened this disease, but simply made it symptomatic; it held the claim noncompensable. The court disagreed, saying that the high arches simply predisposed the claimant to difficulties and that the disease at issue was the painful condition; since the claimant would not have suffered had he not engaged in this activity, the court found the claim compensable.

This case is no different. Thus, even though the physicians diagnosed hyperreactive airways disease, the clinical condition (bronchitis, rhinitis or what have you -- Ex. 1A, Ex. 4) was also diagnosed would not have occurred but for the occupational exposure. Therefore, that clinical condition is compensable. See also, Collins v. Hygenic Corporation of Oregon, 86 Or App 484 (1987); Annette Preston, 40 Van Natta 589 (1988)(Board Member Crider, dissenting).

VIRGINIA K. PADILLA (nka SCOTT), Claimant
Doblie & Associates, Claimant's Attorneys
Larry Dawson, Defense Attorney

WCB 84-06863
January 18, 1989
Order on Review

Reviewed by the Board en banc.

The insurer requests review of those portions of Referee Galton's order that: (1) set aside its denial of claimant's aggravation claim; and (2) assessed penalties and attorney's fees for its unreasonable conduct. We reverse in part and affirm in part.

ISSUES

1. Whether claimant suffered an aggravation of her compensable low back injury.

2. Whether the insurer's delay in authorizing a myelogram constituted unreasonable conduct, thereby entitling claimant to penalties and attorney's fees.

FINDINGS OF FACT

Claimant, 48 years old at hearing, is severely overfocused upon her physical symptoms. In November 1966 she initially injured her cervical spine when a tire fell on her head. Symptoms included headaches, numbness in the right side of her face and some right arm pain. She treated conservatively with Dr. Grewe, neurosurgeon. In November 1968 claimant was involved in a motor vehicle accident. This again caused cervical symptoms including headaches, stiffness through her neck and shoulders and numbness in her right arm and hand. Claimant subsequently developed right leg numbness and in 1972 underwent a lumbar laminectomy. In June 1973 claimant was involved in a second motor vehicle accident. Her symptoms included pain in the neck, right arm and low back. In 1977 she also developed left leg pain. In 1978 Dr. Cruickshank performed a second lumbar laminectomy.

On March 9, 1981, claimant injured her back while weeding for the employer. Her compensable condition was diagnosed as acute lumbosacral strain. As a result of her two previous laminectomies, she was also diagnosed with a transitional vertebra at the lumbosacral junction, abnormally narrow disc spaces, pseudoarthrosis on the left and a minimal residual extradural defect on the left at L4-5.

From the time of the instant industrial injury until the first claim closure on October 21, 1981, claimant's three primary treating physicians included Drs. Ordonez, neurosurgeon, Grewe, neurosurgeon, and Cruickshank, neurosurgeon. As early as June 16, 1981, Dr. Means, psychologist, diagnosed hysterical neurosis. On September 23, 1981, she listed her diagnostic impression as a somatization disorder. On that same day, Dr. Medved, medical examiner at the Callahan Center, diagnosed hysterical conversion.

On March 27, 1981, Dr. Cruickshank released claimant to work without restrictions. Claimant, however, has never returned to work. By September 1981 claimant's chronic lumbar pain had expanded to include almost complete body pain. Since that time, the primary diagnosis of every medical provider that has examined claimant has been severe functional overlay.

On September 23, 1981, claimant was examined by the Orthopaedic Consultants. At that time, her symptoms included pain in her low back and legs, worse on the right than the left. When severe, the pain extended into the cervical area and caused numbness in both legs down to the toes. The pain increased with bending, stooping or walking as little as one city block. She was in great pain and walked with a very guarded and shaky gait.

On October 21, 1981, a Determination Order awarded claimant 20 percent unscheduled permanent disability.

On September 14, 1982, claimant was examined by the Orthopaedic Consultants. At that time, her constant low back and leg pain were worse than during the previous examination. She still experienced intermittent numbness in the legs and hands. Her walking tolerance was reduced to 30 feet. Her sitting tolerance amounted to only a few minutes.

On September 15, 1982, Dr. Grewe diagnosed narrowing of claimant's disc spaces at the L4-5 and L5-S1 levels with sclerosis of the facet joints at L3, L4 and L5 secondary to the two previous laminectomies. By this time, claimant's functional disorder had become entrenched behavior and she continued to experience total body pain. Dr. Grewe suggested that claimant could possibly benefit from a Pain Clinic situation. Despite claimant's extreme pain behavior, she was capable of light-duty work from a physical standpoint.

On January 2, 1983, Dr. Close, chiropractor, examined claimant. She continued to exhibit symptoms of constant pain throughout the spinal area along with pain and numbness in all her limbs. The pain increased depending upon the extent of her physical activity.

On March 3, 1983, claimant's low back pain and numbness in all four extremities remained constant and incapacitating. The pain was so intense that she was unable to achieve any position of comfort.

On March 7, 1983, the Orthopaedic Consultants examined claimant for a third time. Her symptoms of totally incapacitating, almost complete, body pain were unchanged.

On April 11, 1983, Dr. Close examined claimant. He reported that there had been an approximate 50 percent overall improvement in claimant's condition.

On April 13, 1983, claimant's unscheduled permanent disability award was increased by stipulation to 35 percent. Claimant also agreed not to appeal the insurer's denial of her aggravation claim.

Approximately one year later, on April 2, 1984, Dr. Close informed the insurer that claimant's condition had worsened and she was no longer medically stationary.

On June 9, 1984, Dr. Bolin diagnosed a chronic lumbosacral facet syndrome due to a 5th lumbar transitional segment, degenerative disc disease between L4 and L5, and obesity. Dr. Brett, neurological surgeon, also diagnosed an aggravation of claimant's post-operative lumbar condition due to obesity. In March 1981, claimant, who stands 5 feet tall, weighed

166 pounds. By November 1986, claimant's weight had increased to 199 pounds.

On June 25, 1984, the insurer denied claimant's aggravation claim on the grounds that her condition had not worsened.

On June 21, 1985, Dr. Buttler, chiropractor, diagnosed chronic lumbosacral sprain/strain with intervertebral disc derangement due to a severe loss of disc space at the L4-L5 and L5-S1 interspaces as well as a severe loss of size of the L4-L5 intervertebral foramens.

On August 7, 1985, Dr. Morgan diagnosed cervical spondylosis at C5-6 with some widening of the nerve root sleeve on the right and lumbar stenosis at L4-5, above claimant's spinal fusion, L5 to the sacrum.

On October 14, 1985, Dr. Grewe authorized 90 days of time loss benefits for claimant, primarily because she was not working and had no income at the time.

On August 25, 1986, Dr. Brett requested insurer authorization to perform a lumbar myelogram. On September 3, 1986, the insurer declined to provide that authorization until it had received a second opinion from Dr. Grewe on the elective procedure. On September 4, 1986, the insurer informed claimant that it had scheduled an examination for her with Dr. Grewe on October 13, 1986. After examining claimant, Dr. Grewe stated that if Dr. Brett felt that repeat myelography was called for, then authorization should be granted. On October 27, 1986, the insurer authorized myelography.

On November 19, 1986, Dr. Hughes, psychiatrist, diagnosed a longstanding chronic conversion disorder and suspected that claimant had a mixed personality disorder.

On December 20, 1986, Dr. Brett's assessment of claimant's physical limitations included: (1) no lifting greater than 35 pounds; (2) no repetitive bending or stooping; and (3) no sitting or standing for more than two consecutive hours.

Claimant's spinal stenosis at L4-5 and the mild central disc bulge at L4 were caused by her two laminectomies and were in no way worsened as a result of her compensable 1981 injury. In fact, claimant's physical condition has not changed since the parties stipulated to an increased permanent partial disability award in April 1983.

As previously stated, the primary component of claimant's pain behavior is her extreme functional overlay. We find that claimant's symptoms have not increased since April 1983. No worsening of either claimant's lumbar condition or functional overlay occurred subsequent to her last award of compensation in April 1983.

CONCLUSIONS OF LAW

The Referee set aside the insurer's denial of claimant's aggravation claim, reasoning that claimant's industrial injury had aggravated her spinal stenosis, disc bulge and functional disorder. We disagree.

Aggravation

To establish an aggravation claim, claimant must show "worsened conditions resulting from the original injury." ORS 656.273. "Worsened conditions" means a change in condition which makes a claimant more disabled, either temporarily or permanently, than she was when the original claim was closed. Smith v. SAIF, 302 Or 396, 399 (1986). An aggravation caused by a functional overlay is compensable, Pierson v. SAIF, 79 Or App 211, 215 (1986), even if there is no psychogenic component in the original injury. Scheidemantel v. SAIF, 70 Or App 552 (1984).

There are two components to claimant's aggravation claim. The first is whether claimant's underlying condition or symptoms, either physical or psychological, have worsened since April 1983. If we find that claimant's condition or symptoms have in fact worsened, we must consider whether that worsening resulted in more disability. We conclude that claimant has failed to carry her burden of proof on either account.

Low back condition

On January 31, 1985, a CT scan revealed that claimant had spinal stenosis at the L4-5 level and a mild central bulge at L4. However, as early as March 3, 1975, Dr. Grewe noted that there was a narrowing of the L4-5 interspace. On May 6, 1981, Dr. Stoney described a minimal residual extradural defect on the left at L4-5, most probably post-operative in nature. Numerous other medical examiners noted the post-operative bony changes at L4-5 and L5-S1. Dr. Grewe explained that a spinal stenosis refers to a narrowing of the spinal canal. In other words, the January 1985 CT scan revealed nothing new in claimant's condition.

Dr. Grewe testified at hearing that when he examined claimant on March 1, 1985 and October 13, 1986, her objective findings were unchanged from those objective findings that he had noted in 1982. Although he believed that over that same period of time claimant's behavioral changes had been severe, objectively nothing had changed. Dr. Grewe further opined that claimant's stenosis at L4 was due to bone hypertrophy and the settling of the disc spaces caused by the two prior laminectomies. He also stated that it was possible that the 1981 compensable injury had aggravated the process of stenosis. A mere possibility, however, is not sufficient to prove an aggravation of claimant's stenosis condition. Gregg v. Racing Commission, 38 Or App 19 (1979).

Based upon Dr. Grewe's persuasive testimony as claimant's treating physician over a long period of time, we find that claimant's physical condition did not worsen after April 1983. Although the medical terminology changed when the January 1985 CT scan disclosed spinal stenosis at L4-5 and a mild central disc bulge at L4, those findings were no different than had been observed by numerous physicians in the past; they were merely articulated differently. Dr. Grewe, aware of the CT scan and a contemporaneous myelogram, opined that claimant's objective condition remained unchanged since approximately 1982. We agree with that view of the medical evidence.

Functional overlay

Dr. Grewe, however, also testified that claimant's

subjective condition had worsened since claim closure in April 1983. For the following reasons, we give less deference to this opinion. Whereas claimant's physical findings could be ascertained through objective means and, regardless of the medical procedure, those findings remained relatively constant over the course of her claim, the accurate charting of her subjective condition defied medical testing. Therefore, our primary guide in analyzing the state of claimant's functional disorder is claimant herself. Her long trail of symptoms, as detailed from one medical examination to the next, is more persuasive evidence as to the state of her condition than the opinion of one doctor whose infrequent examinations may not represent the complete picture. We, therefore, analyze this type of evidence to determine whether claimant's functional disorder has worsened since the last arrangement of compensation.

Claimant testified at hearing that her condition began to worsen a few months after April 1983. Claimant's personal opinion that her condition has worsened is some evidence but only scant evidence. Albert Nelson, 34 Van Natta 573, 574 (1982). We reject her testimony as inconsistent with her well-documented chronic and unchanging complaints.

When claimant was examined by the Orthopaedic Consultants on September 23, 1981, she complained of almost complete body pain. On September 14, 1982, claimant was again examined by the Orthopaedic Consultants. At that time, her symptoms had become even worse. She was experiencing constant low back and leg pain with intermittent numbness in her arms and hands. She was unable to walk further than 30 feet or sit for more than a few minutes. Claimant's gait was bizarre; she straddled and waddled down the hall, rotating her entire body from side to side and alternately flexing her hips and knees. She refused to walk, attempt a squatting posture or bend forward since the slightest movement of her back, legs or arms produced intense pain in her low back. Backward bending was 10 percent of normal; lateral bending and rotation were 5 percent of normal.

On January 2, 1983, Dr. Close reported that claimant complained of left leg pain and numbness, low and mid back pain, neck pain, right hand numbness and headaches. According to claimant, these symptoms increased depending upon her activity, such as prolonged sitting.

On March 3, 1983, Dr. Close reported that claimant's low back pain was constant and incapacitating. She was experiencing neck and mid back pain as well as tingling pain and numbness in both arms and legs. Dr. Close reported that her pain was so intense that it was difficult for her to achieve any position of comfort.

On March 7, 1983, claimant was examined for a third time by the Orthopaedic Consultants. She described constant lumbar pain associated with pain running down both legs, more so on the left than the right. The leg pain involved the entire leg all the way to the foot and all of the toes. Claimant also complained of feeling knots in the muscle of her thighs, tenderness in her feet, transcient tingling sensation in her arms, hands and legs but no persistent sensory loss. She exhibited a rather slow and broad-based gait without definite lateralized limp. She was able to forward bend to the point that her fingertips were 21 inches from the floor. She could not bend backward. Sideward bending

right and left was 20 percent of normal. Rotational movements right and left were 20 percent of normal.

On September 13, 1984, claimant was examined by the Independent Chiropractic Consultants. She complained of low back pain with associated numbness and tingling sensations in her legs. She further stated that she experienced neck stiffness with pain and headaches, occasional dizziness and numbness in her fingers. She felt that her back was likely to give way at any time as a result of pain and weakness. Her gait was found to be slow and protective but did not display any characteristic limps, lurches or lists. There were no objective signs of neurological deficit.

On May 25, 1985, Dr. Bussanich, chiropractor, reported that claimant complained of constant low back pain, pain in the posterior aspect of the left thigh and in both legs at times. She also complained of numbness and tingling in the bottom of her feet and occasionally in her hands and arms. Neck and mid back pain was also fairly constant. After reviewing the massive medical history, Dr. Bussanich noted that claimant had been rated and received her permanent disability award and her symptoms had not changed significantly since that time.

On January 29, 1986, Dr. Close opined that claimant's condition had worsened somewhat over time. However, due to the absence of information in his report regarding the time period, extent and reason for this alleged worsening, we find this conclusory statement unpersuasive.

Based upon the totality of claimant's complaints from the inception of her claim until the date of hearing, we find that her function disorder did not worsen following the last arrangement of compensation in April 1983. As late as March 3, 1983, claimant continued to experience almost complete body pain, characterized by pain throughout her entire spine as well as pain and numbness throughout all four limbs down to her fingers and toes. Claimant has never attempted to return to work since the day following her original injury. Since April 1983, claimant's symptoms waxed and waned, but she never improved to the point where she believed that she could return to any type of work. The physical condition that she demonstrated to the Orthopaedic Consultants and Dr. Close prior to claim closure indicated a near total inability to work or engage in the most basic daily activities. We find that her symptoms did not subsequently worsen and claimant has failed to prove her aggravation claim.

Penalties and attorney's fees

We adopt the Referee's conclusions as our own.

ORDER

The Referee's order dated May 27, 1987 is reversed in part and affirmed in part. The insurer's denial of claimant's aggravation claim is reinstated and upheld. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee not to exceed $2,350.

Board Member Crider, dissenting in part:

Dr. Grewe, claimant's treating physician, who testified persuasively, opined that claimant's physical condition did not worsen after April 1983 but that her increased subjective complaints were caused by psychological problems brought on by her compensable injury. (Tr. 40-41). Claimant's behavioral changes as a result of this psychological deterioration were severe and disabling. They support the Referee's conclusion that claimant had established an aggravation.

The majority has chosen to disregard the opinion of the treating physician and to find that claimant's functional disorder has not worsened. I, therefore, dissent from that portion of the Board's order which reinstates the denial of the aggravation claim.

MICHAEL A. PLUMB, Claimant
Brian R. Whitehead, Claimant's Attorney
Burt, Swanson, et al., Defense Attorneys
SAIF Corp Legal
Terri Borchers, Assistant Attorney General

WCB 88-07803
January 18, 1989
Order Denying Motion to Dismiss

Claimant has moved for an order dismissing the alleged noncomplying employer's amended request for Board review on the ground that it is untimely. Although we agree that the amended request is untimely, we conclude that we retain jurisdiction pursuant to the employer's prior request for Board review.

FINDINGS

The Referee's order, affirming the Director's finding that the employer was noncomplying, issued September 1, 1988. Thereafter, the employer, through its attorney of record, moved for reconsideration. On September 30, 1988, the Referee's order was abated. On November 7, 1988, the Referee reissued his September 1, 1988 order.

On November 16, 1988, the Board received a request for review of the Referee's November 7, 1988 order. The request, which was dated November 15, 1988, stated that "[t]he claimant respectfully requests" review. However, the request also identified the attorney requesting review as "[o]f Attorneys for Employer." In addition, the request was signed by the employer's attorney of record. The request also included a certificate of personal service by mail upon the parties to the proceeding before the Referee. The certificate was signed by the employer's attorney of record as one "[o]f Attorneys for Employer."

The Board processed the request for review. In so doing, the employer was designated as the appellant and claimant was named as a respondent. On November 17, 1988, the Board mailed a computer-generated letter to the parties acknowledging the request.

On December 22, 1988, the employer filed an amended request for Board review. Specifically, the request stated that the employer, rather than claimant, was requesting review of the Referee's order.

ULTIMATE FINDINGS

The employer requested Board review within 30 days of the Referee's order. All parties received notice of the request within 30 days from the date of the Referee's order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). 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(1). "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).

Here, the employer's December 22, 1988 "amended" request for Board review was submitted more than 30 days after the Referee's November 7, 1988 order. Thus, it is untimely. ORS 656.289(3).

However, we retain jurisdiction to consider this matter pursuant to the timely submitted November 15, 1988 request for review of the Referee's November 7, 1988 order. Admittedly, one portion of the request does state that "[t]he claimant" is requesting Board review. Yet, another portion of the request, as well as the certificate of personal service by mail accompanying the request, expressly identifies the individual requesting review as one "[o]f Attorneys for Employer." Moreover, the individual specifically requesting review is the employer's attorney of record.

Under these circumstances, we conclude that the November 15, 1988 request from the employer's attorney of record establishes that the party requesting review of the Referee's November 7, 1988 order is the employer. Inasmuch as this request was mailed to the Board and copies were also provided to the opposing parties within 30 days of the Referee's order, we conclude that we have jurisdiction to consider the issues raised by the request. See ORS 656.289(3); 656.295(1), (2).

Accordingly, the motion to dismiss is denied. Once a transcript is obtained and copies are distributed to the parties, a briefing schedule will be implemented.

IT IS SO ORDERED.

TONY R. SEELEY, Claimant
Charles D. Maier, Claimant's Attorney
Scheminske & Lyons, Defense Attorneys

WCB 88-15772
January 18, 1989
Order Dismissing Request for Board Review (Remanding)

Claimant has requested Board review of Referee Irving's December 6, 1988 order that allowed the insurer's motion to depose claimant. We have reviewed the request to determine whether the Referee's order is a final order, which is subject to review. Joseph Wilson, 40 Van Natta 66 (1988). We conclude that we lack jurisdiction to consider the request.

FINDINGS

On September 12, 1988, claimant requested a hearing concerning a September 9, 1988 Determination Order. The hearing request listed the issues of premature claim closure and extent of unscheduled permanent disability.

Shortly thereafter and prior to the scheduled hearing, the insurer moved for an order compelling claimant to submit to a discovery deposition. Claimant opposed the motion.

On December 6, 1988, Referee Irving allowed the motion. The Referee's order did not contain a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3). On December 12, 1986, claimant requested Board review of the Referee's order.

ULTIMATE FINDINGS

The Referee's order did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

CONCLUSIONS OF LAW

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139, rev den (1974).

Here, the Referee's order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order resolved a discovery matter in preparation for a forthcoming hearing.

Inasmuch as further action before the Hearings Division is required as a result of the Referee's order, we conclude that it is not a final, appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Consequently, we lack jurisdiction to consider the issues raised by the request for review.

Accordingly, the request for Board review is dismissed and this matter is remanded to Referee Irving for further proceedings.

IT IS SO ORDERED.

EILLENE J. SMITH, Claimant
Charles Robinowitz, Claimant's Attorney
Gretchen Wolfe (SAIF), Defense Attorney

WCB 86-03224
January 18, 1989
Order Denying Reconsideration

Claimant has requested reconsideration of that portion of the Board's Order on Review dated November 23, 1988 that affirmed a Referee's attorney fee award for prevailing against the SAIF Corporation's partial denial. The request is denied.

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 stayed, withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1985).

Here, the Board's November 23, 1988 order has neither been appealed, abated, stayed, withdrawn, republished, nor modified. Thus, it has become final by operation of law. ORS 656.295(8). Accordingly, the Board lacks jurisdiction to consider claimant's request.

IT IS SO ORDERED.

CHERYL A. HANKINS, Claimant
Max Rae, Claimant's Attorney
Kevin Mannix, Defense Attorney

WCB 86-15505
January 19, 1989
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated December 20, 1988. The request is granted, and the Board's prior order is withdrawn.

The insurer raised the issue of extent of permanent partial disability in its respondent's brief on review. In our initial order, we decided the extent question in favor of claimant and awarded her attorney an assessed fee for prevailing on this issue. On reconsideration, the insurer contends that claimant's attorney is not entitled to this fee.

The dispositive inquiry is whether the extent issue raised in the insurer's brief was otherwise before the Board. If not, then claimant's attorney is entitled to an assessed fee for additional legal services rendered on that issue. See Littleton v. Weyerhaeuser Co., 93 Or App 659 (1988); Delphia D. Shobe, 40 Or App 1703 (October 20, 1988).

The insurer sets forth a number of arguments in support of its contention. First, it argues that claimant is not entitled to an assessed fee because it did not "cross-appeal" on the extent issue, but instead, raised the issue in its respondent's brief. We disagree. The Court of Appeals has recently declined to recognize this alleged distinction between a "cross-appeal" and an issue raised informally in a respondent's brief. See Kordon v. Mercer Industries, 94 Or App 582 (January 11, 1989). Claimant's attorney was required to render additional services on the extent issue regardless of the method used to bring the issue before the Board.

The insurer next argues that the extent issue was otherwise before the Board because claimant raised and argued the issue at hearing. The insurer notes that the Board could have addressed the extent issue based upon the record developed at hearing even if the insurer had not raised and argued that issue in its respondent's brief. We are not persuaded by this argument. We recognize that the Board had discretion to reach the extent question even if the insurer had not raised that issue on review. However, we conclude that we would not have done so if the insurer had not raised the issue.

Finally, the insurer argues that the extent issue was otherwise before the Board because claimant raised it in her request for Board review and did not withdraw that request. The

insurer reasons that "[u]nlike cases where the insurer appeals or cross-requests on a new issue and claimant responds to those additional issues, in this case . . . claimant would have had to render legal services on Board review by virtue of [her] filing the Request for Board Review." We disagree. Claimant had the right to withdraw any or all issues raised in her request for review. Claimant's brief on review stated that "[c]laimant requests review of only that portion of [the Referee's order] which declined to set aside the . . . Determination Order as premature." We interpret claimant's brief as a withdrawal of her initial request for review on the extent issue. As a result, her attorney would not have been required to render services on the extent question absent the insurer's cross-request on that issue.

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

IT IS SO ORDERED.

ELEANOR A. EATON, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 87-0728M
January 23, 1989
Own Motion Order

SAIF Corporation initially submitted to the Board claimant's claim for an alleged worsening of her December 27, 1976 industrial injury. Claimant's aggravation rights had expired. The Board issued an order on January 27, 1988 wherein it postponed action on the own motion request until resolution of WCB Case No. 87-18308. That matter was resolved by stipulation dated July 18, 1988. In that settlement, the parties agreed that SAIF would rescind its November 16, 1987 denial and pay for claimant's medical treatment. It was also agreed that SAIF would no longer object to a Board order reopening the claim under ORS 656.278 and that temporary disability benefits should commence June 10, 1987, the date claimant became disabled.

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.

Because we are expressly limited to commencement of benefits from the day the claimant is hospitalized or undergoes outpatient surgery, we are unable to grant compensation in this matter from June 10, 1987. We conclude claimant's compensable condition did worsen and she is entitled to temporary disability benefits from July 1, 1987, the date she was hospitalized.

The parties have agreed to claimant's entitlement to benefits from June 10, 1987. We have previously ruled in Jesus Rodriguez, Own Motion Order, September 9, 1988, that ". . . we are unaware of any authority which would prevent SAIF from voluntarily paying additional permanent disability benefits. See ORS 656.018(4). Yet, since such benefits are not made by the Board pursuant to ORS 656.278, they would not be reimbursable from the Reopened Claims Reserve." Although Rodriguez addressed the payment of permanent disability benefits, we feel our conclusions

in that case are directly applicable here. The parties may choose to provide claimant with the extra temporary disability benefits in accordance with the holding in Rodriguez.

Claimant's claim is reopened with temporary disability benefits to commence July 1, 1987 and to continue until claimant returns to her regular work at her 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.

JERRY HANSEN, Claimant
Willner & Kelly, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-18118
January 23, 1989
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of that portion of Referee McCullough's order that upheld the insurer's denial of claimant's low back injury claim. On review, claimant asserts that his claim is compensable. In the alternative, he requests that this case be remanded to the Referee for the taking of additional evidence. We reverse on the merits.

ISSUES

1. Whether the Referee erred in not admitting Exhibit 20.

2. Whether claimant's claim is compensable.

3. In the alternative, whether this case should be remanded to the Referee for the taking of additional evidence.

FINDINGS OF FACT

At the time of the hearing, claimant had worked for the employer for approximately eight years. His job at the time of his alleged injury involved assembling aluminum frame windows. Specifically, claimant would take aluminum frames and single or double-pane glass panes from a stand, place them on a table, assemble one side and then flip them over in order to complete construction. Claimant worked in a small work area, requiring him to lift window casings off of his work table in order to turn them over. The assembled windows weighed between 20 and 40 pounds for the lighter models, and up to 60 to 100 pounds for the heavier ones.

Claimant regularly performed his work at a greater than expected capacity. Whereas 2.5 windows per hour was considered 100 percent capacity, claimant regularly completed between four and six per hour. He did so both before and after his alleged injury.

September 19, 1987 was a Friday. At approximately 1:30 p.m. on that date, claimant lifted a window at or over head level in order to flip it over. He felt a pulling sensation in his back, although he did not believe he had seriously injured himself. He worked the remainder of his shift (approximately two hours), and went home. Before doing so, he asked Bill George, a foreman, for overtime work during the coming weekend. He did not complain to the foreman or to Carol Oeder, a fellow employee, about a back injury on the date

in question. He did complain to his wife, however, upon speaking to her approximately an hour after leaving work.

After going home, claimant had dinner with his children and went to bed. His wife came home from work after claimant had retired. The next morning, claimant had to be helped from bed by his wife because of pain and stiffness in his low back. Claimant's wife helped him around the house and gave him a back rub. He rested the remainder of the weekend. He did not seek medical attention during the weekend because of his belief that his employer's medical insurance policy precluded weekend medical care. When claimant did not improve by the following Monday morning, his wife contacted the employer and reported his injury. She also contacted Dr. McIntyre, the family's general physician. McIntyre diagnosed a low back sprain and took claimant off work. Claimant's wife took the off-work slip to the employer the same day. Claimant ultimately filed a claim for compensation on September 30, 1987, or approximately two weeks after his alleged injury.

Claimant visited his family physician in 1984, complaining of low back pain.

At hearing, the Referee refused to admit a lengthy decision of the National Labor Relations Board, finding that it lacked relevance.

After the hearing, claimant submitted three additional exhibits and requested that this case be remanded to the Referee for the taking of that evidence. The evidence sought to be admitted was obtainable prior to or at the time of the hearing.

Claimant suffered a low back sprain on the job on September 19, 1987. His work was a material contributing cause of his sprain.

CONCLUSIONS OF LAW

1. Whether the Referee erred in not admitting Exhibit 20

The Referee refused to admit Exhibit 20, finding it of limited relevance. Referees have a measure of discretion with regard to the admission or exclusion of evidence. Rodney R. Rouse, 38 Van Natta 448 (1986). In this case, although the Referee refused to admit Exhibit 20 as substantive evidence, he afforded claimant's attorney the opportunity to reintroduce it for purposes of impeachment. Claimant's attorney declined. We find that under these circumstances, the Referee did not err.

2. Whether claimant's claim is compensable

The Referee found claimant's claim not compensable because of certain inconsistencies in the record. However, the Referee found nothing in claimant's demeanor that made him question claimant's credibility. He made the same finding with regard to claimant's wife. The Referee found the remaining witnesses credible.

We generally defer to a Referee's assessment of credibility when his or her finding is based on demeanor. Humphrey v. SAIF, 58 Or App 360 (1982); Robert W. Cooper, 40 Van Natta 486 (1988). On the other hand, when the Referee's credibility finding is based on the substance of the witnesses' testimony, rather than demeanor, we are

in as good a position to assess credibility as the Referee. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

In the present case, after reviewing the substance of the various witnesses' testimony, we disagree with the Referee's conclusions. The Referee was concerned about the following portions of the record: (1) claimant did not immediately report his injury to his employer; (2) claimant did not seek medical attention immediately; (3) claimant's testimony with regard to the methods used in building windows was inconsistent with that of Carol Oeder, a fellow employee; (4) claimant's testimony with regard to the weight of the windows he built was inconsistent with that of Ms. Oeder; (5) claimant's testimony that he produced at a 150 percent level after his injury was inconsistent with that of his employer, whose records reveal that claimant produced at a level of 202 percent on the date of the alleged injury; (6) claimant testified that he had no prior back problems, whereas the medical record reveals that he visited a physician with low back pain in 1984; and (7) claimant testified that he told Randy Wolf of his back injury, but he did not produce Wolf's testimony at hearing.

We address the Referee's concerns in order.

(1) Claimant reported his injury to his employer three days after it occurred. We do not find this unusual, for the injury occurred on a Friday and claimant rested over the weekend before reporting his injury. We accept claimant's testimony that he initially did not think his injury involved more than a routine muscle pull. Given that fact, we find it reasonable that he did not immediately report his injury.

(2) For the same reasons stated above, we do not find it unusual that claimant waited until the Monday after his Friday accident to seek medical attention, particularly when he was under the impression that his treatment would not be covered by his medical insurance policy.

(3) Claimant's testimony did conflict with that of Carol Oeder with regard to the methods for building windows. Claimant testified that he had to lift windows over his head in order to maneuver them into position. Oeder testified that "to her knowledge," overhead lifting was not necessary. Oeder further admitted, however, that she did not have constant view of claimant's workplace. In fact, on Fridays, Oeder's job duties routinely placed her in a position in which she could not see claimant working. She did not dispute the fact that claimant's workplace was small. Neither did she dispute claimant's testimony that the materials with which windows were made after Oeder stopped building them had changed, thereby requiring different methods of construction. On the whole, we find that Oeder's testimony, while in conflict with that of claimant, does not discredit claimant's version of the facts.

(4) Claimant testified that the windows he was building on the date of injury weighed between 60 and 100 pounds. Carol Oeder testified that they weighed between 20 and 40 pounds. We do not find the discrepancy critical, however, for claimant further testified that he was merely estimating the size and weight of the windows. We do not find his estimate so grossly disproportionate to that of Oeder to be fatal to claimant's claim.

5) Claimant testified that he produced at approximately 150

percent of the expected output after he was injured. The employer's records show that he produced at 202 percent. We do not find claimant's estimate of his productivity to be so different from the employer's records that his testimony must be disregarded.

(6) Claimant testified that he had no prior back problems. The medical record shows that he was treated for a brief period for a low back strain three years prior to the present injury. Claimant further testified, however, that he had experienced "muscle pulls" and other minor injuries in the past. We are not surprised that claimant did not recall a one-time back strain that occurred three years prior to the hearing. Claimant did not receive extensive treatment for that strain, and it is not unreasonable that he simply did not recall its occurrence.

(7) Claimant testified that he told Randy Wolf of his injury. Wolf did not appear at hearing to corroborate claimant's version of the facts. While Wolf's appearance may have been helpful to claimant's case, we will not assume from his failure to appear that claimant has misrepresented the facts.

The facts favorable to claimant's case are these: (1) he reported his injury to his employer within three days; (2) he sought medical attention within three days; (3) his testimony at hearing was entirely consistent with the history he gave the physicians who have examined him; (4) claimant's wife's testimony was entirely consistent with that of claimant regarding times, places and events; (5) each physician corroborated claimant's representation that he incurred physical injury; there is objective evidence of trauma; (6) each physician stated that claimant's injury was materially caused by his employment; and (7) there has been no alternative explanation for claimant's injury.

The aforementioned facts strongly support claimant's claim for accidental injury. This support, coupled with the Referee's neutral credibility finding on demeanor and the explanations for the few inconsistencies in the record, leads us to conclude that claimant's claim is compensable.

3. Whether this case should be remanded for the taking of additional evidence.

Although our conclusion with regard to the compensability of claimant's claim effectively moots the remand issue, we make the following conclusion of law on that issue for purposes of appeal.

We may remand a case to the Referee for further evidence taking if we determine that the case has been improperly, incompletely or insufficiently developed. ORS 656.295(5). Remand, however, is generally appropriate only upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). If evidence was obtainable prior to the hearing, remand is generally not appropriate. See Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

In the present case, claimant has offered two affidavits and a booklet outlining the employer's medical insurance policy. There has been no showing by claimant that this evidence was not obtainable prior to or at the time of the hearing. We, therefore, find remand inappropriate under the present circumstances.

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 authorize 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 authorized.

ORDER

The Referee's order dated October 13, 1987 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's claim for accidental injury is reversed. Claimant's claim is remanded to the insurer for acceptance and processing according to law. The remainder of the Referee's order is affirmed. A client-paid fee not to exceed $1,183.50 is approved.

E. Scott Ferris, dissenting:

I dissent. The majority's attempt to explain away the many discrepancies cited by the Referee is unconvincing. When taken together, the discrepancies strongly support his conclusion that claimant was not injured as he testified. I would affirm the order of the Referee.

FRANK C. JONES, Claimant
Pozzi, et al., Claimant's Attorneys
Terrall & Miller, Defense Attorneys

WCB 87-07847
January 23, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

The insurer requests review of that portion of Referee Podnar's order which found that claimant's neck and low back claim had been prematurely closed. On review, the insurer challenges the Referee's refusal to admit into evidence a surveillance film. In addition, the insurer requests authority to offset temporary disability benefits paid after March 31, 1987. We conclude that the Referee should have admitted the film. On the merits, we affirm.

ISSUES

1. Evidence. Whether the surveillance film was admissible for purposes of impeachment?

2. Medically Stationary Date. Whether claimant was medically stationary as of March 31, 1987, April 21, 1987, or some date thereafter?

FINDINGS OF FACT

Claimant, a 34-year-old sales representative, suffered a compensable car accident in December 1986. His primary treating physician was Dr. Miller, general practitioner, who diagnosed a cervical and lumbar strain. He treated claimant conservatively, prescribing physical therapy, anti-inflammatory medication and muscle relaxants.

Claimant was fired shortly after his injury for reasons unrelated to his injury.

When claimant's condition failed to improve, Dr. Miller

admitted him to the hospital. Hospital x-rays taken on January 8, 1987 disclosed severe degenerative changes of the lower spine. Claimant was discharged from the hospital three days later after exhibiting some improvement.

Dr. Miller continued to treat claimant conservatively. On February 20, 1987, Dr. Miller noted continued complaints of stiffness, pain and tenderness involving claimant's neck, mid and lower back. In addition to continued physical therapy, Dr. Miller suggested regular workouts in a therapy pool.

On March 6, 1987, Dr. Miller reported gradual improvement in claimant's condition.

On March 29, 1987, Dr. Miller reported that it would be 4 to 6 weeks before claimant could return to any type of employment. He also reported a number of temporary restrictions with regard to claimant's physical capacities. On that same date, Dr. Miller signed a job analysis form indicating that the job demands of claimant's at-injury employment were within claimant's physical abilities.

Dr. Langston, orthopedic surgeon, performed an independent medical examination of claimant on March 31, 1987. He reported that claimant was medically stationary.

A copy of this report was sent to Dr. Miller and he was asked whether he concurred with the report. In response, Dr. Miller referred claimant to Dr. Cohen, orthopedic surgeon, for further evaluation. Based upon his examination, Dr. Cohen reported on April 22, 1987 that claimant could be helped with hydrotherapy three times per week.

A May 11, 1987 Determination Order established a medically stationary date of April 21, 1987. The Determination Order did not award any permanent disability.

Dr. Miller reported by chart note dated May 21, 1987 that claimant's neck and low back were gradually improving.

Claimant was involved in an off-the-job automobile accident on May 26, 1987. This accident resulted in an exacerbation of his symptoms.

On June 23, 1987, Dr. Miller suggested that claimant be evaluated by Dr. Lee, psychiatrist. Dr. Miller also prescribed a reduction in physical therapy to twice per week.

Dr. Cohen reported on July 27, 1987 that he had no suggestions for treatment, but that he felt claimant's stiffness would subside with time. He reported by addendum dated July 30, 1987, that claimant was not medically stationary.

Dr. Lee reported on July 22, 1987 that claimant's off-work car accident had "complicated" his condition. He recommended acupuncture to reduce claimant's pain.

At hearing, the insurer offered a film showing claimant talking with his ex-wife in the parking lot of a shopping center. The film was taken the day before the hearing. After reviewing the film, the Referee took its admissibility under advisement. He subsequently determined not to admit the film.

FINDINGS OF ULTIMATE FACT

Claimant was not medically stationary on the date of closure.

CONCLUSIONS OF LAW AND OPINION

Admissibility of the Surveillance Film

The Referee declined to admit the film on the grounds that it had no probative value or relevance concerning the issue of premature closure. The Referee impliedly accepted claimant's contention that the relevant inquiry involved claimant's condition on April 21, 1987, the date of closure, rather than his condition on the day prior to hearing. We agree that this is the relevant issue.

However, the film was offered by the insurer for purposes of impeaching claimant's credibility. Specifically, the insurer argues that claimant's testimony at hearing regarding continuing physical limitations conflicts with his allegedly unrestricted movements as exhibited on the surveillance film. Consequently, argues the insurer, claimant's credibility is impeached thereby raising doubts as to the persuasiveness of any medical opinions dependent upon an accurate history.

We agree that the film is relevant and admissible for purposes of impeachment. See OAR 438-07-017. However, while we find that the film is relevant with regard to the issue of claimant's credibility, we also find that it has little probative value on this question. We note in this regard that claimant's testimony at hearing was not such as to lead us to expect to observe any marked limitations of movement.

Premature Closure

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, 625 (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).

The insurer contends that we should disregard any medical reports generated subsequent to May 26, 1987 because claimant's car accident on that date "changed, if not worsened," his condition. In this regard, evidence not available at the time of closure may be considered in determining whether a claim was prematurely closed to the extent that the evidence addresses the condition at the time of claim closure. Scheuning, supra. We are inclined to find that the medical reports generated subsequent to claim closure do not sufficiently distinguish between claimant's condition at the time of closure and his condition resulting from the May 26, 1987 accident. However, even if we do not consider this evidence, we are nevertheless persuaded that claimant's condition was not medically stationary as of the date of closure.

On March 6, 1987, Dr. Miller noted gradual improvement in claimant's condition. He reported on March 29, 1987 that it would be a month or more before claimant could return to any type of employment. This statement implies that claimant's condition would improve during this period. He also imposed a number of temporary

restrictions. Again, the fact that these restrictions were temporary implies that Dr. Miller anticipated improvement in claimant's condition. Moreover, by chart note dated one month following the medically stationary date established by Determination Order, but still prior to the off-work car accident, Dr. Miller again noted gradual improvement in claimant's condition. These statements support the conclusion that claimant was not yet medically stationary as of April 21, 1987.

The insurer argues that we should rely upon Dr. Langston's opinion that claimant was medically stationary as of March 31, 1987. Moreover, the insurer requests that we authorize an offset of temporary disability benefits paid after that date against any future awards of permanent disability. However, we are not persuaded by Dr. Langston's opinion. Dr. Langston examined claimant only once. By contrast, Dr. Miller began treating claimant three days following the compensable accident and continued to treat him through the date of claim closure. His opinion regarding claimant's medically stationary status is, therefore, entitled to considerable deference. See Brad T. Gribble, 37 Van Natta 92, 97 (1985).

In addition, Dr. Miller's opinion is also supported by Dr. Cohen's April 22, 1987 report to the effect that claimant could be helped with hydrotherapy three times per week. This recommendation is particularly significant as it was made the day after the medically stationary date established by Determination Order.

We conclude that claimant was not medically stationary as of the date of closure. Consequently, the insurer's request for authorization of an offset of temporary benefits paid after March 31, 1987 is rejected.

ORDER

The Referee's order dated August 12, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $700, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $233.50.

CHARLES REIGARD, Claimant
Michael Stebbins, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 84-07376
January 23, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee Mongrain's order that granted claimant permanent total disability, whereas a Determination Order had awarded 35 percent (112 degrees) unscheduled permanent disability for a low back injury. The sole issue on review is extent of disability, including permanent total disability. We affirm.

FINDINGS OF FACT

Claimant, 64 at hearing, has a long history of heavy work, primarily in lumber mills. For ten years prior to the instant injury he worked for the employer as a millwright. He completed the sixth grade, but obtained an associate's degree in industrial sciences some years later.

In 1966 claimant suffered a compensable injury to his left

knee which resulted in an award of 50 percent scheduled permanent disability. In addition, claimant has a history of preexisting chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), hernia, duodenal ulcers, and angina.

Dr. Murray, claimant's treating internist, diagnosed CAD in 1978. In May 1980, he diagnosed COPD and tested claimant at 84 percent of normal lung capacity. In June 1982, claimant's lung capacity was 55 percent of normal.

On September 9, 1981, claimant fell and suffered a compensable low back injury which constitutes his current claim (Ex. 1). He was initially treated conservatively, but ultimately had a spinal fusion at L5-S1 and decompression of the S1 spinal nerve on the right (Ex. 29). He has not returned to work since the surgery.

Claimant's back condition has not improved since surgery. He has continued pain, and was hospitalized twice in 1983 and 1984 due to low back problems (Ex. 41, 59). On April 3, 1984, Dr. Adams, claimant's treating orthopedic surgeon, reported that he doubted claimant would return to work, and recommended medical retirement (Ex. 62-4). This opinion was shared by examining physicians Dr. Campagna (Ex. 57-2) and Dr. Bert (Ex. 53). Dr. Bert also reported that he "would not certify [claimant] for any job or job training." (Ex. 58, 67, 68). Dr. Bert later opined that claimant could possibly do light work not requiring any lifting, bending or stooping, and which allowed him to change positions frequently. (Ex. 79).

In early 1984 a vocational counselor, Mr. Chandler, worked with claimant regarding returning to work in some capacity with the employer. In May 1984 the counselor closed claimant's file on the basis that "vocational services will not resolve the lack of suitable employment for this worker."

On June 24, 1984, a Determination Order issued granting claimant 35 percent unscheduled permanent disability for his low back condition.

In October 1984, claimant was examined by the Orthopaedic Consultants, who reported that given claimant's cardiovascular limitations, low back complaints and left knee impairment, he would be suited only for work of a totally sedentary nature. (Ex. 83).

In January 1985, Dr. Adams reported that, based solely on objective low back findings, claimant might be employable, in light to medium work at most. However, he did not feel that objective and subjective findings could be completely separated. (Ex. 87-5) Dr. Adams conceded that he had considered non-medical factors when he recommended retirement. (Ex. 87-8).

Claimant had at least two heart attacks in 1985. (Ex. 90)

In 1985, Mr. Chandler was asked by the employer to evaluate claimant's employability. Chandler assigned another vocational consultant the task of documenting "that there are available jobs within the community within his skills or employers who would offer him training based on his background." (Ex. 91aaa) She was advised to present claimant's qualifications as a millwright with experience in blueprint reading, mechanical repair and welding; to present his physical limitations as restricted to lifting 10 to 15 pounds, and needing to change positions frequently; and to state his age as "over 50." (Ex. 91aaa, 95).

In March 1986, Dr. Murray reported that, in terms of cardiovascular status, claimant was severely limited. A consulting cardiologist, Dr. Rogers, examined claimant in April 1986 and reported that claimant's heart condition precluded his return to work as a millwright, and that the addition of the lumbar condition made it unfeasible to consider rehabilitation. (Ex. 90, 91).

Dr. Adams reported that he did not believe claimant to be a malingerer (Ex. 87-10). Based on his demeanor at hearing, claimant was a credible witness.

CONCLUSIONS OF LAW AND OPINION

Claimant must prove by a preponderance of the evidence that he is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). There are two types of permanent total disability: (1) that arising entirely from physical or mental incapacity; and (2) that arising from less than total physical incapacity plus non-medical conditions, which together result in permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

Claimant's September 1981 compensable injury ultimately resulted in a myelogram and surgery to fuse the L5-S1 disc and release the spinal nerve at S1. A Determination Order has awarded him 35 percent unscheduled permanent disability for his low back condition. In addition, claimant had a prior left knee injury for which he had received an award of 50 percent scheduled permanent partial disability. He also has a number of preexisting physical conditions which are noncompensable in themselves, but which must be included in assessing claimant's disability. ORS 656.206; Weyerhaeuser Co. v. Rees, 85 Or App 325 (1987). We consider these conditions only as they existed at the time of the injury. Emmons v. SAIF, 34 Or App 603 (1978); John D. Kreutzer, 36 Van Natta 284 aff'd mem 71 Or App 355 (1984); Frank Mason, 34 Van Natta 568, aff'd mem 60 Or App 786 (1982).

In 1978 claimant was diagnosed as suffering from mild CAD. In May 1980, he was diagnosed as having COPD, with a reduced lung capacity of 84 percent. Nine months after his back injury, in June 1982, his lung capacity was 55 percent of normal. He also had a hernia, angina and ulcers. These conditions kept claimant from work only temporarily prior to his back injury.

Claimant's work as a millwright is classified as heavy work. Most recently after his low back injury, claimant's orthopedist, Dr. Adams, and his cardiologist, Dr. Murray, both reported that he could perform sedentary to light work. Because both physicians are of the opinion that he could work, we conclude that claimant has not shown that he is permanently totally disabled on the basis of physical incapacity alone.

Claimant can prove that he is permanently totally disabled based on combined medical and non-medical factors, provided his compensable injury is a material contributing factor in that disability. Destael v. Nicolai Co., 80 Or App 546 (1986). The mere fact that claimant's noncompensable and preexisting heart condition has worsened does not preclude an award for permanent total disability. Claimant's back condition has been essentially the same since 1984. At that time, his treating physicians opined that he was totally disabled. The vocational counselor terminated vocational services because vocational services would not help claimant to find work.

Claimant has been awarded 35 percent permanent disability for his low back. He experiences chronic pain from his back, and his mobility has been severely limited. He cannot bend or stoop, and has been restricted to lifting 10 to 15 pounds. He must change positions regularly. We find that claimant's compensable injury and its sequela are a material contributing factor in claimant's disability.

Non-medical considerations in evaluating permanent total disability include: claimant's age, education, adaptability to non-physical labor, mental capacity, and conditions of the labor market. Welch, supra. Claimant was 64 at the time of hearing. He completed the sixth grade, but has an associate's degree in industrial sciences. His doctors say that he may perform light or sedentary work, such as bench work, for which he has many transferable skills. His lifting restrictions and need for frequent change of position require a modified work setting, however, i.e. a hydraulic lift jack, coworker assistance, and a stool.

A vocational counselor testified that a labor market survey revealed several employers who would consider a person with claimant's work skills, although none guaranteed they would hire him. At least one expressed interest in hiring injured workers, knowing that wage subsidies were available. The vocational counselor admitted, however, that the employers had not been told claimant's age, nor his full history of physical impairment. If those things had been revealed to prospective employers, the counselor conceded that "the only one who would be interested in him is his physician." (Tr. 307)

The vocational counselor opined that, because of claimant's transferable skills, he would be trainable for positions with several employers. However, none of that training had been explored with or offered to claimant at the time of hearing. Disability must be determined based on claimant's current condition, not on his potential for future employment after retraining. Welch, supra.

Claimant has not looked for work since his back surgery. He sent out one application in response to information sent him by the vocational counselor. The employer contends this conduct suggests a lack of motivation to return to work and is fatal to his claim of permanent total disability. We disagree.

Claimant must be willing to seek regular and gainful employment and must make reasonable efforts to obtain such work, ORS 656.206(3), unless the attempt would be futile. Wiley v. SAIF, 77 Or App 486 (1986). Because claimant could not return to his regular work due to his compensable injury and because the vocational counselor had concluded that claimant needed training to be reemployed, we conclude that it was futile for claimant to pursue further work-search once three physicians had informed him he was totally disabled and his vocational counselor had terminated vocational assistance because it would not help him to find work. Accordingly, we conclude that claimant has satisfied ORS 656.206(3) and has established that he is entitled to an award of permanent total disability.

ORDER

The Referee's order dated July 29, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $600, to be paid by the self-insured employer. The Board approves a client-paid fee not to exceed $540.

MARLON SHEWMAKER, Claimant

Own Motion 88-0597M
January 23, 1989
Own Motion Order

On October 27, 1988 the Board issued an Own Motion Order whereby the request for own motion relief was denied as claimant did not require hospitalization for treatment or surgery in accordance with ORS 656.278(1)(a). Claimant's situation has recently changed, in that he underwent surgery on December 12, 1988. The insurer authorized the surgery and agreed to pay the surgery costs, but has denied further medical benefits related to claimant's current herniated nucleus pulposus, L4-5 on the right. Claimant seeks temporary disability benefits during his recovery from surgery. The insurer asks that we deny the relief claimant seeks, as it contends claimant's current condition is not related to the 1980 compensable injury.

The evidence is clear that the insurer authorized and will pay for the December 12, 1988 surgery. Even though the insurer contends that such authorization was mistakenly given, we conclude claimant is entitled to claim reopening and payment of temporary disability benefits during his recovery period. Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date he was hospitalized for surgery in December 1988 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.

The Beneficiaries of
JONG J. AHN, Claimant
Peter O. Hansen, Claimant's Attorney
Meyers & Associates, Defense Attorneys

WCB 85-00438
January 26, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Ahn v. Frito-Lay, Inc., 91 Or App 443 (1988). The court has concluded that the deceased worker's beneficiaries are not entitled to benefits under ORS 656.204 and 656.218 resulting from the worker's deliberate suicide. However, the court has held that the beneficiaries are "still entitled to benefits related to the worker's compensable shoulder and psychiatric conditions, pursuant to ORS 656.218." Consequently, the court has remanded for a determination of those benefits due under ORS 656.218.

ORS 656.218(1) provides that "[i]n case of the death of a worker entitled to compensation, whether eligibility therefor or the amount thereof have been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto."

Here, the Referee found that the deceased worker was entitled to temporary total disability benefits payable between November 29, 1984 and her June 28, 1985 suicide. Consequently, the Referee awarded the difference between the temporary partial disability benefits the decedent had received during this period and the temporary total disability benefits she should have received, i.e., $3,264.12. In addition, the Referee assessed:

(1) a penalty for the self-insured employer's unreasonable claim processing equal to 25 percent of the aforementioned amount; and (2) a reasonable penalty-associated attorney fee of $1,600. See ORS 656.262(10).

On remand, we agree with the Referee that the deceased worker was entitled to the aforementioned benefits and awards as a result of her compensable conditions. Consequently, we adopt those portions of the Referee's May 30, 1986 order, as reconsidered July 15, 1986, which pertained to the issues detailed above.

Accordingly, to the extent that the employer has not previously complied with the aformentioned portions of the Referee's order, claimant is awarded $3,264.12 in temporary disability benefits due between November 29, 1984 and June 28, 1985, a penalty equal to 25 percent of these benefits, and a reasonable attorney fee of $1,600.

IT IS SO ORDERED.

RONALD BLUE, Claimant
John Doherty, Claimant's Attorney
James E. Griffin, Assistant Attorney General

WCB TP-88032
January 26, 1989
Third Party Distribution Order

The SAIF Corporation, as paying agency, has petitioned the Board for resolution of a dispute concerning the proper distribution of proceeds from any third party recovery obtained by claimant. We conclude that SAIF is entitled to a share of the proceeds from any such recovery pursuant to ORS 656.593(1), and (3).

FINDINGS

Claimant sustained an injury while working for SAIF's insured. SAIF accepted the claim and has provided compensation. To date, SAIF has incurred actual claim costs totalling $52,845.12. In addition, it estimates the present value of its reasonably anticipated future claim expenditures to be $20,644.88. However, claimant's claim has not been closed.

Claimant initiated a cause of action against a third party, United Grocers, contending that it was liable for his compensable injury. On or about September 19, 1988, claimant, through his attorney, notified SAIF of the pendency of a settlement conference between claimant and the third party. Other than this notification, claimant has refused to acknowledge SAIF's rights, as a paying agency, to a share of the proceeds from any third party recovery.

FINDINGS OF ULTIMATE FACTS

Claimant sustained a compensable injury in the course of his employment for SAIF's insured. The proceeds from any recovery claimant obtains from the third party are attributable to his cause of action stemming from his compensable injury. Although SAIF has paid benefits to claimant, the extent of his disability has not been finally determined.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third person, the worker shall elect whether to recover damages from the third person. ORS 656.578. The proceeds

of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

"Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576. "Insurer" means SAIF or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state. ORS 656.005(14).

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

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

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). 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).

Here, claimant sustained a compensable injury while working for SAIF's insured. Inasmuch as SAIF has paid benefits to claimant as a result of the compensable injury, it is a "paying agency." See ORS 656.005(14); 656.576.

Furthermore, upon claimant's election to seek the recovery of damages against the third party, the provisions of ORS 656.593 became applicable. Consequently, SAIF is entitled to its statutory share of the proceeds from any third party judgment or settlement obtained by claimant. See ORS 656.593(1), (3).

Finally, SAIF has established that it has incurred actual claim costs of $52,845.12. Thus, it is entitled to recover these costs, to the extent possible, from the remaining balance of proceeds from any third party recovery. See ORS 656.593(1)(c), (3). Yet, the record does not establish that the claim has been closed. In fact, the record suggests that claimant's condition has not become medically stationary. Inasmuch as there not been a final order determining the extent of claimant's disability arising out of his compensable injury, we deem it appropriate to defer ruling on the question of SAIF's entitlement to a lien for anticipated future expenditures. See John T. Elicker, 40 Van Natta 68 (1988); Robert B. Williams, 37 Van Natta 711 (1985).

Accordingly, we hold that SAIF is a paying agency and, as

such, is entitled to its statutory share of the proceeds from any third party recovery obtained by claimant. To achieve this result, claimant is directed to advise SAIF of the existence and amount of any third party recovery. In the event that a third party settlement has been reached, claimant shall distribute the proceeds in accordance with ORS 656.593(3). If a third party judgment has been obtained, claimant shall distribute the proceeds in accordance with ORS 656.593(1). Upon final resolution of the extent of claimant's disability and assuming a dispute exists concerning SAIF's entitlement to the remaining balance of any proceeds from the third party recovery, the parties shall petition the Board for further relief.

IT IS SO ORDERED.

CALVIN D. EDGAR, Claimant
Hayner, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-06739
January 26, 1989
Order Denying Reconsideration

The self-insured employer ("employer") has requested reconsideration of the Board's Order on Review, dated December 21, 1988, which, inter alia, affirmed the Referee's finding that claimant's low back condition was compensable. Specifically, the employer objects to the Board's award of a $1,000 assessed fee for claimant's attorney's services on review. See ORS 656.382(2); OAR 438-15-070.

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 the 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 issues concerning attorney fees where our final or appealed orders did not address the issue of either the counsel's entitlement to, or the amount of, an attorney fee. Jane E. Stanley, 40 Van Natta 831 (1988); Franklin Brown, 40 Van Natta 786 (1988).

Here, our December 21, 1988 order addressed both claimant's counsel's entitlement to, and the amount of, a carrier-paid attorney fee for services on Board review. Inasmuch as our order has neither been appealed, abated, stayed, or republished, it has become final by operation of law. Consequently, we lack jurisdiction to consider the employer's request. Accordingly, the request is denied.

IT IS SO ORDERED.

RICHARD M. EGLI, Claimant
Malagon & Moore, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 87-00050
January 26, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) rejected his request for additional temporary disability compensation; and (2) declined to assess penalties and attorney fees for the self-insured employer's alleged unreasonable failure to pay temporary disability timely and for its alleged unreasonable termination of temporary disability. The employer cross-requests review of that portion of the Referee's order wherein he concluded that he had jurisdiction to consider the merits of the temporary disability issue. We conclude that the Referee had jurisdiction. We reverse on the merits of the temporary disability issue and with regard to penalties and attorney fees.

ISSUES

1. Jurisdiction. Whether claimant's claim is one for aggravation, the exclusive jurisdiction of which rests with the Board pursuant to its "Own Motion" authority under ORS 656.278?

2. Temporary Disability. Whether claimant retired from the work force, thereby defeating entitlement to temporary disability benefits?

3. Penalties and Attorney Fees.

FINDINGS OF FACT

Claimant operated heavy equipment and sometimes worked as a choker setter for the employer. In June 1981, he filed an injury claim for problems relating to his left hip and low back. The employer characterized the injury as nondisabling and deferred acceptance or denial.

Five years passed. The employer took no formal action to accept or deny the claim. Nor was the claim closed. Meanwhile, claimant experienced continuing problems with his hip and back, but he lost no time from work. These problems were particularly troublesome when he worked as a choker setter. Medical reports indicate he will eventually require a left hip replacement.

In June 1986, claimant participated in a labor strike. When the strike was settled several weeks later, claimant's job had been modified. Pursuant to the settlement agreement, he had a choice of either accepting the new job or accepting a severance package. Claimant felt that he could not physically handle the modified job. He elected to take the severance package. He subsequently began receiving unemployment benefits.

In October 1986, the employer formally accepted the claim. The acceptance letter did not indicate whether the claim was accepted as a disabling or a nondisabling injury.

In November 1986, Dr. Collis, orthopedic surgeon, examined claimant and subsequently reported that claimant could perform light work. Dr. Danis, orthopedic surgeon, also reported in November that claimant was limited to light or sedentary work. The physical requirements of the proposed post-strike job duties exceeded these restrictions.

The employer apparently did not respond to the reports. Claimant filed a hearing request alleging, among other things, entitlement to temporary disability benefits. The employer responded with a check for temporary disability covering approximately a four-week period commencing on the date of Dr. Collis' report. This check was followed by two more checks.

Dr. Collis reported in a January 1987 chart note that claimant was attending class(es) at a community college in order to "retrain himself...to do lighter work."

A few months later, in March 1987, the employer informed claimant that his authorization to be off work was received beyond the five-year aggravation date from the time of his original injury. Relying on ORS 656.273(4)(b), the employer recommended claimant contact the Board with regard to an "Own Motion" reopening and the employer discontinued payment of temporary benefits. Claimant filed a supplemental request for hearing challenging the employer's denial of further temporary benefits.

Claimant has not retired from the work force.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The employer argued at hearing that the Referee lacked jurisdiction to hear the temporary disability issue because claimant's aggravation rights had expired. The employer relied upon former ORS 656.262(10)(now ORS 656.262(12)) and ORS 656.273(4) in support of its position. At the time of claimant's 1981 injury, ORS 656.262(10) provided, in pertinent part:

> "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." (Emphasis supplied.)

At the same time, ORS 656.273(4) provided in pertinent part:

> "(a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the first determination made under [ORS 656.268(3)].
>
> "(b) If the injury was nondisabling and no determination was made, the claim for aggravation must be filed within five years after the date of injury." (Emphasis supplied.)

The employer argued that claimant was asserting that his nondisabling 1981 injury had become disabling. Because that claim was being made more than one year after the date of the injury, the employer contended that, pursuant to former ORS 656.262(10), the claim must be made as one for aggravation. Moreover, argued the employer, claimant was required by ORS 656.273(4)(b) to make that claim within five years of the date of injury. Claimant's claim here was outside that five-year period. Consequently, concluded the

employer, claimant was only entitled to relief pursuant to the Board's "Own Motion" authority.

Claimant, on the other hand, asserted that his aggravation rights had not expired because his claim was never closed. He contended, therefore, that the five-year aggravation period had not begun to run. Claimant pointed, in turn, to the Court of Appeals' decision in Davison v. SAIF, 80 Or App 541 recon 82 Or App 546 (1986), for the proposition that all claims, disabling or nondisabling, must be closed before the five-year aggravation statute begins to run.

In Davison, the claimant lost a small portion of his little finger. SAIF accepted the 1982 injury as nondisabling. The claimant did not seek reclassification of the injury from nondisabling to disabling within one year of the injury. See ORS 656.262(12). The claimant later sought reclassification from the Evaluation Division, contending that his claim had never been formally closed either administratively or by Determination Order as required by ORS 656.268(3). SAIF contended that claimant's request for reclassification was untimely because SAIF's previous "Notice of Acceptance" of the claim as nondisabling had simultaneously satisfied the closure requirements of ORS 656.268(3).

The Davison court first found that the claim had been misclassified from the outset. Thus, ORS 656.262(12) did not apply. The court next noted that SAIF conceded that an insurer is required to close a nondisabling claim. SAIF argued, however, that its notice of acceptance met that requirement. The court disagreed. The court found that the notice did not comply with ORS 656.268(3) because it had not informed the claimant that it was a notice of closure as required by statute. Accordingly, since the claim had not been properly closed, the court reasoned that the claimant's right to seek a Determination Order had not yet expired.

The interplay between former ORS 656.262(10) and ORS 656.273(4) was discussed by the Court of Appeals in Smith v. Ridgepine, Inc., 88 Or App 147 (1987). In Smith, claimant sustained a low back injury on February 8, 1980. The insurer accepted the claim as nondisabling. Claimant received treatment for her injury which was apparently paid for by the insurer. The claim was never closed. Subsequently, on February 19, 1985, the insurer received a letter from claimant's physician reporting that claimant suffered from a chronic back strain related to the 1980 injury. The court treated this letter as a claim for temporary disability compensation. The court concluded that the claim was barred because claimant did not file it within five years of her injury as required by ORS 656.273(4)(b). The court did not discuss the fact that the claim had never been closed. Nor did the court address any issues raised by Davison, supra.

We have some difficulty reconciling the two decisions. Moreover, if the Smith rationale is applicable here, then the Referee lacked jurisdiction to consider the merits of the claim. If, on the other hand, the philosophy underlying Davison applies so that claimant's aggravation rights do not begin to run until claim closure, then the Referee properly exercised jurisdiction.

More precisely, we must decide whether former ORS 656.262(10) is applicable. If so, as was true in Smith, then the Referee lacked jurisdiction to hear the claim. If former ORS 656.262(10) is not applicable, as was true in Davison, then the

Referee properly exercised jurisdiction. We conclude in this regard that former ORS 656.262(10) is not applicable.

This conclusion is based upon our determination that former ORS 656.262(10) is premised on the assumption that the carrier will, upon claim acceptance, classify the injury as disabling or nondisabling. At that time, the carrier is required to notify claimant of his right to challenge that classification within one year from the date of injury. If the claimant fails to do so, then a claim for temporary or permanent disability must be made as an aggravation claim. In effect, application of former ORS 656.262(10) results in a de facto closure of the claim after one year.

Here, the employer initially classified the claim as nondisabling and deferred acceptance or denial. However, the employer's October 30, 1986 acceptance letter did not indicate whether the claim was accepted as a nondisabling or a disabling claim. Moreover, even if one could assume that the claim was accepted in 1986 as nondisabling because that was the designation at the time of deferral in 1981, the acceptance letter nevertheless failed to inform claimant of his right to challenge that classification. Under these circumstances, we will not apply former ORS 656.262(10) to treat the claim, in effect, as closed after one year.

In sum, the employer's failure to classify claimant's claim as nondisabling and to inform claimant of his right to challenge such a classification, coupled with the employer's failure to close the claim, convinces us that Davison, rather than Smith, is controlling. We, therefore, conclude that the Referee properly exercised jurisdiction over this claim.

Temporary Disability

The Referee concluded that claimant had retired from the work force. He found that an employee who has retired from the work force, regardless of the reason, is not entitled to temporary disability compensation. Claimant argues on review that he did not retire, but instead simply refused a job outside his physical limitations.

The determinative inquiry as noted by the Supreme Court in Cutright v. Weyerhaeuser Co., 299 Or 290, 296 (1985), and recently applied by the Court of Appeals in Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987), is whether claimant has lost wages because of an inability to work as a result of his compensable condition. Noffsinger, 88 Or App at 121.

Claimant elected severance because he did not feel he could perform the job that was offered to him after the strike. There are no contemporaneous medical reports addressing this point. However, claimant went to see Dr. Kappes, a rheumatologist and internist, about one month following electing severance. Dr. Kappes opined that claimant's prognosis was guarded in terms of long term outlook. He also noted significant hip findings. Two months later, Drs. Collis and Davis opined that claimant was limited to light to sedentary activities. Based upon this evidence, we conclude that claimant has proven by a preponderance of the evidence that, as a result of his compensable injury, he was not capable of performing the post-strike job.

The employer cites the Court of Appeals' decision in Karr v. SAIF, 79 Or App 250 (1986), for the proposition that an involuntary withdrawal from the work force, even though caused by a compensable injury, extinguishes a worker's entitlement to temporary disability benefits. We agree with the employer's characterization of the holding in Karr. We conclude, however, that Karr is factually distinguishable.

Claimant in Karr did not contest the finding that he was retired. He was in his mid-60s at the time. Here, claimant's receipt of unemployment benefits is evidence that he has not retired from the work force. In addition, Dr. Collis reported that claimant was attending classes in order to retrain himself for light work. The employer offered no evidence of retirement other than the fact that claimant severed his employment. We find that claimant has not withdrawn from the work force.

Second, assuming claimant has withdrawn from the labor force, Karr dealt with entitlement to temporary disability benefits upon reopening of a previously closed claim whereas this claim has never been closed. We have serious doubts whether a retirement for reasons related to a compensable injury, prior to claim closure, extinguishes a worker's right to temporary disability benefits.

For these reasons, claimant is entitled to temporary disability benefits until claimant is either medically stationary and has returned to work or the claim is closed.

Penalties and Attorney Fees

Claimant requested penalties for the employer's delayed payment of temporary compensation. There is no evidence in the record when the employer became aware that claimant had elected severance because of his injury. The employer began paying benefits shortly after claimant filed his hearing request. At that time, it paid benefits retroactive to the date when claimant's doctor opined claimant was capable of light work. We do not find that the employer was unreasonable in not paying before then.

Claimant also alleges entitlement to penalties and attorney fees for the employer's subsequent termination of benefits at the same time it recommended claimant seek "Own Motion" relief from the Board. In this regard, once an employer begins paying temporary disability benefits, it may not unilaterally terminate those benefits unless the worker has returned to regular work or is both medically stationary and released for work. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 on recon 93 Or App 103, rev den 307 Or 236 (December 1988).

Here, the employer unilaterally terminated benefits after it had accepted the claim and had begun paying temporary disability compensation. At that time, none of the circumstances justifying unilateral termination of time loss had occurred. Under these circumstances, we find that the employer's unilateral termination of benefits was improper. See Bertha J. Miner, 40 Van Natta 518 (1988). We conclude that a 25 percent penalty is appropriate.

ORDER

The Referee's order dated June 26, 1987 is affirmed in part and reversed in part. That portion of the Referee's order that

declined to award claimant additional temporary disability is reversed. The claim is remanded to the self-insured employer for further processing in accordance with law. Claimant's attorney is awarded an approved fee of 25 percent of claimant's increased temporary total disability compensation, not to exceed $3,800. This fee award is to be paid out of, not in addition to, claimant's increased compensation. That portion of the Referee's order that declined to assess a penalty is also reversed. The employer is assessed a penalty equal to 25 percent of the amount of temporary total disability due and owing under this order. As a reasonable attorney fee on the penalty issue, claimant's attorney is awarded a $500 fee, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed $400.

BERNICE ERWIN, Claimant
Pozzi, et al., Claimant's Attorneys
Bottini, et al., Defense Attorneys

WCB 86-04209
January 26, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals for reconsideration pursuant to the court's opinion in Armstrong v. Asten-Hill Co., 90 Or App 200, 205 (1988). Erwin v. Safeco Insurance Co., 92 Or App 99 (1988). After reconsideration, we issue the following order.

Claimant requests review of Referee St. Martin's order that upheld the insurer's denial of "ongoing" medical treatment for her current back condition on the ground that the need for treatment is not causally related to her compensable injury. Claimant contends that her compensable injury remains a material contributing factor of her current need for treatment. If the Board agrees, the insurer argues that further chiropractic treatment is not reasonable and necessary.

The issue is medical services. In our initial order, issued October 16, 1987, we affirmed the order of the Referee. On remand, we reverse.

FINDINGS OF FACT

Claimant had no back problems prior to December 1974. At that time, she sustained a compensable low back injury while lifting cases of beer for her employer. Her symptoms included back pain and radiating pain and intermittent numbness in both legs. Claimant's treating orthopedist, Dr. Fagan, diagnosed lumbosacral strain and a ruptured lumbar disk. A myelogram performed in April 1975 demonstrated a mildly protruded L4-5 disc, bilaterally. The record contains no evidence of any prior x-rays or myelograms. Claimant filed a claim which was accepted as a disabling injury. Her symptoms improved with conservative treatment, and Dr. Fagan released her to regular work in November 1975.

Claimant lived and worked in Alaska from May 1976 through February 1980, and she returned to Oregon for brief visits. During this period she continued to experience symptomatic back and leg flare-ups. While in Alaska, she self-treated her symptoms with bedrest, exercise, and home traction. During her visits to Oregon she received further treatment from Dr. Fagan. In particular, he hospitalized claimant for traction in January 1977. Surgery was considered at that time, but not performed when claimant responded positively to the traction.

In April 1978, claimant sustained a right knee injury when she bumped into the drawer of a file cabinet. She experienced no increased back or radiating leg symptoms as a result of that injury. A Determination Order, issued July 23, 1979, closed claimant's 1974 back injury claim with no award of permanent disability. In November 1980, claimant and the insurer entered into a stipulation whereby claimant received a 10 percent award of unscheduled permanent partial disability. The parties also stipulated that claimant would be entitled to ongoing medical care and treatment pursuant to ORS 656.245.

In February 1980, claimant experienced a significant exacerbation of low back and bilateral leg pain following falls at her home in Alaska on two separate occasions. Since that time, she has continued to experience fairly constant back and leg symptoms. Repeat diagnostic studies in May 1980, June 1980 and July 1986 demonstrated progressively worsening degenerative disease at L4-5 and L5-S1.

Claimant moved back to Oregon shortly after her February 1980 exacerbation. She has remained in the state except for periods in 1984, 1985 and 1986 when she returned to Alaska for short-term jobs of several month's duration. While in Oregon, she has received chiropractic treatment from Dr. Danis on an as-needed basis since May 1980. While in Alaska, she received massage therapy and DMSO treatment as a substitute for chiropractic manipulation, which was not readily available due to the remoteness of the area in which she lived and worked.

In early 1986, claimant's attorney contacted the insurer and inquired whether it would voluntarily reimburse claimant for the massage therapy and DMSO treatment she received in Alaska. On February 24, 1986, the insurer issued a denial of claimant's massage therapy and DMSO treatment on the ground that they were not covered under the medical rules. The insurer also denied all "ongoing benefits to include medical" on the ground that claimant's current need for treatment was unrelated to his compensable injury.

Claimant requested a hearing on the insurer's denial. At hearing, the insurer increased the scope of its denial to also include denial of further chiropractic treatment on reasonable and necessary grounds. Claimant conceded that her unlicensed medical therapy and DMSO treatment were not compensable and only contested the general denial of ongoing medical benefits.

Claimant credibly testified regarding her continuing symptomatology up to the time of her falls in early 1980.

ULTIMATE FINDINGS OF FACT

Claimant's compensable injury in 1974 contributed to degenerative changes in the lumbar region of her spine. Her compensable injury continues to materially contribute to her current low back condition.

There is no evidence in the record of denied or outstanding medical services claims from claimant for chiropractic treatment.

CONCLUSIONS OF LAW AND OPINION

Denial on Causation Grounds

The insurer's denial was based, in part, on the absence of a causal relationship between claimant's current need for treatment and her compensable injury. The Referee upheld the denial on those grounds after concluding that claimant's fall at home in February 1980 was an "intervening accident [which] supercedes the responsibility of . . . [the insurer]." On review, claimant contends that her compensable injury remains a material contributing cause of her current need for treatment. See Grable v. Weyerhaeuser, 291 Or 387 (1981); Miller v. Weyerhaeuser, 77 Or App 402 (1986). We agree.

The causation issue in this case is sufficiently complex to require expert medical opinion. Claimant relies on the opinions of Dr. Grewe, neurologist, and Dr. Danis, the treating chiropractor. Both physicians traced claimant's current condition to disc damage occurring at the time of her initial injury in 1974. The insurer relies on the contrary opinion of the Independent Orthopaedic and Chiropractic Consultants and Dr. Pasquesi, neurologist. The Consultants attributed claimant's current condition to degenerative disc disease and osteoarthritis, unrelated to the 1974 injury. Dr. Pasquesi opined that claimant's condition was "primarily" attributable to her falls in early 1980.

On review, the insurer argues that the opinion of Dr. Danis is entitled to little weight because he was unaware of claimant's falls in early 1980. We agree and discount his opinion accordingly.

The insurer further contends that Dr. Grewe's opinion is entitled to little weight because it is based on claimant's history of continuing symptoms up to the time of her falls in 1980. The insurer contends that claimant's testimony on that issue was not credible and that the record does not otherwise support a history of continuing symptoms. In support of its argument, the insurer notes: (1) the lack of documentary evidence to support claimant's alleged testimony that she continued to receive chiropractic treatment for her symptoms up to the time of her falls in 1980; (2) the fact that documentary evidence contradicts claimant's testimony that she did not file a claim for the right knee injury she sustained in 1978; and (3) the fact that claimant initially reported that her falls in 1980 were the result of her knee giving way, whereas she testified that she fell because she sneezed.

Apparently, the Referee was persuaded by this argument. In deciding that claimant had not established that her condition was compensable, the Referee stated that the "documentary evidence in the file shows too many contradictory facts." He also noted that he did not believe claimant's testimony that she did not file a claim for the right knee injury she sustained in 1978. We assume that the Referee found these inconsistencies to be relevant insofar as they reflected on the accuracy of the history claimant provided Dr. Grewe. We interpret the Referee's statements as an adverse credibility finding based on the substance of the record rather than claimant's demeanor. As a result we give no special deference to that finding.

Based on our de novo review of the record, we are not persuaded that claimant provided Dr. Grewe with an inaccurate history of continuing symptoms. Contrary to the insurer's assertion, claimant testified that she began receiving regular chiropractic treatment after, not before, her falls in 1980. That testimony is consistent with the absence of chiropractic treatment records prior to mid-1980. Furthermore, claimant provided a satisfactory explanation for her initial statement that she had not filed a claim for her right knee injury. Specifically, she explained that she did not realize that the informal report she gave her employer was considered to be a claim. Finally, claimant's differing stories regarding the precise reason for her falls is a collateral issue which is not directly relevant to determining the nature of her symptoms prior to those falls.

We recognize that inconsistencies on collateral issues can be grounds for disregarding a claimant's entire testimony. In addition, we are aware that claimant exhibited a generally poor memory regarding her symptomatic and treatment history. Nonetheless, the documentary record otherwise establishes that she continued to experience symptoms up to the time of her falls in 1980. First, Dr. Fagan's reports and the insurer's own records indicate that claimant continued to receive treatment from Fagan for symptomatic flare-ups at least until January 1979. Second, claimant has consistently provided a history of continuing symptoms up to the time of her falls in 1980, and there is no contrary evidence that claimant's symptoms had resolved prior to that time. Third, a history of continuing symptomatic flare-ups is consistent with 1975 diagnostic studies demonstrating lumbar disc damage. Finally, the November 1980 stipulation between the parties suggests that further flare-ups were anticipated. Under that stipulation, claimant received an award of 10 percent permanent partial disability and preserved her right to ongoing medical care pursuant to ORS 656.245.

In light of the above discussion, we conclude that the history of continued symptoms on which Dr. Grewe based his opinion was accurate. We further conclude that his opinion is more persuasive than the contrary reports issued by the independent medical examiners. Not only is Dr. Grewe a specialist in neurology, but his opinion is both well-reasoned and consistent with claimant's asymptomatic condition prior to the 1974 injury, her regular symptomatic flare-ups since that time, and 1975 diagnostic studies demonstrating evidence of disc damage.

Furthermore, contrary to the insurer's contention, Dr. Grewe's opinion has been consistent throughout the course of his treatment. The insurer notes that Dr. Grewe initially indicated that claimant's condition was related to a "new injury" and that he concurred with Dr. Pasquesi's position that claimant's current condition was "primarily" attributable to her falls in February 1980. However, Dr. Grewe also stated that he would change his opinion "if there was evidence of a ruptured disc and records suggest [sic] nerve root compression findings in 1974-1975 . . ." Accordingly, the fact that he changed his position after reviewing claimant's April 1975 diagnostic studies does not adversely affect the weight of his opinion. Moreover, Dr. Pasquesi's opinion does not rule out an additional, material contribution from the 1974 injury.

Finally, the contrary opinions from the Orthopaedic and

Chiropractic Consultants are less consistent with the record as a whole. In particular, they do not adequately explain their opinion that the 1974 injury did not contribute to claimant's disc damage. Neither opinion addresses the significance of the 1975 diagnostic studies and the fact claimant was asymptomatic prior to the 1974 injury but has experienced regular symptomatic flare-ups since that time. In fact, the report from the Orthopaedic Consultants indicates that they had no knowledge of the April 1975 diagnostic studies at the time they rendered their opinion.

We, therefore, rely on Dr. Grewe's opinion and conclude that claimant's compensable injury remains a material contributing cause of her current condition. Accordingly, the Referee erred in upholding the insurer's denial on causation grounds.

Denial on Reasonable and Necessary Grounds

We turn to the insurer's alternative contention that ongoing chiropractic treatment is neither reasonable nor necessary. We conclude that its denial on those grounds should also be set aside. There is no evidence in the record of unpaid bills or outstanding medical services claims at the time the insurer issued its denial. We, therefore, conclude that the denial was for all future chiropractic treatment. A denial of all future treatment on reasonable and necessary grounds is overbroad and invalid. Accordingly, we reverse the Referee and set aside the insurer's denial.

Attorney Fee on Review

Finally, claimant is entitled to a reasonable assessed fee for services rendered at hearing and on review regarding the medical services issue. See OAR 438-15-005(2). However, we cannot approve an assessed fee without 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 authorized.

ORDER

The Referee's order dated January 15, 1987 is reversed. The insurer's denial of ongoing medical benefits is set aside. The claim is remanded to the insurer for processing according to law.

RICK J. FAWVER, Claimant
Vick & Gutzler, Claimant's Attorneys
Edward C. Olson, Defense Attorney
Stafford Hazelett, Defense Attorney

WCB 88-04829 & 88-03894
January 26, 1989
Order of Dismissal

Claimant has requested review of Referee Peterson's order dated October 24, 1988. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS OF FACT

The Referee's order issued October 24, 1988. On December 22, 1988, claimant mailed a request for Board review of the Referee's order. The request, which was mailed by certified mail, included a certificate of personal service by mail upon the other parties to the hearing before the Referee. The Board received claimant's request for review on December 23, 1988.

The request for Board review was mailed more than 30 days after the Referee's order. The parties to the proceeding did not receive notice of the request within 30 days of the Referee's order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's October 24, 1988 order was November 23, 1988. Yet, claimant's request for Board review was filed December 22, 1988, the date he mailed, by certified mail, his request for Board review of the Referee's order. See OAR 438-05-046(1)(b). Moreover, the record fails to establish that the other parties to the proceeding were provided with a copy, or received actual knowledge, of claimant's request for Board review within 30 days of the Referee's 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 v. King, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

DAVID C. HOLCOMB, Claimant
John L. Hilts, Claimant's Attorney
James E. Griffin, Ass't. Attorney General

WCB TP-88035
January 26, 1989
Third Party Distribution Order

Claimant's counsel has petitioned the Board for the allowance of an extraordinary attorney fee for services rendered in connection with a third party settlement. Specifically, counsel seeks approval of an attorney fee equal to 40 percent of the $20,000 settlement. i.e., $8,000. The SAIF Corporation, as paying agency, objects to the request. We find that extraordinary circumstances do not exist to justify such an attorney fee.

FINDINGS

Claimant suffered serious compensable injuries while working as a security guard for a hospital, insured by SAIF. Specifically, he was shot by an intoxicated individual, who had previously been arrested for driving under the influence of intoxicants and transported to the hospital to undergo a blood test. The events which led to the assault began when claimant objected to the individual's smoking near some oxygen tanks. Following a struggle, police officers removed the individual from the hospital, but did not incarcerate him. Thereafter, the individual returned to the hospital and shot claimant.

Claimant engaged legal counsel to explore the possibility of bringing suit against the city and its police officers. He and his counsel entered into a contingent fee

agreement. Claimant agreed to pay his counsel 33 1/3 percent of the gross proceeds received by settlement 5 days prior to trial. This fee increased to 40 percent of the proceeds received 5 days "before and through trial and through any appeals."

Eventually, an action for deprivation of claimant's civil rights and negligence was initiated. The third party defendants moved for summary judgment, contending that they were immune from liability because claimant's injuries were covered by workers' compensation and that the police officers were immune from liability. The motion for summary judgment was granted.

Claimant appealed the order of summary judgment to the Court of Appeals. While the appeal was pending, with SAIF's approval, claimant and the third parties settled his cause of action for $20,000.

Claimant's counsel's litigation costs total $2,667.88. He has expended some 116 hours while representing claimant in this matter. These efforts primarily include investigation, legal research, depositions, complaint drafting, responding to the motion for summary judgment, petitioning for judicial review, preparing an appellate brief, and settlement negotiations.

ULTIMATE FINDINGS

This third party case does not present extraordinary circumstances.

CONCLUSIONS OF LAW

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 the third person. ORS 656.578. The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

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

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

To begin, costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1)(a). The attorney fees in no event shall exceed the advisory schedule of fees established by the Board for third party actions. ORS 656.593(1)(a); Shipley v. SAIF, 79 Or App 149, 152-53 (1986).

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).

The Board's advisory schedule concerning attorney fees in third party cases is set forth in OAR 438-15-095. The aforementioned rule provides as follows:

> "Unless otherwise ordered by the Board after a finding of extraordinary circumstances, an attorney fee not to exceed 33 1/3 percent of the gross recovery obtained by the plaintiff in an action maintained under the provisions of ORS 656.576 to 656.595 is authorized."

Extraordinary attorney fees have been awarded in previous third party cases. In Leonard F. Kisor, 35 Van Natta 282 (1983), the Oregon counsel, a specialist in litigation involving the complex issue of asbestos exposure and mesothelioma, had associated with Washington counsel in order to take advantage of Washington's apparently more favorable products liability law. As an example of the complexity of the third party liability issue, the Oregon counsel referred to a similar case, which involved approximately 78,000 pages of documentary material. The paying agency did not object to an extraordinary fee; it only questioned whether it had authority to agree to a fee arrangement which would result in a fee exceeding 33 1/3 percent of the third party recovery. After reviewing the matter, the Board allowed a fee equal to 40 percent of the proceeds from the third party recovery.

In John Galanopoulos, 35 Van Natta 548 (1983), claimant's counsel had proceeded with claimant's medical malpractice action after his prior counsel had recommended a $10,000 settlement. Legal and medical research, as well as investigation and trial preparation, occupied the vast majority of claimant's counsel's time for the three months preceding the 5-day trial. The jury awarded claimant $139,000. Persuaded that these efforts expended by counsel in the course of preparing for and trying the malpractice action represented extraordinary services, the Board allowed an attorney fee equal to 40 percent of the third party judgment.

Finally, in John P. Christensen, 38 Van Natta 613 (1986), claimant's counsel had litigated the third party action over a 10-year period, including two presentations on pre-trial procedural issues before the Oregon Supreme Court. The case was finally tried some 9 years after the commencement of the action. That trial resulted in a mistrial. On the eve of the second trial, the third party action was settled for $87,500. The paying agency raised no objection to claimant's counsel's request for an attorney fee equal to 50 percent of the settlement proceeds. Given such circumstances, the Board allowed the extraordinary attorney fee request.

Here, claimant's counsel has undoubtedly expended many hours in investigation, research, and preparation while representing his client at the circuit and appellate court

levels. In addition, establishing the third party's liability for claimant's injuries would certainly appear to be a challenge. However, the record does not establish that the liability the issue itself, either legally or factually, was particularly complex. See Kisor, supra.

Moreover, unlike Galanopoulos and Christiensen, the settlement of this third party action was not achieved as a result of several days in trial or following a lengthy appellate history. We also note parenthetically that the contingent fee agreement calls for a fee of 33 1/3 percent of the recovery when the settlement is reached 5 days prior to trial. Inasmuch as no trial has ever been held, we consider this contractual provision to be applicable. Finally, apparently because its share of the proceeds would be reduced should we grant claimant's counsel's request, SAIF objects to the allowance of an extraordinary attorney fee.

We are not persuaded that these circumstances compare favorably with those present in the cases previously discussed. Thus, we find that this third party case does not present extraordinary circumstances. Consequently, we conclude that an extraordinary attorney fee is not justified.

Accordingly, we hold that a distribution of proceeds of the third party settlement in accordance with ORS 656.593(1) is "just and proper." See ORS 656.593(3). Claimant's counsel is directed to distribute proceeds in accordance with ORS 656.593(1).

IT IS SO ORDERED.

JAMES LEHRMANN, Claimant
Myrick, Coulter, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 88-0259M
January 26, 1989
Own Motion Order

The Board issued an Own Motion Order on May 24, 1988 whereby claimant's claim was reopened for the payment of temporary disability benefits. On June 13, 1988 SAIF Corporation issued a notice of closure which found claimant released to work on April 1, 1988 and medically stationary as of April 21, 1988. SAIF terminated claimant's temporary disability benefits as of April 1, 1988. Claimant has asked the Board to review SAIF's closure, contending he is entitled to a permanent disability award.

The Board's own motion authority has been significantly restricted by the new law which took effect on January 1, 1988. Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority to award medical services in pre-1966 claims and to grant temporary disability benefits when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. There is no authority which would allow the Board to grant claimant an increased award for permanent disability. Orville D. Shipman, 40 Van Natta 537 (1988). We conclude that claimant's request for further permanent disability benefits must be denied.

SAIF's closure notice indicates that temporary disability benefits were terminated as of April 1, 1988. The evidence indicates that claimant's condition was not medically stationary until April 21, 1988. Current case law states that temporary disability benefits should not be terminated until claimant is both medically stationary

and released to work. Fazzolari v. United Beer Distributors, 91 Or App 592, adhered to on reconsideration 93 Or App 103 (1988), rev den 307 Or 236 (December 20, 1988). We conclude that SAIF's closure notice should be amended to grant claimant temporary disability benefits through April 21, 1988.

IT IS SO ORDERED.

DALE S. MATSEN, Claimant
Malagon & Moore, Claimant's Attorneys
Art Stevens (SAIF), Defense Attorney
Acker, et al., Defense Attorneys

WCB 87-01502 & 87-00140
January 26, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

International Paper Co., a self-insured employer, requests review of Referee Myers' order that held it, rather than the SAIF Corporation, responsible for claimant's current low back condition. The issue on review is responsibility.

The Board affirms and adopts the order of the Referee.

Claimant's counsel has submitted a statement of services in support of his request for a carrier-paid attorney fee for services rendered on Board. We conclude that a reasonable fee is justified.

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, International Paper (IP) requested Board review and sought to shift responsibility for claimant's claim to SAIF. Had IP succeeded, claimant's compensation would have been reduced because IP had the higher rate of temporary disability compensation. Claimant's counsel participated on Board review and contended that the Referee's decision should be affirmed. Under these circumstances, we conclude that claimant's attorney is entitled to a fee services on Board review under ORS 656.382(2), payable by IP. See Rhonda Bilodeau, 41 Van Natta 11 (January 4, 1989); Eleanor M. Thurston, 40 Van Natta 1191 (1988).

After review of claimant's counsel's statement of services and the retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we find that a reasonable assessed attorney fee for services on Board review is $750.

ORDER

The Referee's order dated July 9, 1987 is affirmed. Claimant's attorney is awarded a reasonable fee of $750 for services on Board review, to be paid by International Paper. A client-paid fee, payable from International Paper to its counsel is approved, not to exceed $170.

EUGENE E. McNUTT, Claimant
Rankin, et al., Defense Attorneys

WCB 88-13909
January 26, 1989
Order of Dismissal

Claimant has requested review of Referee Higashi's order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

The Referee's Opinion and Order issued November 29, 1988. Pursuant to the Referee's order, the insurer's denial of claimant's back injury claim was upheld. On December 8, 1988, the Referee approved the insurer's counsel's request for authorization of a client-paid fee, to be paid by the insurer. This approval was contained in a so-called "Order on Reconsideration," which neither stayed, withdrew, nor modified the Referee's prior order. The Referee's December 8, 1988 order also did not contain a statement explaining the parties' rights of appeal under ORS 656.289 and 656.295.

Claimant's request for review, contained in a letter carrying a postmark date of December 29, 1988, was received by the Board on December 30, 1988. Claimant stated that he was "appealing" the decision "that was made on the case." The request, 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 January 4, 1989, the Board mailed a computer-generated letter to the parties acknowledging the request. Receipt of this acknowledgment constitutes the employer's and its insurer's first notice of claimant's request for Board review.

ULTIMATE FINDINGS

The Referee's November 29, 1988 order was neither abated, withdrawn, stayed, republished, modified nor appealed within 30 days of its issuance. The request for review was received by the Board more than 30 days after the Referee's November 29, 1988 order. Neither the employer nor its representatives received notice of the request within 30 days of the date of the Referee's November 29, 1988 order. Claimant is not an aggrieved party concerning the Referee's December 8, 1988 approval of the insurer's counsel's request for authorization to charge a client-paid fee to the insurer.

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).

If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. Id.

As a preliminary matter, claimant's request simply expressed his disagreement with the Referee's decision "that was made on the case." However, since the December 8, 1988 order strictly pertained to the Referee's approval of the insurer's counsel's request for authorization to charge a client-paid fee to the insurer, claimant is not an aggrieved party to that decision. Therefore, claimant would lack standing to request review of that decision. See generally, Orville L. Carlson, 37 Van Natta 30, 32 (1985). Consequently, the decision to which claimant is referring to is the Referee's November 29, 1988 order that upheld the insurer's denial.

Although entitled as an "Order on Reconsideration," the Referee's December 8, 1988 order neither abated, withdrew, stayed, modified, republished, nor reconsidered the Referee's November 29, 1988 order. Thus, the December 8, 1988 order did not extend the time for seeking Board review of the Referee's November 29, 1988 order. Therefore, in order for us to exercise jurisdiction over this matter, the request must be submitted, and copies must be provided to the parties, within 30 days of the November 29, 1988 order. See ORS 656.289(3); 656.295(5).

Claimant's request for Board review of the Referee's November 29, 1988 order was neither mailed by registered nor certified mail. Since the request was actually received by the Board on December 30, 1988, more than 30 days after the issuance of the Referee's order, it is presumed untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b).

Assuming arguendo that claimant could establish that his request for review was timely mailed to the Board, the record suggests that the employer's and its insurer's actual notice of the request occurred sometime after the Board mailed its January 4, 1989 acknowledgment letter. Therefore, the record fails to establish that either the employer or its representatives were provided with a copy, or received actual knowledge, of claimant's request for Board review within 30 days of the Referee's November 29, 1988 order.

Under these 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.

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.

DONALD POTTRATZ, Claimant
SAIF Corp, Insurance Carrier

Own Motion 88-0826M
January 26, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his April 9, 1982 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's November 7, 1988 surgery, but asks the Board to deny the payment of temporary disability benefits as it contends claimant has retired from full time employment.

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 did undergo surgery for his compensable condition in November 1988 and, therefore, may be entitled to temporary disability benefits during his recovery period. He states that he last performed full time employment in 1983, but has provided records to show that he continued to perform part time work through 1987. We conclude claimant has not retired from the work force and is entitled to compensation for temporary disability benefits. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985).

Accordingly, claimant's claim is reopened with temporary disability compensation to commence the date he was hospitalized for the November 1988 surgery 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.

DENNIS C. REDDON, Claimant
Tamblyn & Bush, Claimant's Attorneys
Stoel, Rives, et al., Defense Attorneys

WCB 86-05001
January 26, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Reddon v. Tektronix, Inc. 92 Or App 360 (1988). We have been instructed to reconsider this case in light of Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) and Johnston v. James River Corp., 91 Or App 721 (1988). After reconsideration, we issue the following order.

The self-insured employer requests review of Referee Pferdner's order that: (1) set aside its denial of claimant's aggravation claim relating to his low back; and (2) awarded claimant 20 percent (64 degrees) unscheduled permanent partial disability for his low back. The employer also contends that the Referee erred in excluding two exhibits.

On review, the issues are:

1. Whether the Referee erred in excluding Exhibits 43 and 44.

2. Whether the employer's causation challenge to claimant's aggravation claim is properly before the Board on review.

3. Whether a denial on causation grounds is an improper "back-up" denial.

4. Whether claimant has sustained a compensable aggravation.

5. Extent of claimant's low back disability.

We reverse on the aggravation issue.

FINDINGS OF FACT

Claimant injured his low back on August 3, 1983 while lifting heavy baskets of parts in the course of his employment as an electroplater. He missed two days of work and treated briefly with Dr. Goodall, his family doctor. Dr. Goodall declared claimant medically stationary on August 15, 1983 and released him for regular work. Claimant filed a claim for the injury which was accepted by the employer and closed by notice of claim closure on September 2, 1983.

Claimant worked from August 15, 1983 to November 2, 1984 when he reinjured his back, again while lifting heavy baskets of parts. He sought treatment from Dr. McNeill, an orthopedic surgeon, who diagnosed a lumbosacral strain. Claimant was off work for several weeks and then exacerbated his condition at home when he bent over to pick up his son. This exacerbation included some radiation of pain into his right buttock and leg. Dr. McNeill prescribed conservative treatment and claimant's condition improved. Claimant returned to modified work on January 16, 1985 and to regular work on February 19, 1985. On the latter date, Dr. McNeill declared claimant medically stationary, reported that claimant's physical examination was entirely within normal limits and stated that claimant complained of no pain or other symptoms. He rated claimant's impairment at zero. The employer accepted claimant's November 1984 injury and the subsequent off-work exacerbation as an aggravation of his August 1983 injury. The claim was closed by Determination Order in April 1985 with no award for permanent disability.

Claimant performed his regular work from February 19, 1985 until sometime in December 1985, when the employer's plant shut down for Christmas. During this period, claimant worked, as he always had, at 200 percent efficiency. He experienced no back symptoms of any significance, sought no medical treatment, was on no medications and engaged in a number of strenuous off-the-job activities including hunting, fishing and cutting firewood.

Around Christmas, claimant's father died and claimant and other relatives went to his father's residence to sort through his belongings. Claimant sorted belongings in a number of boxes in the garage. This activity involved repetitive bending and twisting and after an hour or so claimant began to develop pain in his low back. A short time later, he and his relatives sat down

on the garage floor for a coffee break. Claimant was unable to get up after the break because of severe back and right leg pain and was taken to the hospital.

At the hospital, claimant was examined by Dr. Berkeley, a neurosurgeon. Dr. Berkeley ordered x-rays and a CT scan which revealed bilateral spondylolysis at L5, a slight spondylolisthesis at L4-5 and a transitional vertebra at the lumbosacral junction. Dr. Berkeley discharged claimant from the hospital on December 31, 1985 with a diagnosis of "severe low back strain and sprain." After his discharge, claimant received physical therapy and his condition steadily improved. On February 3, 1986, Dr. Berkeley declared claimant medically stationary and released him to return to his regular work.

Claimant was examined by Dr. Gripekoven, an orthopedic surgeon, on February 17, 1986. Dr. Gripekoven diagnosed claimant's December 1985 episode of back pain as "Lumbar sprain, spondylolysis L5-S1." He then offered an ambiguous opinion regarding the causal relation between claimant's 1985 off-work injury and his prior industrial injuries. The employer issued an aggravation denial on March 5, 1986. The basis for the denial is somewhat ambiguous. At one point, the denial states that "[i]t is not in our opinion that your condition was aggravated or arose out of or in the course of employment . . ." However, other language indicates that the employer was not challenging the underlying causal relationship. In particular, the denial states that claimant is entitled to continuing medical services under ORS 656.245.

The hearing was held on December 9, 1986. The employer argued that claimant's current condition was no longer causally related to his compensable injury and that the condition had not worsened. There is no evidence in the record that claimant objected to the causation challenge or requested a continuance to present additional evidence on that question. The Referee set aside the employer's aggravation denial after finding that claimant had established the requisite worsening. The Referee failed to address the causation question in his discussion of the aggravation issue. However, his subsequent discussion on the extent issue indicates that he was persuaded that claimant's current condition was causally related to his compensable injury.

During the hearing, the employer's counsel attempted to introduce Exhibits 43 and 44. Exhibit 43 is a supplemental report from Dr. Gripekoven and is dated December 4, 1986. Exhibit 44 is a supplemental report from Dr. Berkeley and is dated December 5, 1986. Claimant's counsel stated that he had no objection to the exhibits so long as the record was left open for cross-examination of their authors. The Referee excluded Exhibit 43 on the ground that it was untimely and Exhibit 44 on the ground that it was cumulative.

The employer requested Board review. In its brief, the employer contended that the Referee erred in excluding Exhibits 43 and 44. In our original Order on Review, we affirmed the Referee on the evidentiary issue on the ground that the employer had not submitted the disputed exhibits with a supplementary index as required by former OAR 438-07-005(3)(b). However, we reversed on the aggravation issue. Claimant appealed our order to the Court of Appeals. The employer did not cross-appeal on the evidentiary

issue. The court reversed and remanded on the ground that our order was not sufficient for judicial review.

FINDINGS OF ULTIMATE FACT

1. The employer abandoned the evidentiary issue on appeal to the Court of Appeals.

2. Claimant failed to object or request a continuance when the employer raised the causation question at hearing.

3. The employer did not specifically accept the underlying causal relationship between claimant's current condition and his compensable injury.

4. The evidence does not support the conclusion that there was a material causal relation between claimant's 1985 low back sprain and his prior compensable injuries.

5. Claimant's 1984 low back injury did not result in permanent impairment.

CONCLUSIONS OF LAW

Evidence

In our original Order on Review, we upheld the Referee's exclusion of Exhibits 43 and 44. When claimant appealed our order to the court, the employer did not cross-appeal on the evidentiary issue. We conclude that the employer's failure to cross-appeal constitutes an abandonment of the evidentiary issue. We adhere to our decision on the evidentiary issue, therefore, but on this ground.

Scope of Review

The employer has two possible substantive grounds for denying claimant's aggravation claim: (1) lack of a causal relationship between the current condition and the compensable injury; and (2) failure to establish a worsening of the condition since claim closure. See Grable v. Weyerhaeuser Co., 291 Or 387, 400-01 (1981). On review, the employer concedes claimant's condition worsened, but argues that the worsening was not causally related to the compensable injury. Claimant contends that it is procedurally improper for the employer to challenge his claim on causation grounds. We disagree.

In reaching this decision, we are aware that claimant believed the sole basis of the formal denial was absence of a worsening. We are also persuaded that this interpretation was reasonable in light of the ambiguous language of the denial.

Furthermore, we recognize that it may be improper for a Referee or the Board to consider a basis for denial not raised prior to hearing or review in the interests of fairness to a claimant. For example, we recently held that a Referee properly declined to consider a reasonable and necessary challenge to a medical services claim where causation was the only basis for denial previously raised and the claimant objected at hearing to

litigation of that issue. See Patricia N. Hall, 40 Van Natta 1873 (November 29, 1988). Similarly, the Court of Appeals has held that the Board improperly overturned an award of permanent total disability on a causation theory first raised in written closing argument submitted by the employer some five weeks after the close of a hearing. See Anderson v. West Union Village Square, 44 Or App 687 (1980).

Nevertheless, we conclude that it is proper for the Board to consider the causation question in this case. Unlike the situation in Anderson, the present employer raised the causation question at the beginning of the hearing so that claimant had the opportunity to object on the record or request a continuance. Unlike the situation in Hall, the present claimant neither objected nor requested a continuance for presentation of additional evidence. Furthermore, the record was sufficiently developed for the Referee and the Board to rule on the causation question. Under these circumstances, we conclude that claimant has waived any right he might otherwise have had to object to litigation of this issue. Cf. Thomas v. SAIF, 64 Or App 193 (1983). Accordingly, we conclude that the causation question is properly before the Board on review.

Back-Up Denial

Claimant also argues that a denial on causation grounds would be an improper "back-up" denial of a previously accepted condition under the rule set forth in Bauman v. SAIF, 295 Or 788 (1983). We disagree. The Bauman prohibition only applies to conditions specifically accepted in writing pursuant to ORS 656.262(6). See Johnson v. Spectra Physics, 303 Or 49 (1987). Claimant contends that language in the employer's March 1986 denial should be interpreted as an acceptance of the causal relationship between his current condition and compensable injury. In particular, he relies on statements acknowledging claimant's entitlement to continuing medical services under ORS 656.245. However, other language in the denial suggests a contrary position. Specifically, the denial states that "[i]t is not in our opinion that your condition was aggravated or arose out of or in the course of employment . . ." In light of this ambiguity, we conclude that the denial is not the type of specific acceptance required under Johnson v. Spectra Physics. Accordingly, a denial on causation grounds would not be an improper "back-up" denial under Bauman. See also, U.S. Bakery v. Duval, 86 Or App 120 (1987).

Compensability of Aggravation

We turn to the merits of the aggravation claim. As discussed above, the employer concedes claimant's condition worsened, but argues that the worsening was not causally related to the compensable injury.

The only doctor to offer an opinion regarding the causal relation between claimant's industrial injuries and his 1985 off-the job injury was Dr. Gripekoven. He stated:

> "I feel that this man has had repeated soft tissue sprain of his lumbar spine which was superimposed upon a preexisting

> developmental spondylolysis of his lumbar spine which would account for some mechanical instability. There does not appear to be any evidence of nerve root impingement or disc herniation. Prognosis remains somewhat guarded because of this underlying preexisting condition. It will be important that this man put a good deal of emphasis on proper body mechanics, weight control and improved abdominal muscular conditioning to protect his back from recurrent problems. He is at increased risk for recurrent back problems because of his preexisting underlying condition.
>
> "The 1983 injury did not cause the spondylolysis but represents an aggravation of this underlying condition. I do not feel that [claimant] has materially worsened beyond his condition in April of 1985. His more recent flare-up of symptoms would represent a temporary aggravation which rendered him symptomatic. I feel that he can continue with his present employment but may need some job sheltering and probably should avoid heavy repetitive bending and lifting." (Ex. 38-3).

The first line of Dr. Gripekoven's opinion mentions both claimant's "repeated soft tissue sprain[s]" and his "preexisting developmental spondylolysis" and then states "which would account for some mechanical instability." The Referee apparently interpreted this statement to mean that each of claimant's low back injuries had rendered his spondylolysis progressively less stable, thus making him more susceptible to future injury. On that basis, he concluded that there was a material causal relation between claimant's industrial injuries and his current condition. (See O & O at 4). We conclude that another reading of Dr. Gripekoven's opinion is equally plausible.

Later in the first paragraph of the opinion, Dr. Gripekoven stated that claimant's prognosis remained somewhat guarded and that he was at increased risk for future back problems "because of his preexisting underlying condition." These statements give no indication that claimant's low back injuries played any role in the guarded prognosis or his susceptibility to future problems. This suggests, therefore, that the "which" in the first line of the opinion referred exclusively to claimant's "preexisting developmental spondylolysis" and was not meant to allude to his "repeated soft tissue sprain[s]." If the statement is so interpreted, it does not support the conclusion that claimant's industrial injuries had any material causal relation to his subsequent off-work injury.

In the second paragraph of the opinion, Dr. Gripekoven stated that claimant's original industrial injury did not cause the spondylolysis, but "represent[ed] an aggravation of this underlying condition." If "aggravation" is understood to mean a pathological exacerbation of the underlying condition, it supports the conclusion that claimant's 1983 injury and presumably the 1984 injury as well played a role in claimant's 1985 injury. Dr. Gripekoven, however, does not define what he means by

"aggravation." A few lines later, he appears to use the word to refer to claimant's symptoms following the 1985 injury. The second paragraph of the opinion, therefore, is likewise inconclusive on the question of the contribution, if any, of claimant's industrial injuries to his 1985 off-work injury.

Claimant's testimony and medical history do not resolve the above ambiguities. Claimant returned to a virtually asymptomatic state after both of his industrial injuries, received no ongoing medical care and performed his regular work at peak efficiency without restriction or limitation. If anything, these facts suggest that claimant's industrial injuries only temporarily affected his underlying spondylolysis and then totally resolved.

When the evidence presented reflects two equally plausible explanations for a claimant's condition and one of them is noncompensable, the claimant has failed to sustain his burden of proof. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 460, rev den 297 Or 82 (1984). In view of the ambiguities in Dr. Gripekoven's opinion, we cannot determine whether it supports or detracts from the conclusion that claimant's 1983 and 1984 industrial injuries contributed in a material way to the 1985 off-work injury. The other evidence does not resolve this ambiguity in claimant's favor. We conclude, therefore, that claimant has failed to sustain his burden of proof and that the employer's denial should be upheld.

Extent of Disability

In view of our conclusion that claimant has failed to prove a causal relation between his industrial injuries and his December 1985 off-work injury and because the evidence does not otherwise indicate that the 1984 industrial injury resulted in any permanent impairment, we reverse the Referee's award of 20 percent unscheduled permanent partial disability.

ORDER

The Referee's order dated December 19, 1986 is reversed in part. The Referee's exclusion of Exhibits 43 and 44 is affirmed. Those portions of the Referee's order that set aside the self-insured employer's denial dated March 5, 1986 and awarded claimant 20 percent (64 degrees) unscheduled permanent partial disability are reversed. The employer's denial is reinstated and upheld.

LARRY K. ROSE, Claimant
Peter O. Hansen, Claimant's Attorney
Terrall & Miller, Defense Attorneys

WCB 87-02485
January 26, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

EBI Companies requests review of Referee Fink's order that: (1) set aside its "backup" denial of claimant's aggravation claim for his low back condition; and (2) assessed penalties and accompanying attorney fees for its failure to process the claim pursuant to the prior Referee's order. We affirm.

ISSUES

1. Whether EBI was precluded from issuing a "backup"

denial of claimant's aggravation claim, after a prior Referee had already found it responsible for the claim.

2. If the "backup" denial is permissible, whether claimant sustained a compensable aggravation of his accepted December 18, 1984 industrial injury.

3. Whether claimant is entitled to the temporary total disability compensation ordered under the prior Referee's order.

4. Whether claimant is entitled to penalties and attorney fees for its alleged unreasonable failure to process the claim pursuant to the prior Referee's order.

FINDINGS OF FACT

Claimant sustained a compensable left hip and low back injury on December 18, 1984, while working as a janitor for EBI's insured. A May 9, 1985 Determination Order awarded 15 percent unscheduled permanent partial disability.

Claimant continued to have back pain, but did not seek medical treatment again until January 16, 1986, when he began treating with Dr. Stephens for low back pain radiating into his hips and legs. By February 13, 1986, Dr. Stephens suspected malingering, and recommended an evaluation by the Orthopaedic Consultants. The Consultants noted positive findings, but found significant functional interference.

EBI issued a denial of aggravation on February 24, 1986, and at hearing on January 20, 1987, claimant withdrew his request for hearing on that denial.

In June 1986, claimant began working for Mercer Industries (Mercer), where he lifted 60-pound loads of metal bars approximately 200 times per day. On July 10, 1986, he allegedly sustained a new injury to his low back. EBI denied claimant's aggravation claim and Mercer denied his "new injury" claim.

On January 20, 1987, a hearing on the issue of responsibility was held before a prior Referee. The prior Referee found claimant not credible and concluded that claimant's condition was an aggravation rather than a "new injury." Consequently, EBI was found responsible for claimant's condition and directed to process the aggravation claim.

On January 29, 1987, EBI issued a "backup" denial of compensability. Relying upon the prior Referee's adverse finding concerning claimant's credibility, EBI contended that the evidence did not support a worsening of claimant's condition.

Claimant requested a hearing concerning the "backup" denial. The Referee held that EBI was estopped from issuing its denial and that claimant was entitled to temporary disability compensation resulting from the prior Referee's order. In addition, the Referee assessed a penalty based on the compensation payable pursuant to the prior Referee's order. Finally, the Referee awarded a $1,500 insurer-paid attorney fee.

CONCLUSIONS AND OPINION

The Referee concluded as a matter of law that EBI was

estopped from issuing its "backup" denial following the prior Referee's finding that it was responsible for claimant's aggravation claim. We agree and adopt the Referee's opinion with the following supplementation.

Subsequent to the Referee's decision, the Court of Appeals issued its opinion in Knapp v. Weyerhaeuser Company, 93 Or App 670 (November 2, 1988). In Knapp, the employer issued a "backup" denial of a claim that it had been ordered to accept by a prior Referee. The employer contended that it had obtained information that indicated that the claimant had testified untruthfully at her previous hearing. Reasoning that there must be some finality to the process of claims adjudication, the court concluded that the employer's denial was invalid.

Specifically, the Knapp court held that the denial was not permissible as a "backup" denial under the rationale expressed in Bauman v. SAIF, 295 Or 788 (1983), because the employer had not accepted the claim under circumstances of fraud, misrepresentation or other illegal activity. Rather, the employer had been ordered to accept the claim. Inasmuch as the employer had once denied the claim and had the opportunity to litigate that denial, the court reasoned that the employer could not do so again.

Here, as in Knapp, EBI had the opportunity to litigate the compensability of claimant's aggravation claim on the merits before the prior Referee. EBI chose not to avail itself of this opportunity and consented to the issuance of an order designating a paying agent pursuant to ORS 656.307. Thereafter, the prior Referee set aside EBI's denial, requiring it to process the claim in accordance with law. Implicit in the prior Referee's order was a finding that the claim was compensable. Inasmuch as EBI had previously denied claimant's aggravation claim and had an opportunity to litigate the compensability of that claim on its merits, we conclude that it may not deny that same claim again. Consequently, we hold that EBI's "backup" denial is impermissible.

Concerning the issues of temporary total disability, penalties, and attorney fees, we adopt the opinion and conclusions of the Referee.

Claimant's counsel is entitled by statute to a reasonable insurer-paid fee for services rendered on Board review. See ORS 656.382(2). However, we cannot authorize such a 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 July 24, 1987 is affirmed.

THERESA SKOYEN, Claimant
Richard O. Nesting, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-08400
January 26, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Leahy's order that: (1) declined to award temporary total disability benefits; and (2) declined to assess a penalty or attorney fee against the insurer for its allegedly unreasonable delay in submitting her claim to the Evaluation Division for closure.

The Board reverses the order of the Referee on the penalty and attorney fee issue. All remaining portions of the Referee's order are affirmed as amended.

ISSUES

1. Whether claimant is entitled to temporary total disability benefits after July 31, 1985, until her claim is properly closed by a Determination Order.

2. Whether a penalty or attorney fee should be assessed for the insurer's allegedly unreasonable delay in requesting closure of claimant's claim.

PROCEDURAL POSTURE

Claimant, 59 at hearing, compensably injured her low back in July 1982. A Determination Order closed her claim in November 1983 with an award of 20 percent unscheduled permanent disability and a period of temporary disability. Thereafter, she filed a claim for a psychiatric condition, which the insurer denied.

Claimant appealed the insurer's denial. In March 1986, a prior Referee, inter alia: (1) set the insurer's denial aside; and (2) ordered it to pay a certain period of temporary total disability compensation.

In June 1987, the Board affirmed the prior Referee's order. The Board's order has been affirmed without opinion by the Court of Appeals. J.C. Penney Co. v. Skoyen, 93 Or App 625 (1988).

In October 1987, the Board issued its order in David E. Noble, 39 Van Natta 1035 (1987), which disavowed its earlier holding in Sharon Bracke, 36 Van Natta 1245, rev'd on other grounds, 78 Or App 128 (1986). Under Bracke, the Board had held that within 14 days of an Opinion and Order finding a claim compensable, an insurer need only pay temporary disability until the worker had been "declared (as opposed to being determined under ORS 656.268) to be medically stationary."

The instant case proceeded to hearing in December 1987.

FINDINGS OF FACT

In a prior Referee's order, the insurer was ordered, inter alia: (1) to pay temporary total disability benefits from March 14, 1984 through July 31, 1985, the date in which the prior Referee determined that claimant was medically stationary; and (2) to process claimant's psychiatric claim to closure according to ORS 656.268.

After the prior Referee's order issued, the insurer timely paid claimant her temporary total disability benefits through July 31, 1985, as ordered. It did not, however, seek closure of her claim. Consequently, claimant requested a second hearing to enforce that portion of the prior Referee's order that had ordered the insurer to close her claim pursuant to ORS 656.268. Relying on the case of David E. Noble, supra, claimant also sought an increase in the period of temporary total disability compensation ordered by the prior Referee.

On December 8, 1987, three days prior to the second hearing, the insurer submitted claimant's claim to the Evaluation Division for closure.

The insurer paid claimant all the temporary total disability benefits ordered payable by the prior Referee.

The insurer unreasonably delayed requesting closure of claimant's claim, contrary to the order of the prior Referee.

CONCLUSIONS OF LAW

Temporary Disability

In the order portion of his written opinion, the prior Referee stated, inter alia:

> "The carrier's September 24, 1984 denial is set aside and the claim is remanded to the carrier for acceptance and the payment of compensation until closed pursuant to ORS 656.268. The carrier's obligation for payment of temporary total disability is March 14, 1984 through July 31, 1985; subject to the Evaluation Division's further determination of entitlement to temporary total disability benefits." (Emphasis added).

Pursuant to the prior Referee's order, the insurer timely paid claimant temporary total disability compensation from March 14, 1984 through July 31, 1985. It was not required to pay compensation in excess of that ordered by the prior Referee.

The instant Referee found that, pursuant to the prior Referee's order, claimant was not entitled to additional temporary total disability compensation until the "Evaluation [Division] orders it." Although we agree with the result reached by the instant Referee, we do so for different reasons.

Claimant argues that the case of David E. Noble, supra, requires the payment of additional temporary total disability compensation beyond July 31, 1985. We decline to address her argument.

In our view, the issue of whether the prior Referee ordered the proper period of temporary total disability compensation is not properly before us. That issue pertains to the merits of the prior Referee's order, which, has been affirmed by the Board and the Court of Appeals. Claimant apparently did not request judicial review on the particular issue of the proper period of temporary total disability compensation and we do not have jurisdiction to review an issue that a party could have raised on direct appeal of a prior Referee's order. North Clackamus School District v. White, 305 Or 48, 468 (1988). But see Georgia-Pacific v. Hughes, 305 Or 236 (1988).

Accordingly, with respect to the temporary total disability issue raised by claimant, we limit our review to whether the insurer complied with the prior Referee's order.

Claimant does not dispute nor present any evidence that the insurer failed to pay temporary total disability from March 14, 1984 through July 31, 1985. Inasmuch as we have found above that the prior Referee's order directed the insurer to pay temporary total disability through only July 31, 1985, we conclude that the insurer properly complied with the prior Referee's order with respect to the payment of temporary total disability compensation.

Accordingly, we agree with the result reached by the instant Referee, insofar as he declined to award claimant additional temporary total disability compensation.

Penalties and Attorney Fees

Former ORS 656.268(2) provides, inter alia:

> "When the injured worker's condition resulting from a disabling injury has become medically stationary, . . . the insurer or self-insured employer shall so notify the Evaluation Division . . . and request the claim be examined and further compensation, if any, be determined." (Emphasis added).

Here, the prior Referee determined that claimant became medically and psychologically stationary on July 31, 1985. In so doing, he ordered the insurer to accept claimant's psychiatric condition and to process her claim "pursuant to ORS 656.268."

The statute imposed a mandatory burden on the insurer to submit claimant's claim to closure once her condition became medically stationary. The Referee found that claimant's condition became medically stationary on July 31, 1985. The Referee's order issued in March 1986. Yet, the insurer delayed submitting claimant's claim for closure until December 1987.

Penalties and attorney fees may be assessed against an insurer who unreasonably delays or refuses to pay compensation. ORS 656.262(10); ORS 656.382(1). Failure to promptly submit a claim for closure after a claimant becomes medically stationary is one form of unreasonable delay or refusal to pay compensation. Lester v. Weyerhaeuser Co., 70 Or App 307, 311-12, rev den 298 Or 427 (1984); Georgia-Pacific v. Awmiller, 64 Or App 56, 59-60 (1983).

Here, the insurer has offered no explanation for its nearly two year delay in submitting claimant's claim for closure. We conclude, that such a delay was unreasonable. Accordingly, the assessment of a penalty and attorney fee is appropriate. Chester R. Rhodes, 38 Van Natta 1396, 1398 (1986).

ORDER

The Referee's order dated January 15, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that declined to assess a penalty or attorney fee is reversed. In the event that the Evaluation Division has awarded claimant permanent partial disability compensation, the insurer shall, as a penalty for its unreasonable delay in submitting claimant's claim

for closure, pay an additional amount equal to 25 percent of the permanent partial disability compensation awarded, not to exceed $1,000. In addition, claimant's attorney is awarded a penalty associated assessed fee of $300, to be paid by the insurer. The remainder of the Referee's order is affirmed.

WOODIE R. STRIPLIN, Claimant
Vick & Gutzler, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-12406
January 26, 1989
Order on Reconsideration

The self-insured employer has requested reconsideration of the Board's September 30, 1988 Order on Review that affirmed the Referee's order setting aside the employer's partial denial of claimant's chiropractic treatments. Whereas the Referee set aside the partial denial on substantive grounds, the Board concluded that the partial denial was procedurally improper pursuant to Roller v. Weyerhaeuser Co., 67 Or App 583, 586-87, on reconsideration 68 Or App 743, rev den 297 Or 601 (1984). On October 20, 1988, the Board's order was withdrawn and claimant was granted an opportunity to respond. Claimant has not submitted a response within the time period granted. We have proceeded to reconsider the matter.

The employer contends that its partial denial was procedurally proper. Alternatively, the employer argues that its partial denial, although ineffective when issued, became effective following closure of the claim. See Guerrero v. Stayton Canning Co., 92 Or App 209, 212 (1988).

Upon further review, the Board adheres to its prior holding to the effect that the employer's partial denial was procedurally impermissible and, therefore, was ineffective when issued. We next consider the employer's request that we find its partial denial effective as of the date of closure.

In Guerrero we held that an employer's denial of further chiropractic treatments was premature because the claim was still in open status. However, we further concluded that the denial became effective after the employer issued a notice of claim closure. We found, in this regard, that the evidence did not support the compensability of treatments conducted after the notice of claim closure. Ana M. Guerrero, 39 Van Natta 1, 2 (1987).

On review, the court affirmed. With regard to the effective date of the denial, the court reasoned:

> "[Claimant] asked for and received a full hearing on the compensability of the chiropractic treatments received after [the date of the denial], including treatments received after the notice of closure. In fact, claimant does not challenge here the Board's ruling that the chiropractic treatments after [the notice of closure], were not compensable. We conclude that, in these circumstances, the Board had authority to consider that the 1985 denial was effective after the notice of closure." 92 Or App at 212.

Here, claimant's claim was closed by Determination Order issued July 14, 1988. Relying upon Guerrero, supra, the employer argues that, even if its denial was premature when issued, it nevertheless was effective upon closure of the claim. We do not agree.

As noted in Guerrero, both in the Board's order and the court's decision on judicial review, claimant was provided an opportunity at hearing to litigate the compensability of her post-closure treatments. By contrast, the claim here was closed more than seven months following the hearing. Consequently, claimant did not have an opportunity to litigate the compensability of his post-closure treatments. Moreover, that claimant's treatments at the time of hearing were not causally related to his compensable injury does not foreclose the possibility that his compensable condition could have worsened by the date of claim closure to the extent that medical services were required. See Francis M. Mead, 40 Van Natta 1878 (November 29, 1988). Under these circumstances, the employer's partial denial can have no prospective effect. See Thomas A. Beasley, 37 Van Natta 1514, 1516 (1985).

Accordingly, on reconsideration, as amended and supplemented herein, we adhere to and republish our September 30, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

DALE L. TICHENOR, Claimant
Olson Law Firm, Claimant's Attorney
Foss, Whitty, et al., Defense Attorneys
Marcus Ward, Defense Attorney
Charles Lisle (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 87-14700, 87-14698, 87-14699 & 87-17319
January 26, 1989
Order on Reconsideration

Claimant requested reconsideration of that portion of our July 21, 1988 Order on Review that did not award an attorney fee for his attorney's services on Board review. To further consider the matter, we abated our order and granted the insurers an opportunity to respond. Inasmuch as the time to timely respond has elapsed, we proceed with our reconsideration.

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, the SAIF Corporation requested Board review and sought to shift responsibility for claimant's claim to Liberty Northwest Insurance Corporation. No order designating a paying agent pursuant to ORS 656.307 had issued. Thus, despite SAIF's failure to raise the issue on Board review, claimant's entitlement to receive compensation remained at risk. See Thomas W. Williamson, 39 Van Natta 1147 (1987). Claimant's counsel participated on Board review and contended that the Referee's decision should be affirmed. Under these circumstances, we conclude that claimant's attorney is entitled to a fee for services on review under ORS 656.382(2), payable by SAIF.

After review of claimant's counsel's statement of services and the retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we find that a reasonable assessed attorney fee for services on Board review is $740. A client-paid fee, payable from the SAIF Corporation, on behalf of its insured, Lawyer's Process Service, to its outside counsel is approved, not to exceed $187.50.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 21, 1988 Order on Review, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ANNIE L. CARLILE, Claimant
Robert Chapman, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 87-11725
January 31, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Melum's order that upheld the insurer's partial denial of claimant's chiropractic treatments as unrelated to her compensable low back injury. In its brief, the insurer argues that claimant's request for review should be dismissed for failure to mail a copy of the request to all parties. ORS 656.295(2). We decline to dismiss the request for review and we reverse on the merits.

ISSUES

1. Whether claimant's request for review should be dismissed.

2. Whether claimant's current need for chiropractic treatments is causally related to her compensable 1981 injury.

FINDINGS OF FACT

The Board adopts the Referee's factual findings numbered one through eight on pages one and two of his order. In addition, we make the following supplemental findings.

Claimant is credible. She experienced intermittent low back and left leg symptoms since her 1981 injury. She sought no medical treatment for these symptoms; instead, she dealt with these symptoms in part by utilizing techniques she learned at a hospital pain center in August 1982. The incident in the spring of 1985 resulted in the same type of pain in the same place as that following claimant's 1981 injury.

Claimant's April 1981 compensable injury materially contributed to her need for medical treatment commencing in June 1985.

Claimant mailed a copy of her request for review to the insurer's counsel. The request for review was not mailed directly to the insurer.

CONCLUSIONS AND OPINION

Jurisdiction

The insurer contends that claimant's request for review should be dismissed for failure to mail a copy of the request to "all parties" as required by ORS 656.295(2).

The courts have previously held that service upon a

party's attorney is constructive notice to that party. See Schneider v. Emmanuel Hospital, 20 Or App 599, 603 (1975), rev den (1976). Moreover, so long as no prejudice has resulted, the Board's jurisdiction is thereby properly invoked. Id.

The insurer claims no prejudice as a result of the failure of claimant to mail a copy of her request directly to it. Nor does the record disclose any such prejudice. We conclude that we have acquired jurisdiction for review. See Argonaut Insurance v. King, 63 Or App 847, 850-51 (1983); Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976).

Compensability

Dr. DeMarinis' treatments are compensable if claimant's low back and leg condition continues to be causally related to the 1981 injury. Jordan v. SAIF, 86 Or App 29, 32 (1987). The compensable injury need not be the sole cause or the most significant cause of the need for treatment, but only a material contributing cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

Claimant testified to continuing symptoms between the date of her original injury and the June, 1985 bending incident. As noted by the Referee, this testimony is suggestive of a causal relationship between the original injury and her 1985 condition. See Jordan v. SAIF, supra. Consequently, claimant's credibility is central to the dispute here.

The Referee did not explicitly rule on claimant's credibility. Because the Referee made no credibility finding based upon claimant's demeanor, we are left to an examination of the record in order to reach our own conclusion regarding credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). In this regard, we accept claimant's testimony that she dealt with her continuing symptoms by utilizing pain management techniques she learned at the Medford Providence Hospital Pain Center. This testimony is supported by reference in the Western Medical Consultants' May 30, 1987 report to the fact that claimant unsuccessfully attempted to utilize these same techniques to deal with her post-spring 1985 symptoms.

In addition, we find claimant's testimony of continuing symptoms compatible with her work history. Moreover, we do not discount her testimony simply because she referred to her symptoms as progressive at one point versus ongoing at another. Furthermore, we conclude that the Western Medical Consultants' report that claimant had reached "maximum improvement from the 1981 incident" suggests, if anything, that claimant's condition had not completely resolved. After our review of the record, we find that claimant's testimony regarding continuing symptoms was credible.

In addition to her own testimony, claimant relies upon the opinion of Dr. DeMarinis, her treating chiropractor, to establish a causal relationship between her current condition and her compensable 1981 injury. Dr. DeMarinis opined that the onset of severe symptoms in the spring of 1985 resulted from a recurrence of her 1981 injury. Dr. DeMarinis based this conclusion upon claimant's history of ongoing symptoms and her belief that a minor activity such as bending over to pull a weed was insufficient to explain the severity of claimant's symptoms.

The Referee found that Dr. DeMarinis' opinion was not persuasive "in view of the number of incidents of people herniating discs from pure flexion or rotative movements." Claimant objects to this statement as gratuitous. We agree with claimant that the Referee's statement is unsupported by medical opinion in the record and, therefore, inappropriate.

The Western Medical Consultants opined that claimant's symptoms in the spring of 1985 resulted from a new, nonindustrial injury. While their report contains exhaustive findings regarding claimant's physical condition on the date of their examination, their opinion regarding the causation of claimant's low back and leg symptoms is conclusory. In addition, the extent to which claimant's continuing symptoms were considered in arriving at their opinion regarding causation is ambiguous. In light of our acceptance of claimant's testimony concerning ongoing symptoms, we find that the Consultants' failure to address her continuing symptoms is a further ground for discounting their opinion.

We conclude that Dr. DeMarinis' opinion, together with claimant's testimony concerning her continued symptoms, lead us to conclude that her low back and leg condition is related to the 1981 injury, and that treatment of it is compensable. See Van Blokland v. Oregon Health Sciences University, supra, at 698 (1987).

ORDER

The Referee's order dated January 26, 1988 is reversed. The insurer's denial dated June 19, 1987 is set aside. Claimant's medical services claim is remanded to the insurer to be processed in accordance with law. For services at both levels, claimant's attorney is awarded $1,750, to be paid by the insurer. A client-paid fee not to exceed $387 is approved.

RICKY J. HAFLICH, Claimant
Malagon & Moore, Claimant's Attorneys
Acker, Underwood & Smith, Defense Attorneys

WCB 87-02843
January 31, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Mongrain's order that: (1) upheld the self-insured employer's partial denial of a spinal lesion and declined to assess a penalty and attorney fee for that denial; and (2) held that the employer properly refused to recommence payment of temporary disability compensation. In his brief on review, claimant requests that the Board either dismiss the temporary total disability issue without prejudice or award additional benefits and assess a related penalty and attorney fee.

On review, the issues are:

(1) Whether the employer's partial denial of claimant's spinal lesion condition is an improper "backup denial" or an invalid "premature denial."

(2) Temporary Total Disability.

(a) Whether the Board should dismiss the temporary total disability issue without prejudice.

(b) If not, whether the employer properly suspended claimant's temporary total disability benefits.

(3) Whether claimant is entitled to penalties and attorney fees regarding the employer's partial denial and its failure to recommence payment of temporary total disability benefits.

We reverse on the "backup denial" issue.

FINDINGS OF FACT

Claimant sustained a compensable injury in June 1986 while working as a timber faller. He was treated conservatively for persistent thoracic pain, etiology undetermined. Possible diagnoses were thoracic strain/spasm and facet joint dysfunction.

Claimant filed an injury claim for "pulled muscles" in his back, and the employer issued a formal acceptance of claimant's "thoracic back pain" in October 1986. The employer subsequently became aware of studies suggesting the existence of a spinal lesion diagnosed as a "developmental arteriovenous malformation." In February 1987, the employer issued a denial "for the condition thought to be an arteriovenous malformation, or something of that nature" and confirmed continued acceptance of a "dorsal strain."

In February 1987, the employer met with claimant and presented him with an offer of temporary light-duty work as a "flagger/witness" at his regular wage. Claimant accepted the offer and commenced that work on February 17, 1987, and the employer suspended payment of all temporary disability benefits. Claimant commuted to work with coworkers because he had no car or driver's license. Due to the nature of his work, he frequently missed his ride home and walked the two-mile distance while carrying his cork boots, packsack, hard hat and lunch box. He experienced increased low back pain during and after his walk home.

In April 1987, claimant failed to report to his modified work and did not return to that job until the following June. He was terminated several weeks later when he, again, failed to report to work. The employer did not recommence payment of temporary disability benefits following claimant's termination.

At hearing, the employer argued that any issue concerning additional temporary disability benefits was ripe for adjudication and should be raised or waived. Claimant's attorney requested a ruling on whether the issue would be waived if it was not raised at that time. When the Referee declined to rule on the question, claimant's attorney raised and litigated the issue.

FINDINGS OF ULTIMATE FACT

The employer's February 1987 denial was a denial of a condition it had previously accepted in October 1986. The employer has not demonstrated that its initial acceptance was the result of fraud, misrepresentation or other illegal activity. However, in issuing the February 1987 denial, the employer reasonably relied on a colorable interpretation of then-controlling law.

Claimant effectively raised the temporary total disability issue at hearing, and the record has been fully developed on that issue.

Claimant was terminated for reasons unrelated to his compensable injury. He has at all times been physically capable of performing the modified employment offered to him by the employer.

CONCLUSIONS AND OPINION

Compensability and Related Penalty and Attorney Fee

On review, claimant contends that the Referee erred in concluding that the employer's denial was not an improper "back-up" denial of a previously accepted condition. Alternatively, claimant argues that the partial denial was an invalid premature denial of a condition for which claimant had not submitted a claim. Finally, claimant contends that he is entitled to a penalty and attorney fee for the insurer's improper denial.

We agree that the partial denial was an improper "back-up" denial. Once an employer officially accepts a claim for compensation, it may not later deny compensability absent fraud, misrepresentation or other illegal activity. Johnson v. Spectra Physics, 303 Or 49, 55 (1987); Bauman v. SAIF, 295 Or 788, 794 (1983). Subsequent to the Referee's decision in this case, the Supreme Court issued its opinion in Georgia-Pacific Corporation v. Piwowar, 305 Or 494 (1988). In that case, the Court held that an employer accepting a claim for a "sore back" could not subsequently deny compensability when further diagnostic studies demonstrated that the claimant's back pain was attributable to an otherwise noncompensable ankylosing spondylitis condition. Id. at 501-502.

We conclude that the Piwowar decision is controlling in this case. Here, the employer initially accepted a claim for "thoracic back pain" and subsequently issued a denial of a specific spinal lesion condition unknown to the employer when it accepted the claim. As in Piwowar, the employer must continue to compensate claimant for his thoracic pain, regardless of the specific medical cause, and regardless of the employer's lack of knowledge of the specific condition at the time it accepted the claim. Accordingly, we conclude that the employer's subsequent denial of a specific spinal lesion condition was an invalid "back-up" denial, and we reverse the Referee on this issue. As a result, we need not address claimant's alternative argument that the denial was an invalid premature denial.

Turning to the related penalty and attorney fee issue, we are not persuaded that the employer acted unreasonably in issuing its denial. The denial issued before the Supreme Court's recent decision in Piwowar, and it was based on a colorable interpretation of then-controlling law. Under these circumstances, the denial was not unreasonable. See Volk v. SAIF, 73 Or App 643 (1985); Price v. SAIF, 73 Or App 123 (1985); Ginter v. Woodburn United Methodist Church, 62 Or App 118 (1983). Accordingly, we decline to assess a penalty and attorney fee.

Temporary Total Disability and Related Penalty and Attorney Fee

At hearing, claimant's attorney chose to raise and

litigate the temporary total disability issue in response to the employer's contention that the issue would be waived if not raised. On the merits, the Referee concluded that the employer had acted properly in suspending claimant's temporary total disability benefits. On review, claimant requests that the Board dismiss the temporary disability issue without prejudice. In the alternative, he argues that he is entitled to additional temporary total disability benefits and a related penalty and attorney fee.

We first address claimant's request for dismissal of this issue. We recognize that claimant would not have waived the temporary disability issue if he had not raised it at hearing. See North Clackamas School District v. White, 305 Or 48 (1988). However, claimant's attorney did not take that course of action. Instead, he chose to raise and litigate the issue. Furthermore, the Referee had no obligation to issue a ruling on the "raise or waive" issue, and the record on this question has been fully developed. Under these circumstances, we know of no authority supporting a dismissal of the temporary disability issue. Accordingly, we decline claimant's request for dismissal.

On the merits, claimant contends that the employer was obligated to recommence payment of temporary disability benefits after his termination. In support of that argument, he relies on OAR 436-60-030(5). That rule authorizes an employer to reduce temporary total disability payments by potential wage-earnings from modified employment which a claimant refuses. However, the employer must strictly comply with certain procedural safeguards in order to reduce benefits in this manner.

Here, claimant contends that his failure to report to work was a "refusal of employment" within the meaning of OAR 436-60-030(5). He further argues that the employer improperly suspended his benefits because it did not strictly comply with the procedural safeguards required under the rule. The Referee analyzed the case under OAR 436-60-030(5), but concluded that the employer had satisfactorily complied with the requisite procedural safeguards.

We affirm the Referee's decision, but for different reasons. First, we disagree with the Referee's application of OAR 436-60-030(5) to the facts presented in this case. Once claimant accepted and commenced wage-earning employment, that rule no longer applied. Furthermore, the employer's failure to recommence payment of temporary disability was otherwise proper under ORS 656.212 and OAR 436-60-030. The employer had the right to reduce claimant's temporary disability payments to zero when he commenced modified work at his regular wage. See OAR 436-60-030(1), (2) and (3). The employer had no duty to recommence payment of the suspended benefits as long as claimant remained physically capable of performing the modified employment. See OAR 436-60-030(4). Therefore, if claimant was terminated for reasons unrelated to his compensable injury, the employer was not obligated to recommence payment of temporary disability benefits. See Safeway Stores v. Owsley, 91 Or App 475 (1988). See also Donald W. Courtier, 39 Van Natta 705 (1987).

Here, Dr. Bernstein, the treating physician, opined that the modified employment offered to claimant continues to be within his physical restrictions. In addition, although claimant testified that his absence from work was partially due to an increase in back pain, there is no other evidence that his

symptomatic flare-up prevented him from performing his modified employment. Claimant's testimony as a whole instead persuades us that he failed to continue working for personal reasons unrelated to his compensable injury. Accordingly, we conclude that the employer had no obligation to recommence payment of temporary disability benefits after claimant's termination from modified employment. Id.

ORDER

The Referee's order dated December 9, 1987 is reversed in part and affirmed in part. The self-insured employer's partial denial is set aside, and the claim is remanded to the employer for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $1,000 for services at hearing and on Board review regarding the partial denial issue, to be paid by the employer. The Board approves a client-paid fee, not to exceed $459.

BRENDA HINKLE, Claimant
Patrick K. Mackin, Claimant's Attorney
Chelsea Mohnike (SAIF), Defense Attorney

WCB 86-08581, 87-01428 & 87-01429
January 31, 1989
Order on Reconsideration

On October 19, 1988, we issued our Order on Review that, among other findings, affirmed that portion of the Referee's order which upheld the SAIF Corporation's denial of claimant's aggravation claim for her back condition. On October 21, 1988, on our own motion, we abated our order to further consider our application of Gwynn v. SAIF, 304 Or 345, 352-53 (1987).

After conducting our reconsideration, we adhere to and republish our prior order, with the following supplementation and clarification concerning the aggravation issue.

To begin, claimant contends that SAIF only denied that claimant's condition had worsened, not that her condition was related to the compensable injury. We disagree.

SAIF's denial explained that an aggravation requires a worsening of an industrial injury that is causally connected to the compensable condition. Following that explanation, the denial proceeded to conclude that claimant's condition had not worsened. Claimant's assertions notwithstanding, we do not interpret the aforementioned denial as a concession that her current condition was attributable to her compensable injury.

Therefore, to establish a compensable aggravation under ORS 656.273(1), claimant must establish a worsening of her condition and a causal relation between the worsening and her compensable injury. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 459, rev den 297 Or 82 (1984). To prove a worsening, claimant must show a change in her condition since the last arrangement of compensation which entitles her to additional temporary or permanent disability compensation. Smith v. SAIF, 302 396, 399-401 (1986). If 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).

Here, the last award of compensation for claimant's back injury was a 15 percent unscheduled permanent disability award granted by a June 1986 Determination Order. Based upon the evidence available to the Evaluation Division at that time, we conclude that the award anticipated ongoing and periodically fluctuating back muscle tightness and mid to low back pain.

We further conclude that the question of whether claimant's reported increase in symptoms in June 1986 was causally related to her compensable back condition presents a complex medical question requiring expert medical analysis. See Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Thus, to resolve this question we turn to the opinions of the treating physicians.

As noted in our prior order, Dr. Scott, claimant's most recent treating chiropractor, has attributed claimant's current symptoms to her compensable condition and described the symptoms as totally disabling from June 1986 through October 1986. However, Dr. Strasser, a prior treating chiropractor, has attributed claimant's reported increase in symptoms to physical or psychological causes unrelated to the compensable back condition. Following our further consideration of this matter, we continue to find the opinion of Dr. Strasser more persuasive for the reasons detailed in our previous order.

In conclusion, we continue to hold that claimant has failed to establish a causal nexus between her compensable back condition and the increased or additional symptoms she began experiencing in June 1986. Consequently, claimant has failed to prove an aggravation.

Accordingly, on reconsideration, as supplemented and clarified herein, we adhere to and republish our October 19, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

CLARENCE HUNT, Claimant
Coughlin, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier
Industrial Indemnity, Insurance Carrier

Own Motion 89-0046M & 89-0047M
January 31, 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 both the 1975 and 1982 claims have expired. Thus, those claims are 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 shows that claimant was hospitalized briefly in July 1988 for tests. We do not feel that short hospital stays for the sole purpose of diagnostic testing satisfies the requirements set forth in ORS 656.278(1)(a). 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 one of the own motion insurers was 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).

LARRY L. JAY, Claimant
Flaxel, Todd, et al., Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 87-15813
January 31, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Nichols' order which: (1) declined to reinstate claimant's to temporary total disability benefits; and (2) declined to assess a penalty and associated attorney's fee for the SAIF Corporation's failure to reinstate the aforementioned benefits. We affirm.

ISSUES

The issues are whether SAIF should have reinstated claimant to temporary total disability benefits effective April 30, 1987 and whether claimant is entitled to a penalty and associated attorney's fee for SAIF's failure to reinstate him to temporary total disabilty benefits.

FINDINGS OF FACT

Claimant compensably injured his right elbow while working for the employer as a working supervisor of log truck mechanics. In January 1987 claimant returned to modified work with the employer. SAIF paid temporary partial disability benefits. By April 1987 claimant's wages in the modified employment were equal to his salary at injury. Accordingly, the temporary partial disability rate was zero. Consequently, SAIF stopped paying any temporary disability benefits.

The employer terminated claimant's employment on April 30, 1987 because he did not fulfill the employer's expectations for performance of his modified job. SAIF did not reinstate claimant to temporary total disability benefits after his job termination.

CONCLUSIONS

The Referee concluded that when a claimant is receiving temporary partial disability benefits and is fired from a job for violation of a normal employment standard, the claimant is not entitled to resumption of temporary total disability benefits. We conclude that whether or not claimant violated a normal employment standard is irrelevant.

The outcome of this case is controlled by Safeway Stores v. Owsley, 91 Or App 475 (1988). In Owsley, just as here, claimant had returned to modified work at a wage equal to or greater than the wages at injury. The claimant was fired for reasons unrelated to her injury. The court held that once claimant was fired, the employer did not have to begin paying benefits again once she was fired for reasons unrelated to her injury. We interpret Owsley to mean that once a claimant has demonstrated that he or she has lost no wages due to a compensable injury, then the employer or insurer need not resume paying benefits if the claimant stops working for reasons unrelated to the compensable injury.

ORDER

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

PHILLIP E. LEDBURY, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-03490
January 31, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of Referee Wilbur Smith's order which: (1) found that claimant's low back injury claim should not be barred for untimely filing; and (2) set aside the employer's denial of the same claim. We reverse.

ISSUE

Timeliness of low back injury claim.

FINDINGS OF FACT

Claimant alleges that he sustained a compensable low back injury on July 15, 1986. He alleges that he felt a tingling sensation in his left calf while moving refrigerators with a hand truck. He did not report the incident to the employer or his co-workers. The tingling allegedly persisted when he went home and developed into excruciating pain by the middle of the night. The next day, he sought medical attention, but the doctor could find nothing wrong.

Claimant was off work for four to six weeks, receiving conservative treatment for his symptoms. When he returned to work, he continued to have pain in the left calf and a "low-grade" ache in the low back. He worked until November, 1986, when he was taken off work for about one week. During that week, a myelogram and CT scan of the low back revealed two bulging discs at at L4-5 and L5-S1.

On February 16, 1987, claimant filed a workers' compensation claim for his low back injury. Prior to filing the

claim, claimant did not report the alleged industrial injury to the employer. We do not find that claimant attempted to file a claim for the alleged injury prior to February, 1987. The claim was denied on February 23, 1987.

All of the employer's workers are given an orientation, during which workers' compensation procedures are explained to them. When he was hired, claimant received an employe handbook with a section explaining how and when to report work injuries. Claimant knew that he could file a workers' compensation claim at any time.

FINDINGS OF ULTIMATE FACT

Claimant failed to give the employer notice of the alleged industrial accident within 30 days of the accident. Claimant did not have good cause for failing to do so. The employer did not have knowledge of the alleged industrial injury, and it was prejudiced by the lack of timely notice.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had good cause for failing to file his claim in a timely manner. In so finding, the Referee relied on claimant's "credible testimony" that he failed to file a timely claim, because someone at the employer's office convinced him that the claim was barred unless filed within 48 hours. We disagree.

In relevant part, ORS 656.265(1) provides that a worker must notify the employer of an accident resulting in an injury within 30 days after the accident. However, failure to give timely notice does not bar a claim if: (1) notice is given within one year of the accident and the worker establishes that he had good cause for failure to give timely notice; (2) the employer had knowledge of the injury; or (3) the employer has not been prejudiced by failure to receive the notice. ORS 656.265(4)(a), (4)(c).

Good Cause

Whether claimant had good cause for failure to notify the employer within the statutory time is a factual question the answer to which depends upon the circumstances of each case. Wilson v. State Acc. Ins. Fund, 3 Or App 573, 576 (1970); Riddel v. Sears, Roebuck & Co., 8 Or App 438, 441 (1972). Claimant bears the burden of proving good cause. Id.

Claimant testified that he attempted to file a claim with the employer on July 17, 1986, two days after the alleged industrial accident. According to his testimony, claimant telephoned the employer's personnel manager, informing her that he could not get off the couch due to the injury and requesting that a claim form be mailed to him. The manager allegedly refused to do so and told him that he had 48 hours within which to file a claim in person at the personnel office. Claimant testified that he did not file a claim at that time because he thought it was too late to do so.

The personnel manager, Ms. Peterson, had no recollection of the alleged conversation with claimant. She testified that claimant was scheduled to work on July 17, 1986, but that the

employer's computer-generated attendance records recorded no contact between claimant and anyone at work. She maintained that any telephone conversation she had with claimant would have been recorded on the attendance card for that day. Because no such conversation was recorded, she testified that it could not have occurred.

The Referee relied on claimant's testimony, finding him credible. However, it is unclear whether that finding was based on claimant's demeanor or the substance of his testimony. We are as capable of evaluating claimant's credibility as the Referee, where the evaluation is based on the substance of his testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

After reviewing his testimony, we find claimant not credible for three reasons. First, as discussed above, his testimony is not consistent with the employer's attendance records. Second, although claimant testified that he told all of his doctors that his injury occurred on the job, their reports and chart notes prior to July, 1987, do not reflect that history. Dr. Franks received history from claimant that he developed pain "with no known inciting cause." Dr. Crumpacker, who saw claimant in consultation with Franks, reported that claimant's history "goes back to July [1986] when he awoke in the middle of the night one night to have severe cramping pain in his left calf." The only medical report that mentions work activities was issued by Franks in July, 1987, after he received additional history from claimant's attorney. That history was not included in the record and remains unknown.

Finally, claimant testified that he was laid off work after filing his claim on February 16, 1987. Based on that allegation, he filed a complaint against the employer with the Bureau of Labor and Industries. Claimant's testimony was contravened by his supervisor, Mr. Hayden. Hayden testified that he informed claimant on February 14, 1987 that he would be placed on a floating work schedule due to a reduction in work hours. Ms. Peterson testified likewise. Claimant later resigned, citing his work schedule as the reason.

Given our credibility finding, we decline to accept claimant's testimony that he attempted to file a claim in July, 1986. In any event, claimant conceded that he knew he could file a claim at any time. He had received orientation regarding workers' compensation procedures and had a copy of the employe handbook, which outlined the procedures for reporting work injuries. Yet, claimant waited seven months before reporting the alleged work injury. We conclude that claimant has not sustained his burden of proving good cause for his failure to give timely notice of the alleged injury.

Knowledge of Injury

Untimely notice may also be excused if the employer had knowledge of the injury. ORS 656.265(4)(a). Here, claimant did not inform anyone at work of his alleged work injury until filing his claim in February, 1987. We do not find that the employer had knowledge of the alleged injury prior to that time.

Prejudice to Employer

The remaining basis for excusing untimely notice is the

lack of prejudice to the employer. ORS 656.265(4)(a). The employer has the burden of proving prejudice. Inkley v. Forest Fiber Products Co., 288 Or 337, 348 (1980); Ford v. SAIF, 71 Or App 825, 831, rev den 299 Or 118 (1985).

We are persuaded that the employer was prejudiced by the lack of timely notice. Ms. Peterson testified that it was almost impossible to investigate the alleged industrial accident due to the lack of witnesses. As if to confirm that fact, Mr. Hayden testified that he had no recollection of the events on July 15, 1986. He could not recall whether claimant was moving refrigerators on that day. Claimant did not tell anyone at work about the alleged work accident. Claimant's failure to give timely notice impaired the employer's ability to investigate the claim. For that reason, the employer was prejudiced. Vandre v. Weyerhaeuser Co., 42 Or App 705, 709-10 (1979). Claimant's injury claim is barred. See ORS 656.265(4).

ORDER

The Referee's order dated January 19, 1988 is reversed. The self-insured employer's denial is reinstated and upheld. The Board approves a client-paid fee not to exceed $908.

MICHAEL L. ORR, Claimant
William G. Whitney, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 87-10523
January 31, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Bennett's order that: (1) upheld the insurer's denial of his accidental injury claim relating to his left knee; (2) rejected his request for penalties and attorney fees for unreasonable denial; and (3) rejected his request for penalties and attorney fees for untimely denial. We affirm.

ISSUES

1. The compensability of claimant's left knee condition.

2. Penalty and attorney fee for unreasonable denial.

3. Penalty and attorney fee for untimely denial.

FINDINGS OF FACT

Claimant began working for the employer as a garbage collector on or about September 30, 1986. On October 3, 1986, claimant was pushing a trash dumpster toward a garbage truck when his left knee suddenly gave out and he fell to the ground. Claimant told the employer about the incident the same day, but stated that his knee had given out before and that it was related to an injury he had sustained in the military in 1980. He also indicated that he would file a claim with the Veterans' Administration.

Claimant's knee had given out on him several times during the two years prior to October 3, 1986. After the October 3, 1986 incident, claimant sought treatment for the condition and came under the care of Dr. Graham, an orthopedic surgeon. Dr. Graham

performed surgery on claimant's knee on November 11, 1986 and identified the problem as an old complete tear of the anterior cruciate ligament. There is no medical evidence that the October 3, 1985 incident contributed in any way to claimant's need for the surgery.

Claimant's claim with the Veterans' Administration was denied in April 1987. Claimant then returned to the employer's offices in late May or early June 1987 and requested a claim form. After an initial refusal, a claim form was provided. Claimant completed the form and returned it to the employer on or about June 22, 1987. The insurer issued its compensability denial on July 2, 1987.

ULTIMATE FINDINGS OF FACT

1. The incident on October 3, 1986 did not materially contribute to claimant's subsequent need for surgery.

2. The insurer's denial of claimant's condition was not unreasonable.

3. The insurer issued its denial within 60 days of receiving notice that claimant intended to claim workers' compensation benefits for his condition.

CONCLUSIONS OF LAW

Compensability

To establish a compensable accidental injury, claimant has the burden of proving that the incident on October 3, 1986 was a material contributing cause of his subsequent need for surgery. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). The record in this case fails to support such a conclusion.

Dr. Graham, the treating orthopedic surgeon, identified the condition as an old tear of the anterior cruciate ligament and gave no indication that the incident on October 3, 1986 in any way worsened the condition or hastened the need for surgery. The only evidence tending to support claimant's claim was his testimony. Claimant indicated that he had not had any significant problems with his knee since 1980 when he recovered from his service-connected injury. This testimony thus suggested that the October 3, 1986 incident had materially worsened his condition. The Referee rejected this testimony as inconsistent with the histories provided by claimant in the medical record. We reject claimant's testimony for the same reason. Claimant has failed to prove a compensable injury.

Penalty and Attorney Fee for Unreasonable Denial

A penalty and associated attorney fee may be assessed against an insurer which unreasonably denies a claimant's claim for compensation. See ORS 656.262(10); 656.382(1). The medical evidence in the insurer's possession at the time of its denial indicated that claimant's left knee condition was related to an old service-connected injury rather than to the work-related incident on October 3, 1986. The insurer's denial, therefore, was not unreasonable and no penalty or attorney fee may be assessed on that ground.

Penalty and Attorney Fee for Untimely Denial

A penalty and associated attorney fee may be assessed against an insurer which unreasonably delays acceptance or denial of a claim beyond 60 days after receiving notice or knowledge of the claim. ORS 656.262(6) & (10); 656.382(1). A "claim" is "a written request for compensation from a subject worker or someone on the workers' behalf, or any compensable injury of which a subject employer has notice or knowledge." Former ORS 656.005(7). A "compensable injury" is "an accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death." Former ORS 656.005(8)(a).

Claimant immediately informed the employer that his knee had given way on October 3, 1986. At the same time, however, he indicated that the event was related to an old injury and not to his employment. Claimant made no written request for compensation at that time and claimant's statements gave the employer no indication that there was any causal relation between claimant's employment and his knee condition. We conclude, therefore, that claimant made no "claim" for compensation at that time. The first indication that the employer had that claimant intended to make such a claim was in late May or early June 1987. The insurer issued its denial within 60 days of that event. The denial, therefore, was timely and no penalty or attorney fee may be assessed on that ground.

ORDER

The Referee's order dated January 12, 1988 is affirmed. A client-paid fee of up to $1,024.50 is approved.

IRIS J. WIRTH, Claimant
Welch, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-00672
January 31, 1989
Order on Review (Remanding)

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of Referee Shebley's order which: (1) set aside its denial of claimant's thoracic injury claim; and (2) assessed a penalty and associated attorney's fee for an unreasonable denial. Claimant moves to strike the testimony of an investigator. We remand.

ISSUES

The primary issue is whether an incident of August 20, 1986 caused a need for medical treatment.

The second issue is whether the employer's denial was unreasonable.

Finally, claimant contends that the Referee erred in allowing the testimony of an investigator because the transcript of the statement taken by the investigator was not disclosed to claimant's attorney. Claimant moves to strike the investigator's testimony.

FINDINGS OF FACT

Claimant's statement was taken by an investigator.

Claimant's attorney had specifically requested that any statement taken of claimant be disclosed to claimant's attorney. The employer did not disclose the statement prior to hearing.

At hearing, the employer called the investigator to testify. Claimant's attorney objected to the investigator's testifying on the basis that the statement had not been disclosed. The employer argued that the statement was impeaching and it had no obligation to disclose the statement under the administrative rules in effect at that time. The Referee agreed and allowed the testimony.

The employer did not introduce the statement itself into evidence. It did not disclose the statement to claimant's attorney.

CONCLUSIONS

ORS 656.295(5) provides in pertinent part:

> "[I]f the Board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee, it may remand the case to the referee for further evidence taking, correction or other necessary action."

We have held:

> "The rule [former OAR 438-07-015] requires an employer...to disclose to the claimant prior to the hearing all documents pertaining to the claim, 'except evidence offered solely for impeachment. The language of the rule requires either that the evidence be disclosed prior to the hearing or be offered at the time of the hearing. SAIF did neither in this case and effectively prevented claimant from examining the documents. Use of the impeachment evidence exception in this way could lead to obvious abuses which go to the very heart of the hearings process." Kenneth K. Kessel, 39 Van Natta 416, 417 (1987).

In Kessel, we remanded to the Referee with instructions that the insurer should disclose the withheld documents to claimant's attorney unless it had another valid reason for not doing so. Claimant was to be offered a reasonable time to examine the documents and to offer them into evidence if he so chose.

We find Kessel controlling here. Accordingly, we remand on our own motion.

ORDER

The Referee's order of September 30, 1987 is vacated. The case is remanded to Referee Shebley for additional proceedings. The employer is to disclose the disputed statement to claimant's attorney unless it can convince the Referee at hearing that it has some other valid reason for non-disclosure.

Upon disclosure, claimant is to be allowed a reasonable time to examine the statement and to decide whether she wishes to offer the statement into evidence. The Referee shall then reconsider the claim in light of the new evidence, if any is offered. A client-paid fee, not to exceed $1,399.50, is approved.

PAULINE R. YANCEY, Claimant
L. Thomas Clark, Claimant's Attorney
Thomas Andersen (SAIF), Defense Attorney

WCB 87-05573
January 31, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The SAIF Corporation requests review of Referee Higashi's order that set aside its partial denial of claimant's medical services claim for treatment of Crohn's disease. Claimant has not formally cross-requested review, but in her brief she seeks review of that portion of the Referee's order that refused to assess penalties and attorney fees for SAIF's alleged improper partial denial. We affirm in part and reverse in part.

ISSUES

1. Whether SAIF's partial denial of medical services on a previously-accepted claim was permissible.

2. Penalties and attorney fees for SAIF's alleged improper partial denial.

3. If SAIF's denial was permissible, whether claimant's claim for medical services is compensable.

FINDINGS OF FACT

Claimant filed a claim for an alleged stress-related worsening of her preexisting Crohn's disease in 1984. SAIF denied the claim. Claimant requested a hearing from the denial and the claim went to hearing. On July 15, 1985, a prior Referee set aside the denial, finding that claimant's employment was the major contributing cause of not only a worsening of claimant's symptoms, but also of the preexisting disease itself. SAIF appealed the Referee's decision to the Workers' Compensation Board, which affirmed the order of the Referee. The Board's order was not appealed and became final by operation of law.

Claimant's condition improved after she left work in early 1984. By February 1985, however, the condition worsened, requiring that claimant be hospitalized for treatment of severe malnutrition. In November 1986, x-rays revealed a fistula in claimant's transverse colon. Surgery was performed to correct the fistula approximately two weeks after it was discovered. Claimant submitted her medical billings to SAIF for payment under the claim ordered accepted by the Referee and the Board. On March 25, 1987, SAIF issued a partial denial of claimant's claim, asserting that her surgery resulted from the "natural progression" of her disease and that it was unrelated to the "job-related exacerbation" previously accepted by SAIF. The denial came while claimant's claim was in an open status.

CONCLUSIONS OF LAW

1. Whether SAIF's partial denial of medical services on a previously-accepted claim was permissible.

An employer/insurer may not deny the compensability of a previously accepted condition while the claim is in an open status. Safstrom v. Riedel International, Inc., 65 Or App 728 (1983); Roller v. Weyerhaeuser Co., 67 Or App 583 (1984). However, if an employer/insurer establishes that the denied condition is separable from that which was accepted, the denial may be allowed. See Destael v. Nicolai Co., 80 Or App 596 (1986). The determining factor in such cases is the scope of the acceptance. See Johnson v. Spectra Physics, 301 Or 165 (1986).

In the present case, SAIF asserts that it was ordered to accept only a job-related exacerbation of claimant's underlying disease. It further argues that the exacerbation resolved soon after claimant left work, and that the most recent medical treatment resulted from a natural progression of the disease, unrelated to the exacerbation ordered accepted by the Board.

The Referee disagreed with SAIF's interpretation of what it had been ordered to accept, and so do we. The prior Referee's July 1985 order was clear in ordering SAIF to accept claimant's underlying Crohn's condition as a compensable occupational disease. The prior Referee found that claimant's work exposure caused a worsening of the underlying condition itself, necessitating time loss and medical services. He did not merely order SAIF to pay for treatment of symptoms until such time as they resolved.

Because SAIF was ordered responsible for a worsening of claimant's underlying disease, it was impermissible for it to issue a partial denial of that condition while the claim was in an open status. Safstrom, supra; Roller, supra. The Referee was correct to so find.

2. Penalties and attorney fees for an alleged improper denial.

Claimant asserts that the Referee erred in not assessing a penalty and associated attorney fee for SAIF's alleged improper partial denial. It is claimant's burden to prove that the denial was unreasonable. The Referee found that SAIF's denial on the basis of the underlying compensability of the claim was not unreasonable. He did not specifically address whether the partial denial was procedurally improper and, therefore, unreasonable.

We have found that SAIF's denial was impermissible. We further find that it was unreasonable. SAIF should have known from the prior Referee's 1985 order that it was responsible for claimant's underlying Crohn's disease while the claim was in an open status. It should also have known that it was impermissible, under Safstrom and Roller, supra, to issue a partial denial of an accepted claim in open status. Under these conditions, we find that SAIF's partial denial was unreasonable and that a penalty and attorney fee are appropriate.

3. Compensability.

Having found SAIF's partial denial impermissible, we need not address the issue of compensability.

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 March 4, 1988 is affirmed in part and reversed in part. That portion that declined to assess a penalty and associated attorney fee for SAIF's unreasonable partial denial is reversed. SAIF is assessed a penalty equal to 25 percent of the compensation due claimant. The remainder of the Referee's order is affirmed.

TAMARAH L. ANDERSON, Claimant
Vick & Gutzler, Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-02392
February 3, 1989
Order of Dismissal

Claimant requested Board review of that portion of Referee Thye's order that affirmed a Determination Order award of 10 percent (32 degrees) unscheduled permanent disability for a then-compensable respiratory condition. Shortly after the Referee's order issued, the Board found that claimant's respiratory condition was not compensable and upheld the insurer's denial of claimant's occupational disease claim. Tamarah Anderson, 39 Van Natta 1076 (1987).

Claimant petitioned for judicial review of the Board's order and asked that her request for review in this case be stayed pending resolution of her "compensability" appeal. The motion was granted. On October 19, 1988, the Court of Appeals affirmed without opinion the Board's order. Anderson v. Quality Plastics Co., 93 Or App 625 (1988).

Asserting that no further appeal has been taken from the court's decision, the insurer contends that claimant's occupational disease claim has been conclusively determined to be not compensable. Since the claim is no longer compensable, the insurer argues that no further permanent disability can be awarded. Consequently, the insurer moves for dismissal. Although extended an opportunity to respond to the insurer's motion, no response from claimant has been forthcoming.

After reviewing this matter, we conclude that the law of this case is that claimant's occupational disease claim for a respiratory condition is not compensable. Thus, no future disability concerning the claim will be awarded. Furthermore, the questions raised by claimant on review do not concern whether the insurer properly exercised its processing obligations during the period the claim was considered compensable. See Weyerhaeuser Company v. McCullough, 92 Or App 204, 208 (1988). Under these circumstances, the motion to dismiss is granted.

Accordingly, the request for review is dismissed and the Referee's order is final by operation of law.

IT IS SO ORDERED.

VALERIE D. BARRY, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-03048 & 86-07954
February 3, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of those portions of Referee St. Martin's order that: (1) characterized claimant's current low back condition as a "new injury" rather than an occupational disease; (2) set aside its "de facto" denial of claimant's "new injury" claim; (3) awarded claimant additional temporary disability benefits from May 7, 1986 until May 24, 1986; and (4) assessed penalties and related attorney fees for unreasonable claims processing. We reverse in part and affirm in part.

ISSUES

1. Whether claimant's osteochondroma condition and sequelae, including surgery and subsequent development of right lumbosacral facet syndrome, is compensable.

2. Whether claimant's diabetes condition is compensable.

3. Whether claimant's 1986 claim should be characterized as an industrial injury or occupational disease.

4. Whether claimant suffered an aggravation of her compensable 1981 back condition, an industrial injury or occupational disease.

5. Whether claimant is entitled to penalties and related attorney fees.

FINDINGS OF FACT

On September 23, 1981, claimant, a registered nurse who worked in labor and delivery at a hospital, injured her low back when she lifted a heavy patient and subsequently bent over to pick up some rubber tubing. Her symptoms included persistent muscle spasms, as well as aching and burning in her right lower back with pain radiating down the front of her right leg. Prior to this incident, claimant had experienced one other lifting accident in 1976, which had caused her to miss one week from work. She completely recovered from that injury except for occasional pain in the right lower back.

In September 1981, claimant filed a claim for injury form. On that form, the space for "NATURE OF INJURY OR DISEASE" was left blank; the space for "PART OF BODY AFFECTED" stated "BACK." A space adjacent to the latter space provided blocks to indicate "LEFT" or "RIGHT." Claimant placed an "X" in the "RIGHT" block. The space for "DESCRIBE ACCIDENT FULLY" stated "Bent over to get IV tubing from box on floor and had pain in lower back." On October 9, 1981, the self-insured employer accepted that claim for right back pain on the same injury form.

On September 29, 1981, Dr. Kravitz diagnosed a lumbosacral strain. After physical therapy, a body cast and a lumbosacral corset all proved unsuccessful, claimant began treating with Dr. Puziss, orthopedic surgeon. Dr. Puziss diagnosed an osteoblastic mass at the right L5-S1 facet joint.

On April 30, 1982, a Determination Order awarded claimant 10 percent unscheduled permanent disability resulting from injury to her low back.

On May 11, 1982, Dr. Puziss excised the osteochondroma at the right L5-S1 facet joint, fused the facet joint and performed a partial laminectomy. At that time, he also diagnosed possible diabetes mellitus.

On May 24, 1982, claimant's prior Determination Order was set aside in its entirety since she was not medically stationary.

On October 15, 1982, Dr. Puziss released claimant to work with restrictions of no lifting greater than 30 pounds and no repetitive bending, stooping, kneeling or lifting. The lumbosacral strain had completely resolved. Claimant had, however, sustained minimal permanent impairment as a result of surgery-related low back stiffness.

On November 15, 1982, a Determination Order awarded claimant compensation for various periods of temporary disability. On July 10, 1984, claimant entered a stipulated settlement which awarded her 15 percent unscheduled permanent disability for injury to her low back.

Claimant subsequently returned to her regular nursing duties in labor and delivery at a hospital. She worked 20 to 24 hours per week until January 1986. Around January 4, 1986, she began to experience low back pain which progressively worsened. The pain also radiated down her legs into both feet where she experienced slight numbness and tingling in the soles and lateral heels. On January 17, 1986, claimant called Dr. Puziss' office to obtain medication for her low back pain. He diagnosed stenosis of the L5-S1 foramen on the right secondary to severe facet arthropathy caused by her prior surgery. On February 11, 1986, Dr. Puziss took claimant off work; she did not return until May 24, 1986.

The primary causes of claimant's increased low back symptoms were a combination of her work activities, which required frequent bending, and generalized stiffness due to her previous surgery. That surgery was required solely to remove the osteochondroma. Although claimant would not have been disabled without her preexisting impairment resulting from the surgery, the major cause of her symptomatic increase in early 1986 was her work activities.

At that time, claimant also developed leg pain. This pain was not due to work activities or prior surgery, but rather the progression of claimant's diabetes mellitus. Claimant's work activities neither materially caused nor worsened her diabetic condition.

On May 7, 1986, the self-insured employer denied claimant's claim for aggravation of her compensable condition. That denial did not address any "new injury" claim made by claimant.

On July 11, 1986, Dr. Puziss informed the employer that claimant's prescriptions for Ascendin and B6 were for radiculopathy. However, when no lesion of the nerve roots was documented, he could not specifically relate the medications to her compensable injury. On August 29, 1986, the employer denied claimant's request for reimbursement of the aforementioned prescriptions since they were not related to her original on-the-job injury.

On August 22, 1986 and again on October 27, 1986, claimant filed "new injury" claims with the employer. At no time did it deny either of these "new injury" claims. On February 26, 1987, claimant requested a hearing on the compensability of her new "injury claim" and the employer's failure to pay temporary disability benefits.

On November 17, 1986, a third denial was issued denying that claimant's then current low back condition was either caused or worsened by the September 23, 1981 industrial injury.

Claimant's September 23, 1981 lumbosacral strain did not aggravate her preexisting osteochondroma to the extent that it became symptomatic. However, the strain did bring the bony tumor to the attention of Dr. Puziss who had to remove it if claimant were to recover. The removal of the osteochondroma and fusion of the right L5-S1 facet joint in 1982 caused the development of a right lumbosacral facet syndrome. In January 1986 claimant's repetitive bending activities as a nurse caused the facet syndrome to become symptomatic; it did not cause a worsening of that underlying condition. The increased symptoms of her low back condition and need for medical care, therefore, were caused primarily by her work activities as a nurse in labor and delivery.

Claimant's current leg symptoms were caused by the progression of her diabetic neuropathy; those symptoms were not worsened by her work activities.

CONCLUSIONS OF LAW

Scope of Board review

The Referee affirmed the self-insured employer's denial of claimant's aggravation claim, believing that she had instead proven a "new injury." The Referee, however, declined to address prerequisite compensability questions prior to a determination of the aggravation/new injury issue. We disagree with his approach to this complex case and choose to address those issues. We address these issues because we have consistently held that the Board's review is de novo and it may reverse or modify the order of the Referee, or make such disposition of the case as it determines to be appropriate. Miller v. SAIF, 78 Or App 158, 161 (1986).

The Referee's decision to affirm the self-insured's May 7, 1986 denial failed to address the second aspect of its two-pronged analysis of claimant's condition. The relevant paragraphs of that denial are as follows:

> "Our investigation is now complete and the medical information we have received indicates your condition did not materially worsen and that you have an underlying condition not work related which has a significant contribution to your ongoing symptoms. With this information, we must notify you that we will be unable to accept your claim for aggravation to your back." (Emphasis added).
>
> "Our denial is based on the fact it does not appear your condition was worsened by or arose out of and in the course and scope of your employment, either by accident or

occupational disease, within the meaning of the Oregon Workers' Compensation Law." (Emphasis added).

We interpret this denial to mean that the self-insured employer was: (1) stating that claimant's current low back condition was caused by two noncompensable conditions, namely diabetes mellitus and a lumbosacral facet syndrome which resulted from the surgical removal of the osteochondroma; and (2) denying that claimant had suffered an aggravation of her compensable 1981 low back strain. Similarly, the self-insured employer's November 17, 1986 denial was intended to deny the compensability of claimant's current low back condition in the belief that it was neither caused nor worsened by the September 23, 1981 industrial injury.

Since persuasive medical evidence established that claimant's low back symptoms in January 1986 were due in material part to the surgical removal of her osteochondroma and its sequelae, and her leg symptoms were caused entirely by diabetes mellitus, we must first address the question of the compensability of the osteochondroma and diabetic conditions before deciding whether claimant proved either a compensable aggravation or new injury claim.

Compensability of Osteochondroma

The self-insured employer's two denials of May 7, 1986 and November 17, 1986 denied that claimant's then current low back condition was either caused or worsened by the September 23, 1981 industrial injury. Therefore, it denied her entire low back condition. We find, however, that the employer not only accepted claimant's low back strain, which resolved shortly thereafter, but also accepted her osteochondroma condition.

In the absence of fraud, misrepresentation or other illegal activity, an employer/insurer who accepts a claim for compensation may not later deny the same claim. Bauman v. SAIF, 295 Or 788, 794 (1983). The Bauman rule, however, applies only to a claim "specifically" or "officially" accepted. Johnson v. Spectra Physics, 303 Or 49, 55 (1987). Acceptance and denial of claims is governed by ORS 656.262(2), which provides in relevant 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."

Acceptance need not meet any degree of specificity. Georgia-Pacific v. Piwowar, 305 Or 494, 500 (1988). The scope of the written acceptance corresponds to the condition specified in the acceptance notice. Id. at 501. Read together, Johnson and Bauman require the employer to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition. Id.

On September 23, 1981, claimant injured her back while bending over to pick up some rubber tubing. On her claim form, the space for "NATURE OF INJURY OR DISEASE" was left blank; the

space for "PART OF BODY AFFECTED" stated "BACK." A space adjacent to the latter space provided blocks to indicate "LEFT" or "RIGHT." Claimant placed an "X" in the "RIGHT" block. The space for "DESCRIBE ACCIDENT FULLY" stated "Bent over to get IV tubing from box on floor and had pain in lower back." On October 9, 1981, the self-insured employer accepted that claim for right back pain on the same injury form.

In Georgia-Pacific v. Piwowar, supra, the self-insured employer accepted a claim for a sore back, which was merely a symptom of an underlying disease, not a separate condition. Although subsequent to acceptance of the claim, it was discovered that claimant's sore back was due to ankylosing spondylitis, the self-insured employer was precluded from denying the compensability of that condition. Id. at 501-02. The Court reasoned that allowing the self-insured employer to deny a previously accepted claim would merely encourage instability in the workers' compensation system and frustrate the statutory scheme's provision for a speedy resolution of claims. Id. at 499.

Similarly, the self-insured employer in the present matter accepted a claim for right back pain. The fact that subsequent medical information revealed that the cause of that pain was a preexisting osteochondroma at the right L5-S1 facet joint is irrelevant. Since the self-insured employer accepted a claim for right back pain, it could not later deny the compensability of the condition regardless of the cause, without a showing of fraud, misrepesentation or other illegal activity. There was no such showing. Therefore, those portions of the self-insured employer's two denials of claimant's condition which are related to the surgical removal of her osteochondroma and its sequelae are set aside. The compensable osteochondroma claim includes the necessary surgical intervention and subsequent development of the right lumbosacral facet syndrome resulting from that surgery. Since claimant's bending activities in early 1986 caused her compensable right lumbosacral facet syndrome to become symptomatic, thereby requiring medical services, that condition is compensable.

Compensability of Diabetes mellitus

In January 1986 claimant began having leg pain and numbness along with low back pain. Dr. Puziss reviewed a number of studies, including nerve conduction studies, EMGs, a myelogram and CT scan, to determine the etiology of claimant's radicular symptoms. Based upon those studies, he concluded that the sciatic irritation was neither caused by a herniated disc nor due to any true foraminal stenosis, but rather, due to claimant's diabetic peripheral neuropathy. There is no medical evidence to the contrary.

As previously discussed, the self-insured employer accepted claimant's claim for right back pain. It did not specifically accept any original claim for leg pain or numbness. Even if claimant had been treated in 1981 for leg problems, the self-insured employer's knowledge or notice of that condition is not a substitute for a specific written acceptance as defined by Bauman. Johnson v. Spectra Physics, supra at 55. Silence regarding one aspect of a claim is neither acceptance nor denial of that aspect of the claim; silence is neutral. Id. Therefore, those portions of the self-insured employer's two denials of

claimant's condition that concern her diabetic peripheral neuropathy are affirmed.

Compensability of 1986 claim

The Referee concluded that claimant had proven a compensable "new injury" since her work activities were the major contributing factor to her need for medical treatment and time loss in January 1986. Although we find that claimant's activities in January 1986 were the major cause of her increase in symptoms, we disagree that her claim is compensable as either a "new injury" or occupational disease, and conclude instead that claimant suffered an aggravation of her compensable 1981 injury.

Characterization of claim

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 343, 348 (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 working as a registered nurse in labor and delivery. If claimant's low back condition was not an inherent hazard of her bending and lifting activities, or otherwise expected from 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. Id.

Here, claimant's condition cannot be viewed as wholly unexpected in view of the constant bending and lifting activities which she performed on a daily basis. Furthermore, her condition is not associated with any specific incident. Following her initial 1981 injury, she returned to her regular nursing duties in labor and delivery. She worked 20 to 24 hours per week until January 1986. Around January 4, 1986, she began to experience low back pain which progressively worsened. Therefore, her condition cannot be characterized as either "unexpected" or "sudden in onset." We conclude that claimant's condition is properly characterized as an occupational disease.

Occupational disease

Claimant's burden of proof remains as it has always been. To establish compensability, claimant must prove that her work activities, when compared to nonwork activities, were the major contributing cause of the onset or worsening of her low back condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988).

Application of the "last injurious exposure rule" would be inappropriate. Jerry W. Sargent, 38 Van Natta 104, 108 (1986). The "last injurious exposure rule" was adopted by the court in Inkley v. Forest Fiber Products Co., 288 Or 337 (1980), in order to solve problems of proof and assignment of responsibility for compensation where a claimant has worked for more than one employer. See Runft v. SAIF, 303 Or 493, 499 (1987). In the present case, claimant has worked for the same employer throughout the course of her claims. Furthermore, the employer has been self-insured at all relevant times. Since the employer/insurer responsibility is not at issue, it follows that the "last injurious exposure rule" is inapplicable. Jerry W. Sargent, supra.

On September 23, 1986, Dr. Puziss opined that claimant's:

> "underlying condition concerning her lower back has to do with a stiffness resulting from the right lumbosacral facet fusion. I believe at this time there is no pathological worsening of this underlying condition, but the patient's on the job and off the job activities which are quite vigorous altogether are a cause of her ongoing symptoms."

On September 29, 1986, Dr. Puziss supplemented this opinion by stating that claimant's:

> "work activities at [the hospital] were the major contributing factor to her need for medical treatment and time loss between February 11 when I began seeing her and May 20 when I released her to light duty."

Since the medical evidence establishes that claimant's work activities in some way affected her underlying condition, in order to prevail on an occupational disease claim, claimant must also prove by a preponderance of the evidence that: (1) her work activity and conditions; (2) caused a worsening of her underlying disease; (3) resulting in an increase in her pain (4) to the extent that it produced disability or required medical services. Weller v. Union Carbide, 288 Or 27, 35 (1979). Since Dr. Puziss persuasively opined that claimant's work activities did not cause a worsening of the underlying condition, but rather, a symptomatic worsening, claimant has failed to establish the compensability of her occupational disease claim.

Aggravation

To establish a claim for aggravation of his 1981 back claim, 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 an aggravation. Gwynn v. SAIF, 304 Or 345, 352-53 (1987).

Since claimant has shown that an increase in symptoms of her compensable low back condition caused her to become less able to work and she was totally disabled for a period of greater than 14 consecutive days, she has proven an aggravation claim as a matter of law.

Penalties and related attorney fees

The Referee assessed claimant a 25 percent penalty against interim compensation owed from May 7, 1986 to May 24, 1986 and a related attorney fee for the self-insured employer's failure to deny claimant's "new injury" claim. We disagree with regard to the penalty only.

ORS 656.262(10) states that:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

ORS 656.262 requires an employer to make interim compensation payments until a claim is either accepted or denied. Jones v. Emanuel Hospital, 280 Or 147 (1977). Because prejudice to the claimant is no longer an element of a claim processing violation, a carrier is required to pay interim compensation until it actually fulfills its duty to issue a formal denial. Roger G. Prusak, 40 Van Natta 2037 (1988). Where a claim is properly denied, claimant is entitled only to compensation for the period between the date of notice of her claim and the date of its denial. Spivey v. SAIF, 79 Or App 568, 571 (1986).

On May 7, 1986, the self-insured employer denied claimant's aggravation claim. That denial did not address a "new injury" claim. Claimant subsequently made two claims for a new injury with the self-insured employer. One was on August 22, 1986; the other was on October 27, 1986. At no time after these two claims were made did the carrier formally deny that claimant had sustained a new injury. Claimant is therefore entitled to a penalty on any amounts due through the date of hearing. Since claimant is only entitled to interim compensation benefits between notice of her "new injury" claim and the date of hearing, interim compensation benefits were not owed for the period of time from May 7, 1986 until claimant returned to work on May 24, 1986. Since claimant began working thereafter, there were no "amounts then due" upon which to calculate a penalty. Paige v. SAIF, 75 Or App 160, 164 (1985). Therefore, claimant is not entitled to a penalty. Claimant is, however, entitled to an award of a reasonable attorney fee for the self-insured employer's unreasonable failure to deny her "new injury" claim. Spivey v. SAIF, supra at 572.

ORDER

The Referee's order dated June 3, 1987 is affirmed in part and reversed in part. Those portions of the self-insured employer's May 7, 1986 and November 17, 1986 denials that denied the compensability of claimant's osteochondroma condition and sequelae are set aside. Those portions of the aforementioned claim is remanded to the employer for processing according to law. However, those portions of the May 7, 1986 and November 17, 1986 denials that denied the compensability of claimant's diabetic condition are affirmed. That portion of the May 7, 1986 denial that denied that claimant's compensable condition had worsened is set aside. The aggravation claim is likewise remanded to the employer for processing according to law. The self-insured employer's "de facto" denial of claimant's "new injury" claim is reinstated and upheld. We also reverse that portion of the Referee's order that assessed a 25 percent penalty for the self-insured employer's failure to deny claimant's "new injury" claim, but we affirm the award of a reasonable attorney fee. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee not to exceed $104. Claimant's attorney is awarded an assessed fee of $805, to be paid by the self-insured employer.

DWAINE A. DICKSON, Claimant
Craig P. Emerson, Claimant's Attorney
Al Ludwick (SAIF), Defense Attorney

WCB 86-16424
February 3, 1989
Order on Review

Reviewed by Board Members en banc.

The SAIF Corporation requests review of those portions of Referee Foster's order that: (1) set aside its denial of claimant's left hip injury claim; and (2) assessed a penalty for alleged unreasonable claims processing.

The Board affirms the order of the Referee.

ISSUES

1. Whether claimant sustained a compensable left hip injury.

2. Whether a penalty should be assessed against SAIF.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

Claimant, a truck driver, sustained an injury to his left hip on June 24, 1986, after jumping from the running board of his truck at a weigh station in Madras, Oregon. The following morning, he told his supervisor, Mr. Foss, that he had slept incorrectly on his left hip. Shortly thereafter, i.e., within a day-or-two of the June 24, 1986, injury, he told Foss that he had injured his left hip after jumping from his truck.

On June 26, 1986, claimant sought medical treatment from Dr. Cother, a chiropractor, for left hip pain. Claimant did not advise Cother that his pain was work related. Cother diagnosed a strain.

Claimant was examined by Dr. Valenti, M.D., on June 30, 1986. He informed Valenti that he had injured his left hip at work after jumping from his truck. Valenti diagnosed a strain and recommended physical therapy treatments.

Although claimant had initially planned on not filing a workers' compensation claim because he considered his injury to be rather minor, he decided otherwise after Dr. Valenti recommended physical therapy treatments.

On July 7, 1986, claimant signed an "801" claim form, but apparently did not return it to SAIF's insured until July 20, 1986.

Claimant was reexamined by Dr. Cother on July 24, 1986, at which time he informed Cother that he had filed a worker's compensation claim for his left hip injury.

ULTIMATE FINDINGS OF FACT

Claimant is a credible witness. On June 24, 1986, he sustained an on-the-job injury to his left hip resulting in a strain.

CONCLUSIONS OF LAW

Compensability

To establish a compensable industrial injury, a worker must prove, by a preponderance of the evidence, that his accidental injury arose out of and in the course of his employment requiring medical services or resulting in disability. Former ORS 656.005(8)(a). We generally give great weight to a Referee's findings concerning the credibility of a witness. Pinkerton, Inc. v. Brander, 83 Or App 671, 674 (1988).

In our view, this case ultimately rests upon a finding of whether claimant is a credible witness. SAIF argues on review that claimant is not credible and, therefore, he has not sustained his burden of proving a compensable injury. We disagree.

Although, as noted by the Referee, there are minor discrepancies between claimant's testimony and the testimony of Mr. Foss, we are not persuaded that such discrepancies reflect a lack of veracity on the part of claimant. Accordingly, after our de novo review of the lay testimony and documentary evidence, we agree with the Referee's finding that claimant was an "impressive" witness.

Consequently, we conclude that claimant sustained an injury to his left hip on June 24, 1986, after jumping from the running board of his truck during the course of his employment. Drs. Valenti and Cother diagnosed his injury as a strain. Valenti recommended physical therapy treatments. Based on claimant's credible history, Valenti and Cother reported that claimant had sustained a work-related injury. No medical expert has opined to the contrary.

Claimant has established by a preponderance of the evidence that he compensably injured his left hip on June 24, 1986.

Penalty

SAIF offers no explanation for its late denial. Its sole argument against the assessment of a penalty hinges upon the Board

finding claimant's left hip injury not compensable. Since we have found otherwise, we are not persuaded by SAIF's argument.

Therefore, the Referee was correct in assessing a penalty against SAIF.

ORDER

The Referee's order dated June 29, 1987, is affirmed. Claimant attorney is awarded an assessed fee of $750, to be paid by the SAIF Corporation.

Board Member Ferris, dissenting:

I dissent and would reverse the Referee.

Claimant allegedly sustained an industrial injury to his left hip on June 24, 1986, while jumping from a truck. There were no witnesses. He did not report any injury to the employer until a day or two after his alleged injury. On June 26, 1986, he sought treatment from Dr. Cother, a chiropractor. The record contains no evidence that, on that date, claimant informed Cother that he had sustained an industrial injury. In fact, claimant testified that he only informed Cother that he had "hurt my hip." (Tr. 14). A few days later, he was examined by Dr. Valenti, M.D.

Claimant did not file an industrial injury claim until July 7, 1986. Although he was aware that the employer had workers' compensation coverage, he testified that he filed a claim only after he realized that his medical treatment would be expensive. (Tr. 30).

On July 24, 1986, Dr. Valenti filed a First Medical Report form. That form is the first piece of documentary evidence, other than claimant's "801" claim form, to indicate that claimant had sustained an industrial injury. The next day, Dr. Cother also filed a First Medical Report form.

At the hearing, claimant's supervisor, Mr. Foss, testified that claimant had been off work for three days prior to June 24, 1986. Foss "distinctly" recalled that on the morning of June 24, 1986, claimant complained to him of left hip pain from sleeping on it wrong. (Tr. 45-6). Foss' testimony is corroborated by entries in his work diary. (Ex. 9).

Claimant, on the other hand, did not remember "the exact date" of his left hip injury. (Tr. 9). He also did not remember the time of day, in which his injury occurred. (Tr. 10). He even admitted that he had spoken with Mr. Foss regarding sleeping on his hip wrong. (Tr. 31). However, he "think[s]" that he told Foss of his hip pain on July 25, 1986, (i.e., the day following his alleged injury). Id.

Significantly, on cross-examination claimant was asked if his log book entries were "basically lies." (Tr. 24). He responded "yeah," although adding that he was "going to be truthful." Id. The Referee then stated, inter alia:

> "I just think for the record I should indicate to you gentlemen I've heard this logbook 100 times in my 15 years in this business. So it's nothing new."

In his order, the Referee found that claimant was an "impressive" witness. I do not agree.

As I view this case, Mr. Foss had an independent recollection that claimant was off work for three days and then, on July 24, 1986, reported to work with complaints of left hip pain from sleeping on it wrong. Moreover, Foss' work diary corroborates his testimony.

Unlike Mr. Foss, claimant was unsure of specific dates. He even admitted that he had told Foss of a left hip problem related to sleeping. Moreover, regardless of the Referee's belief, unsubstantiated in the record, that it is standard practice for truck drivers to falsify entries in their logbooks, the fact remains that claimant admitted to making untruthful entries. Such actions are highly probative when, as here, the majority concedes that claimant's case "ultimately rests upon a finding of whether [he] is a credible witness."

Here, the Referee's conclusion that claimant was an "impressive" witness was apparently premised on the following findings:

> "The small discrepancies of times and dates is certainly understandable. Also, claimant's delay in filing the 801 [claim form] is also insignificant because of his belief that the injury was only minor."

As I view it, however, the proper analysis is not whether the "small discrepancies" in claimant's testimony are "understandable", but rather whether he has met his burden of proving, by a preponderance of the evidence, that he sustained a compensable injury. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). In weighing the evidence, the majority and I both agree that claimant's credibility is central to his case. We disagree, however, in our assessment of his credibility.

The Board is as capable as the Referee in assessing a witness' credibility, when based on the substance of a witness' testimony. Davies v. Hanel Lumber Co., 67 Or App 35, 38 (1984). Here, I do not find that claimant's testimony is credible. First, his testimony is inconsistent and uncertain. Second, it is in direct conflict with the consistent and certain testimony of Mr. Foss. Last, and most importantly, claimant admitted under oath that he had falsified the entries in his logbook.

On this record, I am not persuaded that claimant has proven a compensable injury. Accordingly, I would not find, as does the majority, that SAIF's denial is unreasonable. Penalties and attorney fees are not warranted under the circumstances of this case.

JOSEPH M. DOOLITTLE, Claimant
JAMES G. MORFORD & RONALD PRENTICE, dba, MORFORD CONSTRUCTION CO., Employer
Michael Green, Claimant's Attorney
SAIF Corp Legal, Defense Attorney
Terri Borchers, Assistant Attorney General

WCB 85-13404 & 85-13908
February 3, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The alleged noncomplying employer, L. E. Wallman Company ("Wallman"), requests review of those portions of Referee Pferdner's order that: (1) set aside the SAIF Corporation's denial, on Wallman's behalf, of claimant's injury claim for a back condition; and (2) set aside the SAIF Corporation's denial, on behalf of another alleged noncomplying employer, Morford & Prentice ("Morford"), for the same condition. In addition, claimant has requested that the Board limit the scope of its de novo review.

The Referee's order is reversed in part and affirmed in part.

ISSUES

1. Whether the Board's de novo review of a Referee's order can be limited upon the motion of a party.

2. Whether either Wallman or Morford are responsible for claimant's injury.

FINDINGS OF FACT

Scope of Board's Review

On September 29, 1986, the Referee issued his order on reconsideration. A few days later, Wallman timely requested Board review of "the Referee's Opinion and Order . . . and the Referee's Order on Reconsideration . . . ." The request for review listed only the Workers' Compensation Board case number for claimant's claim against Wallman.

Shortly thereafter, the Board issued an acknowledgment of Wallman's request for review. In so doing, it listed the Workers' Compensation Board case numbers for both the Wallman and Morford case numbers.

On October 16, 1986, the Board received a letter from claimant contending that the Board had erroneously acknowledged an appeal on his claim against Morford. According to claimant, Wallman's appeal did not "automatically trigger[] appeals by other parties." Consequently, claimant requested that the Board exclude review of SAIF's denial on behalf of Morford. Claimant's letter contained no indication that copies had been mailed to the other parties.

A few days later, the Board issued an order withdrawing its acknowledgment of Wallman's request for Board review insofar as it concerned claimant's claim against Morford. The Board's order did not contain a statement explaining the parties' rights of appeal under ORS 656.295(8).

Wallman or Morford's Responsibility

In October, 1983, Wallman was hired to build a house for

a third party. Shortly thereafter, Wallman entered into a verbal agreement with Morford. Pursuant to that agreement, Morford agreed to frame the third party's house.

Thereafter, Morford began constructing the third party's house. Nearby, Kurt Hafferman and claimant were framing another house. Hafferman and claimant had a verbal understanding that claimant was an independent contractor and not an employee. In addition, they were planning on entering into a partnership. Although the two apparently never discussed claimant's wage, Hafferman eventually paid claimant a lump sum of approximately $500. Claimant reported the $500 on his tax returns as self-employed income.

In late 1983, James Morford helped Hafferman and claimant lift one or more walls at the Hafferman work site. In exchange, Hafferman and claimant apparently offered to provide similar future assistance to Morford.

On January 3, 1984, Morford asked Hafferman for assistance. In response to this request, Hafferman and claimant went to the Morford work site to help raise some walls. Claimant sustained a back injury when one of the walls fell on him.

Thereafter, claimant filed injury claims against Wallman and Morford, but not Hafferman. The Workers' Compensation Department apparently submitted claimant's claims to the SAIF Corporation for processing. Concluding that claimant was not a subject employee of either Wallman or Morford, SAIF denied both claims. Claimant appealed and his two hearing requests were consolidated.

CONCLUSIONS OF LAW

1. Scope of Board's Review

The scope of our de novo review encompasses all issues considered by the Referee. Our review is not limited to those issues specifically raised by the parties on review. Destael v. Nicolai Co., 80 Or App 596 (1986); Russell v. A & D Terminals, 50 Or App 27, 31 (1981). A party has a right to request review of the Referee's "order." ORS 656.295(1). Pursuant to ORS 656.295(6), "the Board may affirm, reverse, modify or supplement the order of the Referee and make such disposition of the case as it determines to be appropriate." (Emphasis added).

Here, Wallman requested review of the Referee's Opinion and Order and Order on Reconsideration. In the interests of substantial justice and in order to reach a proper resolution of the issues present in this case, we determine that it is appropriate to consider whether the Referee correctly set aside SAIF's denial on behalf of Morford. ORS 656.295(6); William E. Wood, 40 Van Natta 999, 1001 (1988). Therefore, we disavow the Board's prior interim order of October 22, 1986, which withdrew its acknowledgment of Wallman's request for review concerning the SAIF denial on behalf of Morford. On review, we consider the entire contents of the Referee's orders.

2. Wallman or Morford's Responsibility

A. Wallman

The Referee utilized ORS 656.029 and found that Wallman

was responsible for claimant's injury of January, 1986. We disagree.

At the outset, we note that the Referee's Opinion and Order does not clearly identify whether he utilized the 1983 or 1985 version of ORS 656.029(1). His paraphrasing of the statute, however, leads us to conclude that he utilized the 1985 version. See Referee's order at Page 2.

The question of whether the 1983 or 1985 version of ORS 656.029(1) applies is, in our view, critical to the correct resolution of this case. That is, unlike the 1985 version, the 1983 version applies only to subject employers:

> "If any person engaged in a business and subject to this chapter as an employer lets a contract involving the performance of labor and such labor is performed by the person to whom the contract is let, with assistance fo others, all persons engaged in the performance of the contract are deemed subject workers of the person letting contract unless the person to whom the contract is let is qualified either as a carrier-insured employer or a self-insured employer." (Emphasis added).

ORS 656.029(1) (1983 version).

The 1985 legislature deleted the above emphasized language from ORS 656.029(1). Therefore, if the 1983 version, rather than the 1985 version, of ORS 656.029(1) applies here, then the trier of fact must determine whether Wallman was a subject employer. See ORS 656.023.

Accordingly, we turn to whether the 1983 or 1985 version of ORS 656.029(1) applies to this case.

Generally, substantive statutes, as opposed to procedural statutes, are applied only prospectively. Fromme v. Fred Meyer, Inc., 89 Or App 397, 399 n. 2 (1988). If a statute will impair existing rights, create new obligations or impose additional duties with respect to past transactions, then it is substantive and is not to be applied retroactively. See Derenco v. Benj. Franklin Federal Savings and Loan, 281 Or 533, 539 n. 1, cert den 439 US 1051 (1981); Joseph v. Lowery, 261 Or 545, 547 (1972).

Here, unlike the 1983 version of ORS 656.029(1), the 1985 version does not contain the limiting language: "subject to this chapter as an employer . . . ." The 1985 version, therefore, broadens an employer's exposure to liability and its retroactive application would impermissibly create a new obligation.

Accordingly, we conclude that the 1985 version of ORS 656.029(1) should not be applied retroactively. We, therefore, apply the 1983 version of that statute, which was in effect at the time of claimant's injury, to the instant case.

Louis Wallman, president of Wallman, testified that he, his wife, his father, and his mother were the sole stockholders in

Wallman. He and his wife owned 50 percent of the stock jointly. The remaining 50 percent was owned by his father and mother jointly. At the time of claimant's injury in January, 1984, Wallman's only "employees," see Ex. 10-7, were Louis Wallman and his father, who was the secretary-treasurer. Since they were the sole owners, they did not have employment contracts with Wallman.

ORS 656.023 provides that subject employers are: "Every employer employing one or more subject workers . . . ." A "subject worker" is defined as any worker who does not fit within the specific subsections of former ORS 656.027. One of those subsections, ORS 656.027(9), provides that a corporate officer who is also a director and has a substantial ownership in the corporation, is not a subject worker.

Here, Louis Wallman and his father were corporate officers, directors, and substantial owners in Wallman. Accordingly, pursuant to ORS 656.027(9), neither he nor his father were subject workers and Wallman, therefore, was not a subject employer. ORS 656.023. Inasmuch as the 1983 version of ORS 656.029(1) is limited to subject employers, it has no application to Wallman.

We, therefore, reverse that portion of the Referee's order that set aside SAIF's denial on behalf of Wallman.

B. Morford

James Morford testified that he and Ron Prentice were equal partners in Morford. See Ex. 9-8. Pursuant to ORS 656.027(8), partners who are engaged in the construction of an improvement on real property are subject workers. Inasmuch as James Morford and Ron Prentice were engaged in the construction of a house at the time of claimant's injury of January, 1984, they were subject workers under ORS 656.027(8). Consequently, unlike Wallman, Morford was a subject employer because it employed James Morford and Ron Prentice. See ORS 656.023.

Turning again to the 1983 version of ORS 656.029(1), it applies only to situations wherein a subject employer:

> "lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let . . . ."

Therefore, we must determine whether Morford let a contract to Hafferman and claimant. The facts are not in dispute. In late 1983, Morford and Prentice helped Hafferman and claimant erect one or more walls. In exchange, Hafferman and claimant offered to perform similar future assistance to Morford and Prentice. When such assistance was performed on January 3, 1984, claimant injured his back.

In addressing whether a contract for hire is established by "reciprocal services," Professor Larson states, inter alia:

> "The essential factor is the presence of an understanding that the services are being performed pursuant to an implied contract for exchange of labor."

1C Larson, Workmen's Compensation Law 8-371, § 47.43(b); see

Debold v. H.P. Martell & Sons, 219 N.W.2d 623 (Minn. 1974); Grant v. Industrial Comm'n, 56 N.W.2d 525 (1953).

In our view, Morford let a contract to Hafferman and claimant based on "reciprocal services." Claimant's testimony indicates that he and Hafferman understood that their services were being performed pursuant to an implied contract for the exchange of labor:

> "A. I asked [Morford and Prentice] if they would help us raise our walls, and they agreed. So we raised two walls, and afterwards [James] Morford asked us . . . if we would help him raise some walls . . . and we agreed.
>
> So the time I was talking about when they helped us was before Christmas, . . . and so we were paying them back for helping us. He had asked us and we were helping them raise some walls.
>
> "* * * * *.
>
> "Q. This was by way of a pay-back arrangement --
>
> "A. Right.
>
> "Q. --that had previously been agreed to?
>
> "A. Correct.
>
> "* * * * *.
>
> "Q. As I understand it, [James] Morford came down and asked you to reciprocate and you went up to the [third party's house]?
>
> "A. The day they helped us, he [James Morford] asked if we would help them when their time came, and we did."

Accordingly, pursuant to the 1983 version of ORS 656.029(1), Hafferman and claimant were subject workers of Morford when claimant injured himself on January 3, 1984.

ORDER

The Board's order dated October 22, 1986 is vacated. The Referee's order dated September 16, 1986, as reconsidered on September 29, 1986, is reversed in part and affirmed in part. That portion of the order that set aside SAIF's denial on behalf of the L. E. Wallman Company is reversed. SAIF's denial on behalf of L. E. Wallman Company is reinstated and upheld. That portion of the Referee's order that set aside SAIF's denial on behalf of Morford & Prentice is affirmed. Claimant's attorney is awarded an assessed fee of $700, to be paid by the SAIF Corporation, on behalf of Morford & Prentice.

THOMAS G. JONES, Claimant
Royce, et al., Claimant's Attorneys
Barbara Brainard (SAIF), Defense Attorney

WCB 86-10895
February 3, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Podnar's order that dismissed his hearing request concerning a Determination Order that awarded 15 percent (48 degrees) for a neck injury and 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm. We reverse.

ISSUES

The issues on review are: (1) whether claimant's application for and acceptance of a lump sum award constituted a waiver of his right to appeal the Determination Order award of permanent disability; and (2) if not, the extent of scheduled and unscheduled disability.

FINDINGS OF FACT

Claimant, age 40 at hearing, suffered compensable injuries to his arm and neck when he fell approximately 30 feet from a scaffold. He initially sought treatment from Dr. Fisher, an emergency room physician. The diagnoses were multiple contusions and lacerations to the upper extremities, and tenderness and pain in the left knee, neck, and shoulders. Claimant was treated conservatively. He returned to light duty one week later. Claimant was laid off in January 1983, because he could not resume full-duty status.

On February 24, 1983, claimant was examined by Dr. Bovard, general practitioner. He diagnosed a cervical disc degeneration and recommended a neurological evaluation.

On March 10, 1983, Dr. Dietrich, neurosurgeon, examined claimant. X-rays revealed a mild cervical degenerative change. A cervical myelogram revealed a moderate cervical disc defect at C5-6. Claimant was treated with cervical traction.

On July 25, 1983, Dr. Dietrich reported that claimant had recovered from his cervical disc protrusion and was released to return to unrestricted work.

On November 3, 1983, Dr. Dietrich reevaluated claimant at Dr. Bovard's request. The examination was normal, except for slight tenderness along the left posterior neck muscles. He recommended that claimant return to work with vocational assistance. On November 29, 1983, Dr. Bovard released him to modified work, with climbing restrictions.

On February 20, 1984, Dr. Butler, orthopedist, reexamined claimant. Claimant's objective findings were normal. The diagnosis was history of cervical strain and a possible cervical disc protrusion secondary to the original injury.

A March 9, 1984 Determination Order awarded claimant 15 percent (48 degrees) unscheduled permanent disability for his neck injury and 5 percent (9.6 degrees) scheduled permanent disability due to the loss of use of his left arm.

On April 10, 1984, claimant, without the aid of counsel, requested a lump sum payment of his award. SAIF provided an application form that contained a waiver which claimant signed, stating, "I understand that by applying for and accepting a lump sum payment of my permanent partial disability award, I waive the right to appeal the adequacy of the award." The Workers' Compensation Department approved the request on April 25, 1984.

After retaining legal counsel, claimant requested a hearing concerning the March 9, 1984 Determination Order. On August 12, 1985, claimant and SAIF entered into a stipulation whereby SAIF agreed to refer claimant for vocational evaluation and services if appropriate. In return, claimant agreed to withdraw his request for hearing on the issues of vocational rehabilitation and extent of disability until vocational assistance was terminated.

On August 15, 1985, Dr. Bovard released claimant to regular-duty work, provided that he avoid work that required climbing. The doctor warned that if claimant climbed, he could risk falling or at least dropping his tools on account of the occasional and unpredictable loss of function in the left arm and hand caused by cervical nerve root irritation.

Return-to-work assistance ended March 19, 1986. On July 9, 1986, claimant requested a hearing raising as issues extent, temporary disability, vocational rehabilitation, and penalties and attorney fees.

Claimant's principal complaints concern residual neck pain aggravated by certain types of heavy lifting, and the occasional total loss of use of his left hand and arm due to numbness.

Claimant has completed the eleventh grade. He took GED classes while in the armed services, but never received a certificate of completion or diploma. Testing indicates claimant has average to above average academic skills. He has worked as a painter, construction worker, machine operator and electric tool worker.

OPINION AND CONCLUSION

Claimant's request for hearing was dismissed by the Referee. The Referee found that claimant was precluded from contesting the adequacy of his award because he had received a lump sum payment.

SAIF contends that claimant's application and acceptance of a lump sum award in 1984 for his 1982 injury constituted a waiver of his right to appeal the adequacy of his award. See ORS 656.304. It relies on ORS 656.202(2), which provides that claimant is bound by the law in effect at the time of the injury unless there exists a specific statutory exception.

When claimant was injured in 1982, ORS 656.230 required payment of lump sum awards for permanent partial disability not exceeding 32 degrees. At the time of claimant's injury, the Compliance Division had the responsibility of approving lump sum payments of permanent partial disability awards in excess of 32 degrees. See former OAR 436-54-250. However, in the interim

between the date of claimant's injury in 1982 and the issuance of the Determination Order in 1984, which awarded claimant 48 degrees permanent disability, former OAR 436-54-250 was amended (effective January 1, 1984) to increase the lump sum payment threshold limit to 64 degrees. The administrative rule also provided that for those claimants injured before August 9, 1983, the insurer, in its discretion, could make a lump sum payment not in excess of 64 degrees provided that the worker was not asked to waive any appeal rights. Former OAR 436-54-250 (2).

Pursuant to former OAR 436-54-250, which was in existence at the time of the March 1984 Determination Order, SAIF chose to pay claimant by means of a lump sum payment. Claimant's application for a lump sum and approval by the Division was not required. See former OAR 436-54-250 (1) and (2). Therefore, we conclude that ORS 656.304 was not applicable. Furthermore, SAIF was not permitted to require claimant to waive any rights to appeal the adequacy of the award as a condition to paying the 48 degrees in a lump sum. Accordingly, we find former OAR 436-54-250 dispositive of this case. Claimant was entitled to a hearing to contest the adequacy of his 1984 award.

Extent of Disability

The Referee took evidence on the issue of extent of disability. He found, in the alternative, that claimant would have been entitled to an additional 20 percent scheduled disability for loss of function of the left arm, and no additional unscheduled disability. We agree.

Unscheduled Disability

The extent of unscheduled permanent partial disability is measured by the permanent loss of earning capacity due to the compensable injury. Barrett v. D & H Drywall, 300 Or 325 (1985), clarified, 300 Or 553 (1986). Earning capacity is defined as the "ability to obtain and hold gainful employment in the broad range of general occupations." Surratt v. Gunderson Bros., 259 Or 65 (1971). It is claimant's burden to prove he has incurred a permanent loss of earning capacity as a result of his November 1982 injury. Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979).

In rating the extent of claimant's unscheduled permanent partial disability, consideration is given to his physical impairment as reflected in the medical record and the testimony at hearing. Garbutt v. SAIF, 297 Or 148 (1984). Relevant social and vocational factors are considered in the totality of the circumstances. See OAR 436-30-380 et seq The rules are merely guidelines used in the evaluation of the extent of permanent partial disability. They are not mechanically applied. Harwell v. Argonaut Insurance Co., 296 Or 505 (1984).

Claimant experiences occasional neck pain with heavy lifting. Dr. Bovard placed claimant's weight lifting limits in the 50 to 75 pound range. Dr. Butler opined that claimant suffered from 10 percent permanent impairment as a result of his cervical injury. Although claimant only attended school through the 11th grade, he has an excellent work history and has experience in a number of occupational areas. Vocational testing indicates his academic skills are good with reading and arithmetic abilities at or above average for his age group. Accordingly, we

agree with the Referee that claimant has failed to prove he is entitled to unscheduled permanent disability in excess of the 15 percent already awarded by Determination Order.

Scheduled Disability

The criteria for rating scheduled disability is the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). Guidelines to assist in the determination of the extent of permanent disability caused by an arm injury are set forth in OAR 436-30-210 and 436-30-220. These rules are not binding, but they are highly persuasive. Harwell v. Argonaut Ins. Co., 296 Or 505 (1984).

Claimant experiences occasional, temporary left arm and hand numbness. These episodes are unpredictable and result in complete loss of left hand grip strength. Claimant is unable to hold tools or other objects in his left hand without dropping them. Claimant is right hand dominant. Because of this condition, Dr. Bovard restricted claimant from any occupation that required climbing. The doctor was concerned claimant might fall or drop tools should he experience an unexpected loss of feeling and strength in the left hand and arm.

Following our de novo review of the medical and lay evidence, we conclude that an award of 25 percent (48 degrees) scheduled permanent disability adequately and appropriately compensates claimant for the permanent loss of use or function of his left arm. We, therefore, increase claimant's award granted by the Determination Order by 20 percent (38.40 degrees).

ORDER

The Referee's order dated March 2, 1987 is reversed. The March 9, 1984 Determination Order is affirmed and modified. The Determination Order award of 15 percent (48 degrees) unscheduled permanent disability is affirmed. In addition to the Determination Order award of 5 percent (9.6 degrees) scheduled disability, claimant is awarded 20 percent (38.40 degrees) scheduled disability for the loss of use or function of his left arm, for a total award to date of 25 percent (48 degrees). Claimant's attorney is awarded 25 percent of the increased compensation granted by this order as an attorney fee, not to exceed $3,800.

MARY R. KENNEDY, Claimant
Scott McNutt, Claimant's Attorney
Foss, Whitty, et al., Defense Attorneys

WCB 86-12152
February 3, 1989
Order on Review

Reviewed by Board Members en banc.

The insurer requests review of that portion of Referee Myers' order that awarded claimant 35 percent (67.2 degrees) scheduled permanent disability for loss of use or function of the right arm, in lieu of a Determination Order awarding no permanent disability. On review, the issue is extent of scheduled permanent disability.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated April 22, 1987, as reconsidered May 14, 1987, is affirmed. Claimant's attorney is awarded $450 for services on Board review, to be paid by the insurer. A client-paid fee, not to exceed $160, is approved.

Board Member Ferris, dissenting:

I respectfully dissent. Claimant has failed to prove any permanent impairment as a result of her compensable injury.

Claimant developed pain in the triceps muscle of her right arm in April 1984 which has been diagnosed as tendinitis or myofascitis. She continued to work and her condition waxed and waned during the next year or so. In August 1985, she experienced another flareup and Dr. Kuzmitz, her treating family practitioner, took her off work. Dr. Kuzmitz provided conservative treatment, claimant's symptoms improved markedly and Dr. Kuzmitz released her to return to regular work on September 30, 1985. According to Dr. Kuzmitz' chart notes, claimant worked without difficulty after that time.

In June 1986, claimant developed a number of symptoms including a persistent fever, loss of appetite, weight loss, forgetfulness, clumsiness and sleep disturbance. Dr. Kuzmitz took her off work and referred her to Dr. Rich, a neurologist with a subspecialty in sleep disorders. Dr. Rich thought that claimant had a viral illness and referred her to Dr. Avery, an internist, for further evaluation. Before her appointment with Dr. Avery, claimant was involved in an off-work motor vehicle accident in which the pickup that she was driving was rear-ended by another vehicle. After the accident, claimant experienced pain in her upper back and numbness and tingling in both arms.

Dr. Avery examined claimant in late July 1986. He found a "trigger point" in claimant's upper back between her right shoulder blade and her spine which produced shooting pains in her right arm when pressed. Claimant told him about the right arm symptoms she had experienced previously in connection with her work. Dr. Avery diagnosed claimant's upper back condition as "fibrositis" and, based on the history received from claimant, opined that it was related to her work activity. He later opined that claimant would probably "have some residual problems with fibrositis."

Dr. Avery was unaware of claimant's motor vehicle accident when he rendered his opinions. When informed about the accident during a later deposition, he stated that the condition which he had previously attributed to claimant's work activity also was compatible with her vehicle accident. In her testimony at the hearing, claimant indicated that the symptoms in her right upper arm had never totally resolved and that they had been worsened by the July 1986 vehicle accident. In his order, the Referee summarily concluded, based on claimant's testimony, that she had experienced permanent impairment to her right arm as a result of her compensable injury and awarded 35 percent scheduled permanent partial disability.

The Referee's conclusion that claimant sustained permanent impairment as a result of her compensable injury is not supported by substantial evidence. The only doctor who suggested that claimant had any such impairment was Dr. Avery. That opinion, equivocal as it

was, was based upon a history which did not include claimant's motor vehicle accident. It, therefore, is of no probative value. See Somers v. SAIF, 77 Or App 259, 263 (1986). This deficiency was not cured during the subsequent deposition.

The only other potential support for the Referee's conclusion was claimant's testimony. In light of the fact that claimant's motor vehicle accident caused an injury to her upper back and both arms, the question of the causal relation, if any, between claimant's compensable injury and the symptoms which she was experiencing at the time of the hearing was a complex medical question about which claimant was not competent to testify. See Uris v. Compensation Department, 247 Or 420, 424-26 (1967). On this record, therefore, I would conclude that claimant has failed to prove any permanent impairment as a result of her compensable injury and would reverse the award granted by the Referee.

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

WCB 85-10736
February 3, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Orozco v. U & I Group, Inc., 92 Or App 585 (1988). In our Order on Review, dated November 4, 1987, we affirmed the order of the Referee, which upheld the self-insured employer's denial of claimant's current chiropractic treatment. The court has instructed the Board to reconsider this case in the light of Armstrong v. Asten-Hill, 90 Or App 200 (1988). We proceed to do so.

ISSUE

Whether claimant's compensable back injury of March, 1982, remains a material contributing cause of his current need for chiropractic treatment.

FINDINGS OF FACT

Claimant, a potato processing trimmer, compensably injured his back in March, 1982. He sought immediate medical attention from Dr. Lopez, M.D. Lopez diagnosed an "[a]cute lumbar strain . . . ."

In May, 1982, claimant began treating with Dr. Banker, a chiropractor. Banker treated claimant's neck, low back, and right leg. In July, 1982, Banker released claimant to regular work.

Due to continuing back pain, claimant consulted Dr. Burgdorff, an orthopedic surgeon, in October, 1982. Burgdorff examined claimant and recommended an EMG of his low back. Claimant did not return to Burgdorff for treatment.

In February, 1983, claimant was examined by Dr. Gambino, an orthopedic surgeon. Gambino diagnosed a "chronic [lumbosacral] strain" and treated with physical therapy. The following month, claimant underwent a bone scan.

Claimant was examined by Dr. Utterback, an orthopedist, in December, 1983. At that time, claimant was still experiencing low back and right leg pain. X-rays revealed that claimant's injury of March, 1982, had resulted in an old lumbar fracture. Utterback recommended claim closure without an award of permanent disability.

In June, 1984, claimant was seen by Dr. Smith, an orthopedist. Smith found little physiological findings to support claimant's complaints of pain.

Claimant began treating with Dr. Feinberg, a chiropractor, in May, 1985.

In August, 1985, the employer issued a denial of claimant's current chiropractic treatment as allegedly no longer materially related to his compensable injury of March, 1982.

The following month, The Diagnostic Panel ("Panel"), a team of physicians, reviewed claimant's medical file at the insurer's request. Included on this Panel was Dr. Voiss, M.D. In December, 1985, Voiss, by written letter, attempted to clarify the Panel's conclusions.

In a letter of March, 1986, Dr. Feinberg specifically disagreed with the conclusions of the Panel and Dr. Voiss. Later that month, claimant was examined by Dr. Fleck, M.D. After examining claimant and noting continuing complaints of pain, Fleck diagnosed: "Chronic low back pain."

Prior to the the hearing, additional reports were written by Drs. Voiss and Fleck.

Diagnostic studies reveal that claimant's compensable injury of March, 1982, resulted in a lumbar fracture. He has experienced continuing symptoms of low back pain since his compensable injury of March, 1982.

CONCLUSIONS OF LAW

A worker is entitled to medical services for "conditions resulting from the injury for such a period as the nature of the injury or the process of recovery requires . . . ." ORS 656.245(1). The compensable injury need not be the sole or principal cause of a worker's need for medical services, but only a material contributing cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987).

Here, the Referee upheld the employer's denial without any discussion of the facts and pertinent law. We, therefore, proceed to analyze this case on remand.

Claimant injured his low back in March, 1982. His condition was diagnosed as an "acute" strain. Thereafter, he sought medical attention from several experts for continuing low back pain. His condition was eventually diagnosed as a "chronic" strain. Diagnostic studies, including x-rays and an MRI, confirmed that his compensable injury resulted in a fracture at L-3 and L-4.

When the medical evidence is divided, we must determine which medical hypothesis is correct. McClendon v. Nabisco Brands, 77 Or App 412 (1986). After reviewing the medical evidence, we are persuaded by the opinion of Dr. Feinberg, over that of the Panel and Dr. Voiss. Somers v. SAIF, 77 Or App 259 (1986). Feinberg was of the opinion that her chiropractic care was causally related to claimant's compensable injury of March, 1982. Both the Panel and Voiss, however, suggested that claimant's

"voluntary" responses indicated that his current complaints were not related to his compensable injury of March, 1982. In particular, Vois opined that "emotional factors" were "the most likely etiology of this [claimant's] alleged symptoms . . . ."

In our view, however, Dr. Feinberg persuasively rebutted the opinion of the Panel and Dr. Vois, stating, inter alia;

> "Dr. Voiss says that it is the opinion of the Diagnostic Panel that there was no causal relationship between the March 23, 1982[,] industrial injury and [claimant's] current complaints. He indicated that '[t]he most likely etiolgy of this [claimant's] alleged symptoms are [a] consequence of emotional factory [sic] unrelated to the described injury. No where in the report of the Diagnostic Panel or in Dr. Voiss's letter is there any description of precisely what emotional factors Dr. Voiss is talking about. Neither is there is [sic] a discussion of any objective means of determining that the man has emotional factors which might or might not tie into his complaints. The contention that one can diagnose back pain of an emotional etiology on the basis of '. . . the inconsistencies, contradictions and voluntary resitances noted during the examination of 23 Aug, '85' is not reasonable to me."

Accordingly, on this record, we conclude that claimant's compensable injury of March, 1982, is a material contributing cause of his current need for chiropractic treatment.

Inasmuch as we have not received a Statement of Services from claimant's attorney, we cannot award an assessed fee. OAR 438-15-010(5); 438-15-055(2).

ORDER

The Referee's order, dated December 19, 1986, is reversed. The self-insured employer's denial of claimant's current chiropractic treatment is set aside and the claim is remanded to the employer for processing according to law.

WILLIAM B. POTTS, Claimant
Connall & Lorenz, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 87-04119
February 3, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of those portions of Referee Galton's order which: (1) found that claimant had established good cause for failing to file a timely hearing request from the employer's denials; (2) set aside the employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (3) awarded a reasonable attorney fee of $1,200. We reverse.

ISSUE

Good cause for claimant's delay in filing his hearing request.

FINDINGS OF FACT

Claimant filed an occupational disease claim for bilateral carpal tunnel syndrome. It was denied. Claimant received the denial on or about November 25, 1986. He did not file his hearing request until February 18, 1987, almost three months after receiving the denial.

During that three-month delay, claimant was caring for his wife who was diagnosed with cancer in June, 1986, and was receiving daily radiation treatment. After 30 to 45 days of radiation treatment, his wife began regular chemotherapy. Claimant was responsible for taking his wife to and from the doctor's office. He performed all of the housework and most of the child care for their four-year-old daughter. He also maintained a full-time job.

FINDING OF ULTIMATE FACT

We do not find that claimant had good cause for his failure to file the hearing request within 60 days after receiving the denial.

CONCLUSIONS OF LAW AND OPINION

Claimant has 60 days to request a hearing on the denial, or 180 days if good cause for the failure to request within the 60 days is shown. ORS 656.319(1). The Referee found that claimant's preoccupation with his wife's illness, his child's care and his own job constitutes good cause for his delay in filing the hearing request. We disagree.

The test for determining if good cause exists has been equated to the standard of "mistake, inadvertance, surprise or excusable neglect" recognized under former ORS 18.160 and present ORCP 71B(1). Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

We conclude that claimant has not met his burden. Cogswell, supra, is dispositive here. In that case, the claimant filed her hearing request more than 60 days after notification of the denial. One of the primary reasons for the delay was the concern about her sister's health. Apart from that concern, the court found no event or occurrence which could have interfered with the claimant's timely filing a hearing request. The court concluded that claimant's delay was attributable to lack of diligence and that good cause was not established.

Like Cogswell, the claimant here explains that he was preoccupied with other concerns during the three-month delay. These concerns, though legitimate, did not prevent him from the relatively simple task of filing a hearing request. At most, these concerns distracted him from filing. Lack of diligence does not constitute good cause. Id.

ORDER

The Referee's order dated October 28, 1987, as amended on October 29, 1987 and reconsidered on December 29, 1987, is reversed. The self-insured employer's denial of November 25, 1986 is reinstated and upheld. The Referee's award of an assessed fee for prevailing on the denial is disallowed. The Board approves a client-paid fee not to exceed $994.

RICHARD L. SHORT, Claimant
Brian R. Whitehead, Claimant's Attorney
Roberts, et al., Defense Attorneys
Stafford J. Hazelett, Defense Attorney

WCB 85-12701, 85-15197 & 85-15198
February 3, 1989
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of Referee Wilson's order which: (1) upheld the Kemper Group's denial of compensability of claimant's bilateral tendinitis; (2) upheld the Kemper Group's denial of compensability of claimant's carpal tunnel syndrome; (3) upheld the Kemper Group's denial of responsibility for the aforementioned conditions; (4) upheld Liberty Northwest Insurance Corporation's denial of responsibility for claimant's bilateral tendinitis and carpal tunnel syndrome; (5) upheld Liberty Northwest's denial of compensability for the aforementioned conditions; (6) upheld Liberty Northwest's denial of aggravation claims for claimant's March 6, 1979 tendinitis, February 7, 1980 right elbow tendinitis, and May 12, 1980 left wrist/hand condition; (7) declined to assess penalties and related attorney fees against the Kemper Group for unreasonable claims processing and unreasonable failure to pay interim compensation; and (8) declined to assess penalties and related attorney fees against Liberty Northwest for unreasonable claims processing and unreasonable failure to pay interim compensation. We reverse.

ISSUES

Liberty Northwest

(1) Compensability of aggravation of March 6, 1979 claim, tendinitis, right hand.

(2) Compensability of aggravation of February 7, 1980 claim, tendinitis, right elbow.

(3) Compensability of aggravation of May 12, 1980 claim, left wrist and hand.

(4) Compensability and responsibility of injury of January 23, 1984, tendinitis, both arms.

(5) Compensability and responsibility of June 6, 1985 claim for carpal tunnel syndrome.

(6) Penalties and related attorney fees for unreasonable claim processing for 1 through 5 above.

Kemper Group

(7) Compensability and responsibility of injury January 23, 1984, tendinitis, both arms.

(8) Compensability and responsibility of June 6, 1985 claim for carpal tunnel syndrome.

(9) Penalties and related attorney fee for unreasonable claim processing for 7 and 8 above.

FINDINGS OF FACT

Claimant worked for the employer, a paper products manufacturer, from March 1977 through July 1985. During this period, the employer was insured by Liberty Northwest until April 1, 1981, when coverage changed to the Kemper Group.

Claimant filed his first claim, for tendinitis of the right hand, on March 8, 1979. Liberty Northwest accepted the claim as nondisabling and paid all medical bills. Claimant returned to work the following day and no temporary disability benefits were paid.

Claimant filed a second claim, right "tennis elbow", on February 7, 1980. Claimant's treating physician, Dr. Winthrop, released claimant from work until March 10, 1980. Temporary disability benefits were paid, and the condition was declared stationary on April 4, 1980.

Claimant filed a third claim, for a left wrist and hand injury, on May 12, 1980. This claim was filed while the second claim was in an open status. In August 1980, a Determination Order issued, closing claimant's second and third claims, as they were handled under the same claim number, and awarded temporary disability benefits only. No hearing request from this Determination Order was filed.

On January 23, 1984, a claim for bilateral tendinitis was filed on behalf of claimant, by Dr. Winthrop. The claim was sent to the employer care of Kemper and requested a reopening of claimant's February 7, 1980 claim. In the request, Dr. Winthrop referred to the claim number used by Liberty for the February 7, 1980 claim. Kemper received this on January 30, 1984 and referred it to Liberty for handling on February 3, 1984. Claimant was sent a copy of the transmittal to Liberty and was requested to contact Kemper if he felt that the insurer had misinterpreted claimant's request to reopen. This claim was not accepted or denied by Kemper within 60 days of its receipt. The transmittal was received by Liberty Northwest on February 7, 1984 and was treated as a request for medical services under former ORS 656.245. Medical bills, including a billing for bilateral tendinitis, were paid. No time loss was paid as the only documented time off work was for three days. Neither insurer formally accepted or denied the claim.

In March 1985, claimant filed a claim for injury to his left hand occurring when the hand was caught in a machine. This claim was forwarded to the Kemper Group as it was the employer's insurer at that time. The condition resulting was diagnosed by the doctor at the hospital emergency room as left hand abrasions and contusions. Kemper accepted this claim. The doctor authorized five days of time loss.

On June 6, 1985, a claim for bilateral carpal tunnel syndrome was filed on behalf of claimant by Dr. Winthrop with the employer/Kemper. The 827 form noted that claimant was released for modified work. No specific date of injury was shown on the 827 form. In the place provided for writing the date of injury, the words "six months" were written. The form did not list an old claim number.

Kemper received this on June 10, 1985 and fowarded it to Liberty Northwest without retaining a copy. Its agent thought that this was related to a continuation of a Liberty-handled claim. In early December 1985, claimant's attorney forwarded a request for a paying agent, pursuant to ORS 656.307, to Kemper. On December 26, 1985, Kemper issued a denial advising that it had received no information that claimant had suffered an aggravation of an accepted medical-only claim of June 1, 1984, which was for a left knee injury and that no claim had been filed for for any injury of June 6, 1985. The denial was for aggravation of the 1984 claim and a work injury or aggravation on June 6, 1985.

The June 6, 1985 claim was received by Liberty Northwest on August 19, 1985. The claims examiner contacted Dr. Winthrop who informed her that claimant had bilateral epicondylitis, aggravated in 1984 and work-related carpal tunnel syndrome. Liberty then referred claimant to Dr. Button, who examined claimant and authored a report. On March 17, 1986, Liberty issued a responsibility denial on the basis that claimant had sustained a "new injury" rather than an aggravation of the February 7, 1980 claim.

No medical benefits were paid and no time loss was paid. After hearing Dr. Button's testimony at the hearing, Liberty orally amended its denial to deny compensability of claimant's carpal tunnel syndrome. Claimant orally amended his request for hearing to challenge the denial of compensability.

FINDINGS OF ULTIMATE FACT

Claimant's right "tennis elbow" condition is causally related to his prior compensable injuries.

Claimant's work activities in late 1983 and early 1984 did not independently contribute to his right "tennis elbow" condition.

Claimant's work activities in late 1983 and early 1984 were the major contributing cause of his left "tennis elbow" condition.

Claimant first suffered an onset of disability due to his left "tennis elbow" in January 1984, while Kemper was on the risk.

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

Claimant first suffered an onset of disability due to his bilateral carpal tunnel syndrome in June 1985, while Kemper was on the risk.

Liberty Northwest's claim processing in regard to claimant's February 7, 1984 and June 6, 1985 claims, was unreasonable.

Kemper's claim processing in regard to claimant's June 6, 1985 claim was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Bilateral Tendinitis Claim

The Referee failed to discuss the compensability and responsibility for the bilateral "tennis elbow" condition, but upheld the denials of the condition. We disagree.

Before entering into a discussion of claimant's bilateral tendinitis or "tennis elbow" claim it is first necessary to note that Liberty Northwest previously accepted a claim for right "tennis elbow" in February 1980. There has not, however, been an acceptance, by either Liberty Northwest or Kemper, of left "tennis elbow."

In regard to the right "tennis elbow" condition, the only evidence in the record are Dr. Winthrop's chart notes. Dr. Winthrop reported that claimant's bilateral elbow condition was precipitated by his work activities. Dr. Winthrop also reported that the condition was caused by the lifting and pulling of paper that claimant performed at his work. He characterized the right elbow condition as a recurrence of symptoms claimant had suffered in the past as a result of his work activities. In light of Dr. Winthrop's notes, we find that claimant has established that his prior compensable injury remains a material contributing cause of his 1984 right "tennis elbow" condition. Accordingly, the condition is compensable.

As we have found the right "tennis elbow" condition compensable, the issue becomes that of responsibility for the condition. In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court announced that unless work activities at the later employer/insurer independently contribute to the worker's disability (i.e. cause a worsening of the underlying condition) then the worker has sustained a mere recurrence of symptoms and the earlier employer/insurer remains responsible.

The only evidence in the record, in regard to claimant's right "tennis elbow" condition is a report from Dr. Winthrop, claimant's treating physician. In January 1984, Dr. Winthrop wrote Kemper, who ultimately forwarded the report to Liberty Northwest, advising that claimant had bilateral "tennis elbow, worse on the right." He further noted that claimant had experienced similar problems before and that the condition was exacerbated by claimant's work. Dr. Winthrop then requested a reopening of claimant's February 1980 claim.

Dr. Winthrop's report characterizes claimant's right elbow condition as a recurrence of symptoms he had experienced previously. His report does not indicate that claimant's underlying condition had worsened, but rather work activities at that time were causing an exacerbation of symptoms. Accordingly, we conclude that claimant has sustained an aggravation of his previously accepted right "tennis elbow" condition and that Liberty Northwest remains responsible.

In regard to claimant's left "tennis elbow" claim it is important to note that a claim for this condition has not been made previously. As with claimant's right elbow claim, the only evidence in regard to claimant's left elbow claim is Dr. Winthrop's chart notes indicating that the condition was precipitated by claimant's work activities. He further notes that the condition was caused by lifting and pulling paper at claimant's work was the cause of the bilateral "tennis elbow."

We find that claimant's claim is for an occupational disease in that his need for treatment and ultimate disability developed gradually, rather than by way of a discrete event. See James v. SAIF, 293 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184 (1982). Accordingly, it is claimant's burden to establish that his work activities were the major contributing cause of his left "tennis elbow" condition. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

In light of Dr. Winthrop's notes, we find that claimant has established that his "left tennis elbow" condition was caused by his work and is compensable.

As we have found claimant's left "tennis elbow" condition compensable, it is necessary to allocate responsibility for that condition. In an occupational disease context, the last injurious exposure rule fixes responsibility with the insurer on risk at the onset of disability if work conditions with that employer could have contributed to the disability, even though conditions when the first insurer was at risk also could have caused the disease. See Boise Cascade Corp v. Starbuck, 296 Or 238 (1984).

A review of the evidence establishes that claimant's left "tennis elbow" condition is related to his employment. Yet, claimant did not suffer an onset of disability due to this condition until February 1984 when Kemper was at the risk. As claimant was at the same employment, causal conditions existed at the time Kemper was at the risk. Further, there is no evidence that Liberty Northwest's coverage was the sole cause of the condition, nor was it impossible for conditions during Kemper's coverage to had contributed to the disease. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). Accordingly, responsibility for claimant's left "tennis elbow" condition lies with Kemper. Starbuck, supra.

Bilateral Carpal Tunnel Syndrome condition

The Referee further concluded that claimant's bilateral carpal tunnel syndrome was not compensable. In reaching this conclusion, the Referee was persuaded by claimant's lack of credibility and Dr. Button's opinion. We disagree based on the following reasoning.

We first examine the credibility issue. The Referee accepted Dr. Button's opinion over the opinions of the other physicians based on Dr. Button's review of a videotape representation of the work claimant performed for the employer. Dr. Button, after reviewing the tape, felt that it differed from claimant's description of the work, and opined that claimant's work was not a significant cause of the bilateral carpal tunnel syndrome. The Referee felt that claimant's credibility was placed in doubt because of the discrepancy between the videotape and claimant's description of the work activity.

In exercising de novo review we generally defer to the Referee's determination of credibility, when it is based on the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360, 363 (1982). However, when the Referee's conclusion is based not on demeanor, but on an objective evaluation of the substance of a witness's testimony, the Referee has no greater advantage in determining credibility than we do. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Davies v. Hanel Lumber Company, 67 Or App 35, 38 (1984).

Following our de novo review of the record, we find claimant's testimony to be credible. Dr. Poulson reviewed the same videotape and felt that it was consistent with the history that claimant had given him. Further, claimant did not testify that the videotape was wholly inaccurate, but rather that he performed the tasks somewhat differently than the workers shown on the tape and that the tape did not fully portray activities that happened in an

entire workday. Accordingly, we are not persuaded that claimant's credibility is impeached by the tape or by Dr. Button's change in opinion.

We now turn to the medical evidence. On July 20, 1985, Dr. Winthrop reported that claimant's bilateral carpal tunnel syndrome had been confirmed by nerve conduction studies and that there "was no question in his mind that the [condition] was work-related." Dr. Winthrop referred claimant to Dr. Becker, orthopedist, who reported on July 30, 1985 that claimant had bilateral carpal tunnel syndrome and that given his significant callouses and history of multiple trauma on the job, it was more likely that the condition was work-related.

Claimant was next examined by Dr. Button, orthopedist, who felt the bilateral carpal tunnel syndrome was not related to prior injuries and concluded claimant's work was not the sole contributing factor since he remained symptomatic despite not working for the previous 6 months. Dr. Button further noted that claimant still had callouses on his hands, which to him suggested other activity as a cause for claimant's bilateral carpal tunnel condition. After reviewing a video tape, representative of claimant's work activities, Dr. Button opined that the work did not cause claimant's condition.

Claimant was also examined by Dr. Poulson, orthopedist, who reviewed the same video tape seen by Dr. Button. Dr. Poulson opined that claimant's work would cause carpal tunnel syndrome in someone who had a propensity for the disease. Dr. Poulson further indicated that someone who had sustained permanent damage as a result of carpal tunnel syndrome would continue to experience symptoms after discontinuing the repetitive activity that originally caused the disease. Dr. Poulson also concluded that the presence of hand callouses indicate some hand activity, but do not necessarily indicate activity detrimental to the carpal tunnel.

Following our de novo review, we are persuaded by the opinions of Drs. Winthrop, Becker, and Poulson, all of whom relate the onset of claimant's bilateral carpal tunnel syndrome to his work activities. We do not find Dr. Button's opinion persuasive as it relies on his view of the videotape and the presence of callouses on claimant's hand. This reliance is controverted by claimant's credible testimony as well as the opinion of Dr. Poulson. Accordingly, we find the well-reasoned opinion of Dr. Poulson, as well as the opinions of Dr. Winthrop and Becker persuasive. Somers v. SAIF, 77 Or App 259 (1986).

As we have found claimant's bilateral carpal tunnel syndrome compensable, it is necessary to allocate responsibility for the condition. In cases of occupational diseases, the last injurious exposure rule fixes responsibility in the first instance, with the insurer on risk at the onset of disability if work conditions with that employer could have contributed to the disability. Bracke v. Baza'r, 293 Or 239, 247-48 (1982); Spurlock v. International Paper Co., 89 Or App 461, 465 (1988).

A review of the medical and lay evidence establishes claimant's bilateral carpal tunnel syndrome is related to his employment. Yet, claimant did not suffer an onset of disability due to this condition until July 1985 when Kemper was at the risk. In July 1985, Dr. Winthrop released claimant to full work, but set restrictions in regard to lifting and turning. Further, as claimant was at the same employment, potentially causal conditions existed at

the time Kemper was at risk. Liberty Northwest's coverage was not the sole cause of the claimant's bilateral carpal tunnel syndrome, nor was it impossible for conditions during Kemper's coverage to have contributed to the disease. FMC Corp. v. Liberty Mutual Ins. Co., supra. Given this, responsibility for claimant's bilateral carpal tunnel syndrome lies with Kemper. Bracke, supra; Spurlock, supra.

Temporary Disability Benefits

Claimant argues that he is entitled to temporary disability benefits both after the filing of the January 20, 1984 claim for bilateral "tennis elbow" and after the filing of the July 6, 1985 claim for bilateral carpal tunnel syndrome.

January 20, 1984 Claim

On the 827 form Dr. Winthrop filed on behalf of claimant in January 1984, Dr. Winthrop indicated that he was releasing claimant from work for 3 days. Claimant testified that he could not exactly remember, but thought that he was off work from 5 to 7 days and then later off another 3 or 4 days. Given claimant's lack of definiteness, we find that claimant was off work 3 days as documented by Dr. Winthrop's report.

As claimant was off work only 3 days, no temporary disability compensation was due on the left "tennis elbow" claim which has been determined to be Kemper's responsibility. See former ORS 656.210(3).

With regard to the right "tennis elbow" claim, Liberty's responsibility, again claimant was documented as being off work for only 3 days. However, this is an aggravation claim pursuant to ORS 656.273(6) and claimant had previously been paid time loss benefits for this condition. Because claimant had previously received time loss benefits for this condition, he had already satisfied the three day "waiting period" set forth in former ORS 656.210(3). Therefore, Liberty Northwest had a duty to pay temporary disability benefits after receiving a medical verification of inability to work. Dr. Winthrop's report satisfies the medical verification requirement in this provision. Accordingly, Liberty Northwest should have paid the 3 days of temporary disability benefits.

July 6, 1985 Claim

On July 6, 1985, Dr. Winthrop submitted a claim for bilateral carpal tunnel syndrome on behalf of claimant. The report indicated that claimant was released for work with some restrictions. The record indicates that claimant did not lose any time from work. Therefore, no interim compensation was due between that date, and July 29, 1985, the date claimant was terminated. See Bono v. SAIF, 298 Or 405 (1984).

In regard to temporary disability after claimant was terminated on July 29, 1985, we find that claimant is not entitled to temporary disability benefits. He was off work for reasons unrelated to his injury. i.e., he was fired. Therefore he is not entitled to temporary disability benefits after this period. Nix v. SAIF, 80 Or App 656, 659-60 (1986).

Penalties and Attorney Fees

Under ORS 656.262(10), if an employer/insurer unreasonably

delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the employer/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.

KEMPER

Kemper received Dr Winthrop's report of bilateral "tennis elbow" on January 30, 1984. The report specifically referred to a Liberty Northwest claim number. Kemper forwarded the request to Liberty Northwest. In light of this, we do not find Kemper's failure to process the claim to be unreasonable, therefore no penalties are warranted.

Kemper received Dr. Winthrop's report of bilateral carpal tunnel syndrome on June 10, 1985. This report did not refer to a Liberty Northwest claim number. Nonetheless, Kemper again forwarded the report to Liberty Northwest. Kemper did not take any action on this claim until it was contacted by claimant's attorney in late 1985 in regard to the issuance of a ".307 order." Following this contact, Kemper issued a denial on December 26, 1985. Given that this was an occupational disease claim, submitted 4 years after Kemper had assumed the position as the employer's insurer, and without reference to a Liberty Northwest claim number, we find that Kemper's action was unreasonable. ORS 656.262(6), (10).

Despite Kemper's unreasonable behavior, the record does not establish that there are any "amounts due." Therefore, there is nothing on which to base a penalty. ORS 656.262(10). However, an attorney fee can be awarded and we find it appropriate to do so in this instance. Spivey v. SAIF, 79 Or App 568 (1986).

LIBERTY NORTHWEST

Liberty received Dr. Winthrop's report on claimant's bilateral "tennis elbow", from Kemper on February 7, 1984. It paid claimant's medical expenses, but did not pay temporary disability benefits. Dr. Winthrop's report authorized 3 days release from work which constitutes a medically verified inability to work. ORS 656.273(6). Liberty offers no explanation for its failure to pay pursuant to Dr. Winthrop's report, and we consider its failure to pay temporary disability benefits to be unreasonable. Accordingly, a 25 percent penalty and related attorney fee, based on 3 days temporary disability benefits, is appropriate.

In regard to the June 6, 1985 claim for bilateral carpal tunnel syndrome, Liberty received notice on August 19, 1985. It did not issue a denial until March 17, 1986. We find this failure to timely process the claim to be unreasonable. ORS 656.262(6), (10). Despite Liberty's unreasonable behavior, the record does not establish that there are any "amounts due.". Therefore, there is nothing to base a penalty on. ORS 656.262(10). However, an attorney fee can be awarded and we find it appropriate to do so in this instance. Spivey v. SAIF, supra.

ORDER

The Referee's order dated January 20, 1987 is reversed. Liberty Northwest's denial of claimant' bilateral elbow tendinitis is set aside insofar as it pertains to claimant's right elbow, and the claim is remanded to Liberty Northwest for processing according to law. For services at hearing and on Board review concerning this

issue, claimant's attorney is awarded a reasonable fee of $1,500, to be paid by Liberty Northwest. Kemper's denial of claimant's bilateral tendinitis is set aside insofar as it pertains to claimant's left elbow and this claim is remanded to Kemper for processing according to law. For services at hearing and on Board review concerning this issue, claimant's attorney is awarded a reasonable fee of $1,500, to be paid by Kemper. Liberty Northwest's denial of claimant's bilateral carpal tunnel syndrome is upheld. Kemper's denial of claimant's bilateral carpal tunnel syndrome claim is set aside and the claim is remanded to Kemper for processing according to law. For services at hearing and on Board review concerning this issue, claimant's attorney is awarded a reasonable fee of $3,000 to be paid by Kemper. In addition, claimant's attorney is awarded a reasonable fee of $250 concerning Kemper's untimely denial of claimant's bilateral carpal tunnel syndrome claim, to be paid by Kemper. Claimant is awarded temporary total disability benefits for the period between January 20, 1984 through January 23, 1984, to be paid by Liberty Northwest. Liberty Northwest is further assessed a penalty equal to 25 percent of these benefits. In addition, claimant's attorney is awarded a reasonable attorney fee for this penalty issue of $250, to be paid by Liberty Northwest. Claimant's counsel is further awarded a reasonable fee of $250 for establishing unreasonable claims processing, concerning Liberty Northwest's untimely denial of claimant's bilateral carpal tunnel syndrome claim, to be paid by Liberty Northwest. A client-paid fee, payable from Kemper Group to its counsel is approved, not to exceed $160.

Board Member Ferris, dissenting:

I respectfully dissent and would affirm the order of the Referee on all issues. I am particularly disturbed by the majority's conclusion that the three-day waiting period of ORS 656.210(3) does not apply to an aggravation claim if it has already been satisfied in connection with the original claim.

The unspoken premise of the majority's conclusion is that an aggravation claim is merely a continuation of the original claim. That premise is erroneous. When an original claim is closed, the claimant's entitlement to temporary disability compensation is terminated and the claimant's extent of permanent disability is determined. See ORS 656.268. To receive additional disability compensation after claim closure, the claimant must file a claim for aggravation. ORS 656.273(2). The carrier must process the claim the same as it does a claim for an original injury. ORS 656.273(6). If the carrier denies the claim, the claimant must request a hearing. ORS 656.273(7). At the hearing, the claimant must prove a change in his condition since the last arrangement of compensation, a causal relation between the change and the original injury and renewed entitlement to temporary disability compensation or entitlement to additional permanent disability compensation. ORS 656.273(1); Smith v. SAIF, 302 Or 396, 399-401 (1986); see also Gwynn v. SAIF, 304 Or 345, 350 (1987). In essence, therefore, a claim for aggravation is a new claim and should be treated accordingly. Barrett v. Union Oil Distributors, 60 Or App 483, 487-88 (1982), rev den 294 Or 569 (1983) (application of amendment to ORS 656.273 governed by date of aggravation rather than date of original injury); Brian W. Johnston, 39 Van Natta 1026, 1028-29 (1987), on reconsideration, 40 Van Natta 58, aff'd mem., 94 Or App 343 (1988) (a carrier may require a claimant to attend another three independent medical examinations under ORS 656.325(1) after aggravation of his condition).

When, as is usually the case, an aggravation claim is premised on entitlement to additional temporary disability compensation, a claimant should be required to satisfy all of the elements of ORS 656.210, including the three-day waiting period of ORS 656.210(3). The Court of Appeals stated as much, albeit in dicta, in Silsby v. SAIF, 39 Or App 555, 561 (1979). The same conclusion follows from the Supreme Court's unqualified references to ORS 656.210 in Smith v. SAIF, supra, 302 Or at 400-01 and to ORS 656.210(3) in Gwynn v. SAIF, supra, 304 Or at 351 & n.4. It also follows from an examination of the purpose of the three-day waiting period.

The three-day waiting period was added to ORS 656.210 in 1965. Or Laws 1965, ch 285, § 22c. As is clear from the legislative history of the provision, its purpose was to reduce the cost of administering the workers' compensation system by excluding from coverage (and thus from processing requirements) a large number of insignificant temporarily disabling injuries. See Minutes, House Committee on Labor and Management, January 18, 1965 p. 2; Minutes, Senate Committee on Labor and Industries, March 8, 1965, pp. 2-3 & March 18, 1965, pp. 2-3. That purpose is as applicable to insignificant aggravations as it is to insignificant original injuries.

Under the majority's interpretation of ORS 656.210(3), a claimant whose original claim was closed without an award of permanent partial disability and who subsequently misses work for a day or even less than a day due to a flare-up of his condition has, as a matter of law, proven a compensable aggravation. In every such case, therefore, the carrier must expend the administrative resources necessary to evaluate, accept or deny, and process the claim to closure or other resolution. This wasteful interpretation of ORS 656.210(3) is unnecessary and contrary to the intent of the legislature. I would rule that a claimant who premises a claim for aggravation solely on three days or less of temporary total disability has, as a matter of law, failed to establish a compensable aggravation by virtue of the three-day waiting period of ORS 656.210(3).

VICTOR L. SOUTHWELL, Claimant
Bennett, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-13227
February 3, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of that portion of Referee Seymour's order that set aside its denial insofar as it denied claimant's post-1971 progressive bilateral hearing loss. On review, the issue is compensability. We reverse that portion of the Referee's order that upheld the employer's denial insofar as it pertained to claimant's pre-1971 bilateral hearing loss.

FINDINGS OF FACT

Claimant, 58 years of age at the time of hearing, has worked for this employer as a millwright since 1966. When first employed, claimant underwent a hearing test that indicated he suffered no hearing loss.

On July 17, 1971, claimant consulted Dr. Chowning, ear

specialist. He reported that his right ear had been plugged up for several weeks and that he had had some hearing loss for several years. Dr. Chowning cleaned out claimant's right ear and tested claimant's hearing and diagnosed acoustic traumatic hearing loss. According to the audiogram results, claimant suffers bilateral high-tone loss. Dr. Chowning recommended that claimant wear ear protection in noisy environments.

Dr. Chowning told him that his type of hearing loss was typical of people that worked in high noise areas. Claimant did not file a hearing loss claim at that time.

Claimant underwent another hearing test in 1972 which demonstrated he suffered a 15.5 percent hearing loss in his right ear and no hearing loss in his left ear. Claimant notified his employer of the results of this test.

In September 1986, claimant was examined by Dr. Lipman, hearing specialist. The tests indicated bilateral high-tone sensorineural hearing loss with moderately reduced speech discrimination. Dr. Lipman indicated that claimant's hearing loss was due to chronic noise exposure.

Claimant has undergone approximately 12 hearing tests from 1971 through 1987. Many of these tests were conducted at the plant under the auspices of the employer. These tests indicate claimant has experienced bilateral hearing loss. Claimant suffered hearing loss over and above that anticipated due to the aging process.

Claimant worked in a pulp mill around electric motors, high speed machinery and steam under pressure. He operated equipment, including grinders. He is continuously exposed to industrial noise. The noise at this employer's plant is of the type that can cause hearing loss. Industrial exposure is the major contributing cause of claimant's hearing loss.

On October 18, 1985, claimant filed a claim for loss of hearing due to excessive industrial noise. The employer issued its denial of compensability on August 20, 1986.

The employer was not predjudiced in any way by the alleged delay in claimant's notice of injury.

CONCLUSIONS OF LAW AND OPINION

The employer offers two arguments to support its denial. The first is that the Referee had no jurisdiction over this claim because it was not timely filed under the version of ORS 656.807 in effect at the time claimant filed his occupational disease claim. The second argument is that claimant failed to prove a rateable hearing loss and thus has suffered no compensable injury.

The version of ORS 656.807 in force when this claim was filed provided:

> "(1) * * * [A]ll occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer within five years after the last exposure in employment subject to the workers' compensation law and

within 180 days from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease, which ever is later."

The first requirement of the statute is that a claim be filed within five years after the last injurious exposure. In this case, claimant continued to work under conditions of noise capable of causing hearing loss when he filed his claim; thus he satisfied the first requirement.

In addition, the claim must be filed within 180 days of the date claimant became disabled or has been advised that he has an occupational disease, whichever is later. Here, claimant did not file a claim within 180 days of July 17, 1971 when he saw a doctor about a hearing problem. The employer argues that claimant may not recover because claimant was informed of his disease by Dr. Chowning in 1971 and he failed to file his claim within the 180 day limit.

This argument must be rejected for three reasons:

(1) Case law requires that the claimant be clearly told that his injury is caused by work so that the limitation period may commence. See Robinson v. SAIF, 69 Or App 534 (1984). This requirement is not met if some doctors tell the claimant his hearing loss might be work related and other doctors tell him it is not. Davidson Baking v. Industrial Indemnity, 20 Or App 508 (1975). Nor is it sufficient for a doctor to tell the claimant that there is a relationship between his medical difficulties and his work. The doctor must clearly state the claimant's injury is caused by his work. See Templeton v. Pope & Talbot, Inc., 7 Or App 119 (1971).

Here, claimant saw Dr. Chowning because his ear had been plugged up for several weeks; he also reported that he had some hearing loss for several years. Dr. Chowning cleared claimant's ear and performed an audiogram. The audiogram indicated claimant had high-tone hearing loss and acoustic trauma. Dr. Chowning recommended that claimant use hearing protection at work.

Dr. Chowning told him his hearing loss was typical of people who work around high industrial noise experience. There is no evidence that Dr. Chowning clearly stated that claimant's hearing loss was due to industrial exposure. Thus, under the case law, the statute did not begin to run with the 1971 office visit.

(2) The statute requires that the claimant be disabled before the limitation period will begin to run. Disability for the purposes of ORS 656.807 means inability to work. It does not mean loss of use or function. Moreover, it does not mean rateable loss under the Medical Director's rules. In Robinson, supra, the court found that claimant was disabled for purposes of 656.807 when she terminated employment due to her occupational disease, although she had suffered dizzy spells and chronic fatigue before that time.

In Johnson v. SAIF, 53 Or App 627 (1981), the claimant was found disabled when she could no longer work due to her back pain even though she had earlier suffered severe back pain causing her to miss several weeks of work. Similarly, in Mathis v. SAIF, 10 Or App 139 (1972), the court found the claimant disabled for

purposes of 656.807 the day she left work although she had "suffered" from asbestosis for 10 days before. In that case, the court quoted Professor Larson and noted that the date of disability was used for limitations period purposes because it produced a bright line test which was "cessation of work on a definite date." The court concluded that the disability language of 656.807 conformed to that view. Thus, in this case, where claimant never left work due to the hearing loss, he has never become disabled so as to begin the limitations period.

(3) Finally, in order to bar the claim, the employer would also have to show that it was prejudiced because of the delay in filing. Inkley v. Forest Fiber Products Co., 288 OR 337 (1980); Robinson v. SAIF, supra. Therefore, even if claimant had been disabled and even if in 1971 his doctor had told him that his hearing loss was due to the industrial injury, his claim was not barred because there is neither contention nor proof that the employer was prejudiced. Indeed, hearing tests were performed at the plant under the auspices of the employer; the employer was aware of the hearing loss and had monitored it.

Finally, the employer argues that claimant's hearing loss is due to the aging process and therefore not compensable. As used in the present case, rateable hearing loss means loss of hearing that is above and beyond presbycusis. We have found that claimant did suffer hearing loss beyond presbycusis. We relied for this finding on the hearing tests administered by the employer over the years and the tests performed by Derek S. Lipman. We have rejected the opinion of Dr. Mettler that there is no notable loss as unreliable because it is based on aberrant audiogram results.

Although we agree with the Referee that claimant's occupational disease claim is timely as well as compensable, we disagree that the employer's denial should be set aside only with respect to the post-1971 hearing loss. Therefore, we reverse that portion of the Referee's order that found claimant's pre-1971 hearing loss not compensable. Accordingly, the employer's denial is set aside with respect to claimant's pre-1971 hearing loss, as well as his post-1971 hearing loss.

ORDER

The Referee's order dated December 21, 1987 is reversed in part. The self-insured employer's denial is set aside in its entirety and the claim is remanded to the employer for processing according to law. Claimant's attorney is awarded an assessed fee of $770, to be paid by the self-insured employer. A client-paid fee, not to exceed $1,170, is approved.

JOHN C. WOOD, Claimant
Biel, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys
Cummins, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Terri Borchers, Assistant Attorney General

WCB 88-20635
February 3, 1989
Order Dismissing Request for Board Review (Remanding)

Safeco Insurance Company has requested Board review of Referee Irving's January 20, 1989 order that joined it, Liberty Northwest Insurance Corporation, and the SAIF Corporation (on behalf of an alleged noncomplying employer), as parties to a forthcoming hearing. We have reviewed the request to determine whether the

Referee's order is a final order, which is subject to review. Joseph Wilson, 40 Van Natta 66 (1988). We conclude that we lack jurisdiction to consider the request.

FINDINGS

On January 17, 1989, Underwriters Adjusting Company moved for the joinder of Safeco, Liberty Northwest, and SAIF (on behalf of Angell Transport, an alleged noncomplying employer), as necessary parties to a forthcoming hearing concerning the compensability of, and the responsibility for, claimant's current left shoulder condition.

On January 20, 1989, Referee Irving granted the motion. In addition to joining the aforementioned entities as parties, the Referee directed that new files be created and that notices of hearing be sent to all parties to the proceeding. Finally, the Referee directed that the newly created case numbers be consolidated for the forthcoming hearing.

On January 24, 1989, Safeco requested Board review of the Referee's order.

ULTIMATE FINDINGS

The Referee's order did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

CONCLUSIONS OF LAW

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139, rev den (1974).

Here, the Referee's order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order joined several potentially responsible employers/insurers as necessary parties for a future hearing.

Inasmuch as further action before the Hearings Division is required as a result of the Referee's order, we conclude that it is not a final, appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra; William L. Miller, 39 Van Natta 1020 (1987). Consequently, we lack jurisdiction to consider the issues raised by the request for review.

Accordingly, the request for Board review is dismissed and this matter is remanded to Referee Irving for further proceedings.

IT IS SO ORDERED.

BUDDY TILLMAN, Claimant
Vick & Gutzler, Claimant's Attorneys
Lin A. Zimmerman, Defense Attorney

Own Motion 86-0445M
February 3, 1989
Own Motion Order

On September 24, 1986 the Board issued an Own Motion Order whereby claimant's claim was reopened with temporary disability benefits to commence March 31, 1986. EBI Companies was authorized to recover its overpayment from claimant's bimonthly time loss checks in the amount of 25 percent. Claimant has asked the Board to reconsider this authorization and direct EBI to pay him his full time loss check every two weeks. EBI contends the Board's September 24, 1986 order is final and should be upheld.

ORS 656.278(1) authorizes the Board to ". . . modify, change or terminate former findings, orders or awards if in its opinion such action is justified." The exceptions to this rule outlined in ORS 656.278(5) do not apply to this issue in this case. We conclude, therefore, we have the authority to grant the relief claimant seeks if we find sufficient justification.

The Board issued two orders in this case, both in 1986, wherein it was stated that EBI could recover any overpayment from further temporary or permanent disability benefits. Both of these orders predated the issuance of William J. Dale, 39 Van Natta 632 (1987) and Harold D. Bates, 38 Van Natta 992 (1987). These cases permit recovery of overpaid disability benefits from permanent disability awards only. It is our conclusion that EBI properly held back 25 percent of claimant's bimonthly time loss payments and, therefore, should not be required to repay these amounts to claimant. However, we conclude we have the authority to limit EBI's future recovery of overpaid amounts from claimant's subsequent awards of permanent disability only.

Therefore, commencing the date of this order, EBI is directed to pay claimant his full temporary disability benefit check in accordance with the applicable law. Any further recovery of overpaid benefits will be taken from future permanent disability benefits. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $400 as a reasonable attorney's fee.

IT IS SO ORDERED.

FRANK L. DUNN, Claimant
Quintin B. Estell, Claimant's Attorney

WCB 87-05740
February 9, 1989

authorization of a client-paid fee for services rendered in this case. The request included an attorney referral letter and a statement of services.

On February 11, 1988, the administrator for the Board notified all practitioners with cases currently pending review that executed retainer agreements or referral letters, 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 to receive such approval a statement of services should be filed within 15 days after the submission of stipulations and disputed claim settlements.

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 rules. Stanley, supra; Eyler, supra. Consequently, requests must be accompanied by an executed retainer agreement and a statement of services, which shall be filed within 15 days after the "proceeding." OAR 438-15-010(1); 438-15-010(5); 438-15-027(1)(d).

Here, the authorization request has been accompanied by

considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, payable from the insurer to its counsel, not to exceed $404.50.

IT IS SO ORDERED.

SHIRLEY FOURIER, Claimant
Michael Dye, Claimant's Attorney
Judy Johnson (SAIF), Defense Attorney

WCB 86-14932
February 9, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Foster's order that upheld the SAIF Corporation's denial of medical services relating to her left knee.

ISSUES

1. Whether claimant's medical services claim is barred by res judicata.

2. Whether claimant's industrial injury to her left knee was a material contributing cause of her need for the claimed medical services.

FINDINGS OF FACT

Claimant originally injured her left knee in September 1975 in the course of her employment as a teacher's aide when she stepped on a rock and twisted her knee while walking across a playground. SAIF accepted the claim for the injury and the claim was closed by Determination Order dated October 31, 1975 with no award of permanent partial disability.

Claimant injured her left knee a second time in November 1978 while working for the same employer when she stepped down from a porch. SAIF also accepted the claim for that injury and the claim was closed by Determination Order dated July 18, 1980 with no award of permanent partial disability.

On July 22, 1983, SAIF issued a denial of an anti-inflammatory medication taken by claimant for her left knee. The basis of the denial was that the medication was for an underlying osteoarthritic condition rather than any residual effect of the November 1978 industrial injury. Claimant timely requested a hearing on the denial and the request came to hearing before Referee Foster in January 1984. Medical reports which either affirmed or denied a causal relation between the 1978 industrial injury and claimant's then-current condition were submitted as part of the record. Claimant testified concerning her injuries and ongoing symptoms. On January 20, 1984, Referee Foster issued an Opinion and Order in which he upheld SAIF's medical services denial on the ground that there was no causal relation between claimant's degenerative left knee condition and the 1978 industrial injury. The order was later affirmed by the Board and was not further appealed.

In February 1986, claimant began treating with Dr. Cook, an orthopedic surgeon. He diagnosed advanced degeneration of the medial compartment of the left knee and recommended surgery. The following month, Dr. Cook performed a left medial

hemiarthroplasty. On October 22, 1986, SAIF issued an aggravation denial of claimant's left knee condition. The basis of the denial was that there was no causal relation between claimant's then-current left knee condition and her 1978 industrial injury. Claimant timely requested a hearing on the denial. Because claimant's aggravation rights on the 1978 industrial injury had expired, an own motion file was established and SAIF's aggravation denial was restyled as a denial of medical services for purposes of the current hearing.

Claimant has degenerative osteoarthritis of the left knee which preexisted her 1978 industrial injury. There is a possibility that the 1978 industrial injury accelerated or permanently worsened claimant's osteoarthritis.

OPINION AND CONCLUSIONS

Res Judicata

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). "Claim preclusion" is the name for the preclusive effect of a prior adjudication on a claim and "issue preclusion" for the preclusive effect of a prior adjudication on an issue. Id.; Restatement (Second) of Judgments, Introduction at 1-5 (1982).

The rule of claim preclusion is that if a claim is litigated to a final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Id. §§ 17-19, 24; see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). A claim or cause of action is an aggregate of operative facts which compose a single occasion for judicial (or administrative) relief. Carr v. Allied Plating Co., supra, 81 Or App at 310. The number of operative facts viewed as part of the same claim must be determined by practical considerations such as whether the facts are related in time, space, origin, or motivation, whether they form a convenient trial unit, and whether their treatment as a unit conforms to the parties' expectations. Restatement (Second) of Judgments § 26(1)(a) (1982); see also Dean v. Exotic Veneers, Inc., 271 Or 188, 192-93 (1975); Carr v. Allied Plating Co., supra, 81 Or App at 310.

The rule of issue preclusion is that if an issue of fact or law is actually litigated and determined by a valid final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. North Clackamas School District v. White, supra, 305 Or at 53; Restatement (Second) of Judgments § 27 (1982).

A Referee's Opinion and Order is a "judgment" within the meaning of the above rules. See North Clackamas School District v. White, supra, 305 Or at 51-53.

The claim which was the subject of Referee Foster's January 1984 Opinion and Order was a claim for medical services in the form of medication. The current claim is for medical services provided in 1986. These two claims arose at different times and

none of the medical services claimed are common to either claim. The claims are distinct, therefore, and the rule of claim preclusion does not apply. See Consolidated Freightways v. Poelwijk, 81 Or App 311, 315, rev den 302 Or 296 (1986).

The rule of issue preclusion, however, does apply. One of the issues litigated at the 1984 hearing was the causal relation between claimant's 1978 industrial injury and her degenerative left knee condition. Referee Foster determined that there was no causal relation and that determination was essential to his decision. The medical services provided in 1986 were for the same degenerative left knee condition. Under these circumstances, the rule of issue preclusion mandates the conclusion that the medical services provided for claimant's degenerative left knee condition in 1986 were not causally related to the 1978 industrial injury. See Proctor v. SAIF, 68 Or App 333, 335-36 (1984). Accordingly, SAIF's denial will be upheld on that basis.

Medical Services

Assuming for the sake of argument that the rule of issue preclusion does not require affirmation of SAIF's 1986 medical services denial, claimant has the burden of proving by a preponderance of the evidence that her 1978 industrial injury was a material contributing cause of the need for medical services in 1986. See Florence v. SAIF, 55 Or App 467, 470 (1981). Claimant contends that the 1978 industrial injury accelerated or worsened her preexisting degenerative left knee condition and thus that the medical services provided in 1986 were materially related to the 1978 industrial injury. This is a complex issue requiring expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The only medical opinion in the record concerning the causal relation between claimant's 1978 industrial injury and the medical services provided in 1986 is a short, two-paragraph letter by Dr. Cook. He concluded that claimant had degenerative arthritis which preexisted the 1978 industrial injury and opined that "[t]he 1978 industrial injury certainly could have exacerbated or accelerated the deterioration of her knees but was not the primary cause of the condition." He provided no explanation of the mechanism by which the exacerbation or acceleration could have occurred.

We read Dr. Cook's opinion as saying that there is a medical possibility that the 1978 industrial injury worsened or accelerated claimant's preexisting left knee arthritis. The possibility of a material contribution is insufficient to satisfy claimant's burden of proof. Queen v. SAIF, 61 Or App 702, 706 (1983); Gormley v. SAIF, 52 Or App 1055, 1060 (1981). On the merits, therefore, we would conclude that there was no material causal connection between claimant's 1978 industrial injury and the medical services provided for her left knee in 1986.

ORDER

The Referee's order dated December 21, 1987 is affirmed.

Board Member Crider, concurring in the result:

I concur in the Board's conclusion that the evidence is insufficient to establish that claimant's current need for medical services (specifically, Naprosyn) is materially related to her industrial injury. Therefore, I agree that the Referee's order, upholding the denial, must be affirmed. I do not agree, however, with the primary ground of the majority opinion. The claim is not barred by res judicata.

The issue framed by the 1983 medical services denial was this: Was claimant's need for Naprosyn related to the compensable injury? The insurer at that time contended that claimant's need for treatment was not related to the compensable injury because it was in fact needed for treatment of a preexisting osteoarthritis condition that had not been worsened by the industrial injury. However, Referee Foster upheld the denial without adopting this view. The Referee's rationale for upholding the 1983 denial is not entirely clear; that is, he made no findings of fact. Rather, he quoted a portion of an unintelligible physician's report and characterized the report as saying that there was "no relationship between her current knee condition and her industrial injury." (Emphasis added.) Ex. 20. He went on to find that, "The left knee has continued to cause problems, but the treating physician insists there is no relationship to the industrial injury."

Referee Foster's 1984 order did not decide whether or not the industrial injury aggravated the underlying osteoarthritis but rather only decided that claimant's then-current condition and need for services was unrelated to the industrial injury. That being the case, no finding in the 1984 order requires us to find that claimant's need for services in 1986 was not related to the industrial injury.

The Supreme Court, in North Clackamas School District v. White, 305 Or 48, modified, 305 Or 468 (1988), held that relitigation of issues is not precluded unless "the decision on a particular issue or determinative fact . . . was essential to the judgment." Id., 305 Or at 53 (slip opinion of February 17, 1988 at 4). In this case, the Referee did not decide whether the preexisting osteoarthritis had been worsened by the injury and such a finding was not essential to the determination that medical services were properly denied. All that was necessary to the judgment was the finding that the claimant's then-current condition was not compensably related to the industrial injury. In that sense, this case is very similar to White. There, a Referee had determined in an extent of disability case that the claimant had failed to establish "a medical connection between her present condition and her industrial injury." The Referee also observed that claimant had been unable to establish "to what extent the nodules are related to the hip discomfort and the industrial injury." The Court determined that that order did not preclude the claimant from later seeking medical services for her hip condition. The Court observed that the fact that the claimant's condition at the time of the earlier hearing was unrelated to the compensable injury did not preclude her from submitting evidence to suggest that at a later time her condition was so related. That is exactly what we are faced with here.

Therefore, claimant is not barred by res judicata from

litigating the relation of her current condition to the industrial injury. Moreover, since the 1984 order made no finding with respect to the affect of the compensable injury on the claimant's osteoarthritis condition, she is not precluded from litigating the question whether the compensable injury worsened the osteoarthritis condition thereby entitling her to medical services for her osteoarthritis condition. These issues should be decided on the record without reference to principles of issue preclusion.

MARK F. GILLES, Claimant
Galton, et al., Claimant's Attorneys
Brian L. Pocock, Defense Attorney
Kevin Mannix, Defense Attorney

WCB 87-02778 & 87-02777
February 9, 1989
Order on Reconsideration

Claimant has requested reconsideration of our Order on Review dated January 17, 1989 that reversed a Referee's order finding that Aetna Insurance Company, rather than Liberty Northwest Insurance Corporation, was responsible for claimant's low back and neck condition. Specifically, claimant submits that we failed to award his counsel a reasonable attorney fee for services related to overturning Aetna's denial.

An order designating a paying agent pursuant to ORS 656.307 issued prior to the hearing. Claimant's counsel rendered services which eventually resulted in Aetna's concession of compensability and the issuance of the .307 order. These services primarily included correspondence with: (1) claimant's treating chiropractor; (2) Aetna's claims examiner; and (3) the Compliance Division requesting the issuance of a .307 order. At hearing, claimant's counsel contended that claimant's condition constituted a "new injury," for which Liberty Northwest was responsible. Claimant's weekly temporary total disability rate on the Liberty Northwest "new injury" claim is larger than the rate on the Aetna aggravation claim.

Among other things, the Referee set aside Liberty Northwest's denial of claimant's "new injury" claim and awarded claimant's counsel a $1,400 insurer-paid attorney fee, to be paid by Liberty Northwest. The Referee also assessed a penalty and a $800 attorney fee against Aetna for an unreasonable delay in responding to claimant's aggravation claim and for an unreasonable delay in cooperating in the issuance of the .307 order.

We reversed that portion of the Referee's order that found Liberty Northwest, rather than Aetna, responsible for claimant's low back and neck condition. We also concluded that claimant was not entitled to an insurer-paid attorney fee. The remainder of the Referee's order was affirmed.

On reconsideration, we adhere to our prior order with the following supplementation and modification.

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); see Shoulders v. SAIF, 300 Or 606, 611-16 (1986).

Here, claimant's entitlement to receive compensation was resolved prior to the hearing through the issuance of a .307

order. See former ORS 656.307(1); Hunt v. Garrett Freightliners, 92 Or App 40, 42 (1988); Petshow v. Farm Bureau Insurance Co., 76 Or App 563, 569 (1985), rev den 300 Or 722 (1986); Ronald L. Warner, 40 Van Natta 1082, on recon, 40 Van Natta 1194 (1988). Thus, after the issuance of the .307 order, compensability was not at issue. Consequently, no fee may be awarded for services at hearing on the compensability issue. See Donald D. Davis, 40 Van Natta 2000 (1988). Moreover, if a claimant is ever entitled to an attorney fee under ORS 656.386(1) in a pure responsibility case, this would not be the case because claimant's contention that Liberty Northwest was responsible did not prevail. Donald D. Davis, supra.

Although claimant's attorney is not entitled to a fee for services after the issuance of the .307 order, we conclude that a fee for services rendered before the issuance of the .307 order is appropriate. As a result of the aforementioned efforts of claimant's counsel, Aetna eventually conceded compensability, thereby permitting the issuance of the .307 order. A fee payable by Aetna for those efforts is justified under ORS 656.386(1). See former OAR 438-47-015; Donald D. Davis, supra. After reviewing the circumstances of this case, including claimant's previously awarded $800 penalty-related attorney fee, and considering the factors set forth in OAR 438-15-010(6), we conclude that a reasonable attorney fee for his counsel's "pre-.307 order" services is $600, to be paid by Aetna.

Accordingly, our January 17, 1989 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our prior order, in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ROBERT L. KREBS, Claimant
Francesconi & Associates, Claimant's Attorneys
Gail Gage (SAIF), Defense Attorney

WCB 87-17029
February 9, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's partial denial relating to claimant's arteriosclerosis and associated surgery. We affirm.

ISSUE

Whether the need for claimant's left carotid-subclavian bypass surgery was accelerated by his compensable left hand injury.

FINDINGS OF FACT

Claimant pinched the fingers of his left hand between the ends of two irrigation pipes in June 1987 in the course of his employment as a farm worker. About two weeks later, he noticed that the tips of the index, ring and little fingers of his left hand were turning purple. This discoloration later spread up the affected fingers. Claimant sought medical treatment and a narrowing of the left subclavian artery due to chronic, arterio-sclerotic vascular disease was diagnosed. The discoloration of

the fingers waxed and waned during June and July, the fingers sometimes appearing normal. In late July or early August 1987 claimant underwent a surgical operation in the area of his neck called a left carotid-subclavian bypass. After the surgery, claimant's finger condition improved.

ULTIMATE FINDINGS OF FACT

The discoloration of the fingers of claimant's left hand was due solely to blood clots associated with his underlying arteriosclerosis condition. Claimant's industrial injury to his fingers played no role in producing the discoloration of his fingers and did not hasten the need for the carotid-subclavian bypass.

CONCLUSIONS OF LAW

To establish the compensability of the carotid-subclavian bypass surgery, claimant has the burden of proving that the compensable injury to his fingers materially contributed to or accelerated the need for the surgery. See Williams v. Gates, McDonald & Co., 300 Or 278, 281 (1985). We conclude that claimant has failed to carry this burden.

There are three opinions regarding the relation between claimant's industrial injury and his need for surgery. Drs. Smith and Pribnow, both general practitioners, summarily opined on several occasions that claimant's industrial injury had damaged the tissues of his fingers and that the surgery was necessary to promote the healing of the finger injuries. Dr. Porter, the Head of the Division of Vascular Surgery at Oregon Health Sciences Center, opined in detailed testimony at the hearing that claimant's symptoms were caused by small blood clots which had formed at the site of the obstruction of his subclavian artery, that these blood clots subsequently migrated down claimant's arm and became lodged in his fingers, resulting in a diminished blood supply and discolorization and that the migration of the clots had nothing to do with the injuries to claimant's fingers.

When faced with conflicting medical opinions, we give greater weight to those that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). In the present case, Dr. Porter's greater expertise and the thoroughness of his explanation render his opinion more persuasive than the unexplained opinions of Drs. Smith and Pribnow. Consequently, we conclude that claimant has failed to carry his burden of proving that the injury to his fingers in any way contributed to or accelerated the need for his carotid-subclavian bypass surgery.

ORDER

The Referee's order dated February 10, 1988 is affirmed.

DANIEL S. MARTINEZ, Claimant
Stephen D. Finlayson, Claimant's Attorney
Gary Wallmark (SAIF), Defense Attorney

WCB 87-01633
February 9, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's denial of his claim for a skin condition in both ears. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, a custodian, compensably injured his head on February 24, 1982, when he fell and struck the back of his head against a toilet. The diagnosis was a hairline basilar skull fracture. As a result of the injury, claimant suffered headaches, neck pain, and total neurosensory hearing loss in the left ear accompanied by constant, moderate tinnitus. Those conditions were accepted by SAIF, and the claim was closed by Determination Order on July 7, 1983 with 88.25 percent scheduled permanent disability for the loss of hearing in the left ear.

Within six months after the compensable injury, claimant developed itchiness in the left ear canal, a condition he had never experienced before the injury. During a July, 1982, office visit, Dr. Kammer found scaly material deep in the left ear canal and, after removing it, observed reddened and slightly irritated skin in the canal. By March, 1983, Kammer also found a "slight amount of debris" in the right ear canal. Kammer initially diagnosed left external otitis (inflammation of the ear). By November, 1986, Kammer modified diagnosis to bilateral external otitis and otomycosis (fungal infection of ear canal).

On December 16, 1986, SAIF denied the compensability of the diagnosed skin conditions in both ears.

In December, 1986, claimant began treating with Dr. Thornfeldt, a dermatologist. Thornfeldt reported scaling and reddened skin in both ear canals and dignosed severe seborrheic dermatitis. Thornfeldt treated the dermatitis condition with various medications. On four occasions, claimant received emergency room treatment for allergic reactions to certain medications.

FINDING OF ULTIMATE FACT

The compensable head injury materially contributed to claimant's seborrheic dermatitis condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had failed to sustain his burden of proving a causal connection between the compensable injury and the dermatitis condition. We disagree.

To establish compensability, claimant must prove by a preponderance of the evidence that the compensable injury materially contributed to his need for treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). Stated differently, claimant must prove that the injury materially contributed to the seborrheic dermatitis condition.

The medical evidence is divided. Dr. Thornfeldt, the treating dermatologist, related the dermatitis condition to the compensable injury. Although he acknowledged the difficulty of distinguishing between trauma-induced seborrheic dermatitis and idiopathic seborrheic dermatitis, he opined that evidence that the condition did not precede the industrial accident and that it was present within three to six months after the accident convinced him that it was induced by trauma. Thornfeldt also noted that the dermatitis is worse on the left side, which is the side of the head that suffered most from the injury.

Contrary opinions were offered by Drs. Girod and Lee. Both reviewed claimant's records on SAIF's behalf, but did not examine him. Dr. Girod, who specializes in infectious diseases, questioned Thornfeldt's opinion and opined that a minor neurologic injury, such as occurred here, should not predispose one to seborrheic dermatitis. Dr. Lee, an otolaryngologist, indicated that trauma-induced seborrheic dermatitis is extremely unusual. Lee "strongly doubt[ed]" the causal connection between the injury and the dermatitis, citing medical reports that the condition started "later in the course of events." Lee further indicated that there were "multiple other reasons" for the condition: the change in employment, the presence of chemicals in the workplace, and the change in lifestyle.

We are more persuaded by Thornfeldt's opinion for three reasons. First, his opinion was supported by the record. We accept claimant's testimony that he had no seborrheic dermatitis problems prior to the injury. In addition, Dr. Kammer's July 1, 1982 chart note demonstrates that claimant had scaling and irritation in his left ear canal within six months after the injury. These facts form the bases of Thornfeldt's opinion. Second, while we recognize that Drs. Girod and Lee are competent to offer opinions regarding skin disorders, we give greater weight to the opinion of the dermatologist, Thornfeldt. See Abbott v. SAIF, 45 Or App 657, 661 (1980). Indeed, Girod's lack of expertise was underscored by the tentative nature of his opinion, which appeared to defer final judgment on the causation question until a dermatologist could conduct an independent medical examination (IME). That recommended IME never took place. Third, Thornfeldt's opinion was better reasoned than the others. Somers v. SAIF, 77 Or App 259, 263 (1986). For these reasons, we find that the compensable head injury materially contributed to the seborrheic dermatitis. We conclude, therefore, that the claim for treatment of the seborrheic dermatitis condition is compensable.

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

ORDER

The Referee's order dated January 15, 1988 is reversed. The SAIF Corporation's denial of December 16, 1986, is set aside and the claim is remanded to SAIF for processing according to law.

JAMES A. ROSS, Claimant
Welch, et al., Claimant's Attorneys
Stafford Hazelett, Defense Attorney

WCB 87-15924
February 9, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Peterson's order that set aside its denial of claimant's hearing loss claim. The issue is compensability. We reverse.

FINDINGS OF FACT

At the time of hearing, claimant was a 39-year-old aircraft service supervisor. Claimant began working as a mechanic for the employer in 1979.

Claimant's employment exposed him to high noise levels, but he was conscientious about wearing the appropriate hearing protection. Claimant's chief complaint, however, concerned the loud telephone ring of the portable telephone he carried. He used the phone for about five years before filing this claim.

The telephone was designed with a loud ringer in the ear piece. Claimant generally held the telephone to his right ear. When the employer received a second call for claimant, while he was already on the telephone, he was informed of the waiting call, on the public address system. After claimant hung up the first call, the office forwarded the new call to him. Since claimant was often able to anticipate the ring, he had time to remove the phone from his ear.

Over the course of claimant's employment, successive audiometric testing documented a pattern of increasing high frequency hearing loss in the right ear. For example, testing, conducted by the employer in 1981, revealed a mild high frequency neurosensory hearing loss in the right ear. However, by May 1987, Dr. Delorit, M.D., diagnosed a moderately severe high frequency loss in the right ear and a mild high frequency loss in the left ear.

Dr. Delorit indicated that he was unable to determine a causal relationship between claimant's employment and the high frequency hearing loss. In a subsequent narrative report, the doctor outlined claimant's work and medical history, but expressed no opinion concerning the relationship between claimant's employment and his hearing loss condition.

The audiometric testing reports noted that claimant was exposed to off-the-job noise factors. During the fall months, claimant uses an electric chain saw almost every other weekend. In addition, he has been exposed to high noise levels, while he served in the Air Force.

ULTIMATE FINDINGS OF FACT

Claimant has not established that his employment was the major contributing cause of his high frequency neurosensory hearing loss.

CONCLUSIONS AND OPINION

In determining that claimant established the

compensability of his hearing loss claim, the Referee focused on the absence of evidence contraindicating compensability. The Referee concluded that the claim was compensable because: (1) claimant was exposed to loud noise at work and very little noise off the job; (2) he experienced a hearing loss during a time when he worked for employer; (3) Dr. Delorit, although somewhat ambiguously, implied that the hearing loss resulted from noise exposure at work; and (4) there was no contrary evidence. We disagree.

Claimant failed to establish the compensabilty of his hearing loss condition because he presented no evidence to establish a causal relationship between his employment and the hearing loss. Claimant must show that noise exposure at work was the major contributing cause of his hearing loss and was of a degree to which he was not ordinarily exposed other than during his employment. Former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298 (1983).

Claimant presented no expert opinion to support compensability of the condition. For example, Dr. Delorit was unable to determine whether claimant's hearing loss condition was work related. Dr. Delorit's May 19, 1987 report merely recites claimant's medical and employment history and does not establish a causal relationship between claimant's employment-related noise exposure and his hearing loss.

If we concluded, as did the Referee, that the doctor's recitation of claimant's history somehow implies a causal relationship we would, nevertheless, find his opinion unpersuasive. In addition to failing to express any opinion concerning the relationship between the hearing loss and work related noise exposure, Dr. Delorit failed to consider and weigh other factors that could have played a role in the development of claimant's hearing loss. For example, claimant testified that, during the fall months, he frequently used an electric chain saw on the weekends. Claimant also admitted to noise exposure while serving in the Air Force. In addition, we find nothing in the audiometric studies that would establish a relationship between claimant's employment and his hearing loss.

Although we find claimant's testimony credible, it is insufficient to establish the necessary causal relationship in this medically complex claim. See Kassahn v. Publishers Paper, 76 Or App 105 (1985). Accordingly, claimant has failed to prove compensability of his hearing loss claim by preponderant evidence.

ORDER

The Referee's order dated February 2, 1988, is reversed. The insurer's denial is reinstated and upheld.

JACKLYN WILSON, Claimant
Malagon & Moore, Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 88-00086
February 9, 1989
Order on Reconsideration

Claimant has requested reconsideration of that portion of the Board's November 15, 1988 Order on Review that awarded an insurer-paid attorney fee of $725 for services at hearing and on review concerning her successful attempt to overturn the SAIF Corporation's denial of her medical services claim for an "MMPI". Specifically, claimant requests that her attorney fee be increased

to $2,500. In order to fully consider the matter, we abated our prior order and granted SAIF an opportunity to respond. After receiving SAIF's response and further considering this matter, we make the following conclusions.

Pursuant to OAR 438-15-010(6), the amount of a reasonable attorney fee shall be based on: (1) the time devoted to the case; (2) the complexity of the issues presented; (3) the value of the interest involved; (4) the skill and standing of counsel; (5) the nature of the proceedings; (6) the results secured; (7) the risk that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Here, in determining claimant's attorney fee award, the aforementioned points were fully considered. On reconsideration, we conclude that a reasonable fee for services at the Hearings level and on Board review is $1,200. This award is in lieu of, rather than in addition to, the $725 awarded in our prior order.

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

IT IS SO ORDERED.

SABRINA J. HAUSE, Claimant
Pozzi, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 86-15038
February 10, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee McMurdo's order that upheld the insurer's denial of her right knee condition.

The Board affirms the order of the Referee.

ISSUE

Whether claimant sustained a compensable injury to her right knee on July 20, 1986.

FINDINGS OF FACT

The Board adopts the Referee's statement of facts with the following supplementation.

Claimant did not slip and fall injurying her right knee on July 20, 1986, while at work.

CONCLUSIONS OF LAW

The Board agrees with the result reached by the Referee, but for different reasons.

The Referee found that claimant, Ms. Hoffman, and Ms. Muise were "completely credible" based on their demeanor. We generally defer to a Referee's credibility finding when it is based on a witness' demeanor. Pinkerton, Inc. v. Brander, 83 Or app 671, 674 (1987). However, given the unsupported substance of

claimant's testimony, we cannot do so in the present case. See Davies v. Hanel Lumber Co., 67 Or App 35, 38 (1984).

Claimant testified that she immediately reported her alleged injury of July 20, 1986, to the bartender and Ms. Muise. Muise, however, testified that the bartender had informed her that he was unaware of any such injury. Muise, further testified that she herself first became aware of the alleged injury several weeks after July 20, 1986. Moreover, Ms. Hoffman testified that in mid-August, 1986, claimant informed her that she had injured her right knee in an off-the-job hiking accident.

The substance of claimant's testimony regarding the alleged injury of July 20, 1986, is contradicted by the testimony of Ms. Muise. Ms. Hoffman's testimony casts further doubt on the substance of claimant's testimony. In sum, we find that claimant is not a credible witness.

Accordingly, on this record, we are not persuaded that claimant injured her right knee on July 20, 1986, while at work.

ORDER

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

Board Member Crider, dissenting:

Claimant suffers from a compensable inner ear condition as a result of a July 5, 1986 incident suffered while working for the employer. As a result of that condition, she immediately began suffering spells of dizziness and loss of balance which resulted in repeated falls. Claimant reported these spells and falls to her treating physician on July 29, 1986, mentioning in particular a fall at a golf course and another fall, at an unspecified location, which caused left knee injury. Ex. 4-1, 2. A couple of days thereafter, claimant reported that this fall associated with the dizziness and causing the knee injury occurred at work on July 20. Ex. 6-2.

I would be disinclined to find that the alleged at-work fall did not occur on the basis of one co-worker's testimony that she did not report it promptly and another co-worker's vague testimony that she mentioned that she, while outdoors at an uncertain location, lost her balance and "slipped and fell and hurt her knee." Tr. 37-38.

Assuming, however, that the Board, refusing to credit claimant's testimony concerning the alleged at work fall because of the discrepancy between her testimony and that of the co-workers, correctly found that no fall occurred at work, I can phathom no reason for not finding that claimant did suffer a fall -- albeit perhaps not at work -- caused by dizziness and that that fall caused the knee injury. If, in fact, claimant was hurt as a result of an off the job fall as described by one of the co-workers, then her knee injury is nonetheless compensable because it was caused in material part by the compensable inner ear condition. It makes no difference whatever where the fall occurred.

The Board, however, has made no clear findings in this regard. Instead, finding claimant not credible, it has failed to finish its job.

I would find that claimant suffered a fall associated with dizziness caused by the inner ear condition which resulted in injury to the knee. I would reverse.

DEBORAH NOYES, Claimant
Vick & Gutzler, Claimant's Attorneys
Gail M. Gage (SAIF), Defense Attorney

WCB 87-14480
February 10, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee Garaventa's order that upheld the SAIF Corporation's partial denial relating to her head, neck, upper back and upper extremities.

We affirm and adopt the order of the Referee with the following findings of fact and conclusions of law relating to an issue not decided by the Referee. That issue is whether SAIF's denial is invalid under the rule of Roller v. Weyerhaeuser Co., 67 Or App 583, adhered to on reconsideration, 68 Or App 743, rev den 297 Or 601 (1984).

ADDITIONAL FINDINGS OF FACT

SAIF accepted claimant's claim as nondisabling. SAIF has never closed claimant's claim by notice of claim closure or submitted the claim to the Evaluation Section for closure.

ADDITIONAL CONCLUSIONS OF LAW

Claimant contends that SAIF's denial is invalid under Roller because SAIF was required to close her nondisabling claim under former ORS 656.268(3), see Webb v. SAIF, 83 Or App 386, 390 (1987), and SAIF has never done so.

We reject claimant's argument. In Webb v. SAIF, supra, the court stated in dicta that former ORS 656.268(3) required closure of nondisabling claims. The court's statement presumably was based upon the express reference to nondisabling claims in the original version of that subsection. See Or Laws 1979, ch 839, § 4. Effective January 1, 1986, however, the reference to nondisabling claims in former ORS 656.268(3) was deleted. See Or Laws 1985, ch 600, §§ 8, 19. After that date, therefore, closure of nondisabling claims was not required.

All of the relevant events in the present case occurred after the effective date of the amendment to former ORS 656.268(3). Consequently, SAIF was not required to close claimant's nondisabling claim and its partial denial is procedurally proper.

ORDER

The Referee's order dated February 5, 1988 is affirmed as supplemented by this order.

ANN M. RYAN, Claimant
Coons & Cole, Claimant's Attorneys
Kate Waldo (SAIF), Defense Attorney

WCB 87-04171
February 10, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee Baker's order which upheld the SAIF Corporation's partial denial of claimant's depressive psychological condition. On review, the sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a plywood mill worker, sustained a compensable injury to her back and neck in September 1983. The injury was diagnosed as a mild to moderate cervical-thoracic strain. Following the injury, claimant returned to work under a light-duty work release. She was told by her treating chiropractor, Dr. Russell, to avoid working on the "driers" as it involved heavy work. However, on the release form, Dr. Russell indicated that sweeping and dryer work was permitted.

The employer continued to assign claimant to work on the "driers" in spite of her protests. In mid-1984, she suffered exacerbations of her compensable injury and depressive episodes. Thereafter, claimant sought treatment from various health care providers for symptoms of carpal tunnel syndrome, alopecia areata (hair loss), and thoracic strain.

Claimant's claim was closed by a March 1985 Determination Order which awarded her 5 percent unscheduled permanent partial disability. Also in March 1985, SAIF issued a partial denial of claimant's carpal tunnel syndrome and alopecia areata. In February 1986, the parties entered into a Disputed Claim Settlement in which SAIF's partial denial of the carpal tunnel syndrome was upheld. The agreement also placed the other aspects of claimant's claim in an inactive status at that time.

In October 1986, the parties entered into a second settlement which upheld SAIF's denial of claimant's alopecia areata. The settlement also reserved claimant's right to contest the extent of permanent disability awarded by the March 1985 Determination Order as her claim was considered "open" at that time. A February 1987 Determination Order closed claimant's claim which increased claimant's unscheduled permanent partial disability award to 15 percent.

In March 1987, claimant was referred to Dr. Carter, psychologist, for treatment of depression and anxiety. In April 1987, SAIF issued a partial denial of Dr. Carter's treatment on the basis that the psychological condition was unrelated to claimant's compensable injury.

Prior to her compensable injury, claimant had preexisting personality disorders. Following her compensable injury, claimant had a myriad of stressors in her life, most of which were not work related.

FINDINGS OF ULTIMATE FACT

Claimant's 1983 compensable injury is not a material

contributing factor to her current psychological condition and need for treatment.

CONCLUSIONS OF LAW

The Referee concluded that claimant's 1983 compensable injury was not a material contributing factor to her current psychological condition and need for treatment. We agree based on the following reasoning.

A claimant asserting the compensability of a psychological condition following an industrial injury must prove by a preponderance of the evidence that the compensable injury was a material cause of the condition, or if the mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen, Inc. v. Page, 73 Or App 136, 139 (1985); Partridge v. SAIF, 57 Or App 163, 167, rev den 293 Or 394 (1982). We find that claimant has not carried her burden of proof.

The issue of whether claimant's industrial injury is a material contributing factor to her current psychological condition 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. Carter, claimant's treating psychiatrist, opined that it was medically probable that the compensable injury played a significant and material role in cueing and perpetuating claimant's psychological ailments. His opinion, however, is based on the assumption that claimant's hair loss, and carpal tunnel syndrome, were part of her compensable injury. Further, Dr. Carter does not explain why he believes that the initial injury perpetuates claimant's problems. Given these facts, we find Dr. Carter's opinion unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

By contrast, Dr. Holland believed that the compensable injury was not a "material injury" in that there were little compelling physical findings which explained claimant's prolonged disablement. He reasoned that claimant's present disability could not be explained on the basis of the injury because of the long time lapse. Instead, Dr. Holland attributed claimant's current disability to her preexisting psychopathology. Dr. Holland concluded that the compensable injury had not materially contributed to claimant's psychological condition.

In conjunction with Dr. Holland's opinion, Dr. Colbach believed that claimant overfocused on her compensable injury and unconsciously developed one of the psychological pain syndromes. He opined that the injury was responsible for some of her problems, but that there were many other issues that led to the prolongation of her symptoms. He concluded that the injury was a factor in claimant's psychological condition, but not a material factor.

Considering Drs. Holland and Colbach's opinions that the industrial injury is not a material contributing cause of claimant's current psychological condition and our finding that Dr. Carter's opinion is unpersuasive, we conclude that claimant has failed her burden of establishing that her compensable injury

was a material contributing cause of her psychological condition and need for treatment. Accordingly, claimant's current psychological condition is not compensable.

ORDER

The Referee's order dated January 27, 1988 is affirmed.

Board Member Crider, dissenting:

The majority concludes that claimant's psychological condition is not compensable. In doing so, it rejects Dr. Carter's opinion for incorrect reasons and relies, inappropriately, on Dr. Colbach's ultimate conclusion that claimant's industrial injury was not a material cause of her depression.

Dr. Colbach, an examining physician, diagnosed a psychogenic pain disorder resulting in mild psychiatric impairment. He acknowledged that the industrial injury "did lead to this pain disorder, at least insofar as it provided her a point of focus. She did injure herself and she had some muscle strain but then she just wouldn't let go of this injury." Moreover, he indicated that:

> "the industrial injury was responsible for some of her current situation but certainly there are so many other issues here that have led to the prolongation of symptoms that much else has to be looked at to explain just why she is in the predicament that she is in now. I think the injury was a factor here but I cannot say that it was a material factor."

Ex. 34-6.

In short, although Dr. Colbach clearly indicates that the compensable injury was a significant factor in the development of psychological impairment in a woman who functioned adequately prior to the compensable injury, he would not allow that the injury was material. Materiality is a legal, not a medical, concept. The physician's conclusion notwithstanding, his medical findings lead inexorably to the conclusion that claimant's injury was a material cause of her psychological difficulty. His opinion thus supports that of Dr. Carter, claimant's treating psychiatrist.

The majority rejects the opinion of Dr. Carter on the ground that Carter believed that claimant's hair loss was compensably related to the industrial injury whereas, in fact, the parties have agreed that it is not. While it is true that Carter's opinion is inconsistent with the law of the case in this regard, this inconsistency is not fatal. Dr. Carter opined that the hair loss combined with the compensable back injury caused claimant's depression. Nevertheless, it is clear that he believed the pain resulting from the back injury was signficant and that he did not suggest that the depression stemmed only from the hair loss. Thus, his opinion should not have been dismissed out of hand.

DONALD C. ANDERSON, Claimant
Vick & Gutzler, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney
David O. Horne, Defense Attorney

WCB 86-10302 & 86-15456
February 13, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Wausau Insurance Company requests review of Referee Myers' order which found it, rather than Liberty Northwest Insurance Corporation, the responsible insurer for claimant's current right shoulder condition. On review, Wausau contends that Liberty Northwest is responsible for claimant's right shoulder condition.

We affirm and adopt the order of the Referee.

Under ORS 656.382(2), 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." Here, Wausau requested Board review, seeking to shift responsibility to Liberty Northwest. Had Wausau succeeded, claimant's compensation would have been reduced because Wausau has the higher rate of temporary disability compensation. Claimant participated on Board review, contending that the Referee's order should be affirmed. Under these circumstances, claimant's attorney is entitled to a reasonable fee for services on Board review under ORS 656.382(2), payable by Wausau. Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989).

ORDER

The Referee's order dated July 22, 1987 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $400, to be paid by Wausau Insurance Co. A client-paid fee, payable from Liberty Northwest to its counsel, is approved, not to exceed $300.

NELSON W. BAKER, Claimant
Charles Robinowitz, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-06028 & 87-01455
February 13, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of that portion of Referee Galton's order in WCB Case No. 86-06028, which granted claimant permanent total disability benefits. Claimant cross-requests review of that portion of the Referee's order which granted claimant an "approved" attorney fee in the amount of $2,000. Claimant also requests review of Referee Daughtry's order in WCB Case No. 87-0145S, which concluded that he lacked jurisdiction to increase claimant's attorney fee as previously awarded by Referee Galton. We affirm.

ISSUE

1. Whether claimant is entitled to permanent total

FINDINGS OF FACT

On March 9, 1976, claimant first consulted Dr. Faber with complaints of chest tightness and difficulty breathing. Dr. Faber diagnosed acute bronchospasm. Claimant was 54 years of age at the time and had worked for the employer as a millwright for nearly 20 years. On June 8, 1976, Dr. Faber indicated that claimant had moderate chronic obstructive lung disease (COPD) with an element of acute bronchospasms when subjected to contaminated air. Claimant continued to receive medical care and treatment throughout 1976 and 1977.

On April 6, 1978, Dr. Faber executed a health insurance claim form with diagnoses of COPD and hypertension, noting that claimant's employment was contributing to his condition.

On April 10, 1978, the employer accepted claimant's disabling occupational disease.

On May 23, 1978, Dr. Faber reported that claimant's condition was probably stable and he could probably do some types of manual work in a non-polluted atmosphere. However, Dr. Faber also indicated that claimant's lung reserve capacity was compromised to the extent that he did not feel that claimant could do a great deal of heavy manual labor due to his pulmonary condition.

On June 19, 1978, Dr. White, internist, reported that, since early March 1978, claimant had been disabled from engaging in his usual occupation due to moderately severe COPD. He recommended that claimant should never return to any type of work which exposed him to dust, fumes or smoke. He also doubted that vocational rehabilitation efforts would be successful.

On July 11, 1978, Dr. Faber stated that claimant was probably permanently disabled from working in the machine shop at the employer and that it may well be impossible for claimant to find work in any other job.

On August 9, 1978, Dr. Vitums, a specialist in respiratory medicine, examined claimant. He reported that claimant could not tolerate the environment at his work as a result of his COPD.

On August 25, 1978, a Determination Order awarded claimant 50 percent unscheduled permanent disability resulting from the injury to his respiratory system.

On November 7, 1978, Dr. Faber examined claimant again and discussed the possibility of returning to work at the employer as a slip feeder, boom man or clean-up person. Claimant felt that he could not perform any of those jobs. Dr. Faber concurred that claimant would have an extremely difficult time doing either slip feeding or boom man duties because of his physical problems and probable lack of dexterity.

Soon thereafter, claimant's mental condition began deteriorating because he felt that: (1) it was impossible to return to the jobs offered by the employer; and (2) he could no longer find any type of work due to his age and physical condition. Claimant was having symptoms of depression, insomnia, lack of interest in things and trouble communicating with his wife. He was also experiencing spells of dizziness, ataxia and chest pain. On December 13, 1978,

Dr. Keppel diagnosed progressive dyspnea, and on December 27, 1978, Dr. Prewitt prescribed Elavil for claimant's depression.

On July 25, 1980, Dr. Henke, claimant's family physician, reported that claimant was not capable of functioning at a level where he could perform any job on a regular basis at that time.

On December 29, 1982, claimant's claim was reopened by Opinion and Order due to the worsening of claimant's compensable psychological condition. On December 16, 1983, the Workers' Compensation Board found, instead, that claimant's claim had been prematurely closed. Accordingly, they set aside the August 25, 1978 Determination Order.

By March 1983, claimant had become more withdrawn and more settled into his depression. Dr. Lindemann, a psychologist and professor of medical psychology at the University of Oregon Health Sciences University, diagnosed moderate to severe depression with psychophysiological reaction. With regard to treatment, Dr. Lindemann recommended personal counseling and the introduction of a limited amount of volunteer activities. At that time, he was not optimistic that, even with successful counseling, claimant could return to work.

In March 1984, Dr. Lindemann referred claimant for treatment to Dr. Gregor, psychologist. This referral, however, was not successful. Initially, Dr. Gregor made some progress. Eventually, their relationship deteriorated as a result of claimant's suspicions that the employer wanted him to see Dr. Gregor so that it could terminate his workers' compensation benefits. In January 1985, Dr. Gregor reported that claimant's suspicion that continued therapy would cause his benefits to be terminated made further treatment useless. In early 1985, claimant stopped seeing Dr. Gregor and has not sought psychological treatment since that time nor has he actively sought employment.

On July 11, 1985, Drs. Turco and Parvaresh diagnosed dysthymic disorder of neurotic proportions.

On December 5, 1986, Dr. Lindemann examined claimant and diagnosed chronic depression. His prognosis for improvement was poor.

On April 9, 1987, a Determination Order awarded claimant 30 percent unscheduled permanent disability.

As a result of the combined effects of claimant's compensable physical and psychological conditions, he is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW

We adopt the Referee's "Findings and Opinion" section as our conclusions of law with the following comment regarding claimant's attorney fee.

Former OAR 438-47-025 provides that:

> "In a proceeding before a referee requested by claimant on the extent of permanent disability, a fee of 25 percent of any

increase in permanent disability awarded by the referee, but not more than $2,000, shall be approved for claimant's attorney."

The Referee awarded claimant the maximum attorney fee allowable under the former rules. Therefore, we decline to increase that fee.

ORDER

The Referee's order dated March 6, 1987 and April 30, 1987 are affirmed. The Board approves a client-paid fee not to exceed $150. Claimant's attorney is awarded an assessed fee of $1,341.25 for services on review concerning the permanent total disability issue, to be paid by the self-insured employer.

RANDALL BURDICK, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0028M
February 13, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim to the Board for an alleged worsening of his May 8, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim for the payment of temporary disability benefits as claimant's current treatment does not satisfy the requirements of ORS 656.278.

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. Claimant has recently been treated with physical therapy and participated in a work hardening program. However, there is no indication for surgery or hospitalization for treatment. 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.

MERLE O. HANSEN, Claimant
Francesconi & Cash, Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 89-0005M
February 13, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his October 1, 1976 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the recent neck surgery and recommends claimant's 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 review of this record, we are persuaded that claimant's compensable injury has worsened requiring further surgery. Claimant has specifically requested benefits to commence

November 29, 1988, the date he was hospitalized for a myelogram. We decline to grant benefits until the date claimant was hospitalized for surgery. We do not feel hospitalization for diagnostic testing alone satisfies the requirements set forth in the law. Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date claimant is hospitalized for the proposed 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 $200 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.

ROSEANN HIRSHMAN, Claimant
Horton & Koenig, Claimant's Attorneys
H. Thomas Andersen (SAIF), Defense Attorney

WCB 86-16820
February 13, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Garaventa's order that rejected claimant's constitutional challenge to application of the Director's medical services fee schedule, OAR 436-10-090(6), to out-of-state providers. On review, claimant contends that application of the fee schedule to out-of-state medical service providers violates her rights under the Workers' Compensation Law, as well as the Oregon and United States Constitutions. We conclude that the Hearings Division and the Board lack jurisdiction to consider this matter.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

ORS 656.248 gives the Director the authority to promulgate administrative rules for medical fee schedules. Pursuant to that directive, the Director, in OAR 436-10-090(6), has limited reimbursement to the vendor of medical services to the 75th percentile of the usual and customary fee as determined by the Director. Claimant raises a constitutional challenge to ORS 656.248 and the administrative rule promulgated thereunder. However, before we address claimant's constitutional arguments, we are first required to determine whether we have jurisdiction. See Schlect v. SAIF, 60 Or App 449, 451 n. 1 (1982).

The precise issue before us is whether the Hearings Division and the Board have jurisdiction to review a dispute between claimant and SAIF over the appropriate amount of payment of a doctor's fee for services in connection with an accepted claim. The Court of Appeals addressed this question in Haynes v. Weyerhaeuser Co., 75 Or App 262, rev den 300 Or 332 (1985). In Haynes, a Referee had held that jurisdiction over such disputes is vested in the Director. We affirmed.

On review, the court first noted that ORS 656.283(1) provides that any party may request a hearing "on any question concerning a claim." Id. at 264. The court then considered the effect of ORS 656.704(3), which provides:

"For the purpose of determining the respective authority of the director and the board to conduct hearings, *** 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. However, such matters do not include any proceeding under ORS 656.248 or any proceeding resulting therefrom." (Emphasis supplied.)

The court concluded that a dispute over the amount of a medical service provider's fee is excluded by the terms of ORS 656.704(3) from the jurisdiction of the Hearings Division. Id.

The court's decision in Haynes is controlling. Therefore, we do not reach the merits of claimant's constitutional argument.

ORDER

The Referee's order dated June 25, 1987 is affirmed.

LEONARD JENNSEN, Claimant
Emmons, et al., Claimant's Attorneys
John Motley (SAIF), Defense Attorney

WCB 83-02943
February 13, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Baker's order that: 1) upheld the SAIF Corporation's denial of claimant's aggravation claim, as well as its partial denial of compensability of claimant's thoracic outlet syndrome, rib resection surgery, and general polyneuropathies; (2) found that claimant's claim for his compensable hand, wrist and forearm condition had not been prematurely closed; and (3) declined to award additional temporary disability benefits. In his brief, claimant requests attorney fees for services rendered in evoking an alleged partial acceptance of a denied claim at time of hearing. Claimant also moves for remand for the taking of additional evidence. We affirm in part and reverse in part.

ISSUES

(1) Remand;

(2) Compensability of claimant's thoracic outlet syndrome, rib resection surgery and general polyneuropathies;

(3) Aggravation;

(4) Premature closure;

(5) Entitlement to temporary disability benefits; and

(6) Attorney fees for services at hearing.

FINDINGS OF FACT

Claimant, 45 at hearing, was employed doing heavy

physical labor digging water lines. He suffered numbness, tingling and pain in his hands and forearms during the five weeks preceding October 20, 1980. Claimant subsequently filed a workers' compensation claim which was denied by SAIF. Claimant requested a hearing on the denial.

Prior to hearing, claimant was examined by a number of physicians with varying specialties. Claimant's primary complaints related to his hands and forearms. However, he also reported minor neck discomfort. Many diagnoses were suggested including bilateral carpal tunnel syndrome, multiple neuropathies, neuropathy secondary to diabetes, and atypical thoracic outlet syndrome. There was no definitive diagnosis of the condition causing claimant's symptoms.

Following hearing, a March 11, 1982 Referee's order found the claim compensable. The Referee stated, in part:

> "I concluded that claimant's heavy physical work activity during five weeks preceding October 22, 1980 caused claimant to suffer numbness, tingling, and pain in his hands and arms, regardless of the actual etiology of the condition. Thus claimant's claim is compensable...."

The order was not appealed.

Medical reports in October 1982 and January 1983, from examining physicians, noted complaints of pain in claimant's trapezius muscles, bilaterally. Claimant's primary complaints, however, were of pain and tingling in his hands and forearms.

The claim was first closed by a March 23, 1983 Determination Order with awards of 10 percent (15 degrees) scheduled permanent disability for partial loss of use or function of the right forearm, and 5 percent (7.5 degrees) scheduled permanent disability for partial loss of use or function of the left forearm.

On June 1, 1983, claimant's treating neurologist, Dr. Knox, took claimant off work for 60 days. SAIF reopened the claim and recommenced time loss.

Dr. Knox referred claimant to Dr. Erkilla, orthopedic surgeon, for surgical consultation in August 1983. Dr. Erkilla's diagnostic impressions included bilateral ulnar neuropathies and a left median neuropathy. He found that claimant's symptoms had been essentially unchanged since the injury, and recommended against surgery at that time.

In November 1983, Dr. Knox felt that claimant was a candidate for surgery, and referred claimant to Dr. McGee, neurologist, for a second opinion. Dr. McGee felt that surgery was not indicated for the median nerve, but was indicated for the ulnar nerve. He noted that claimant's findings of ulnar and peripheral neuropathies, and mild carpal tunnel syndrome, were suggestive of chronic alcohol intake.

Claimant's claim was again closed on February 16, 1984 with an award for temporary disability benefits through January 13, 1984, but with no award of additional permanent disability.

On October 9, 1984, claimant was reexamined by

Dr. Erkilla. He felt that there was a documented worsening of claimant's condition, and recommended surgery to decompress the right ulnar nerve. He conducted the surgery on December 6, 1984. That surgery did not result in significant improvement of claimant's condition, and Dr. Erkilla therefore did not recommend surgery on the left. He reported that claimant was medically stationary on February 11, 1985.

A Determination Order closed the claim on March 26, 1985. However, Dr. Knox reported that claimant was not medically stationary, and on July 5, 1985, the claim was reopened. Dr. Knox also reported complaints of shoulder pain, which he diagnosed as referred pain from claimant's ulnar neuropathies.

On September 24, 1985, Dr. Knox examined claimant and found him to be medically stationary as of that date.

Dr. Erkilla examined claimant on January 6, 1986. He again reported that surgery was not indicated, and declared claimant to be medically stationary.

Claimant's claim was closed by Determination Order on January 22, 1986, with temporary disability to be paid through January 6, 1986. Claimant was awarded time loss, and permanent disability of 10 percent for the right arm, and 15 percent for the left arm, in lieu of the prior award.

Dr. Knox examined claimant on January 27, 1986, and noted some limited motion in claimant's left shoulder. Diagnostic tests conducted in March 1986 showed apparent C7-8, T1 radiculopathy or brachial plexus neuropathy, as well as thoracic outlet syndrome. On April 1, 1986, Dr. Knox referred claimant to Dr. Gerstner, neurologist, regarding surgery for thoracic outlet syndrome.

SAIF denied claimant's aggravation claim on June 11, 1986.

Dr. Gerstner examined claimant on June 30, 1986. He found the results of Dr. Knox's latest tests constituted good evidence of bilateral thoracic outlet syndrome. He recommended a bilateral rib resection and scalenectomy.

FINDINGS OF ULTIMATE FACT

Claimant's current condition is the same condition which was ordered accepted by Referee's order dated March 11, 1982.

Claimant's condition was medically stationary at the time the claim was closed by Determination Order in March 1983 and again in January and February 1986.

We are unable to find that claimant's compensable condition worsened subsequent to January 22, 1986.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant has moved for remand for the taking of additional evidence. That evidence is a report from Dr. Knox dated September 2, 1987. The Board may remand a case to the Referee if it finds that the record has been incompletely, improperly or otherwise insufficiently developed. ORS 656.295(5). Generally,

this may be done only if the evidence is unobtainable by due diligence. See Bernard L. Osborn, 37 Van Natta 1054 (1985). The hearing in this case was conducted on November 11, 1986. At that time, the record was left open to allow SAIF time to examine some exhibits claimant offered into the record on that day. The record was left open for no other purpose, and was subsequently closed. Dr. Knox has been claimant's treating physician, and has seen him regularly since 1981. The report which claimant seeks to admit is a restatement of Dr. Knox's opinions. We conclude that it was obtainable with due diligence prior to the hearing, and therefore deny the motion to remand. We do not consider the report on review.

Compensability

At hearing, SAIF accepted continuing responsibility for claimant's hand and forearm symptoms. However, SAIF attempted to deny responsibility for any symptoms arising above the elbow and for any treatment of those symptoms. Specifically, SAIF denied responsibility for all polyneuropathies, thoracic outlet syndrome and proposed bilateral rib resection on the basis that they were not compensably related to the accepted claim.

Dr. Knox believes that claimant's thoracic outlet syndrome, polyneuropathies, and need for a rib resection are causally related to claimant's compensable injury. Several other doctors who have treated or examined claimant have reported that claimant suffers from a disease unaffected by his work activities. We conclude, however, as explained below, that we need not decide whether claimant's condition is work related.

Since the Referee's decision in this claim, the Supreme Court has decided Georgia-Pacific v. Piwowar, 305 Or 494 (1988). In that case, the self-insured employer accepted a claim for "sore back." After claim closure, the employer learned that claimant's back problems might have arisen from a disease which was unrelated to claimant's employment and therefore not compensable. The employer subsequently issued a partial denial of the disease condition. The Court found the attempted partial denial invalid. The Court held that a carrier had to compensate claimant for the specific condition accepted ("sore back"), regardless of the cause of that condition. The Court reasoned that to allow the employer to deny compensation for a previously accepted condition once it becomes known that the condition is attributable to a specific noncompensable disease opens the door to instability, uncertainty and delay -- a result found unacceptable in Bauman v. SAIF, 295 Or 788 (1983). Piwowar, 305 Or at 501.

Here, SAIF did not initially accept the condition. Instead, SAIF was ordered to accept the condition by a Referee. However, we see no reason to distinguish between a condition accepted by notice from the insurer, and a condition accepted under order from the Referee, Board, or court. See Knapp v. Weyerhaeuser Co., 93 Or App 670 (1988). Therefore, we conclude that SAIF remains responsible for the conditions ordered accepted by the Referee, regardless of the cause of those conditions.

Moreover, SAIF's attempt to separate claimant's hand and forearm symptoms from his upper arm and shoulder symptoms, and to deny the latter, runs contrary to both the facts of this case and the policy expressed by the Court in Piwowar, supra. In this regard, claimant is experiencing the same symptoms now that he has

experienced throughout his claim. Moreover, while the medical experts continue to disagree with regard to a diagnosis, we are persuaded that claimant's condition now, regardless of diagnosis, is the same condition from which he has suffered since October 1980. Further, thoracic outlet syndrome was one of the original diagnoses of his condition. Pursuant to the Court's reasoning in Piwowar, supra, SAIF is precluded from denying claimant's polyneuropathies and thoracic outlet syndrome regardless of whether those conditions are causally related to the 1980 work activities. It follows that SAIF is also precluded from denying treatment for those conditions.

Aggravation

Claimant contends that his condition has worsened, and seeks an additional award of permanent disability. To reopen a claim because of aggravation, claimant must prove that a worsening of his condition renders him more disabled, i.e. less able to work, than at the time of his last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986).

Claimant's last award of compensation was the January 22, 1986 Determination Order. On Janaury 27, 1986, Dr. Knox reported that claimant's condition had worsened. However, this worsening occurred, if at all, at an unspecified time between claimant's last visit with Dr. Knox on September 24, 1985, and January 27, 1986. Dr. Knox offers no opinion as to when this worsening took place. It is at least as probable, if not more probable, that the worsening referred to by Dr. Knox took place during the four-month period prior to the Janaury 22, 1986 Determination Order rather than the five-day period following the order. In addition, Dr. Collada, neurosurgeon, examined claimant in 1984 and again in April 1986. Dr. Collada opined that claimant's condition was no worse in April 1986 than it had been in 1984. We conclude that the medical evidence is insufficient to prove a compensable aggravation.

Expert medical evidence is not required to prove a compensable aggravation. Lay testimony may be sufficient. Garbutt v. SAIF, 297 Or 148, 151-52 (1984). In this regard, claimant reported at the November 1986 hearing that his symptoms had become more prominent in the prior year or so, but he did not compare his symptoms on January 22, 1986 with his symptoms thereafter. Thus, we are again unable to determine whether that alleged worsening occurred prior to the last award of compensation or subsequent thereto. In addition, claimant's testimony regarding the alleged worsening is entirely conclusory. Further, it conflicts with prior testimony that his condition did not change in 1986. In sum, claimant's lay testimony does not persuade us that his condition worsened subsequent to Janaury 22, 1986.

We conclude that claimant has failed to prove a compensable worsening of his condition since Janaury 22, 1986.

Premature Closure

Claimant contends that his claim was prematurely closed in January 1986. A claim is properly closed when claimant becomes medically stationary, unless he is enrolled in training. ORS 656.268(2). Claimant's treating physician noted that claimant was medically stationary on September 24, 1985. The surgeon, Dr. Erkilla, reported claimant was medically stationary on January 11, 1986. Once both doctors who were closely involved in

claimant's medical treatment had found his condition stationary, the claim was properly closed.

The Board may consider evidence available after closure, which relates to claimant's condition at the time of closure, to determine whether the claim was prematurely closed. Scheuening v. J.R. Simplot Co., 84 Or App 622, rev den 303 Or 590 (1987). In this case, there is no evidence that claimant was not medically stationary on January 22, 1986. There is a June 1986 report by Dr. Knox that claimant is temporarily totally disabled retroactive to January 27, 1986. However, no reason is given in support of this conclusion. We conclude that claimant was medically stationary, and his claim properly closed, on January 22, 1986.

Temporary Disability Benefits

Claimant contends that he is entitled to temporary disability benefits from March 28, 1983 to June 1, 1983, and from January 27, 1986 to the date of hearing.

Because we find that his claim was properly closed in January 1986, he was entitled to no temporary disability benefits after that date.

Similarly, because there is no evidence to support a contention that the claim was prematurely closed in 1983 or that claimant aggravated before June 1, 1983, we award no further benefits for temporary disability in 1983.

On February 10, 1983, Dr. Knox reported that claimant was medically stationary effective December 3, 1982. The Evaluation Division issued a Determination Order on March 23, 1983, closing claimant's claim. The record contains no further evidence on the matter until June 1, 1983, when Dr. Knox took claimant off work for 60 days and the claim was reopened. Claimant was not temporarily disabled after the date of closure, but before reopening.

Claimant could have remained entitled to temporary benefits while enrolled in an authorized training program. ORS 656.268. However, claimant's vocational assistance at the time consisted only of direct employment assistance. He was not entitled to temporary benefits while in that program. We can find no basis to support claimant's entitlement to temporary benefits, and affirm the Referee.

Attorney Fees

Claimant contends that he prevailed from a general denial by SAIF, when, at hearing, SAIF conceded its continuing responsibility for his hand and forearm condition. However, there is no evidence in the record that SAIF had denied such responsibility. Instead, SAIF's denial was of an aggravation. Pursuant to our decision, SAIF is prevailing on that aggravation denial.

On the other hand, claimant is prevailing on SAIF's partial denial at hearing of all polyneuropathies, thoracic outlet syndrome, and bilateral rib resection. Claimant is entitled to an assessed attorney fee when he finally prevails from a decision denying a claim for compensation. ORS 656.386(1); OAR 438-15-035. Therefore, claimant's attorney is entitled to a reasonable,

carrier-paid fee for services rendered at hearing and on Board review, on this issue. See ORS 656.386(1). 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 awrded.

ORDER

The Referee's order dated Janaury 29, 1987 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the SAIF Corporation's partial denial at hearing of all polyneuropathies, thoracic outlet syndrome, and rib resection surgery is reversed. The medical services claim for these conditions is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed.

ANTHONY NETRICK, Claimant
Welch, et al., Claimant's Attorneys
Lin A. Zimmerman, Defense Attorney

Own Motion 88-0483M
February 13, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his August 27, 1979 industrial injury. Claimant's aggravation rights have expired. The Board postponed action on the request for own motion relief until resolution of the request for hearing then pending in the Hearings Division. The parties entered into a settlement agreement on December 9, 1988 whereby the insurer agreed to accept responsibility for claimant's medical treatment. However, the insurer asks that the Board deny the request for temporary disability benefits in that it contends claimant has retired 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. Claimant was hospitalized in May 1988 for his compensable condition. However, claimant has advised the insurer that he is currently retired and receiving Social Security benefits. There is no indication in our record that claimant has attempted to return to work recently. We conclude claimant is not entitled to compensation for temporary disability benefits. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985). The request for own motion relief is hereby denied.

IT IS SO ORDERED.

LARRY J. SALEE, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Terrall & Miller, Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-14493 & 86-01006
February 13, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Safeco Insurance Co. (Safeco) requests review of those portions of Referee Shebley's order that: (1) set aside its denial of claimant's aggravation claim for his low back condition; and (2) upheld a denial of claimant's "new injury" claim for the same condition issued by Unigard Insurance (Unigard). In his respondent's

brief, claimant contends that he is entitled to an insurer-paid attorney fee for services at hearing. On review, the issues are responsibility and attorney fees.

We modify the Referee's order to award an insurer-paid attorney fee for services at hearing. We affirm the remainder of the Referee's order.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

In November 1984 claimant injured his back while working as a welder. The diagnosis was sprain/strain with Grade II sciatic extension neuralgia. Safeco accepted the claim. Claimant missed approximately 5 days of work. In January 1985, he was found medically stationary without evidence of permanent impairment. Thereafter, his claim was closed by means of a Notice of Closure.

In August 1985, when claimant's symptom's increased, he filed an aggravation claim with Safeco. Safeco denied the claim, alleging that claimant's current condition was the result of a "new injury." On September 10, 1985, claimant filed a "new injury" claim with the employer, who had become insured by Unigard on January 1, 1985. Unigard denied responsibility for the claim. In addition, Unigard denied compensability, alleging that the claim had not been timely filed.

Safeco requested the designation of a paying agent pursuant to ORS 656.307. However, because of Unigard's compensability denial, no ".307" order issued.

ULTIMATE FINDINGS OF FACT

Claimant's work activities, while Unigard was on the risk, did not independently contribute to a worsening of his underlying condition.

Unigard's denial of compensability on timeliness grounds was unreasonable.

As a result of Unigard's compensability denial, claimant's right to compensation was at risk at the hearing.

CONCLUSIONS OF LAW

We adopt that portion of the Referee's order which concluded that Safeco was responsible for claimant's current condition. We conclude that claimant's condition represents a recurrence of symptoms attributable to his accepted claim with Safeco. See Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984); Smith v. Ed's Pancake House, 27 Or App 361 (1976). In short, we agree with the Referee's analysis that claimant's work activities while Unigard was on the risk did not independently contribute to a worsening of his underlying condition. See Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

We also adopt that portion of the Referee's order which concluded that Unigard's denial of compensability on the basis of untimeliness was unreasonable. In addition, we agree with the Referee's assessment of a penalty and associated attorney fee for this unreasonable conduct.

The Referee further awarded claimant's attorney a fee of 25 percent of claimant's compensation, not to exceed $750. We agree that claimant's counsel is entitled to an attorney fee for services at hearing. However, rather than payable from claimant's compensation, we conclude that it should be insurer-paid. Furthermore, we hold that the fee should be paid by Unigard, the insurer who denied compensability of the claim and prevented the issuance of a ".307" order.

We have previously held that a carrier ultimately determined not responsible for a claimant's condition may nonetheless be required to pay the claimant's attorney a fee under ORS 656.386(1) if the carrier denies the claim on a basis which threatens the claimant's entitlement to receive compensation and the responsible carrier denies the claim only on responsibility grounds. Ronald L. Warner, 40 Van Natta 1082, 1194 (1988); Ronald J. Broussard, 38 Van Natta 59, 61 aff'd mem, 82 Or App 550 (1986); Karen J. Bates, 39 Van Natta 42 (1987), aff'd SAIF v. Bates, 94 Or App 666 (January 11, 1989). The basic policy underlying this holding is to encourage carriers to seek or accede to the issuance of a ".307" order (with the attendant continuation of compensation payments to injured workers) if they do not seriously contest the claimant's entitlement to receive compensation. Warner, supra, 40 Van Natta at page 1085.

Here, Safeco conceded the compensability of claimant's condition, but contested its responsibility for the claim. Consequently, it requested the issuance of a ".307" order. However, Unigard denied the compensability of claimant's "new injury" claim, contending that the claim was untimely filed. Thus, as a result of Unigard's denial, no ".307" order could issue. Under such circumstances, claimant's entitlement to receive compensation remained at risk and unresolved through the hearing. Warner, supra.

Accordingly, we conclude that claimant's attorney was entitled to an insurer-paid attorney fee under ORS 656.386(1). We further hold, in accordance with the policy articulated in Warner and Bates, that Unigard, the nonresponsible insurer who prevented the issuance of a ".307" order, is responsible for claimant's attorney fee for services at hearing concerning the essentially inseparable compensability and responsibility issues.

After review of claimant's counsel's statement of services and the retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we find that a reasonable assessed attorney fee for services at hearing concerning the aforementioned matter is $1,800.

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, Safeco requested Board review and sought to shift responsibility for claimant's claim to Unigard. As previously discussed, no order designating a paying agent pursuant to ORS 656.307 had issued. Consequently, claimant's entitlement to receive compensation remained at risk. See Thomas W. Williamson, 39 Van Natta 1147 (1987). Claimant's counsel participated on Board review and contended that the Referee's responsibility decision should be affirmed. Under these circumstances, we conclude that claimant's attorney is entitled to a fee for services on review under ORS 656.382(2), payable by Safeco, the insurer who initiated Board review.

After review of the statement of services and the attorney referral letter, as submitted by Safeco's counsels, and considering the factors set forth in OAR 438-15-010(6), we approve a reasonable client-paid fee to be paid by Safeco to its counsels, not to exceed $1,949.50. In reaching this conclusion, we have reduced one of Safeco's appellate counsel's hours from 51.5 hours to an amount we consider to be reasonable for services on Board review in this case, i.e., 10 hours.

ORDER

The Referee's order dated February 27, 1987 is affirmed in part and modified in part. For services at hearing concerning the compensability/responsibility issue, and in lieu of the Referee's award of attorney fees to be paid by Safeco from claimant's compensation, claimant's attorney is awarded a reasonable insurer-paid fee of $1,800, to be paid by Unigard Insurance Company. The remainder of the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $1,200, to be paid by Safeco Insurance Company. A client-paid fee, payable from Safeco to its counsels, is approved, not to exceed $1,949.50. A client-paid fee, payable from Unigard to its counsel, is approved, not to exceed $122.

MARGARET A. SMITH, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-01739, 86-16138 & 86-18106
February 13, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer ARA Services, through its claims processor, Crawford & Co., requests review of those portions of Referee Podnar's order that: (1) set aside its denial of claimant's "new injury" claim for her current back condition; (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition; and (3) awarded claimant's attorney a carrier-paid fee for services at hearing. We affirm.

ISSUES

On review, the issues are: (1) responsibility; (2) claimant's entitlement to a carrier-paid attorney fee; (3) payment of the attorney fee by Crawford & Co.; and (4) amount of the attorney fee.

FINDINGS OF FACT

Claimant, 32 at hearing, is a cafeteria worker. She compensably injured her low/mid back on December 18, 1985, while working for Liberty Northwest's insured. She treated conservatively with Dr. Nelson, a chiropractor, and wore a back brace when working. She missed only one day of work as a result of this injury. This claim had not been closed, or Notice of Closure sent, prior to claimant's second injury and claim.

On October 9, 1986, claimant was working for ARA Services. She was removing a lasagna pan from an oven when she experienced a sudden pain in her whole back. She has not worked since because of the pain. Claimant continues to treat with Dr. Nelson.

On October 10, 1986, claimant filed a claim for compensation with both Liberty Northwest and Crawford & Co.

On October 13, 1986, Dr. Nelson reported that claimant had experienced an "aggravation while working which has necessitated an increase in her treatment program."

On December 5, 1986, Dr. Nelson wrote that "on October 9, 1986 [claimant] was involved in a new injury. . .This incident aggravated a pre-existing low back condition, thus causing a worsening disability."

On December 18, 1986, Liberty Northwest issued a letter denying responsibility for the October 9, 1986 incident. They did not deny compensability, and paid claimant time loss from October 9 to December 18.

On June 8, 1987, Crawford & Co. issued a letter denying responsibility. The letter indicated they would seek an order designating a paying agent under ORS 656.307.

On July 20, 1987, the day before the hearing, Crawford & Co. contacted the Workers' Compensation Division to request designation of a paying agent.

Hearing was held on July 21, 1987. On that date, Liberty Northwest announced that it also agreed to the designation of a paying agent under ORS 656.307. However, no .307 order issued prior to hearing. Claimant's temporary disability compensation rate is higher if Crawford & Co., rather than Liberty Northwest, is the responsible carrier.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had sustained a new injury on October 9, 1986. He based his decision on the fact that claimant was able to work without time loss before the 1986 injury; the 1986 injury was the result of a distinct, identifiable event; the course of the 1985 injury was materially altered by the 1986 injury; and claimant was unable to return to work after the 1986 injury.

We agree. The 1986 injury caused a change in diagnosis and significant change in symptoms. The pain is different in kind and degree from that experienced after her 1985 injury. Whereas that pain was localized and could be controlled with treatment and aspirin, the pain now is diffuse, traveling up to her neck and down her legs. Claimant experiences more severe spasming, and takes prescription pain relievers. Because we find the 1986 incident independently contributed to a worsening of claimant's underlying condition, Crawford & Co. is the responsible carrier. Mission Ins. Co. v. Dundon, 86 Or App 470 (1987); Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

The Referee awarded claimant's attorney a $1,500 carrier-paid attorney fee for services at hearing, to be paid by ARA Services/Crawford & Co. Crawford & Co. contests this award.

It first contends that claimant is not entitled to a carrier-paid fee for services at hearing. We disagree.

Prior to the hearing, neither carrier was expressly contesting the compensability of claimant's claim. However, both carriers were dilatory in seeking an order designating a paying agent under ORS 656.307 and, in fact, no such order had issued by the time of hearing. Under such circumstances, we have held that claimant's right to compensation is at risk against all of the potentially responsible carriers, including those which do not contest the issue of compensability. See Ronald L. Warner, 40 Van Natta 1082, 1194 (1988); Thomas S. Williamson, 39 Van Natta 1147 (1987). Consequently, we conclude that claimant's attorney is entitled to a carrier-paid attorney fee to be paid by the responsible carrier, Crawford & Co., for services rendered at the hearing.

Second, Crawford & Co. contends that the fee is too large. We have considered the relevant factors. Barbara A. Wheeler, 37 Van Natta 122 (1985). We consider the Referee's award of $1,500 to be reasonable.

Claimant contends that the Board lacks jurisdiction to consider the attorney fee award. She is incorrect. Under Greenslitt v. City of Lake Oswego, 88 Or App 94 (1987), the Board has jurisdiction in all cases except when the sole issue being contested by the employer is the amount of an attorney fee. See Ronald L. Warner, supra.

Finally, under ORS 656.382(2), 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." Here, Crawford & Co. sought Board review, seeking to shift responsibility to Liberty Northwest. Had Crawford & Co. prevailed, claimant's compensation would have been reduced because Crawford & Co. had the higher rate of temporary disability compensation. Claimant participated on Board review and asserted that the Referee's order should be affirmed. Under these circumstances, claimant's attorney is entitled to a fee for the Board level under ORS 656.382(2), payable by Crawford & Co.

ORDER

The Referee's order dated August 5, 1987 is affirmed. For services on Board review concerning the responsibility issue, claimant's attorney is awarded a reasonable fee of $500, to be paid by Crawford & Co. A client-paid fee, payable from Liberty Northwest to its counsel, is approved, not to exceed $572. A client-paid fee, payable from Crawford & Co. to its counsel, is approved, not to exceed $120.

ANA TEPEI, Claimant
Peter O. Hansen, Claimant's Attorney
Acker, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

WCB 88-00489
February 13, 1989
Order Denying Motion to Enjoin

Liberty Northwest Insurance Corporation has moved the Board for an order enjoining Referee Tenenbaum from reopening the record in the aforementioned case. The motion is denied for lack of jurisdiction.

FINDINGS

The first of several hearings in this case involving

claimant, Liberty Northwest, and the SAIF Corporation was held on February 2, 1988. Thereafter, the hearing was continued on a number of occasions. The last hearing convened on December 6, 1988. At that hearing, the Referee ruled that claimant was precluded from raising the issue of premature closure because it had been untimely raised. Consequently, closing arguments were submitted and the record was closed.

On January 9, 1989, on her own motion, the Referee issued an "Order Reopening Record." Reasoning that "full development of the record, and the overriding concern of substantial justice" justified such an action, the Referee concluded that claimant should be permitted to raise the premature closure issue and that the insurers should be allowed to respond. When the Referee declined to reconsider the order, Liberty Northwest moved the Board for an order enjoining the Referee from reopening the record.

ULTIMATE FINDINGS

The Referee's order did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

CONCLUSIONS OF LAW

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139, rev den (1974).

Here, the Referee's order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order addressed an evidentiary matter prior to the eventual issuance of an Opinion and Order.

Inasmuch as further action before the Hearings Division is required as a result of the Referee's order, we conclude that it is not a final, appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Consequently, we currently lack jurisdiction to consider the issues raised by Liberty Northwest's motion. Any objections to the Referee's evidenciary and procedural rulings must wait to be considered at the time of Board review, assuming the Referee's forthcoming final order is appropriately appealed. See ORS 656.289(3); 656.295.

Accordingly, Liberty Northwest's motion to enjoin the Referee is denied for lack of jurisdiction.

IT IS SO ORDERED.

CLEOLIA J. WILDER, Claimant
Carney, et al., Claimant's Attorneys
David Smith (SAIF), Defense Attorney

WCB 86-09344
February 13, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee St. Martin's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 45 percent (144 degrees), as awarded by a

Determination Order, to 75 percent (240 degrees). The issue is extent of permanent disability, including permanent total disability. We find that claimant is permanently totally disabled.

FINDINGS OF FACT

Claimant, a 64-year-old custodial employee at a hospital, compensably injured her lower back while lifing a bag of linen. When conservative treatment failed to improve her condition, a myelogram was performed by Dr. Grewe, neurosurgeon. The myelogram revealed a probable herniated disc. Dr. Grewe recommended surgery.

SAIF had claimant examined by Dr. Langston, orthopedic surgeon. Dr. Langston agreed that surgery was necessary.

Dr. Grewe performed a discectomy and laminectomy at multiple levels in August 1985. The following February, he performed a closing examination. He noted that claimant should be limited to light work with a lifting restriction of ten pounds. Claimant reported to him that she could walk for about three-quarters of an hour; sit for a little over one hour; and walk about and change positions for about two hours at a time.

Dr. Langston reexamined claimant after Dr. Grewe's examination. He noted that her pain was not as severe as it was prior to the surgery. He also stated that claimant interfered with the examination to such a degree that it affected its accuracy. He found that claimant was mildly moderately impaired. He also stated that she could perform some of her prior work duties with modification, but that heavy lifting, frequent bending, and activities requiring torque movements such as scrubbing floors and walls would cause a recurrence of her pain.

Dr. Grewe indicated that he concurred with Dr. Langston's report. He ordered follow-up x-rays which revealed scoliosis and mild degenerative changes of the lumbar spine with a laminectomy defect at L-4.

On April 30, 1986, a Determination Order issued awarding temporary total disability and unscheduled permanent partial disability of 45 percent.

In May 1986, claimant began receiving vocational rehabilitation services. These services were aimed toward a direct employment program. Claimant was informed by her employer that she would have a position as an elevator operator once some construction was completed. The construction was delayed several months. Claimant requested and received a 120-day extension of her vocational assistance eligibility. The employer subsequently notified claimant that the position was unavailable. Claimant's eligibility expired without identification of any further employment options.

In July 1986, Dr. Grewe reported that claimant had significantly improved in the last two months and that she was taking almost no medication. At the same time, he questioned whether she could be employed.

Claimant has an 11th grade education. She has done general laundry and drycleaning work most of her life. She worked

in the shipyards during World War II. While working for the employer, she also did domestic housekeeping work twice per week. She is presently physically capable of performing work in the light or sedentary categories.

Claimant continues to experience back and right leg problems. The back pain is constant, although it waxes and wanes in terms of severity. The leg pain is not constant. Claimant does her own housework with the help of her daughter. As of the date of hearing, claimant received physical therapy once per week. She takes "Tylenol 3" once per day, aspirin, Motrin and Flexeril. She does daily home exercises.

Claimant has looked for an elevator position at three other hospitals. She also reads the newspaper "help wanted" advertisements and reviews an employer job update newsletter. Other than the hospital positions, she has applied for no other positions because she has not found any within her limitations.

Claimant has not applied for Social Security.

CONCLUSIONS OF LAW AND OPINION

On review, claimant argues that she is entitled to an award of permanent total disability pursuant to the "odd-lot" doctrine. Under the "odd-lot" doctrine, a worker's physical impairment as well as contributing nonmedical factors such as age, education, adaptability to nonphysical labor, and emotional conditions can establish permanent total disability. Clark v. Boise Cascade Co., 72 Or 397 (1985). Claimant relies upon her age, education and limited work experience to establish her claim. She notes that, other than the elevator job, no other employment was identified by the vocational rehabilitation efforts. She concludes that, without retraining, it is exceedingly unlikely that any jobs exist which she could perform.

We are persuaded that claimant has sustained her burden of proving that she is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1). While claimant's physical incapacities are not so severe as to preclude future employment in the light or sedentary categories, her social and vocational factors weigh strongly in favor of a finding of permanent total disability.

Our conclusion is supported by the opinions of both claimant's treating physician and her vocational counselor. In the same chart note in which he notes significant improvement in claimant's condition, Dr. Grewe nevertheless opines that claimant probably could not be employed. In addition, claimant's vocational counselor opined that, if the elevator job did not materialize, "it is very unlikely that further waiting or other services [to] return her to work outside the employer at injury will be productive." Furthermore, all of claimant's prior work experiences involve lifting and bending requirements in excess of her present capabilities. When this fact is combined with claimant's age, education and lack of transferable skills, it becomes apparent that she has sustained her burden of proving entitlement to an award of permanent total disability.

SAIF argues, inter alia, that claimant did not make a reasonable effort to find work. We do not agree. An injured worker who has some physical capacity for employment is

statutorily required to make reasonable efforts to find work, although she need not engage in job-seeking activities that, in all practicality, would be futile. ORS 656.206(3); Welch v. Banister Pipe Line, 70 Or App 699 (1984), rev den 298 Or 470 (1985). For more than six months, claimant believed that she had a position pending with the employer. We agree with the Referee that claimant was not obligated to "pound the sidewalks" during this period. Moreover, claimant received the newspaper help wanted advertisements on a daily basis. She also regularly received a job update newsletter from the employer. In addition, she personally pursued job possibilities within her restrictions with three other hospitals. We conclude that claimant has made reasonable "seek-work" efforts.

ORDER

The Referee's order dated May 19, 1987 is reversed. Claimant is granted permanent total disability as of April 21, 1987, the date of hearing. The SAIF Corporation is authorized to offset against the permanent total disability benefits due, any permanent partial disability benefits paid subsequent to April 21, 1987. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total of fees allowed by the Referee and the Board shall not exceed $6,000.

Board Member Ferris, dissenting:

I dissent. Claimant has not sustained her burden of proving that she is permanently incapacitated from regularly performing work at a gainful and suitable occupation. Accordingly, I would affirm the Referee's order.

The record is devoid of any medical or vocational finding that claimant is unemployable. Dr. Grewe, the treating physician, never opined that claimant could not be employed. In the chart note cited by the majority, Grewe merely speculated that claimant will probably be found unemployable at the conclusion of litigation in this case. It is not at all clear whether Grewe himself would make that finding. In that same chart note, Grewe reported significant improvement in claimant's condition during the previous two months. That improvement followed an independent medical examination (IME) during which Dr. Langston found claimant capable of performing modified work, with restrictions against heavy lifting, frequent repetitive bending or activities requiring a torque movement. Moreover, Langston reported functional inconsistencies and interference during the IME which affected the exam's accuracy. Dr. Grewe concurred with Langston's report.

Langston's report and claimant's subsequent improvement, as documented by Grewe, not only establish that claimant is physically capable of modified work, but also cast doubt on the reliability of claimant's testimony regarding her physical restrictions.

Vocationally, claimant is a young-appearing 64 years of age, with more than 11 years of formal education. She has worked most of her life in laundry and dry cleaning. There is no evidence in the record that laundry or dry cleaning work exceeds her physical limitations. Yet, this vocational option was never explored. Indeed, the only vocation explored was the elevator operator position. Vocational rehabilitation services were

terminated when the position was no longer available. There is no evidence that any other vocation was actively pursued by either claimant or her vocational counselor. For that reason, the counselor's statement that further time or vocational services would not likely return claimant to work is sheer supposition, and I am not persuaded by it. Given claimant's physical capabilities, her extensive work experience and the failure to pursue alternative vocations, I am not persuaded that claimant has sustained her burden of proving entitlement to permanent total disability benefits.

BRENDA M. BROOKS, Claimant
Donald L. and Leah L. Kimberling, dba
THE COACH HOUSE RESTAURANT, dba
THE COLONIAL TIMBER INN, Employer
Ackerman, et al., Claimant's Attorneys
E. Jay Perry, Attorney
Les Huntsinger (SAIF), Defense Attorney
Terri Borchers, Assistant Attorney General

WCB 86-15811, 87-02076, 86-09009 & 86-12401
FEBRUARY 16, 1989
Order on Reconsideration

The SAIF Corporation has requested reconsideration of the Board's Order on Review, dated October 31, 1988, which found that: (1) the Kimberlings were a complying employer from April 1 through August 6, 1986; and (2) claimant's July 1986 back injury claim was compensable.

In our prior order, we found that the Director had not received a copy of SAIF's notice to the Kimberlings terminating their worker's compensation insurance coverage. ORS 656.427(1) & (2) provides that a termination of coverage is effective not less than 30 days after the date the notice is received by the Director. In our order, we found that SAIF's notice was not received by the Director and concluded that the Kimberlings' coverage was not effectively terminated.

SAIF contends that the Board failed to correctly heed ORS 656.740(1), which provides, inter alia:

> "A person may contest a proposed order of the director declaring that person to be a noncomplying employer * * * by filing with the department * * * a written request for hearing. * * * An order by the director under this subsection is prima facie correct and the burden is upon the employer to prove that the order is incorrect." (Emphasis added).

The phrase "prima facie correct" does not elimate our obligation to issue orders that contain findings of fact which are supported by substantial evidence in the record. See Armstrong v. Asten-Hill, 90 Or App 200 (1988).

Our order of October 31, 1988, finds that the Director did not receive SAIF's order of cancellation. Perhaps we should restate our conclusion somewhat differently: There is no evidence in the record that the Director received SAIF's cancellation. Without such evidence, we are unable to make a finding of fact that the Director in fact received SAIF's cancellation. Without a finding of fact that the Director received SAIF's cancellation, there is no basis to conclude that the Kimberlings' workers'

compensation insurance coverage ended on March 31, 1986, or that it ended on any other date. Therefore, we cannot affirm the Director's order.

There is evidence in the record of a guaranty contract insuring the Kimberlings. There is no evidence that this contract was ever cancelled. Therefore, we reverse the Director's order of noncompliance.

SAIF argues on reconsideration that this shifts the burden of proof to an insurer to prove cancellation. We agree that it does. When an employer produces evidence of a guaranty contract in a noncompliance hearing, we hold that the burden of proof shifts to the insurer to prove cancellation of that contract. While the statute directs that the initial burden of proof is on the employer, it is not unheard of in Workers Compensation law for the burden of proof to shift to another party. For example, although a claimant must establish entitlement to a penalty, once the claimant has established that an insurer did not accept or deny a claim within 60 days, the burden shifts to the insurer to establish that the delay was not unreasonable. See Roger G. Prusak, 40 Van Natta 2037, 2042 (1988); See also, Bauman v. SAIF 298 Or 788 (1983).

Accordingly, we find that there is evidence of a guaranty contract and no evidence that the guaranty contract was ever cancelled. On reconsideration, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

PHYLLIS M. HAHN, Claimant
Kenneth D. Peterson, Claimant's Attorney
Rick Barber (SAIF), Defense Attorney

WCB 87-18524
February 16, 1989
Order of Remand

Claimant requests review of Referee Higashi's order that dismissed her request for hearing on timeliness grounds. She asks that the case be remanded for further development of the record and reconsideration. We reverse and remand.

ISSUE

Whether the evidence supports the conclusion that a copy of the Determination Order which is the subject of claimant's request for hearing was mailed to claimant more than one year before December 3, 1987.

FINDINGS OF FACT

Claimant filed a request for hearing on December 3, 1987 on a Determination Order dated November 14, 1986. On December 21, 1987, the SAIF Corporation moved that claimant's request for hearing be dismissed on timeliness grounds. Claimant's attorney filed a response on December 30, 1987 in which he alleged that claimant had first learned of the Determination Order when she received a copy of it from SAIF on December 3, 1987. The only document which is part of the record is the copy of the Determination Order addressed to SAIF and received by SAIF on November 18, 1986. No hearing was held. The Referee issued an order dismissing claimant's request for hearing on January 29, 1988.

ULTIMATE FINDING OF FACT

The evidence does not support the conclusion that a copy of the Determination Order was mailed to claimant more than one year before December 3, 1987.

CONCLUSIONS OF LAW

Under former ORS 656.268(6), claimant has one year from the date upon which the Determination Order was "mailed" to her within which to request a hearing. The record is devoid of any evidence that a copy of the Determination Order was mailed to her at any time, let alone that it was mailed to her more than one year before she filed her request for hearing. The Referee erred in dismissing claimant's request for hearing without allowing claimant the opportunity to present evidence concerning whether the Determination Order was mailed to her, and, if so, when. See Anton V. Mortensen, 40 Van Natta 1177, on recon 1702 (1988).

Accordingly, we reverse the Referee's order and remand the case for further development of the record. See ORS 656.295(5) & (6). The Referee is instructed to proceed in any manner that will achieve substantial justice. See ORS 656.283(7). In pursuit of that objective, should the Referee find that a bifurcation of the jurisdictional and substantive issues is appropriate, then the Referee should proceed in that manner. In addition, if the Referee concludes that the hearing request is untimely, the Referee is not required to proceed to the substantive issues on an alternative basis.

ORDER

The Referee's order dated January 29, 1988 is reversed and the case is remanded to the Referee for further proceedings consistent with this order.

ROBERT L. AKERSON, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-14555 & 86-11545
February 17, 1989
Order on Reconsideration

The Board issued an Order on Review in this case on January 12, 1988. The insurer requested reconsideration of that portion of our order that set aside its denial of claimant's claim for physical and psychological effects of pesticide intoxication. Claimant requested reconsideration of that portion of our order relating to attorney fees. We abated our order on February 5, 1988. After reconsideration, we reinstate the insurer's denial. In view of this result, the attorney fee issue is moot.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of his claim for physical and psychological effects of exposure to pesticides and subsequent medical treatment. We affirm.

ISSUE

Whether claimant sustained compensable physical or psychological effects from his exposure to pesticides or the medical treatment he subsequently received.

FINDINGS OF FACT

Claimant began working for the employer, a wholesale florist, in 1981. He worked as a general laborer from that time until 1982, when he left his employment for other work. Claimant returned to work for the employer in early 1983 and worked through August 1, 1985. During the second period of employment, claimant worked primarily as a sales and delivery person. This involved making phone and personal contacts with retail clients, retrieving plants from greenhouses for customer orders, cleaning plants and delivering the plants to the clients.

The employer's facility consisted of a large, open-sided breezeway surrounded by nine greenhouses. In one corner of the breezeway was a closed office and employee break area. The employer also used the office for storage of numerous pesticides and chemicals. Claimant sometimes worked in the employer's greenhouses while plants were being sprayed with pesticides and he sometimes handled plants which were wet with pesticide spray. Claimant occasionally used gloves, but otherwise wore no protective gear.

During the spring of 1985, insect pests began to multiply in the employer's greenhouses and a number of plants also became infected with diseases. Claimant's co-workers began to spray or otherwise apply a number of carbamate and organophosphate pesticides and other chemicals to the plants in an attempt to eradicate the pests and control the diseases. Early in the summer of 1985, claimant noticed that he would sometimes get a rash on his hands or arms. He associated the rashes with touching plants wet with pesticide spray. Later, he began to experience a number of other symptoms including headaches, excessive perspiration and mental confusion. By the end of July 1985, several of claimant's co-workers were complaining of symptoms similar to those he was experiencing and health officials inspected the employer's premises. After its inspection, the Accident Prevention Division of the Workers' Compensation Department closed the employer's facility for a few days, beginning August 1, 1985. On August 26, 1985, the Accident Prevention Division cited the employer for a number of safety violations which increased the risk of employee exposure to pesticides. The employer did not contest the citation.

Claimant did not return to work after August 1, 1985. Blood and urine samples taken the following day at the behest of the Lane County Health Department failed to reveal any chemical residue in claimant's body. A few days later, claimant visited Dr. Rice, a family practitioner, for an evaluation of his condition. Dr. Rice had no experience with pesticide intoxication and was unable to offer any opinion regarding claimant's condition.

At that point, claimant and a number of his co-workers consulted an attorney who referred them to Dr. Redfield, a specialist in occupational medicine, and Dr. Leveque, an osteopath with an interest in toxicology. Dr. Redfield evaluated claimant on August 6, 1985. He recorded complaints of shortness of breath, cold sweats, headaches, abdominal cramping, muscle tremors and rigidity, memory loss, mood swings, blurred vision and skin rashes. He then performed a physical examination and ordered lung function and blood tests. The only unusual finding from the physical examination was decreased grip strength bilaterally. The blood and lung function tests revealed no significant

abnormalities. Based on claimant's subjective complaints, Dr. Redfield diagnosed apparent exposure to organophosphate and other pesticides with residual symptoms.

Claimant's first meeting with Dr. Leveque occurred on August 14, 1985. Dr. Leveque took no medical history from claimant and, other than testing claimant's grip strength by having him squeeze his fingers, performed no physical examination. Based solely upon information received from claimant's attorney and claimant's then-current subjective complaints, he diagnosed severe organophosphate poisoning. Thereafter, for a number of months, Dr. Leveque conducted weekly group meetings with claimant and his co-workers. The meetings usually were held in claimant's attorney's office, although at least one meeting was held at a shopping mall. During these meetings, Dr. Leveque encouraged claimant and his co-workers to describe and discuss their subjective complaints. Dr. Leveque also prescribed a headache medicine containing barbituates and other medications for claimant.

A short time after claimant's initial meeting with Dr. Leveque, Leveque referred him to a psychologist, Dr. Kurlychek, for psychological and neuropsychological testing. The testing was administered in two sessions, on August 25 and September 26, 1985. In a report dated October 28, 1985, Dr. Kurlychek stated that the psychological tests reflected significant depression and extreme levels of anxiety regarding bodily functions. He interpreted the neuropsychological tests to show disruption of cognitive abilities and motor coordination. He related these problems to pesticide intoxication. He indicated that organophosphates are stored in the fatty tissues of the body and slowly dissipate over a period of several months to a year. He opined that claimant's condition would improve gradually as this occurred.

On November 19, 1985, claimant was examined by Dr. Carter, a psychiatrist, on referral from Dr. Leveque. Dr. Carter recorded complaints of memory loss, occasional headaches, blurred vision, mood swings, mental confusion, neck popping and a 40 to 50 pound weight gain. Based upon these complaints and the history received from claimant, Dr. Carter diagnosed organic brain syndrome due to chemical intoxication and an adjustment disorder with anxiety and depression.

In November 1985, claimant was examined by Dr. Bardana, the Head of the Allergy and Immunology Division of the Department of Medicine at Oregon Health Sciences University. At the time of the examination, claimant complained of a number of symptoms including shortness of breath, mood swings, headaches, diarrhea and excessive sweating. Dr. Bardana reviewed claimant's medical history, conducted a physical examination and ordered blood and lung function tests. The physical examination revealed acneform dermatitis on claimant's face and back, folliculitis (inflammation of the hair follicles) on his abdomen and legs and cold, bluish-colored hands. The blood tests revealed the presence of alcohol and barbituates in claimant's body, but otherwise reflected no significant abnormalities. The lung function test was normal.

Based upon the information received from claimant, the medical records and his own examination and tests, Dr. Bardana opined that it was doubtful that claimant had experienced any

carbamate or organophosphate intoxication. Instead, he attributed claimant's symptoms to Raynaud's syndrome (a circulatory disorder of the hands), acneform dermatitis, folliculitis of the lower abdomen and legs, possible substance abuse syndrome and an anxiety-tension syndrome. In later testimony, Dr. Bardana stated that the human body metabolizes carbamates and organophosphates into harmless chemicals within a few days and thus that pesticide intoxication could not be the cause of claimant's ongoing complaints. The insurer issued a denial of claimant's claim in December 1985.

In February 1986, claimant was examined by Dr. Bayer, the Director of the Poison Center at Oregon Health Sciences University. Dr. Bayer conducted an extensive survey of the literature regarding carbamate and organophosphate intoxication and noted that claimant had reported and continued to complain of certain symptoms uncommon to such intoxication. Like Dr. Bardana, Dr. Bayer indicated that carbamates and organophosphates are rapidly metabolized and eliminated from the body. In view of these facts, the duration of claimant's symptoms and the absence of any past or present indication of pesticide residue in claimant's body, he opined that claimant had not experienced pesticide intoxication.

In March 1986, claimant was examined by a psychiatrist, Dr. Holland. Dr. Holland obtained a detailed history and administered a number of psychological tests which he interpreted to show a propensity toward "somatization." He found no evidence of ongoing carbamate or organophosphate intoxication. He diagnosed atypical somatoform disorder, which he later described as a fixation upon the workings of the body, accompanied by subjective complaints without objective support. Regarding the cause of claimant's atypical somatoform disorder, Dr. Holland indicated that the disorder represented a symptomatic exacerbation of preexisting personality traits induced by medical opinions to the effect that he had been severely damaged through exposure to pesticides.

Claimant timely requested a hearing on the insurer's denial. In April 1986, an initial hearing session was held before Referee Garaventa. After this session, claimant's case was consolidated with three other cases involving claims by his co-workers. A hearing was conducted on all four cases by Referee Myers in three sessions, on September 23 and 24, 1986 and January 7, 1987.

Before mid July 1985, claimant drank an average of six bottles of beer per week. Between mid July and September 1985, he drank up to six bottles of beer per day. In 1976, claimant was in an automobile accident and suffered a concussion.

FINDINGS OF ULTIMATE FACT

Claimant did not experience physical or psychological effects of exposure to pesticides which were disabling or required medical services. The medical treatment claimant received after he left work was a material contributing cause of a worsening of his psychological condition.

CONCLUSIONS OF LAW

Claimant raises both accidental injury and occupational

disease theories of compensability for alleged physical and psychological effects of exposure to pesticides. Under either theory, claimant has the burden of proving some physical or psychological harm as a result of the exposure which resulted in disability or required medical services. See Brown v. SAIF, 79 Or App 205, 209, rev den 301 Or 666 (1986).

Claimant alleges that he experienced a number of physical effects from exposure to pesticides. This allegation finds some support in the opinions of Drs. Redfield, Leveque, Kurlychek and Carter. It is disputed by Drs. Bardana and Bayer. Our conclusion on this question, therefore, turns upon which group of opinions we accept.

The persuasiveness of a medical opinion depends upon three basic factors: the source of the opinion, its factual basis and its logical force. The source of the opinion has reference to the expertise and objectivity of the one giving it. See Abbott v. SAIF, 45 Or App 657, 661 (1980). The factual basis of the opinion relates to the completeness and correctness of the information upon which it is based. See Somers v. SAIF, 77 Or App 259, 263 (1986). The logical force of the opinion concerns the depth, clarity and cogency of the analysis. See id.

Drs. Bardana and Bayer both have considerable expertise in the field of toxicology. Their opinions are based upon detailed histories, complete physical examinations and a number of objective tests. Their understanding of the nature of carbamate and organophosphate chemicals and of the effects of these chemicals upon the human body find considerable support in the medical literature. Their opinions are thoroughly and clearly explained.

The opinion of Dr. Redfield was preceded by a thorough physical examination and a number of objective tests. He specializes in occupational medicine, but his expertise in toxicology is not reflected in the record. His opinion is based solely upon claimant's subjective complaints and is inconsistent with the objective evidence. Dr. Leveque is an osteopath. He has some interest in toxicology, but his expertise in that field is questionable. His understanding of the nature of carbamate and organophosphate chemicals and their effect upon the human body finds little or no support in the medical literature. His opinion was based upon claimant's subjective complaints. He conducted virtually no physical examination of claimant and obtained no medical history from him. His opinion is poorly explained. Dr. Kurlychek is a psychologist. His expertise in toxicology is not reflected in the record, but his understanding of the nature and effects of carbamate and organophosphate chemicals was similar to that of Dr. Leveque. His opinion was based upon a battery of psychological and neuropsychological tests, but was poorly explained. In particular, he failed to discuss the potential role of claimant's alcohol and prescription drug consumption or his past head injury in the deficits he identified. Dr. Carter is a psychiatrist. His expertise in toxicology is not reflected in the record. His opinion was based upon claimant's subjective complaints, is inconsistent with the objective evidence and is poorly explained.

In view of the above analysis and our comparison of the various opinions rendered in this case, we conclude that the opinions of Drs. Bardana and Bayer are more persuasive than those

of Drs. Redfield, Leveque, Kurlychek and Carter and thus that the medical evidence fails to establish any physical effects from pesticide exposure.

As for claimant's opinion regarding the cause of his complaints, his expertise in the field of toxicology is very limited and the question of what caused his symptoms is a complex one. His opinion, therefore, is of little probative value. The only relatively simple physical symptom which claimant identified with apparent contact with pesticides was the rash he sustained on his hands and arms. Dr. Bardana, however, concluded that the rash was due to Raynaud's syndrome, acneform dermatitis or folliculitis. We find Dr. Bardana's opinion regarding the cause of the rash more convincing than claimant's.

Turning to the question of whether claimant sustained compensable psychological effects from his exposure to pesticides, claimant presents two theories. First, he contends that his condition was caused by stress associated with his exposure to pesticides at work. Second, he contends that his condition was caused by the medical treatment he sought as a result of his exposure to pesticides.

Other than some general statements by Drs. Bayer and Bardana regarding the possibility of "mass hysteria" and some ambiguous remarks by Dr. Holland, claimant's first theory finds no support in the medical record. The theory involves medical issues which are sufficiently complex that we cannot decide them without adequate professional assistance. See Uris v. Compensation Department, 247 Or 420, 424-26 (1967). In view of the poor development of the record on this issue, we are unable to conclude that claimant established a compensable psychological condition under his first theory.

Regarding the second theory, Dr. Holland opined that the medical treatment that claimant received after he left work was at least a material contributing cause of a worsening of his psychological condition. There are no contrary opinions. The insurer contends, however, that the medical treatment that worsened claimant's psychological condition was not reasonable and necessary and cannot give rise to compensable consequences for that reason. We conclude that claimant's psychological condition is not compensable for other reasons.

As a general rule, a carrier is responsible for harmful effects of medical treatment if there is a material causal connection between the treatment and a compensable condition. Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985); see 1 A. Larson, The Law of Workmen's Compensation § 13.21 (1985). This standard is the same regardless of whether the compensable condition for which treatment is sought is an injury or an occupational disease. See Janice G. Thon, 40 Van Natta 606, 607 (1988); see also Jeld-Wen, Inc. v. Page, 73 Or App 136, 138-39 (1985). Treatment may be unreasonable, unnecessary or excessive from a medical standpoint or may be negligently or otherwise tortiously performed and still be causally related to a compensable condition. In such cases, the causal connection between the compensable condition, the improper or tortious treatment and the harmful effect of the treatment remains intact. When this occurs, the harmful effect is compensable even if the treatment which caused it is not. See 1 A. Larson, supra § 13.21 at 3-415 & n.84 (1985 & Supp 1988); Gray v. Church's Fried Chicken, Inc., 504 So. 2d 979, 981-82 (La. App. 1987). When, on the other hand, the treatment is not causally related to a

compensable condition or the causal relation is broken by the deliberate intention of the claimant to produce an injury, harm resulting from the treatment is not compensable. See ORS 656.156(1); 656.245; 1 A. Larson, supra § 13.21 at 3-419 to 3-425.

In the present case, claimant was exposed to pesticides at work and coincidentally developed a number of symptoms. He sought medical treatment for his symptoms and some of this treatment, particularly that provided by Dr. Leveque, caused a disabling psychological reaction. If the condition for which claimant sought treatment was compensable, there would be a causal connection between a compensable injury, the treatment received and the harmful psychological effect and claimant's psychological condition would be compensable. As discussed above, however, we were unable to conclude on the record as developed that the condition for which claimant sought treatment was a compensable injury or disease. Under these circumstances, the requisite causal connection between claimant's employment and the harmful effect of the treatment he received is absent and the harmful effect is not compensable.

ORDER

The Referee's order dated February 27, 1987 is affirmed. A client-paid fee, not to exceed $150, is approved.

Board Member Crider, dissenting:

I dissent from that portion of the Board's order on reconsideration that concludes that claimant did not suffer a compensable worsening of his preexisting psychological problems, diagnosed by Dr. Holland as an anxiety-tension syndrome.

Whether or not the record establishes that claimant suffered physical injury due to toxic exposure, it establishes that claimant suffered from a long term anxiety disorder manifest by somatization -- that is, the expression of tension due to psychological stress in the form of physical symptoms. Claimant's knowledge that he had been exposed to unsafe working conditions involving exposure to pesticides was objectively stressful. Dr. Holland opined, and I would find, that this stress was the major contributing cause of an aggravation of claimant's "pre-existing emotional disequilibrium." Ex. 32-23. The medical treatment he sought after his exposure also was a factor in the worsening of his condition. Ex. 32-20, 21. Because job stress was the major contributing cause of the worsening of claimant's psychological disorder, he has suffered a compensable disease. The denial of December 19, 1985 should be set aside.

EARL M. BROWN, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-00251
February 17, 1989
Order on Reconsideration

The Board issued an Order on Review in this case on January 12, 1988. The insurer requested reconsideration of that portion of our order that set aside its denial of claimant's claim for physical and psychological effects of pesticide intoxication. Claimant requested reconsideration of that portion of our order relating to attorney fees. We abated our order on February 5, 1988. After reconsideration, we reinstate the insurer's denial. In view of this result, the attorney fee issue is moot.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of his claim for physical and

psychological effects of exposure to pesticides and subsequent medical treatment. We affirm.

ISSUE

Whether claimant sustained compensable physical or psychological effects from his exposure to pesticides or the medical treatment he subsequently received.

FINDINGS OF FACT

Claimant began working for the employer, a wholesale florist, in November 1984. The employer's facility consisted of a large, open-sided breezeway surrounded by nine greenhouses. In one corner of the breezeway was a closed office and employee break area. The employer also used the office for storage of numerous pesticides and chemicals. During the first several months of his employment, claimant performed a variety of duties in and around the greenhouses including plant propagation and transplantation and retrieving plant orders from the greenhouses for shipment. He also applied pesticides to plants on a few occasions.

In May 1985, claimant was promoted to the position of greenhouse manager. In this position, he supervised the other employees and performed a variety of administrative tasks. After the promotion, he was in the greenhouses only about 10 percent of his workday and had limited direct contact with plants.

During the spring of 1985, insect pests began to multiply in the employer's greenhouses and a number of plants also became infected with diseases. Claimant's co-workers began to spray or otherwise apply a number of carbamate and organophosphate pesticides and other chemicals to the plants in an attempt to eradicate the pests and control the diseases.

During June and July 1985, claimant began to receive complaints from the workers he was supervising of skin rashes and feeling "sick." Claimant himself contracted a rash on his hands and arms on at least one occasion and on his face on another occasion which he associated with touching plants. During the same period, claimant experienced a number of other symptoms including blurry vision in his right eye, headaches, hand tremors, nosebleeds, night sweats, nausea, abdominal cramps and diarrhea.

In late July, claimant became concerned that he and his co-workers were being exposed to pesticides and contacted the Lane County Health Department. Thereafter, a number of health agencies investigated the employer's premises. The case also generated considerable media attention. After its inspection, the Accident Prevention Division of the Workers' Compensation Department closed the employer's facility for a few days, beginning on August 1, 1985. On August 26, 1985, the Accident Prevention Division cited the employer for a number of safety violations which increased the risk of employee exposure to pesticides. The employer did not contest the citation.

Claimant did not return to work after August 1, 1985. Blood and urine samples taken the following day at the behest of the Lane County Health Department failed to reveal any chemical residue in claimant's body. A few days later, claimant visited Dr. Rice, a family practitioner, for an evaluation of his condition. Dr. Rice had no experience with pesticide intoxication and was unable to offer any opinion regarding claimant's condition.

At that point, claimant and a number of his co-workers consulted an attorney who referred them to Dr. Redfield, a specialist in occupational medicine, and Dr. Leveque, an osteopath with an interest in toxicology. Dr. Redfield evaluated claimant on August 6, 1985. He recorded complaints of muscle tremors, irritability, headaches, abdominal cramps, blurred vision in the right eye, sleep disturbance, lethargy, night sweats and morning phlegm. He then performed a physical examination and ordered lung function and blood tests. The only unusual findings from the physical examination were hand and tongue tremors and a tender spot on the back of the head. The blood tests were indicative of liver dysfunction, but were otherwise normal. The lung function test was normal. Dr. Redfield diagnosed apparent exposure to organophosphate and other pesticides with residual symptoms. He continued to see claimant periodically thereafter and monitored his liver function with blood tests.

Claimant's first meeting with Dr. Leveque occurred in mid August 1985. Dr. Leveque took no medical history from claimant and performed no physical examination. Based solely upon information received from claimant's attorney and claimant's then-current subjective complaints, he diagnosed severe organophosphate poisoning. Thereafter, for a number of months, Dr. Leveque conducted weekly group meetings with claimant and his co-workers. The meetings usually were held in claimant's attorney's office, although at least one meeting was held at a shopping mall. During these meetings, Dr. Leveque encouraged claimant and his co-workers to describe and discuss their subjective complaints. Dr. Leveque also prescribed muscle relaxers and other medications for claimant.

A short time after claimant's initial meeting with Dr. Leveque, Leveque referred him to a psychologist, Dr. Kurlychek, for psychological and neuropsychological testing. The testing was administered in two sessions, on August 26 and October 16, 1985. In a report dated October 31, 1985, Dr. Kurlychek stated that the psychological tests reflected extreme levels of anxiety regarding bodily functions. He interpreted the neuropsychological tests to show disruption of "visual-motor integration" and impairment of attention and concentration abilities. He related these problems to pesticide intoxication. He indicated that organophosphates are stored in the fatty tissues of the body and slowly dissipate over a period of several months to a year. He opined that claimant's condition would improve gradually as this occurred.

On November 14, 1985, claimant was examined by Dr. Knecht, a gastroenterologist, on referral from Dr. Redfield. The purpose of the examination was to determine the cause of the liver dysfunction indicated by earlier blood tests. Dr. Knecht conducted a physical examination and reviewed the results of the blood tests ordered by Dr. Redfield. The physical examination revealed no abnormalities. The blood tests, however, indicated that claimant's liver function had deteriorated somewhat between August and November. Dr. Knecht suggested several possible causes for claimant's liver problems including hepatitis, Wilson's disease, hemochromatosis, primary biliary cirrhosis and organophosphate poisoning. He recommended further tests to rule out some of these possibilities, but, as far as the record reflects, the tests were never conducted. Based upon the information available at the time of his report, Dr. Knecht

indicated that organophosphate poisoning was one of the least likely causes of claimant's liver dysfunction.

In November 1985, claimant was examined by Dr. Bardana, the Head of the Allergy and Immunology Division of the Department of Medicine at Oregon Health Sciences University. At the time of the examination, claimant complained of continuing problems with a number of symptoms including headaches, forgetfulness, mood swings, nosebleeds and night sweats. Dr. Bardana reviewed claimant's medical history, conducted a physical examination and ordered blood and lung function tests. Other than liver tenderness, the physical examination revealed no significant abnormalities. The blood tests confirmed the liver dysfunction identified by Drs. Redfield and Knecht. The lung function test was indicative of bronchial hyperreactivity. In reciting claimant's medical history, Dr. Bardana noted that claimant had experienced rashes as a result of contact with plants off the job as well as at work.

Based on the information received from claimant, the medical records and his own examination and tests, Dr. Bardana opined that it was doubtful that claimant had experienced any carbamate or organophosphate intoxication or contact dermatitis. He indicated that the body metabolizes carbamates and organophosphates into harmless chemicals within a few days and thus that pesticide intoxication could not be the cause of claimant's ongoing complaints. Instead, he attributed claimant's complaints to psychological causes or to some as yet undiagnosed disease process unrelated to pesticide intoxication. He suggested hepatitis, mononucleosis or excessive alcohol consumption as the cause of claimant's liver dysfunction. The insurer issued a denial of claimant's claim in December 1985.

In February 1986, claimant was examined by Dr. Bayer, the Director of the Poison Center at Oregon Health Sciences University. Dr. Bayer conducted an extensive survey of the literature regarding carbamate and organophosphate intoxication and noted that claimant had reported and continued to complain of certain symptoms uncommon to such intoxication. Like Dr. Bardana, Dr. Bayer indicated that carbamates and organophosphates are rapidly metabolized and eliminated from the body. In view of these facts, claimant's limited exposure to pesticides and the absence of any past or present indication of pesticide residue in claimant's body, he opined that claimant's complaints were not due to pesticide intoxication.

In March 1986, claimant was examined by a psychiatrist, Dr. Holland. Dr. Holland obtained a detailed history and administered a number of psychological tests which revealed that claimant was anxious and agitated. He found no evidence of ongoing carbamate or organophosphate intoxication. He diagnosed an adjustment disorder with mixed emotional features and alcohol dependence. Regarding the cause of claimant's adjustment disorder, Dr. Holland indicated that it represented a psychological reaction to a belief, induced by medical opinions, that he had been severely damaged through exposure to pesticides.

Claimant timely requested a hearing on the insurer's denial. Three of claimant's co-workers also requested hearings on denials or partial denials of their claims. An initial hearing session was held in one of these cases before Referee Garaventa on

April 7, 1986. All four requests for hearing were later consolidated and three hearing sessions were held by Referee Myers, on September 23 and 24, 1986 and January 7, 1987. Eight lay witnesses and three medical professionals testified in the sessions held by Referee Myers. The parties stipulated that the relevant portions of Dr. Bayer's testimony in the hearing before Referee Garaventa should be made part of the record in the present case.

Before claimant left work on August 1, 1985, he drank up to 12 cans of beer and 2 or 3 mixed drinks per week. After leaving work, claimant drank up to 12 cans of beer per day. He experienced his worst symptoms during December 1985. (Tr. 76). Claimant has been in a number of fist fights during his lifetime and has been knocked unconscious several times.

FINDINGS OF ULTIMATE FACT

Claimant did not experience physical or psychological effects of exposure to pesticides which were disabling or required medical services. The medical treatment claimant received after he left work was a material contributing cause of a worsening of his psychological condition.

CONCLUSIONS OF LAW

Claimant raises both accidental injury and occupational disease theories of compensability for alleged physical and psychological effects of exposure to pesticides. Under either theory, claimant has the burden of proving some physical or psychological harm as a result of the exposure which resulted in disability or required medical services. See Brown v. SAIF, 79 Or App 205, 209, rev den 301 Or 666 (1986).

Claimant alleges that he experienced a number of physical effects from exposure to pesticides. This allegation finds some support in the opinions of Drs. Redfield, Leveque and Kurlychek. It is disputed by Drs. Bardana and Bayer and, with regard to claimant's liver dysfunction, by Dr. Knecht. Our conclusion on this question, therefore, turns upon which group of opinions we accept.

The persuasiveness of a medical opinion depends upon three basic factors: the source of the opinion, its factual basis and its logical force. The source of the opinion has reference to the expertise and objectivity of the one giving it. See Abbott v. SAIF, 45 Or App 657, 661 (1980). The factual basis of the opinion relates to the completeness and correctness of the information upon which it is based. See Somers v. SAIF, 77 Or App 259, 263 (1986). The logical force of the opinion concerns the depth, clarity and cogency of the analysis. See id.

Drs. Bardana and Bayer both have considerable expertise in the field of toxicology. Their opinions are based upon detailed histories, complete physical examinations and a number of objective tests. Their understanding of the nature of carbamate and organophosphate chemicals and of the effects of these chemicals upon the human body find considerable support in the medical literature. Their opinions are thoroughly and clearly explained. Dr. Knecht has considerable expertise in evaluating liver function, although his expertise in toxicology is not reflected in the record. His opinion is based upon a thorough

physical examination and the results of a series of blood tests ordered by Dr. Redfield.

The opinion of Dr. Redfield was preceded by a thorough physical examination and a number of objective tests. He specializes in occupational medicine, but his expertise in toxicology is not reflected in the record. His opinion is equivocal and poorly explained. Dr. Leveque is an osteopath. He has considerable interest in toxicology, but his expertise in that field is questionable. His understanding of the nature of carbamate and organophosphate chemicals and their effect upon the human body finds little or no support in the medical literature. His opinion was based upon claimant's subjective complaints. He conducted no physical examination of claimant and obtained no medical history from him. His opinion is poorly explained. Dr. Kurlychek is a psychologist. His expertise in toxicology is not reflected in the record, but his understanding of the nature and effects of carbamate and organophosphate chemicals was similar to that of Dr. Leveque. His opinion was based upon a battery of psychological and neuropsychological tests, but was poorly explained. In particular, he failed to discuss the potential role of claimant's liver disorder, his alcohol consumption or his past head injuries in the deficits he identified.

In view of the above analysis and our evaluation of the various opinions rendered in this case, we conclude that the opinions of Drs. Bardana, Bayer and Knecht are more persuasive than those of Drs. Redfield, Leveque and Kurlychek and thus that the medical evidence fails to establish any physical effects from pesticide exposure.

As for claimant's opinion regarding the cause of his complaints, his expertise in the field of toxicology is very limited and the question of what caused his symptoms is a complex one. His opinion, therefore, is of little probative value. The only relatively simple physical symptom which claimant identified with contact with plants was the rash he sustained on his face, hands and arms. Dr. Bardana noted, however, that claimant had experienced rashes from contact with plants off the job as well as at work and opined that the rash was not caused by exposure to pesticides. We find Dr. Bardana's professional opinion regarding the cause of the rash more convincing than claimant's lay opinion.

Turning to the question of whether claimant sustained compensable psychological effects from his exposure to pesticides, claimant presents two theories. First, he contends that his condition was caused by stress associated with his exposure to pesticides at work. Second, he contends that his condition was caused by the medical treatment he sought as a result of his exposure to pesticides.

Other than some general statements by Drs. Bayer and Bardana regarding the possibility of "mass hysteria," claimant's first theory finds no support in the medical record. The theory involves medical issues which are sufficiently complex that we cannot decide them without adequate professional assistance. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965). In view of the poor development of the record on this issue, we are unable to conclude that claimant established a compensable psychological condition under his first theory.

Regarding the second theory, Dr. Holland opined that the

medical treatment that claimant received after he left work was at least a material contributing cause of a worsening of his psychological condition. There are no contrary opinions. The insurer contends, however, that the medical treatment that worsened claimant's psychological condition was not reasonable and necessary and cannot give rise to compensable consequences for that reason. We conclude that claimant's psychological condition is not compensable for other reasons.

As a general rule, a carrier is responsible for harmful effects of medical treatment if there is a material causal connection between the treatment and a compensable condition. Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985); see 1 A. Larson, The Law of Workmen's Compensation § 13.21 (1985). This standard is the same regardless of whether the compensable condition for which treatment is sought is an injury or an occupational disease. See Janice G. Thon, 40 Van Natta 606, 607 (1988); see also Jeld-Wen, Inc. v. Page, 73 Or App 136, 138-39 (1985). Treatment may be unreasonable, unnecessary or excessive from a medical standpoint or may be negligently or otherwise tortiously performed and still be causally related to a compensable condition. In such cases, the causal connection between the compensable condition, the improper or tortious treatment and the harmful effect of the treatment remains intact. When this occurs, the harmful effect is compensable even if the treatment which caused it is not. See 1 A. Larson, supra § 13.21 at 3-415 & n.84 (1985 & Supp 1988); Gray v. Church's Fried Chicken, Inc., 504 So. 2d 979, 981-82 (La. App. 1987). When, on the other hand, the treatment is not causally related to a compensable condition or the causal relation is broken by the deliberate intention of the claimant to produce an injury, harm resulting from the treatment is not compensable. See ORS 656.156(1); 656.245; 1 A. Larson, supra § 13.21 at 3-419 to 3-425.

In the present case, claimant was exposed to pesticides at work and coincidentally developed a number of symptoms. He sought medical treatment for his symptoms and some of this treatment, particularly that provided by Dr. Leveque, caused a disabling psychological reaction. If the condition for which claimant sought treatment was compensable, there would be a causal connection between a compensable injury, the treatment received and the harmful psychological effect and claimant's psychological condition would be compensable. As discussed above, however, we were unable to conclude on the record as developed that the condition for which claimant sought treatment was a compensable injury or disease. Under these circumstances, the requisite causal connection between claimant's employment and the harmful effect of the treatment he received is absent and the harmful effect is not compensable.

ORDER

The Referee's order dated February 27, 1987 is affirmed. A client-paid fee, not to exceed $172.50, is approved.

Board Member Crider, dissenting:

I dissent from the Board's order on reconsideration. I would adhere to the Board's original order in which we concluded that claimant suffered transient physical injury due to pesticide exposure and, as a consequence of the treatment, developed a psychological condition. Both are compensable.

The majority relies on Dr. Bardana's opinion to conclude that claimant suffered no physical effects of pesticide exposure. It declines to rely on clamant's testimony because claimant is not an expert in toxicology. Under the circumstances, claimant's testimony is entitled to greater weight -- his lack of expertise notwithstanding. The record as a whole establishes that claimant did suffer a rash, a material cause of which was pesticide exposure.

Claimant was exposed to pesticides while working for the insured as a greenhouse manager. During a period of intense pesticide use, a number of employees developed rashes. Claimant himself picked up a plant in a greenhouse still wet with spray and immediately developed a rash. He self-treated and the rash went away within a few days.

There is no doubt that the pesticides to which claimant was exposed are capable of causing a rash. Therefore, I am more persuaded by claimant's own testimony of the immediate effect of exposure than by Dr. Bardana's conclusory opinion that it is "doubtful" that claimant suffered from a dermatitis due to the exposure. Dr. Bardana examined claimant long after the rash had disappeared. His examination and his opinion were addressed more to the possibility of residual effects of the exposure than to its transient effects. It appears that he was unwilling to find any toxic effect because he felt claimant's history "improbable." We are also in position to evaluate claimant's credibility; finding credible his testimony concerning the immediate effect of contact with a plant, I would find his claim compensable.

If, as I suggest, claimant suffered transient toxic effects from pesticide exposure which are compensable, it follows that the worsening of claimant's psychological condition, which the majority finds to have resulted from the medical services claimant sought due to his exposure, is also compensable. Terry L. Link, 41 Van Natta 297 (Issued this date); Barbara D. Olinghouse, 41 Van Natta 303 (Issued this date). Because the majority upholds the denial, I dissent.

RICK J. FAWVER, Claimant
Vick & Gutzler, Claimant's Attorneys
Edward C. Olson, Defense Attorney
Stafford Hazelett, Defense Attorney

WCB 88-04829 & 88-03894
February 17, 1989
Second Order Dismissing Request for Board Review and Directing Republication of Referee's Order (Remanding)

It has come to our attention that our October 7, 1988 Order Dismissing Request for Board Review and Directing Republication of Referee's Order (Remanding) failed to list LWO Corporation, Liberty Northwest's insured, as a party of interest to these proceedings. Inasmuch as our order was not mailed to all parties in interest, it is not final. ORS 656.289(2), (3); Martin N. Manning, 40 Van Natta 374 (1988).

Consequently, the Referee lacked jurisdiction to issue his October 24, 1988 Opinion and Order on Remand and all subsequent actions concerning this case have been null and void. Instead, jurisdiction over this matter has remained with the Board.

To correct this oversight, all our prior orders are withdrawn. In their place, we issue this corrected order, which

adheres to and republishes our October 7, 1988 order in its entirety, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

LIBRADO GARAY, Claimant
Robert Chapman, Claimant's Attorney
Terri Borchers, Assistant Attorney General

WCB 87-10175
February 17, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Quillinan's order which dismissed his hearing request for a right shoulder injury claim on the basis of lack of jurisdiction. On review, the issue is jurisdiction, and alternatively, compensability. We agree that the Referee lacked jurisdiction, but for reasons other than those expressed by the Referee.

FINDINGS OF FACT

Claimant was injured on or about April 24, 1987 allegedly while working as a tree planter for the employer. The diagnosis was a rotator cuff injury to the right shoulder.

Claimant advised the employer of his injury in May 1987 and was directed to file a Washington claim. Claimant filed the Washington claim on May 18, 1987. The Washington claim was denied on the basis that claimant was an Oregon worker. Claimant requested reconsideration of Washington's decision and, at the time of the hearing, that request was still pending.

On June 22, 1987, claimant filed a request for hearing, a copy of which was sent to the employer. The same day, claimant's counsel submitted the Washington claim form, along with a request for investigation into the employer's status, to the Workers' Compensation Department, Compliance Division. At the time of hearing, there was no evidence that such an investigation had yet been undertaken.

FINDINGS OF ULTIMATE FACT

The request for hearing was filed less than 60 days after the employer had notice or knowledge of claimant's injury claim.

CONCLUSIONS OF LAW

The Referee dismissed claimant's injury claim on the basis that claimant's Washington claim form did not constitute sufficient notice to the employer that there was a possible claim under Oregon law. We disagree. ORS 656.265(2) provides:

> "The notice need not be in any particular form. However, it shall be in writing and shall apprise the employer when and where and how an injury has occurred to a worker. A report or statement secured from a worker, or from the doctor of the worker and signed by the worker, concerning an accident which may involve a compensable

injury shall be considered notice from the worker and the employer shall forthwith furnish the worker a copy of any such report or statement."

The Washington claim form advised the employer that claimant had sustained an injury while working in Oregon. Under these circumstances, we find that the employer was put on notice that claimant had sustained an injury that could come within Oregon's workers' compensation law.

We further note that the Referee was concerned as to the progress of the Compliance Division's investigation into the employer's status. We have previously held, however, that the issue of noncompliance is generally not necessary to the decision of compensability. Henry C. Adovnik, 36 Van Natta 14 (1984). Whether the employer is complying can be established by a separate order of the Director under ORS 656.052(2), and is not essential to the decision of compensability. Id. at 15. It is a necessary issue, only when the question of coverage is raised as a defense to a claim for compensation. Wilfred L. Speckman, 40 Van Natta 2076, 2080 (1988).

Although we have concluded that the employer did have knowledge of a possible Oregon claim, we find that the Referee was without jurisdiction to hear the claim on the basis the claimant's request for hearing was prematurely filed.

ORS 656.262(6) allows an employer/insurer 60 days in which to accept or deny a claim after it has notice or knowledge of the claim. A claim is deemed denied "de facto" after expiration of the 60-day period, if the employer/insurer has not accepted or denied it. Syphers v. K-W Logging Inc., 51 Or App 769 rev den 291 Or 151 (1981). A premature request for hearing on the issue or whether a claim should be accepted is ineffective and void. Syphers v. K-W Logging, Inc., supra; see also Barr v. EBI Companies, 88 Or App 132 (1987).

In the present case, the employer received knowledge of the alleged compensable injury in early May 1987, through a phone call by claimant's wife. The claim itself was filed on May 18, 1987. The request for hearing was filed on June 22, 1987. Even assuming the employer had knoweldge of the claim as of May 1, 1987, the 60-day period had not expired by June 22, 1987, when claimant requested a hearing. In light of this, the request for hearing was premature, therefore ineffective and void. Syphers v. K-W Logging Inc., supra.

ORDER

The Referee's order dated October 1, 1987 is affirmed.

The Board issued an Order on Review in this case on January 12, 1988. The insurer requested reconsideration of that portion of our order that set aside its "de facto" partial denial relating to claimant's psychological condition. Claimant requested reconsideration of that portion of our order relating to attorney fees. We abated our order on February 5, 1988. After reconsideration, we adhere to that portion of our order relating to the insurer's denial of claimant's psychological condition. We modify that portion of our order relating to attorney fees.

Claimant requests review of Referee Myers' order that upheld the insurer's partial denials relating to physical and psychological effects of exposure to pesticides and subsequent medical treatment.

ISSUES

1. Whether claimant continued to experience physical effects of pesticide intoxication after April 8, 1986.

2. Whether claimant sustained compensable psychological effects from his exposure to pesticides or the treatment he received for his physical condition.

3. The amount of the attorney fee to be awarded claimant's attorney for services rendered at the hearing and Board review levels.

FINDINGS OF FACT

Claimant began working for the employer, a wholesale florist, in March 1985. The employer's facility consisted of a large, open-sided breezeway surrounded by nine greenhouses. In one corner of the breezeway was a closed office and employee break area. The employer also used the office for storage of numerous pesticides and chemicals. During the first couple of months of his employment, claimant performed a variety of duties in and around the greenhouses including watering, pruning, repotting and cleaning plants and retrieving plant orders from the greenhouses for shipment. After that, the employer selected claimant to fill a position vacated by a co-worker. In this position, claimant spent several hours two or three times per week spraying or otherwise applying pesticides in the employer's greenhouses. While doing this, claimant wore protective clothing over most of his body. The clothing was tattered in places, however, and leaked.

During the spring of 1985, insect pests began to multiply in the employer's greenhouses and a number of plants also became infected with diseases. Claimant sprayed or otherwise applied a number of carbamate and organophosphate pesticides and other chemicals to the plants in an attempt to eradicate the pests and control the diseases. During June 1985, claimant noticed a rash developing on his hands and feet. Over the next several weeks he began to experience other symptoms including shortness of breath, headaches, lethargy, forgetfulness, mood swings, nausea, abdominal cramps, blurred vision, muscle tremors and excessive

perspiration. By the end of July 1985, several of claimant's co-workers were complaining of symptoms similar to those he was experiencing and health officials inspected the employer's premises. After its inspection, the Accident Prevention Division of the Workers' Compensation Department cited the employer for a number of safety violations which increased the risk of employee exposure to pesticides. The employer did not contest the citation.

Claimant left work on August 1, 1985. Blood and urine samples taken the following day at the behest of the Lane County Health Department failed to reveal any chemical residue in claimant's body. A few days later, claimant visited Dr. Church, a family practitioner, for an evaluation of his complaints. Dr. Church recorded claimant's subjective complaints and diagnosed "symptoms consistent with organophosphate poisoning." She recommended that claimant avoid further exposure to pesticides.

At that point, claimant and a number of his co-workers consulted an attorney who referred them to Dr. Redfield, a specialist in occupational medicine, and Dr. Leveque, an osteopath with an interest in toxicology. Dr. Redfield evaluated claimant on August 9, 1985. He performed a physical examination and ordered lung function and blood tests. During the physical examination, Dr. Redfield noted small healing sores on claimant's hands and feet, excessive perspiration, rhinorrhea and mild wheezing. The blood tests revealed no significant abnormalities. The lung function test reflected an obstructive lung defect. Dr. Redfield diagnosed apparent exposure to organophosphate and other pesticides with residual symptoms.

Claimant's first meeting with Dr. Leveque occurred on August 14, 1985. Dr. Leveque took no medical history from claimant and, other than a cursory examination of the sores on claimant's hands and a blood pressure check, performed no physical examination. Based solely upon information received from claimant's attorney and claimant's then-current subjective complaints, he diagnosed severe organophosphate poisoning. Thereafter, for a number of months, Dr. Leveque conducted weekly group meetings with claimant and his co-workers. The meetings usually were held in claimant's attorney's office, although at least one meeting was held at a shopping mall. During these meetings, Dr. Leveque encouraged claimant and his co-workers to describe and discuss their subjective complaints. Dr. Leveque also prescribed muscle relaxant, tranquilizing and antidepressant medications for claimant.

A short time after claimant's initial meeting with Dr. Leveque, Leveque referred him to a psychologist, Dr. Kurlychek, for psychological and neuropsychological testing. The testing was administered in two sessions, on August 20 and September 24, 1985. In a report dated October 22, 1985, Dr. Kurlychek reported that the psychological tests reflected extreme levels of anxiety regarding bodily functions. He interpreted the neuropsychological tests to show disruption of cognitive abilities and impairment of fine motor coordination. He related these problems to pesticide intoxication. He indicated that organophosphates are stored in the fatty tissues of the body and slowly dissipate over a period of several months to a year. He opined that claimant's condition would improve gradually as this occurred.

On September 17, 1985, claimant was examined by Dr. Jones, an asthma and allergy specialist, on referral from Dr. Redfield. Dr. Jones recorded a history for claimant of seasonal asthma and allergic rhinitis since early childhood. Claimant received immunotherapy (allergy shots) for nine years, beginning when he was eight years old. After that, his condition was controlled with prescription inhalant medications. He was 19 years old at the time of Dr. Jones' examination. Dr. Jones performed sensitivity tests by skin prick technique which revealed an extreme reaction to grass pollen, considerable reactions to weed pollen, tree pollen, mold spores and dog and cat dander and a small reaction to house dust. He noted that claimant had two cats. Given this information, Dr. Jones diagnosed a flare-up of claimant's longstanding asthma and allergic rhinitis. He was unable to give an opinion regarding whether the pesticides to which claimant was exposed at work played any role in generating the flare-up. Dr. Jones later prescribed corticosteroid and other medications for claimant's condition.

In November 1985, claimant was examined by Dr. Bardana, the Head of the Allergy and Immunology Division of the Department of Medicine at Oregon Health Sciences University. At the time of the examination, claimant complained of continuing problems with shortness of breath, lethargy, forgetfulness and mood swings. Dr. Bardana reviewed claimant's medical history, conducted a physical examination and ordered blood and lung function tests. The physical examination was normal. The blood tests confirmed the allergies identified by Dr. Jones, but otherwise revealed no significant abnormalities. The lung function test indicated the presence of asthma. Based on the history received from claimant, Dr. Bardana opined that he had sustained "probable acute, transient carbamate/organophosphate intoxication." He did not think any of claimant's ongoing symptoms were due to pesticide residue in his body. He indicated that the body metabolizes carbamates and organophosphates into harmless chemicals within a few days and thus that pesticide residue could not be the cause of claimant's ongoing complaints. Instead, he attributed claimant's ongoing complaints to allergies and psychological causes.

In January 1986, the insurer notified claimant that it was accepting his claim for "acute, transient carbamate/organophosphate intoxication." It deferred acceptance or denial of any psychological condition pending examination of claimant by a psychiatrist.

In February 1986, claimant was examined by Dr. Bayer, the Director of the Poison Center at Oregon Health Sciences University. Dr. Bayer noted that many of the symptoms which claimant had experienced were typical of pesticide intoxication, except for their duration. He thought it was possible that claimant had experienced transient pesticide intoxication. Like Dr. Bardana, however, he indicated that carbamates and organophosphates are rapidly metabolized and eliminated from the body. In view of this fact, the absence of any indication of pesticide residue in claimant's body, claimant's medical history and personality profile, he opined that claimant's ongoing complaints were due to allergies, asthma and psychological factors, rather than pesticide intoxication.

Dr. Bardana revised his prior report in late February 1986 and opined that transient carbamate/organophosphate poisoning in claimant's case was only "possible" rather than "probable."

In March 1986, claimant was examined by a psychiatrist, Dr. Holland. Dr. Holland obtained a detailed history and administered tests which he interpreted to show dependent personality characteristics and a preoccupation with physical symptoms and problems. He found no evidence of chronic carbamate or organophosphate intoxication. He diagnosed atypical somatoform disorder which he described as a fixation upon the workings of the body, accompanied by subjective complaints without objective support. He also thought that some of claimant's complaints regarding mood swings could relate to the corticosteroid medication prescribed by Dr. Jones. Regarding the cause of claimant's atypical somatoform disorder, Dr. Holland indicated that the disorder represented a symptomatic exacerbation of preexisting personality traits induced by medical opinions to the effect that he had been severely damaged through exposure to pesticides.

On April 8, 1986, the insurer issued a partial denial relating to claimant's allergy and asthma conditions. On April 24, 1986, claimant's claim was closed by Determination Order with no award of permanent partial disability.

Claimant timely requested a hearing on the insurer's partial denial. Three of claimant's co-workers also requested hearings on denials or partial denials of their claims. An initial hearing session was held in one of these cases before Referee Garaventa on April 7, 1986. All four requests for hearing were later consolidated and three hearing sessions were held by Referee Myers, on September 23 and 24, 1986 and January 7, 1987. Eight lay witnesses and three medical professionals testified in the sessions held by Referee Myers. The parties stipulated that the relevant portions of Dr. Bayer's testimony in the hearing before Referee Garaventa should be made part of the record in the present case. The insurer received a copy of the report authored by Dr. Holland a short time after it was written, but never issued a formal partial denial regarding the psychological condition he diagnosed. The compensability of the condition, however, was litigated at the hearing.

FINDINGS OF ULTIMATE FACT

1. Claimant did not continue to experience physical effects of pesticide intoxication after April 8, 1986.

2. The medical treatment claimant received for his compensable condition was a material contributing cause of a worsening of his psychological condition.

CONCLUSIONS OF LAW

1. The Partial Denial Relating to Claimant's Physical Condition

To prevail against the insurer's partial denial relating to his physical condition, claimant has the burden of proving that his exposure to pesticides at work continued to be a material contributing cause of his disability or need for medical services after April 8, 1986, the date of the denial. See Lobato v. SAIF, 75 Or App 488, 492 (1985); see also Barrett v. D & H Drywall, 300 Or 325 (1985), clarified, 300 Or 553 (1986); Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

The only opinions which would support the conclusion that claimant continued to experience physical effects from his exposure to pesticides after April 8, 1986 are those of Drs. Kurlychek and Leveque. Drs. Kurlychek and Leveque both thought that carbamate and organophosphate chemicals may be stored in the body for up to a year after exposure. Given this premise, they opined that claimant's ongoing complaints were due in material part to chemical residues in his body. Dr. Leveque also opined that claimant's exposure to pesticides had caused permanent brain or nerve damage which contributed to his symptoms.

The idea that residues of carbamates or organophosphates may be stored in the human body for up to a year was disputed by Drs. Bardana and Bayer. They stated that such residues are rapidly metabolized and eliminated from the body within a few days or weeks at the most. These statements regarding the properties of carbamates and organophosphates were fully explained in their reports and testimony and were based on their expertise in the field of toxicology. The statements of Drs. Kurlychek and Leveque on the subject were not well explained and their expertise in the field of toxicology was not as great as that of Drs. Bardana and Bayer. In addition, none of the blood or urine tests taken after claimant left work revealed any chemical residue in his body. For these reasons, we conclude that claimant has failed to prove that he continued to experience physical symptoms after April 8, 1986 due to pesticide intoxication.

Dr. Leveque's opinion that claimant's exposure to pesticides had resulted in permanent brain or nerve damage is similarly deficient. The opinion was unsupported by objective evidence, was poorly explained and was outside Dr. Leveque's area of expertise. It was also disputed by Dr. Bayer. (Tr. 80-82, Garaventa Hearing). Given this record, we conclude that claimant has failed to prove any physical damage to his nervous system from pesticide exposure.

2. The Partial Denial Relating to Claimant's Psychological Condition

Claimant presents two theories for the compensability of his psychological condition. First, he contends that his condition was caused by stress associated with his exposure to pesticides at work. Second, he contends that his condition was caused by the medical treatment he sought as a result of his exposure to pesticides. The Referee rejected both theories. We conclude that claimant's psychological condition is compensable under the second theory. In view of this, we do not address the first theory.

Dr. Holland opined that the medical treatment that claimant received after he left work was at least a material contributing cause of a worsening of his psychological condition. There are no contrary opinions. The insurer contends that the medical treatment that worsened claimant's psychological condition was not reasonable and necessary and cannot give rise to compensable consequences for that reason.

As a general rule, a carrier is responsible for harmful effects of medical treatment if there is a material causal connection between the treatment and a compensable condition.

Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985); see 1 A. Larson, The Law of Workmen's Compensation § 13.21 (1985). This standard is the same regardless of whether the compensable condition for which treatment is sought is an injury or an occupational disease. See Janice G. Thon, 40 Van Natta 606, 607 (1988); see also Jeld-Wen, Inc. v. Page, 73 Or App 136, 138-39 (1985). Treatment may be unreasonable, unnecessary or excessive from a medical standpoint or may be negligently or otherwise tortiously performed and still be causally related to a compensable condition. In such cases, the causal connection between the compensable condition, the improper or tortious treatment and the harmful effect of the treatment remains intact. When this occurs, the harmful effect is compensable even if the treatment which caused it is not. See 1 A. Larson, supra § 13.21 at 3-415 & n.84 (1985 & Supp 1988); Gray v. Church's Fried Chicken, Inc., 504 So. 2d 979, 981-82 (La. App. 1987). When, on the other hand, the treatment is not causally related to a compensable condition or the causal relation is broken by the deliberate intention of the claimant to produce an injury, harm resulting from the treatment is not compensable. See ORS 656.156(1); 656.245; 1 A. Larson, supra § 13.21 at 3-419 to 3-425.

In the present case, claimant was exposed to pesticides at work and developed a number of symptoms. These symptoms were accepted as a compensable occupational disease by the insurer and the causal connection between them and the compensable condition cannot now be denied absent evidence of fraud, misrepresentation or other illegal activity on the part of claimant. Bauman v. SAIF, 295 Or 788 (1985). There is no such evidence in this case. Claimant sought medical treatment for his compensable condition from licensed physicians. Some of this treatment, particularly that provided by Dr. Leveque, caused a worsening of his psychological condition. There is no suggestion in the record that claimant sought treatment from Dr. Leveque or any other doctor in order to injure himself. The causal connection between claimant's compensable condition, the treatment he received and the harmful psychological effect, therefore, remains intact. Under these circumstances, the harmful effect is compensable irrespective of whether the treatment claimant received was reasonable and necessary and the insurer's "de facto" partial denial relating to claimant's psychological condition must be set aside.

3. Attorney Fees

Claimant's attorney is entitled to an attorney fee for services rendered at the Board and hearing levels for prevailing against the insurer's partial denial. ORS 656.386(1). The statement of services submitted by claimant's attorney reflects a total of 106 hours of attorney time and 5 hours of paralegal time. The names of the claimants in all four of the cases consolidated for the hearing before Referee Myers are listed at the top of the statement. An identical statement was submitted in connection with the other three cases. Under these circumstances, we understand the statement of services to reflect the total number of hours expended in all four cases rather than those expended just in the present case. We award a fee in accordance with this understanding and in accordance with the factors enumerated in OAR 438-15-010(6).

ORDER

The Referee's order dated February 27, 1987 is reversed in part. That portion of the Referee's order that upheld the insurer's "de facto" partial denial relating to claimant's psychological condition is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a total fee of $3,170 for services at the hearing and on Board review, to be paid by the insurer. A client-paid fee, not to exceed $150, is approved.

BARBARA D. OLINGHOUSE, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-01750
February 17, 1989
Order on Reconsideration

The Board issued an Order on Review in this case on January 12, 1988. The insurer requested reconsideration of that portion of our order that set aside its partial denial relating to claimant's psychological condition. Claimant requested reconsideration of that portion of our order relating to attorney fees. We abated our order on February 5, 1988. After reconsideration, we adhere to that portion of our order relating to the insurer's denial of claimant's psychological condition. We modify that portion of our order relating to attorney fees.

Claimant requests review of Referee Myers' order that upheld the insurer's partial denials relating to physical and psychological effects of exposure to pesticides and subsequent medical treatment.

ISSUES

1. Whether claimant continued to experience physical effects of pesticide intoxication after June 13, 1986.

2. Whether claimant sustained compensable psychological effects from her exposure to pesticides or the treatment she received for her physical condition.

3. The amount of the attorney fee to be awarded claimant's attorney for services rendered at the hearing and Board review levels.

FINDINGS OF FACT

Claimant began working for the employer, a wholesale florist, in March 1984. The employer's facility consisted of a large, open-sided breezeway surrounded by nine greenhouses. In one corner of the breezeway was a closed office and employee break area. The employer also used the office for storage of numerous pesticides and chemicals. Claimant performed a variety of duties in and around the greenhouses including plant propagation, transplantation, fertilization and cleaning. She also retrieved plant orders from the greenhouses for shipment.

Within a few months of beginning her employment, claimant developed a rash on her chest, arms and neck. She sought treatment from her family doctor, Dr. Church, who prescribed medications. The rash cleared up temporarily and then reappeared. In January or February 1985, Dr. Church referred claimant to a dermatologist, Dr. Mohajerin. Dr. Mohajerin

diagnosed contact dermatitis and opined that it was related to claimant's work. He prescribed additional medications and took claimant off work for a few days and the rash again cleared up.

During the spring of 1985, insect pests began to multiply in the employer's greenhouses and a number of plants also became infected with diseases. Claimant's co-workers sprayed or otherwise applied a number of carbamate and organophosphate pesticides and other chemicals to the plants in an attempt to eradicate the pests and control the diseases. During this period, claimant worked in the greenhouses soon after pesticides had been applied and sometimes handled plants which were wet with pesticide spray. Other than rubber gloves, claimant wore no protective gear.

Early in the summer of 1985, claimant's skin rash returned, but she was able to control it with the medication prescribed by Dr. Mohajerin. She also began to experience a number of other symptoms including shortness of breath, headaches, lethargy, forgetfulness, mood swings, nausea, abdominal cramps, diarrhea, muscle weakness and excessive perspiration. Her symptoms intensified one Saturday in late July after she worked in a greenhouse around plants that had been sprayed the previous day with an organophosphate pesticide.

By the end of July 1985, several of claimant's co-workers were complaining of symptoms similar to those she was experiencing and health officials inspected the employer's premises. After its inspection, the Accident Prevention Division of the Workers' Compensation Department cited the employer for a number of safety violations which increased the risk of employee exposure to pesticides. The employer did not contest the citation.

Claimant left work on August 1, 1985. Blood and urine samples taken the following day at the behest of the Lane County Health Department failed to reveal any chemical residue in claimant's body. A few days later, claimant visited Dr. Church for an evaluation of her complaints. Dr. Church found little or nothing objectively wrong with claimant, but diagnosed "multiple symptoms probably related to pesticide exposure."

At that point, claimant and a number of her co-workers consulted an attorney who referred them to Dr. Redfield, a specialist in occupational medicine, and Dr. Leveque, an osteopath with an interest in toxicology. Dr. Redfield evaluated claimant on August 13, 1985. He took a complete medical history, performed a physical examination and ordered pulmonary function and blood tests. None of these procedures revealed any significant abnormalities, but based on claimant's subjective complaints Dr. Redfield diagnosed apparent exposure to organophosphate and other pesticides with residual symptoms.

Claimant's first meeting with Dr. Leveque occurred sometime during mid August 1985. Dr. Leveque conducted no physical examination of claimant and took no medical history. Based solely upon information received from claimant's attorney and claimant's then-current subjective complaints, he diagnosed severe organophosphate poisoning. Thereafter, for a number of months, Dr. Leveque conducted weekly group meetings with claimant and her co-workers. The meetings usually were held in claimant's attorney's office, although at least one meeting was held at a shopping mall. During these meetings, Dr. Leveque encouraged claimant and her co-workers to describe and discuss their

subjective complaints. Dr. Leveque prescribed antispasmodic and antidiarrheal medications for claimant's stomach and intestinal tract.

A short time after claimant's initial meeting with Dr. Leveque, Leveque referred her to a psychologist, Dr. Kurlychek, for psychological and neuropsychological testing. The testing was administered in two sessions, on August 19 and September 19, 1985. In a report dated October 22, 1985, Dr. Kurlychek reported that the psychological tests reflected moderate levels of depression and anxiety. He interpreted the neuropsychological tests to show impairment of fine motor coordination and disruption of attention and concentration abilities. Regarding the cause of these problems, Dr. Kurlychek indicated that organophosphates are stored in the fatty tissues of the body and slowly dissipate over a period of several months to a year. He opined that claimant's condition would improve gradually as this occurred.

In November 1985, claimant was examined by Dr. Bardana, the Head of the Allergy and Immunology Division of the Department of Medicine at Oregon Health Sciences University. At the time of the examination, claimant complained of continuing problems with headaches, lethargy, forgetfulness, mood swings, abdominal cramps and diarrhea. Dr. Bardana reviewed claimant's medical history, conducted a physical examination and ordered blood and lung function tests. Except for the lung function test, which indicated the presence of mild obstructive airways disease, none of these procedures revealed any abnormalities. Based on the history received from claimant, Dr. Bardana opined that she had sustained contact dermatitis and "probable acute, transient carbamate/organophosphate intoxication." He did not think any of claimant's ongoing symptoms were due to pesticide residue in her body. He indicated that the body metabolizes carbamates and organophosphates into harmless chemicals within a few days and thus that pesticide residue could not be the cause of claimant's ongoing complaints. He attributed claimant's decreased lung function to cigarette smoking and her various ongoing complaints to psychological causes.

In January 1986, the insurer notified claimant that it was accepting her claim for "acute, transient carbamate/organophosphate intoxication" and "contact dermatitis." It deferred acceptance or denial of any psychological condition pending examination of claimant by a psychiatrist.

In February 1986, claimant was examined by Dr. Bayer, the Director of the Poison Center at Oregon Health Sciences University. Dr. Bayer conducted an extensive survey of the literature regarding carbamate and organophosphate poisoning and noted that claimant had not reported certain symptoms common to such poisoning. Based upon the absence of these symptoms, Dr. Bayer opined that claimant had not experienced systemic carbamate or organophosphate poisoning. He did think, however, that she had sustained contact dermatitis as a result of her pesticide exposure. Like Dr. Bardana, he attributed claimant's various ongoing complaints to psychological causes.

Dr. Bardana revised his prior report in late February 1986 and opined that transient carbamate/organophosphate poisoning in claimant's case was only "possible" rather than "probable."

In April 1986, claimant was examined by a psychiatrist, Dr. Holland. In reviewing claimant's medical history, Dr. Holland noted that claimant had experienced difficulties with ulcers in the 1960's and early 1970's and had experienced depression and anxiety in connection with the death of her husband in 1974 and the death of her son in 1983. Dr. Holland also administered psychological tests which he interpreted to show a propensity toward "psychophysiologic reactions." He found no evidence of chronic carbamate or organophosphate intoxication. Given these facts, Dr. Holland diagnosed a preexisting psychological condition characterized by "extreme suggestibility" or hypochondriasis and opined that this condition had "interacted with the medical and legal advise [sic] she ha[d] received" to produce her ongoing complaints.

On May 15, 1986, the insurer issued a partial denial relating to the psychological problems diagnosed by Dr. Holland. On May 23, 1986, claimant's claim was closed by Determination Order with no award of permanent partial disability. On June 13, 1986, the insurer issued a second partial denial. This denial disputed any causal relation between claimant's ongoing complaints and the accepted claim for contact dermatitis and acute, transient carbamate or organophosphate intoxication.

Claimant was examined by a second psychiatrist, Dr. Radmore, on several occasions in June and July 1986. Dr. Radmore agreed with Dr. Holland that many of claimant's ongoing symptoms were more characteristic of a psychological reaction than of chronic pesticide intoxication. She thought, however, that Dr. Holland had overemphasized claimant's preexisting psychological makeup in arriving at his conclusions. She diagnosed an adjustment disorder with anxious mood caused by claimant's knowledge of her exposure to pesticides and of their potentially harmful effects. She further opined, in agreement with Dr. Holland, that iatrogenic factors had worsened claimant's psychological condition.

Claimant timely requested a hearing on the insurer's partial denials. Three of claimant's co-workers also requested hearings on denials or partial denials of their claims. An initial hearing session was held in one of these cases before Referee Garaventa on April 7, 1986. All four requests for hearing were later consolidated and three hearing sessions were held by Referee Myers, on September 23 and 24, 1986 and January 7, 1987. Eight lay witnesses and three medical professionals testified in the sessions held by Referee Myers. The parties stipulated that the relevant portions of Dr. Bayer's testimony in the hearing before Referee Garaventa should be made part of the record in the present case.

FINDINGS OF ULTIMATE FACT

1. Claimant did not continue to experience physical effects of pesticide intoxication after June 13, 1986.

2. The medical treatment claimant received for her compensable condition was a material contributing cause of a worsening of her psychological condition.

CONCLUSIONS OF LAW

1. The Partial Denial Relating to Claimant's Physical Condition

To prevail against the insurer's partial denial relating to her physical condition, claimant has the burden of proving that her exposure to pesticides at work continued to be a material contributing cause of her disability or need for medical services after June 13, 1986, the date of the denial. See Lobato v. SAIF, 75 Or App 488, 492 (1985); see also Barrett v. D & H Drywall, 300 Or 325 (1985), clarified, 300 Or 553 (1986); Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

The only opinions which would support the conclusion that claimant continued to experience physical effects from her exposure to pesticides after June 13, 1986 are those of Drs. Kurlychek and Leveque. Drs. Kurlychek and Leveque both thought that carbamate and organophosphate chemicals may be stored in the body for up to a year after exposure. Given this premise, they opined that claimant's ongoing complaints were due in material part to chemical residues in her body. Dr. Leveque also opined that claimant's exposure to pesticides had caused permanent brain or nerve damage which contributed to her symptoms.

The idea that residues of carbamates or organophosphates may be stored in the human body for up to a year was disputed by Drs. Bardana and Bayer. They stated that such residues are rapdily metabolized and eliminated from the body within a few days or weeks at the most. These statements regarding the properties of carbamates and organophosphates were fully explained in their reports and testimony and were based on their expertise in the field of toxicology. The statements of Drs. Kurlychek and Leveque on the subject were not well explained and their expertise in the field of toxicology was not as great as that of Drs. Bardana and Bayer. In addition, none of the blood or urine tests taken after claimant left work revealed any chemical residue in her body. For these reasons, we conclude that claimant has failed to prove that she continued to experience symptoms after June 13, 1986 due to pesticide intoxication.

Dr. Leveque's opinion that claimant's exposure to pesticides had resulted in permanent brain or nerve damage is similarly deficient. The opinion was unsupported by objective evidence, was poorly explained and was outside Dr. Leveque's area of expertise. It was also disputed by Dr. Bayer. (Tr. 80-82, Garaventa Hearing). Given this record, we conclude that claimant has failed to prove any physical damage to her nervous system from pesticide exposure.

2. The Partial Denial Relating to Claimant's Psychological Condition

Claimant presents two theories for the compensability of her psychological condition. First, she contends that her condition was caused by stress associated with her exposure to pesticides at work. Second, she contends that her condition was caused by the medical treatment she sought as a result of her exposure to pesticides. The Referee rejected both theories. We conclude that claimant's psychological condition is compensable under the second theory. In view of this, we do not address claimant's first theory.

Dr. Radmore and Dr. Holland both agree that the medical treatment that claimant received after she left work was at least a material contributing cause of a worsening of her psychological state. The insurer contends that the medical treatment that worsened claimant's psychological condition was not reasonable and necessary and cannot give rise to compensable consequences for that reason.

As a general rule, a carrier is responsible for harmful effects of medical treatment if there is a material causal connection between the treatment and a compensable condition. Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985); see 1 A. Larson, The Law of Workmen's Compensation § 13.21 (1985). This standard is the same regardless of whether the compensable condition for which treatment is sought is an injury or an occupational disease. See Janice G. Thon, 40 Van Natta 606, 607 (1988); see also Jeld-Wen, Inc. v. Page, 73 Or App 136, 138-39 (1985). Treatment may be unreasonable, unnecessary or excessive from a medical standpoint or may be negligently or otherwise tortiously performed and still be causally related to a compensable condition. In such cases, the causal connection between the compensable condition, the improper or tortious treatment and the harmful effect of the treatment remains intact. When this occurs, the harmful effect is compensable even if the treatment which caused it is not. See 1 A. Larson, supra § 13.21 at 3-415 & n.84 (1985 & Supp 1988); Gray v. Church's Fried Chicken, Inc., 504 So. 2d 979, 981-82 (La. App. 1987). When, on the other hand, the treatment is not causally related to a compensable condition or the causal relation is broken by the deliberate intention of the claimant to produce an injury, harm resulting from the treatment is not compensable. See ORS 656.156(1); 656.245; 1 A. Larson, supra § 13.21 at 3-419 to 3-425.

In the present case, claimant was exposed to pesticides at work and developed a number of symptoms. These symptoms were accepted as a compensable occupational disease by the insurer and the causal connection between them and the compensable condition cannot now be denied absent evidence of fraud, misrepresentation or other illegal activity on the part of claimant. Bauman v. SAIF, 295 Or 788 (1985). There is no such evidence in this case. Claimant sought medical treatment for her compensable condition from licensed physicians. Some of this treatment, particularly that provided by Dr. Leveque, caused a worsening of her psychological condition. There is no suggestion in the record that claimant sought treatment from Dr. Leveque or any other doctor in order to injure herself. The causal connection between claimant's compensable condition, the treatment she received and the harmful psychological effect, therefore, remains intact. Under these circumstances, the harmful effect is compensable irrespective of whether the treatment claimant received was reasonable and necessary and the insurer's partial denial relating to claimant's psychological condition must be set aside.

3. Attorney Fees

Claimant's attorney is entitled to an attorney fee for services rendered at the Board and hearing levels for prevailing against the insurer's partial denial. ORS 656.386(1). The statement of services submitted by claimant's attorney reflects a total of 106 hours of attorney time and 5 hours of paralegal

time. The names of the claimants in all four of the cases consolidated for the hearing before Referee Myers are listed at the top of the statement. An identical statement was submitted in connection with the other three cases. Under these circumstances, we understand the statement of services to reflect the total number of hours expended in all four cases rather than those expended just in the present case. We award a fee in accordance with this understanding and in accordance with the factors enumerated in OAR 438-15-010(6).

ORDER

The Referee's order dated February 27, 1987 is reversed in part. That portion of the Referee's order that upheld the insurer's partial denial dated May 15, 1986 relating to claimant's psychological condition is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a total fee of $3,170 for services at the hearing and on Board review, to be paid by the insurer. A client-paid fee, not to exceed $135, is approved.

JOHN W. BENNINGER, Claimant
Velure & Yates, Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 86-12595
February 22, 1989
Order on Remand

This case is before the Board on remand from the Court of Appeals. Benninger v. Weyerhaeuser Co., 92 Or App 709 (1988). The court reversed our Order on Review dated October 16, 1987 and remanded the case to the Board for reconsideration in light of the court's decisions in Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) and Johnston v. James River Corp., 91 Or App 721 (1988).

The self-insured employer requests review of Referee Quillinan's order that set aside its partial denial relating to claimant's low back and awarded claimant's attorney a fee of $1,100. On reconsideration, we affirm the order of the Referee.

ISSUES

1. Compensability of claimant's current low back condition.

2. Amount of the carrier-paid attorney fee assessed by the Referee.

FINDINGS OF FACT

Claimant compensably strained his low back on December 2, 1985 when he straightened stacks of particle board by pushing on them with his upper back and shoulders. Prior to this injury, claimant had injured his low back twice. The first injury occurred in late 1983 or early 1984 and resulted from a [illegible]

The employer issued a nonspecific acceptance of claimant's low back injury in February 1986.

Dr. Herriott declared claimant medically stationary and released him to return to regular work in late March 1986. Claimant returned to his regular work, but within a week experienced a marked increase in low back and bilateral leg pain. Dr. Herriott took him off work for about two weeks. Claimant then resumed light-duty work, but thereafter experienced gradually increasing low back and lower extremity pain. He was evaluated by a number of neurologists and orthopedists during mid-1986. All of them indicated that claimant's spondylolysis and the associated spondylolisthesis was the source of his problems and that fusion surgery could be required if his symptoms did not improve with conservative treatment.

In August 1986, the employer issued a partial denial which stated that the earlier acceptance had been of a "soft tissue injury." It then stated that claimant's condition at the time of the denial related to his preexisting spondylolisthesis and denied "any further temporary total disability benefits (TTD), and any further medical or surgical benefits." (Ex. 13-1). In late 1986, Dr. Podemski, a neurologist, and Dr. Logan, an orthopedic surgeon, both opined that claimant's December 1985 industrial injury continued to be a material contributing cause of the symptoms associated with his preexisting spondylolysis and spondylolisthesis and thus of claimant's disability and need for surgery. Claimant underwent fusion surgery in October 1986.

After the employer issued its denial in August 1986, claimant retained an attorney. In September 1986, the attorney filed a request for an expedited hearing. The following month, he submitted one exhibit to the Referee. He submitted an additional exhibit at the time of the hearing. The transcript of the hearing in this case, including closing arguments, totals 26 pages. A total of 20 exhibits make up the documentary record. In her Opinion and Order, the Referee set aside the employer's partial denial and ordered the employer to pay claimant's attorney a fee of $1,100.

Claimant's claim for the December 1985 industrial injury remains in open status.

FINDINGS OF ULTIMATE FACT

1. Claimant's compensable December 1985 injury continues to be a material contributing cause of the symptoms associated with his spondylolysis and spondylolisthesis. The symptoms caused disability and necessitated medical treatment, including fusion surgery.

2. The attorney fee assessed against the employer by

basis, she held that claimant's current condition was materially related to the industrial injury and thus was compensable. The employer contends that the Referee erred in finding that the December 1985 injury had any lasting effect upon claimant's preexisting condition and argues that claimant's current symptoms relate solely to that preexisting condition. Claimant responds only on the merits. He has made no argument regarding the procedural propriety of the employer's denial and thus we do not address that question.

To establish the compensability of his current condition, claimant has the burden of proving that his December 1985 industrial injury continues to be a material contributing cause of his disability and need for medical services. See Lobato v. SAIF, 75 Or App 488, 492 (1985); see also Barrett v. D & H Drywall, 300 Or 325 (1985), clarified, 300 Or 553 (1986); Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Lobato v. SAIF, supra, 75 Or App at 492.

In the present case, only Drs. Podemski and Logan addressed the question of whether claimant's December 1985 injury continues to be a material contributing cause of his current condition. They both opined that it does. Claimant's current condition, therefore, is compensable. Neither Podemski, Logan nor anyone else, however, opined that claimant's December 1985 injury worsened his underlying condition. The Referee's finding to that effect, therefore, is not supported by the record and, in any event, was unnecessary to her decision. We expressly negate that finding.

Attorney Fees

Claimant is entitled to a reasonable carrier-paid fee for services rendered at the hearing level. ORS 656.386(1). After considering the efforts of claimant's attorney in light of the factors set forth in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we conclude that the Referee's award of a fee of $1,100 was appropriate. The fee, therefore, shall be affirmed.

ORDER

The Referee's order dated January 5, 1987 is affirmed. Claimant's attorney is awarded an attorney fee of $200 for services rendered on Board review, to be paid by the self-insured employer.

JIMMY P. DAVIS, Claimant
Heiling & Morrison, Claimant's Attorneys
Mitchell, et al., Defense Attorneys

WCB TP-88036
February 22, 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). Specifically, the dispute pertains to the paying agency's entitlement to a lien for anticipated future expenditures. We find that the paying agency is not entitled to a share of the remaining proceeds for its projected future claim costs.

FINDINGS OF FACT

In November 1984, while performing his employment duties as a truck driver, claimant was involved in a motor vehicle accident with another truck. As a result of this accident, claimant sustained injuries primarily involving his neck, left shoulder, and back.

Claimant's injury claim was accepted by the paying agency and processed to claim closure. To date, it has paid $31,679.03 in temporary and permanent disability compensation and incurred $11,274.54 in medical expenses.

A third party action was initiated on behalf of claimant against the owner and the driver of the other truck. Prior to trial, the paying agency's counsel provided claimant's attorney with the agency's "updated lien amounts." These amounts coincided precisely with the aforementioned actual claim costs. The "update" neither listed nor referred to future claim costs.

Thereafter, with the paying agency's approval, a $50,000 settlement was reached. To effectuate this settlement, the paying agency agreed to reduce its lien. After the settlement was achieved, the paying agency asserted its entitlement to a $2,000 lien for its future claim expenditures. Claimant's counsel was under the impression that the paying agency had reduced its lien to $20,000 and was requiring claimant to be responsible for the first $2,000 of his future claim costs. The paying agency's counsel believed that the parties had agreed to compromise the agency's lien, including future costs, for $22,000.

After deducting claimant's one-third attorney's fee, litigation costs, his one-third statutory share, and the paying agency's reduced lien, a balance of $1,537.74 remains. This sum represents the amount of the third party settlement that is disputed.

Claimant is approximately 50 years of age. In October 1986, his life expectancy was projected at 24.4 years. He has received a total of 20 percent unscheduled permanent disability as a result of this injury. He has also been awarded 5 percent unscheduled permanent disability stemming from a prior low back injury.

Claimant's condition has been diagnosed as cervical and thoracic sprain, with aggravation of a preexisting osteoarthritic neck and back condition. Treatment has been conservative, primarily consisting of chiropractic therapy. The treatments have been administered by Dr. Michels, who has recommended continuing treatments as necessary for claimant's intermittent symptomatic exacerbations. Claimant received two treatments in 1988, each costing $42. Prior to these June and July 1988 treatments, claimant was last treated in September 1987.

FINDINGS OF ULTIMATE FACT

When representing its claimed lien during the negotiations leading to the third party settlement, the paying agency did not assert its entitlement to a lien for future claim costs.

CONCLUSIONS OF LAW

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

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

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). 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).

When an agency represents the amount of its claimed lien to a worker, knowing that the worker is in the process of negotiating a third party settlement, the agency may not claim as its "just and proper" share of the settlement any more than the originally asserted lien, even if the total amount claimed is not in excess of the lien authorized by ORS 656.593(1) and (2). Estate of Troy Vance v. Williams, supra at page 621.

Here, the paying agency contends that its lien for future claim costs was contemplated by the parties at the time it approved the third party settlement. Claimant agrees that future claim expenses were discussed, but not until after the settlement had been achieved. Considering the disparity between the respective counsels' recollections of the negotiations leading to the paying agency's approval of the third party settlement, we cannot conclude that there was a "meeting of the minds" sufficient to constitute an oral agreement regarding this issue.

Inasmuch as each counsel apparently had a different understanding concerning the amount and composition of the paying agency's lien at the time the third party settlement was achieved, we turn to the written record to reach a resolution of this matter. The record establishes that the paying agency provided claimant with a written "update" detailing its claim costs. This "update" was submitted at a time when the agency anticipated that settlement negotiations either were, or would be, proceeding. Because the paying agency's written representation concerning its "updated lien amounts" did not include future claim costs and since the issue of a lien for future claim costs was not documented until after the third party settlement was reached, we conclude that the agency may not claim those costs as part of its third party lien. See Estate of Troy Vance v. Williams, supra.

Accordingly, we hold that the paying agency is not entitled to the remaining balance of proceeds from the third party settlement. Consequently, claimant's attorney is directed to distribute the remaining balance to claimant as a "just and proper" distribution. See ORS 656.593(3); 656.593(1)(d).

IT IS SO ORDERED.

TIMOTHY W. ELDER, Claimant
Malagon & Moore, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 85-05329
February 22, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Elder v. Willamette Industries, Inc., 92 Or App 593 (1988). The court has reversed our prior order which had affirmed without opinion Referee Gruber's order upholding the closure of claimant's bilateral carpal tunnel syndrome claim and declining to award additional temporary disability benefits. We have been instructed to reconsider this case in light of the court's opinion 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 Referee Gruber's order which: (1) found that claimant's bilateral carpal tunnel syndrome claim was not prematurely closed; and (2) declined to award additional temporary total disability benefits. The issues are premature claim closure and entitlement to additional temporary total disability benefits. We affirm.

FINDINGS OF FACT

In May 1984, claimant filed a claim related to wrist pain. The condition was diagnosed as bilateral carpal tunnel syndrome and the claim was accepted. Claimant underwent surgery to relieve nerve entrapment in the right wrist in June 1984. He underwent similar surgery for the left wrist in September 1984.

Claimant was released to return to his regular work in December 1984. A Determination Order subsequently closed the claim in March 1985 and awarded temporary disability benefits only. Following his return to work, claimant again experienced numbness and tingling in his hands. His claim was reopened in April 1985 due to these continued symptoms.

In August 1985, claimant was referred to Dr. Butters, orthopedist, for further evaluation and treatment of his wrist problems. Dr. Butters originally felt that claimant might require additional surgery; however, nerve conduction studies proved to be within normal limits. Dr. Butters then referred claimant to Dr. Thayer, orthopedist, for an additional opinion about the need for surgery.

In December 1985, Dr. Thayer indicated that he would be hesitant to recommend surgery as nerve conduction studies were within normal limits. Prior to this time, claimant had also been examined by Dr. Ellison, orthopedist. In October 1985 Dr. Ellison had felt that claimant probably needed surgery, but did not recommend it unless Dr. Butters was so inclined.

Following his review of Dr. Thayer's consultation, Dr. Butters, in a letter dated January 17, 1986, informed the self-insured employer that claimant was medically stationary and

that he had nothing further to offer him medically at that time. On February 7, 1986, Dr. Butters wrote the employer again and noted that he had no further treatment or workup to offer claimant. He further noted that claimant did not need any surgical treatment and recommended electrical studies only as a final documentation of the claim.

Claimant's claim was closed by a February 1986 Determination Order which found him to be medically stationary as of January 17, 1986 and terminated temporary disability benefits as of that date.

In March 1986, claimant was examined by Dr. Fleshman, orthopedist, who had seen claimant eleven months earlier. Dr. Fleshman reported that claimant had no "major" problems with his hands and felt that claimant's difficulties at work would be better resolved through labor arbitration rather than on a medical level.

On April 28, 1986, claimant was again examined by Dr. Ellison. At that time, claimant complained that his symptoms were increasing in severity and that he experienced numbness, three to four times during the week, at night while sleeping. Dr. Ellison recommended that claimant undergo a microscopic neurolysis of both nerves. The claim was then reopened and temporary disability benefits were reinstated as of April 28, 1986.

Dr. Ellison performed additional surgeries on the claimant's wrists in August and September of 1986, with satisfactory results. Claimant returned to his normal job duties on November 10, 1986.

FINDINGS OF ULTIMATE FACT

Claimant was medically stationary from January 17, 1986 until April 28, 1986.

CONCLUSIONS OF LAW

The Referee found that claimant was medically stationary between January 17, 1986 and April 28, 1986. We agree based on the following reasoning.

In order to establish that the February 1986 Determination Order prematurely closed his claim, claimant must demonstrate that he was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625 (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. Butters, claimant's treating physician at the time of claim closure, opined that claimant was stationary as of January 17, 1986 and that there was nothing further he could medically do for claimant. Dr. Butters' opinion was corroborated by the consulting physician, Dr. Thayer. We agree with the Referee that Dr. Butters' letter of February 7, 1986 is somewhat confusing in that he recommends closure after nerve conduction studies scheduled for March 3, 1986. However, the same letter noted that the conduction studies were needed only as a final documentation and repeated Dr. Butters' January 17, 1986 statement that no further treatment was either necessary or contemplated.

Dr. Fleshman, who had treated claimant 11 months prior, examined claimant again on March 19, 1986. Dr. Fleshman felt that claimant was a difficult patient with atypical complaints and reported that he had no "major" difficulties with his hands. Dr. Fleshman concluded that from an anatomic point of view, claimant should have no problems continuing with his regular work, but that the situation would be better resolved on a labor abitration level, rather than a medical level.

Dr. Ellison, who performed claimant's most recent surgeries, noted in a June 1986 report that claimant had not been medically stationary since he had examined him on April 28, 1986. In the April 28, 1986 report, Dr. Ellison noted that claimant's pain complaints had increased in severity since he had last seen claimant in October 1985.

In light of the foregoing medical evidence, we find that claimant was medically stationary on January 17, 1986. In making this finding we are persuaded by the reports of Drs. Butters, Thayer, and Fleshman. We further find that claimant's condition worsened in April 1986, prompting Dr. Ellison to report that he was not stationary as of that date. Nothing in Dr. Ellison's report indicates that claimant was not stationary prior to that date. There is no other persuasive evidence in the record that claimant was not medically stationary between January 17, 1986 and April 28, 1986. Accordingly, the claim was not closed prematurely by the February 1986 Determination Order.

As we have found that claimant's claim was not prematurely closed, we find that claimant is not entitled to additional temporary disability benefits for the time period between January 17, 1986 and April 28, 1986.

ORDER

The Referee's order dated January 26, 1987 is affirmed.

Board Member Crider, dissenting:

Claimant's claim was prematurely closed. The record does not support the majority's conclusion that claimant was medically stationary on January 17, 1986.

The majority relies on the opinion of treating physician Butters that claimant was medically stationary on that date. Dr. Butters' opinion is not persuasive. He initially "leaned toward" further surgery and changed his position on the basis of Dr. Thayer's hesitancy to perform surgery in light of claimant's normal electrical studies. However, Dr. Thayer did not recommend that the matter be dropped and the claim closed. He, instead, recommended that further studies be performed during or following active hand use when claimant was symptomatic. Although Dr. Butters subsequently revised his opinion based on Dr. Thayer's report, there is no evidence that the additional studies recommended by Thayer were ever performed.

Furthermore, the record otherwise demonstrates that claimant would have benefited from further surgery when he was found medically stationary in January 1989. Contrary to the majority's rationale, the fact that claimant's pain and numbness

worsened following claim closure does not establish that further surgery could not have been expected to produce improvement in January 1986. The report from claimant's repeat surgeries in September and August 1986 provide important additional information regarding his condition in January 1986. See Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625 (1987). Those reports document scar tissue at the site of claimant's prior carpal tunnel operations. There is nothing in the record to suggest that this scarring occurred after claim closure. To the contrary, claimant's residual symptoms in January 1986 suggest that a significant amount of scarring was present at that time. Moreover, claimant's repeat surgeries resulted in a marked improvement in the symptoms he was experiencing in January 1986, as distinct from a mere resolution of the "worsened symptoms" he reported in April 1986.

It, therefore, appears that claimant could have been expected to improve with further treatment at the time of claim closure. Accordingly, the closure should have been set aside as premature and further temporary disability awarded.

CHARLES H. REIGARD, Claimant
Michael Stebbins, Claimant's Attorney
Brian Pocock, Defense Attorney

WCB 84-07376
February 22, 1989
Order on Reconsideration

Claimant has requested reconsideration of our January 23, 1989 Order on Review that affirmed a Referee's order granting claimant an award of permanent total disability. Specifically, claimant asks that we establish an effective date for the permanent total disability award. On reconsideration, claimant's request is denied.

Here, claimant requested a hearing regarding a Determination Order. He sought an award of permanent total disability. The Referee granted claimant an award of permanent total disability, but did not expressly specify an "effective date" for the award. The self-insured employer requested Board review, contending that claimant was not permanently and totally disabled. Claimant neither formally nor informally filed a cross-request regarding the effective date of his permanent total disability award. Instead, he submitted a respondent's brief defending the Referee's order.

We have previously concluded that the effective date of a permanent total disability award is implicit in every case involving such an award. Robert D. Hanks, 40 Van Natta 2067 (1988). However, Hanks is distinguishable from the present situation.

In Hanks, the claimant requested a hearing concerning a Determination Order, seeking an award of permanent total disability. Although the claimant did not specify the date he contended the award should be effective, the Referee granted permanent total disability effective the date of his order. The insurer requested review of the permanent total disability award and the claimant cross-requested on the effective date. On Board review, the insurer contended that claimant could not raise the effective date issue because he had failed to raise it at hearing. We rejected the insurer's contention that claimant could not challenge the effective date for failing to raise it at hearing, saying that the effective date issue is implicit in any request for permanent total disability. Consequently, we proceeded to address the cross-request.

Simply put, Hanks stands for the proposition that a claimant raises the "effective date" issue before a Referee when he or she seeks an award of permanent total disability at hearing. Likewise, the "effective date" issue is raised when a claimant requests Board review of a Referee's order that declined to grant permanent total disability. See Floyd W. Farmer, 40 Van Natta 1209 (1988); Gene L. Lancaster, 40 Van Natta 979 (1988).

Phrased another way, the failure to explicitly raise the "effective date" issue when seeking permanent total disability at hearing does not mean that the issue is waived or that the Referee need not determine the effective date based on the evidence presented. Yet, such reasoning does not mean that we should address the "effective date" issue on Board review when: (1) a Referee grants permanent total disability; (2) the insurer challenges the award; and (3) neither party raises the "effective date" issue either by formal or informal request or cross-request.

Here, the Referee's order did not expressly set an "effective date" for the permanent total disability. However, neither party raised the "effective date" issue either formally or informally at hearing or on Board review. In this regard, we note that claimant's respondent's brief contains a statement that he has been permanently and totally disabled since the issuance of the Determination Order. Yet, despite this statement, claimant did not seek modification of any portion of the Referee's order. Such circumstances do not lead us to conclude that claimant informally raised the "effective date" issue on review. Therefore, we will not address the issue on motion for reconsideration.

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 23, 1989 order in its entirety, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

IRIS J. WERTH, Claimant
Welch, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-00672
February 22, 1989
Order on Reconsideration (Remanding)

Claimant requests reconsideration of our Order on Review (Remanding) dated January 31, 1989 that vacated the Referee's order, which had set aside the self-insured employer's denial of claimant's thoracic injury claim and assessed a penalty and associated attorney's fee for an unreasonable denial, and remanded the case to the Referee. We also instructed the Referee to conduct further proceedings where the employer would disclose a previously-withheld statement from an investigator, unless the employer could convince the Referee that it had a valid reason for nondisclosure of the statement.

Asserting that our order did not disallow or reduce her compensation, claimant asks that we award a reasonable attorney fee for her counsel's services on Board review. Alternatively, claimant requests that the Referee be instructed to award such a fee for services on review should the Referee continue to find the claim compensable on remand.

If a request for Board review is initiated by a carrier

and the Board finds that the compensation awarded to a claimant should not be disallowed or reduced, the carrier shall be required to pay a reasonable attorney fee in an amount set by the Board for claimant's counsel's services on review. ORS 656.382(2). Our rules refer to such an attorney fee as an "assessed fee." OAR 438-15-005(2); 438-15-070.

Here, as previously noted, we remanded the case to the Referee with instructions to conduct further proceedings. In doing so, the Referee's order, which had found the claim compensable, was vacated.

Inasmuch as the Referee's order has been vacated, it would be premature for us to find that "claimant's compensation has not been disallowed or reduced." Rather, such a determination will not be possible until the Referee follows our instructions and issues an Order on Remand. Consequently, on remand, if the Referee subsequently concludes that claimant's compensation should not be disallowed or reduced as a result of the employer's request for Board review, he is directed to award claimant's counsel an attorney fee for services rendered on review.

Accordingly, the motion for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 31, 1989 order in its entirety, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

DANNY R. AKERS, Claimant
Vick & Gutzler, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-11855
February 23, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Mulder's order that upheld the insurer's "back up" denial of claimant's back injury claim and denial of claimant's aggravation claim. We affirm.

ISSUES

1. Whether the insurer's "back up" denial of claimant's accepted claim was supported by fraud, misrepresentation or other illegal activity.

2. If the insurer's "back up" denial was proper, whether claimant's back condition was compensable.

FINDINGS OF FACT

Claimant filed an 801 form with the employer alleging that an on-the-job injury occurred on May 23, 1986. The 801 reported that Charley Clemens, a co-worker, witnessed claimant leaning to his left on a man lift when Mr. Clemens pushed the "up" button. This sudden movement allegedly caused a sharp pain in claimant's back.

On June 9, 1986, the insurer accepted and processed claimant's claim as nondisabling.

In 1976 claimant had sustained a neck injury as a result of

a motor vehicle accident. During the 1970's he treated with a doctor "quite a few times" as a result of this injury.

In 1981 claimant was seriously injured while in the U.S. Army. He was traveling in a personnel transporter, which was rear-ended by a semi-truck. Claimant was thrown from the truck, injuring his neck, middle back and lower back. He was released from medical care and advised not to lift more than 15 to 20 pounds. He wore a neck brace for one or two months subsequent to this accident and had headaches occasionally, which ultimately subsided.

On December 7, 1985, claimant fell at an auto supply company injuring his back again. At that time, claimant had been treating with Dr. Brown for years for his back problems. Claimant's back complaints continued through at least January, 1986.

At hearing, however, claimant stated that he had no low back problems for two years preceding his May 23, 1986 injury. He later indicated that he meant no "major" problems.

Claimant believed that his first visit with Dr. Mulrooney's office was the same day of the injury. Dr. Mulrooney's records, however, revealed that May 27 was his first visit.

The history given to Dr. Mulrooney by claimant was that while he was leaning over the right side of a "manlift" at work, when Mr. Clemens suddenly pushed the "up" button.

The history given to Dr. Bussanich by claimant was that while he was in the process of bending over to pick up something inside the hydraulic lift cage, it suddenly went up, causing immediate low back pain and pain down both legs. Dr. Bussanich diagnosed: (1) marked lumbosacral sprain/strain with attendant myofascitis, syndesmitis, accompanying bilateral radicular signs; and (2) cervicothoracic strain.

On May 27, 1986, Dr. Mulrooney began treating claimant for bilateral sacroiliac dysfunction as well as mid back and neck dysfunction. Dr. Mulrooney opined that, in spite of the presence of previous impairment, the nature of the man lift accident as described by claimant, and the extent of claimant's injury warranted a classification of his condition as a new injury and not an exacerbation of the 1981 injury. There was no medical evidence to the contrary.

Claimant missed no time from work following the alleged incident of May 23, 1986.

On the weekend of June 28, 1986, claimant's condition exacerbated while moving large automobile parts. This activity was not job-related and did not produce a new injury or a substantial worsening of the condition that claimant presented to Dr. Mulrooney on May 27, 1986. Dr. Mulrooney believed that the June 28 injury was an exacerbation of the May 23 incident. There was no medical evidence to the contrary.

On July 1, 1986, Dr. Mulrooney took claimant off work. He did not return until September 22, 1986, when Dr. Mulrooney released him for his regular duties.

On July 25, 1986, the insurer denied claimant's aggravation claim, alleging that claimant's current disability resulted from the June 28 noncompensable lifting incident.

Claimant had a history of seizures that were controlled with medication until the age of 21. At that time, the medication was discontinued and the seizures did not return.

On August 2, 1986, claimant fell down some steps when his legs gave out. As a result, he sustained an acute cervical and lumbar strain. A seizure disorder was ruled out.

On September 23, 1986, the insurer issued a "back up" denial of claimant's entire claim, alleging that a thorough investigation had revealed that the May 23, 1986 incident had never occurred.

On November 6, 1986, claimant stopped treatment with Dr. Mulrooney. However, he continued to experience back pain and, on December 29, 1986, returned to the doctor's clinic for reevaluation. Dr. Mulrooney again took claimant off work.

On February 2, 1987, Dr. Mulrooney released claimant for work with restrictions of no lifting greater than 25 pounds and no repetitive bending or stooping.

We expressly find that claimant was not credible and we do not rely on his testimony. We make this finding based on the inconsistencies and evasions of his testimony as well as the testimony of Mr. Clemens. For example, claimant stated to the insurer's investigator that he had gone to Dr. Mulrooney's office the same day of the injury. The doctor's records, however, revealed that May 27 was claimant's first visit. Dr. Brown's chart notes revealed that claimant had suffered back problems for years and was still being treated as late as January, 1986 for those same problems. Claimant testified, to the contrary, that he had experienced no back problems for two years prior to the man lift incident. Also, while some medical documents reported that claimant had leaned to the left over the man lift, others reported claimant leaning to the right.

We also agree with the Referee that there was no reason to question the credibility of Mr. Clemens' testimony. He stated that he would "cover" for claimant unless litigation ensued; he did exactly that. Despite claimant's counsel's vigorous cross examination, no apparent motive for Mr. Clemens to lie was revealed. At the time of the hearing, Mr. Clemens was no longer working for the employer. Therefore, we expressly adopt Mr. Clemens' version of the May 23 incident and find that claimant did not sustain an injury on that date.

CONCLUSIONS OF LAW

ORS 656.262(6) states that "[w]ritten 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. . ." This statute has been interpreted to hold that, when an insurer has notified a claimant that his claim has been accepted, the insurer may not, in the absence of fraud, misrepresentation or other illegal activity, deny the compensability of the claim. Bauman v. SAIF, 295 Or 788, 794 (1983); Pinkerton, Inc. v. Brandner, 83 Or App 671, 673 (1987); Parker v. D. R. Johnson Lumber Co., 70 Or App 683, 686 (1984).

Where a "back up" denial is involved, the burden of going forward with evidence of fraud, misrepresentation or other illegal

activity lies with the insurer. Once the insurer shows a Bauman exception by a preponderance of the evidence, it is the claimant's ultimate burden to prove the compensability of the claim. Skinner v. SAIF, 66 Or App 467 (1984).

On May 27, 1986, claimant filed an 801 form alleging that while working for the employer on May 23, 1986, he sustained a low back injury. According to that form, claimant was standing on a hydraulic man lift, leaning to his left, when Charley Clemens, a co-worker, pushed the "up" button. The sudden movement allegedly caused claimant to feel a sharp pain in his back.

On June 9, 1986, the insurer accepted claimant's claim for injury and classified the claim as nondisabling. On the weekend of June 28, 1986, claimant aggravated his back condition while moving large automobile parts. That activity was not job-related.

On July 1, 1986, Dr. Mulrooney authorized temporary total disability for claimant. On July 25, 1986 the insurer issued a denial of claimant's claim for aggravation benefits, alleging that claimant's current disability was a result of the June 28 lifting incident.

On September 23, 1986, the insurer issued a "back up" denial of the entire claim. The basis of that denial was that, following a thorough investigation into the circumstances surrounding the alleged incident of May 23, 1986, it did not appear that an accident had ever occurred.

There was no medical evidence to contradict Dr. Mulrooney's assertion that the May 23 incident, as described by claimant, caused a new injury and was not an exacerbation of claimant's 1981 injury. The investigation which produced the "back up" denial was centered around statements made by claimant's alleged witness to the May 23 incident, Charley Clemens. Therefore, the propriety of the insurer's denial hinged upon the credibility of claimant and Mr. Clemens.

At hearing, claimant testified that on May 23, 1986 he and his co-workers were beginning to do the "high work." He alleged that, at that time, he bent over to pick up something while on the hydraulic lift and Mr. Clemens hit the "up" button. As a result of the unexpected jolt, claimant felt a sharp pain in his back. Claimant wrote "reinjury" on the 801 form, but explained that he was referring to his 1981 injury, not wanting the employer to think that he was hiding anything.

Mr. Clemens testified that he worked for the employer in May 1986. He stated that claimant had asked him to say that he was on the man lift, leaning to the left, when Mr. Clemens pushed the "up" button, thereby causing a sharp pain in claimant's back. Mr. Clemens agreed to "cover" claimant and support the assertion of injury, unless the case went to court. If it came to that, he would not perjure himself. Mr. Clemens did not remember claimant being on the man lift. Nor did he remember claimant ever saying that he hurt himself on the job.

Robin Eidem, who was previously safety director for the employer, where he had worked approximately ten months, stated that it was "possible" that the man lift could cause the type of injury claimant described.

The Referee explicitly found that claimant's credibility and reliability were eroded by inconsistencies and evasions in his

Claimant had a history of seizures that were controlled with medication until the age of 21. At that time, the medication was discontinued and the seizures did not return.

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On February 2, 1987, Dr. Mulrooney released claimant for work with restrictions of no lifting greater than 25 pounds and no repetitive bending or stooping.

We expressly find that claimant was not credible and we do not rely on his testimony. We make this finding based on the inconsistencies and evasions of his testimony as well as the testimony of Mr. Clemens. For example, claimant stated to the insurer's investigator that he had gone to Dr. Mulrooney's office the same day of the injury. The doctor's records, however, revealed that May 27 was claimant's first visit. Dr. Brown's chart notes revealed that claimant had suffered back problems for years and was still being treated as late as January, 1986 for those same problems. Claimant testified, to the contrary, that he had experienced no back problems for two years prior to the man lift incident. Also, while some medical documents reported that claimant had leaned to the left over the man lift, others reported claimant leaning to the right.

We also agree with the Referee that there was no reason to question the credibility of Mr. Clemens' testimony. He stated that he would "cover" for claimant unless litigation ensued; he did exactly that. Despite claimant's counsel's vigorous cross examination, no apparent motive for Mr. Clemens to lie was revealed. At the time of the hearing, Mr. Clemens was no longer working for the employer. Therefore, we expressly adopt Mr. Clemens' version of the May 23 incident and find that claimant did not sustain an injury on that date.

CONCLUSIONS OF LAW

ORS 656.262(6) states that "[w]ritten 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. . ." This statute has been interpreted to hold that, when an insurer has notified a claimant that his claim has been accepted, the insurer may not, in the absence of fraud, misrepresentation or other illegal activity, deny the compensability of the claim. Bauman v. SAIF, 295 Or 788, 794 (1983); Pinkerton, Inc. v. Brandner, 83 Or App 671, 673 (1987); Parker v. D. R. Johnson Lumber Co., 70 Or App 683, 686 (1984).

Where a "back up" denial is involved, the burden of going forward with evidence of fraud, misrepresentation or other illegal

activity lies with the insurer. Once the insurer shows a Bauman exception by a preponderance of the evidence, it is the claimant's ultimate burden to prove the compensability of the claim. Skinner v. SAIF, 66 Or App 467 (1984).

On May 27, 1986, claimant filed an 801 form alleging that while working for the employer on May 23, 1986, he sustained a low back injury. According to that form, claimant was standing on a hydraulic man lift, leaning to his left, when Charley Clemens, a co-worker, pushed the "up" button. The sudden movement allegedly caused claimant to feel a sharp pain in his back.

On June 9, 1986, the insurer accepted claimant's claim for injury and classified the claim as nondisabling. On the weekend of June 28, 1986, claimant aggravated his back condition while moving large automobile parts. That activity was not job-related.

On July 1, 1986, Dr. Mulrooney authorized temporary total disability for claimant. On July 25, 1986 the insurer issued a denial of claimant's claim for aggravation benefits, alleging that claimant's current disability was a result of the June 28 lifting incident.

On September 23, 1986, the insurer issued a "back up" denial of the entire claim. The basis of that denial was that, following a thorough investigation into the circumstances surrounding the alleged incident of May 23, 1986, it did not appear that an accident had ever occurred.

There was no medical evidence to contradict Dr. Mulrooney's assertion that the May 23 incident, as described by claimant, caused a new injury and was not an exacerbation of claimant's 1981 injury. The investigation which produced the "back up" denial was centered around statements made by claimant's alleged witness to the May 23 incident, Charley Clemens. Therefore, the propriety of the insurer's denial hinged upon the credibility of claimant and Mr. Clemens.

At hearing, claimant testified that on May 23, 1986 he and his co-workers were beginning to do the "high work." He alleged that, at that time, he bent over to pick up something while on the hydraulic lift and Mr. Clemens hit the "up" button. As a result of the unexpected jolt, claimant felt a sharp pain in his back. Claimant wrote "reinjury" on the 801 form, but explained that he was referring to his 1981 injury, not wanting the employer to think that he was hiding anything.

Mr. Clemens testified that he worked for the employer in May 1986. He stated that claimant had asked him to say that he was on the man lift, leaning to the left, when Mr. Clemens pushed the "up" button, thereby causing a sharp pain in claimant's back. Mr. Clemens agreed to "cover" claimant and support the assertion of injury, unless the case went to court. If it came to that, he would not perjure himself. Mr. Clemens did not remember claimant being on the man lift. Nor did he remember claimant ever saying that he hurt himself on the job.

Robin Eidem, who was previously safety director for the employer, where he had worked approximately ten months, stated that it was "possible" that the man lift could cause the type of injury claimant described.

The Referee explicitly found that claimant's credibility and reliability were eroded by inconsistencies and evasions in his

testimony. The Referee also found no reason to question Mr. Clemen's credibility.

Where a Referee makes express credibility findings, as the Referee did in this case, we are loathe to second guess his subjective impressions. Davies v. Hanel Lumber Company, 67 Or App 35 (1984); Humphrey v. SAIF, 58 Or App 360 (1982); Donald W. Hardiman, 35 Van Natta 664 (1983). Although there are occasions where we would not defer to the Referee's findings of credibility, specifically those based on an objective, rather than a subjective, evaluation of the substance of the witness' testimony, this is not one of those cases. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). The Referee's credibility findings were based on both inconsistencies and evasiveness. Evasiveness goes to the demeanor of the witness. Also, we agree that the objective inconsistencies only served to further erode claimant's credibility. Neither do we find any objective reason to question Mr. Clemen's credibility. His testimony appeared straightforward and consistent. We therefore adopt Mr. Clemens' contention that no injury occurred to claimant on May 23, 1986.

Based on Mr. Clemens' credible testimony and claimant's lack of credibility, we hold that the insurer has proved by a preponderance of the evidence that fraud or misrepresentation by claimant was discovered more than 60 days after acceptance of the original claim. Therefore, the September 23, 1986 "back up" denial was proper and is upheld. Since we find that an injury did not occur on May 23, claimant can not prove a compensable claim. It follows that the July 25, 1986 denial of aggravation benefits stemming from the June 28 exacerbation was also proper and is upheld.

ORDER

The Referee's order dated June 18, 1987 is affirmed.

AKSINIA ANFILOFIEFF, Claimant
Donald L. Dickerson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-17325
February 23, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Young's order which dismissed claimant's request for hearing from the insurer's denial of her low back injury claim. Claimant contends that she has shown good cause for her failure to file the December 11, 1986 request for hearing within 60 days after the August 25, 1986 denial.

Claimant has asked the Board to accept her untimely appellant's brief as a reply brief. Because claimant's appellant's brief was not accepted on timeliness grounds, it will not be considered upon resubmission as a reply brief. Harold C. Kimsey, 39 Van Natta 1166 (1987); Deryl E. Fisher, 38 Van Natta 982 (1986).

The Board affirms and adopts the order of the Referee. Brown v. EBI Companies, 289 OR 455, 457-458 (1980).

ORDER

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

ROBERT M. BRYANT, Claimant
Scott M. McNutt, Claimant's Attorney
Brian L. Pocock, Defense Attorney
By the Board en banc.

WCB 86-01731
February 23, 1989
Order on Review

Claimant requests review of Referee Peterson's order that upheld the self-insured employer's denial of claimant's chiropractic treatments for his current low back condition. The issue is medical services. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's factual findings as its own with the following supplementation.

The employer's January 30, 1986 denial stated:

> "As a result of the recent medical examination done by Richard K. Howell, D.O., it has been determined that further chiropractic treatment is not reasonable or necessary as it relates to your industrial injury of August 28, 1979. Therefore, [the employer] will not be responsible for any treatment rendered after January 30, 1986."

FINDINGS OF ULTIMATE FACT

The employer's January 30, 1986 denial was addressed to no service rendered. It was entirely prospective in nature.

CONCLUSIONS OF LAW AND OPINION

A claim for medical services is generally made in the form of a medical bill or a request for authorization of treatment addressed to the self-insured employer or insurer. Billie J. Eubanks, 35 Van Natta 131 (1983). Claims, in the form of billings, must be promptly paid or denied. OAR 436-10-100. If denied, the worker may request a hearing. ORS 656.245(2). Here, the employer has accepted all claims for medical services filed through the date of the denial. The denial purports to address all post-January 30, 1986 chiropractic treatment. The denial can be read only as a denial of future medical benefits.

Yet, an injured worker is entitled to all reasonable and necessary medical services for a compensable injury. ORS 656.245(1). The nature of treatment which is reasonable depends upon the worker's condition at the time the treatment is rendered; what will be reasonable in the future cannot be foreseen. Thus, the res judicata effect of a denial is limited to pre-denial services. Leonard A. Chambers, 40 Van Natta 117, 969 (1988). See also North Clackamas School District v. White, 305 Or 48, modified 305 Or 468 (1988). A denial of care in the future 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).

In Beasley, supra, the insurer denied claimant's "current treatment" at a time when the insurer had paid for all treatment claimed and the claimant was, in fact, receiving no treatment. The Board held that such a denial was void and of no effect upon claimant's right to future treatment. Consequently, a

subsequent denial of services premised upon claimant's failure to challenge the initial denial was set aside. It follows that, when, as here, the claimant does challenge the initial prospective denial, it must be set aside.

In sum, claimant remains entitled to make claims in the future for medical services. We make no determination regarding the propriety of a denial that might be issued with respect to such claims. See, e.g., Coronda J. Johnson, 39 Van Natta 1171 (1987), where we set aside a broad denial and upheld a narrower denial issued at a later time. However, the employer's denial here will be set aside.

ORDER

The Referee's order dated May 13, 1987 is reversed. The self-insured employer's January 30, 1987 denial is set aside. Claimant's attorney is awarded an assessed fee of $750, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed $420.

Board Member Ferris, dissenting:

I respectfully dissent. The majority sets aside the employer's denial on the ground that it is an improper prospective denial of medical services. The majority misconstrues the denial.

In the first place, the employer's denial was not just a denial of medical services. The denial states that further chiropractic treatment "is not reasonable and necessary as it relates to your industrial injury of August 28, 1979." (Ex. 20) (emphasis added). Although not a model of clarity, the emphasized phrase calls into question the causal relation between claimant's compensable 1979 injury and his then-current condition. The denial mentions only chiropractic treatment because that was the sole form of compensation claimant was claiming at that time. The denial also expressly mentions an examination performed by Dr. Howell which led him to conclude that claimant's compensable injury had fully resolved by July 1980 and that claimant's condition after that time was unrelated to the compensable injury. (Ex. 17-6). Later, the denial states that the employer would not be responsible for any treatment rendered after the date of the denial, thus reinforcing the impression that the denial was of the condition being treated and not just the treatment itself. Fairly construed, the denial is a partial denial of the compensability of claimant's then-current condition, not just a denial of medical services. See Ohlig v. FMC Marine & Rail Equipment Division, 291 Or 586, 594-97 (1981).

Claimant certainly understood the denial in this way. In his application to schedule a hearing, claimant designated both compensability and medical services as issues. At the beginning of the hearing, claimant's attorney listed the issues as reasonableness and necessity of treatment and the causal relation

the objection on Board review. Given this record, the majority's gratuitous narrowing of the issues is unsupportable and inexplicable. The Board should address the employer's partial denial on the merits.

Even assuming, however, that the majority correctly limited the issue to that of medical services, the Board should still address the employer's denial on the merits. The majority refuses to do this on the ground that the denial "can be read only as a denial of future medical benefits" and as such represents an acceptance of all treatment rendered prior to the date of the denial. I strongly disagree.

Even if the majority is correct in construing the employer's statement about treatment after the date of the denial as a denial of future medical services, that is all it is. It does not follow that the statement also represents an acceptance of all treatment rendered prior to the denial. Indeed, the reference in the denial to Dr. Howell's conclusions belies any such interpretation. The most that can fairly be inferred from the employer's statement is that the employer had paid or would pay for all treatment rendered prior to the date of the denial. Assuming this inference to be correct (and there is no direct evidence that it is), merely paying or providing compensation is not acceptance of a claim or an admission of liability. ORS 656.262(9). The employer may have paid for the pre-denial treatment through mistake or inadvertance or simply to promote goodwill between it and claimant. The mere fact of payment for the treatments, therefore, does not establish their compensability or otherwise preclude the employer from contesting that issue. The majority errs in concluding that it did.

DANIEL T. COBBIN, Claimant
C. David Hall, Claimant's Attorney
Thomas Sheridan (SAIF), Defense Attorney
Anne Kelley, Assistant Attorney General

WCB 87-07206
February 23, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Hoguet's order that found that claimant was not entitled to the fair market value of a 1976 Datsun pickup truck (truck). We affirm, but modify the Referee's reasoning.

ISSUE

Whether the Director's decision was characterized by an abuse of discretion or clearly unwarranted exercise of discretion.

FINDINGS OF FACT

Claimant, a 45-year-old former truck driver, injured his low back on June 16, 1980. He has been awarded a total of 50

In early February 1982, with the use of a wage subsidy, Ms. Rutz located employment for claimant as an exterminator with a pest control company. Since the job required that claimant use his own vehicle, the Workers' Compensation Department (Department) purchased a truck for claimant at the cost of $2,950. On March 31, 1982, claimant and the FSD coordinator signed a "LETTER OF AGREEMENT PURCHASE OF MOTOR VEHICLE." This agreement stated, in relevant part, that:

> "4. Claimant agrees to obtain in his/her name as registered owner, with the Department as the legal owner holding title, the following insurance coverage (to be effective upon delivery of vehicle): [Followed by a description of the required coverage]."
>
> "5. On 3-30-83 (Date) the Department shall review the vocational progress of claimant. If the claimant is employed and has continued employment prospects, as verified by the employer, the Department shall sign off all security interest in the property and equipment and all loss payable and additional insureds endorsements on all insurance policies and transfer title of such equipment to claimant."
>
> "6. If at any time during the period that WCD holds legal title to the above-described vehicle, WCD determines:"
>
> "(a) Positive evidence of unsatisfactory vocational progress, or"
>
> "(b) Failure of claimant to maintain vehicle in good repair with adequate levels of insurance as described in the agreement, Claimant hereby agrees to:"
>
> "- Return the vehicle to the Department in good repair at 21 Labor and Industries Bldg (Address); and"
>
> "- Excecute (sic) all legal documents to clear the title entirely to the Department."

By April 1, 1982, claimant's employer had agreed to provide insurance coverage on his policy for claimant's truck, commencing March 31, 1982. Claimant thereafter commenced employment. On July 16, 1982, FSD closed claimant's file as successfully returned to work.

On August 10, 1982, claimant was involved in an auto

[illegible] inoperable truck as lien holder and sold it to a bonafide purchaser.

After the accident, claimant returned to the employer hanging sheetrock and developed further back problems, resulting in an accepted aggravation claim. Between August 1982 and November 1983, claimant was unable to work. Finally, on April 1, 1985, claimant began another training program in copy machine repair.

On April 29, 1987, the Director concluded in his Review and Order that claimant was not entitled to the fair market value of the truck because, in violation of his Letter of Agreement with the Department, he did not maintain insurance coverage for the vehicle. Claimant timely appealed that decision.

CONCLUSIONS OF LAW

ORS 656.283(2) provides that:

> "If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must first apply to the director for administrative review of the matter before requesting a hearing on that matter . . . The decision of the director may be modified only if it:"
>
> "(a) Violates a stature 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."

Insurance coverage

The Referee found that the Director abused his discretion in holding that claimant had failed to satisfy his primary obligation to assure appropriate insurance coverage by relying on his employer's promise to purchase coverage. We disagree.

Paragraph 6(b) of the Letter of Agreement specifically stated that if, at any time during the period that WCD held legal title to the vehicle, WCD determined that claimant failed to maintain it in good repair with adequate levels of insurance as described in the agreement, claimant agreed to return the vehicle to the Department in good repair and execute all legal documents to

Claimant's lack of employment on March 30, 1983

Although the Director did not address the issue of claimant's lack of employment or employment prospects through March 30, 1983, the Referee concluded that, since claimant was not employed on March 30, 1983, he was not entitled to the fair market value of the truck. We agree.

Paragraph 6(a) specifically provided that if, at any time prior to March 30, 1983, the Department discovered positive evidence of unsatisfactory vocational progress, i.e., lack of employment or continued employment prospects, claimant was obligated to return the truck and clear title to the Department.

Claimant was not employed on March 30, 1983. In fact, claimant was not employed from August 1982 until April 1985, when he began another vocational training program in copy machine repair. Once terminated, claimant was obligated by Paragraph 6(a) to return the truck to the Department and to assist the Department in clearing title to the Department. Therefore, claimant is not entitled to the fair market value of the truck.

ORDER

The Referee's order dated November 25, 1987 is affirmed, as supplemented.

ROBERT E. COCHRAN, Claimant
David Hollander & Associates, Claimant's Attorneys
Meyers & Associates, Defense Attorneys

WCB 87-07532
February 23, 1989
Order on Review

By the Board en banc.

The self-insured employer requests review of those portions of Referee Irving's order which set aside its denial of chiropractic treatment exceeding two office visits per month and assessed penalties and attorney fees for the employer's unreasonable denial of those treatments. We reverse in part and affirm in part.

ISSUES

1. Whether claimant's chiropractic treatments exceeding those allowed in the OAR guidelines are reasonable and necessary.

2. Whether the employer's denial of treatments in excess of the guidelines was unreasonable, justifying penalties and attorney fees.

FINDINGS OF FACT

Claimant, a bus driver with a good work record, noted the gradual development of neck, right shoulder, and upper back pain beginning in the spring of 1985. He filed a claim for thoracic strain. Claimant first saw Dr. Noall, M.D., on September 9, 1985, who diagnosed right rhomboid bursitis and thoracic strain. Claimant was treated conservatively with rest, ultrasound, hot packs, medication, physical therapy, and exercises. During this period of time, an unrelated tumor on the left scapula was discovered and biopsied. Claimant returned to work part time on March 24, 1986, and gradually built up to full

time. In June, 1986, the Orthopaedic Consultants examined him and felt that he was stationary and able to return to regular work without restriction. Dr. Noall released claimant to regular work without restriction as of October 1, 1986. August 6, 1986 and August 22, 1986 Determination Orders granted a total of 5 percent unscheduled permanent partial disability.

On December 19, 1986, claimant started chiropractic treatment. At that time, he complained of neck and upper back stiffness and soreness during and immediately after work. Dr. Apple diagnosed moderate cervical thoracic strain, sprain and neuroforaminal compression syndrome with paraspinal muscular hypotonicity. He felt that claimant was not medically stationary, but that he was able to work eight hours per day. Eventually, treatments were provided on an as-needed basis, which has worked out to about three times per week.

On April 6, 1987, claimant presented for an independent evaluation by Dr. Duncan, chiropractor. Dr. Duncan felt that claimant's compensable condition had been transitory and had long since resolved. He found no objective evidence of sensory or motor loss and felt that claimant was no longer in need of curative or palliative treatment.

On April 30, 1987, the employer denied treatments in excess of the OAR guidelines.

Dr. Danis, chiropractor, evaluated claimant at Dr. Apple's request on April 14, 1987. Complaints included tightness in the neck, upper back, and shoulder area after driving, stiffness in the morning, and more easily fatigued than before the injury. He diagnosed chronic moderate cervico-thoracic lumbosacral strain/sprain syndrome with radiculitis of several cervical and lumbar nerve roots. He felt that claimant was in need of continued curative treatment, and that, without it, his condition would continue to deteriorate.

On May 13, 1987, Dr. Apple declared claimant medically stationary, with approximately 15 percent "disability" and the need for at least 8 to 12 months of palliative treatment. A May 11, 1987 Determination Order granted additional temporary total and temporary partial disability, but no additional permanent disability.

Claimant hurts after working and chiropractic treatments relieve the pain. Claimant has a hot tub and uses it for relief when he is unable to see Dr. Apple.

ULTIMATE FINDING OF FACT

Claimant has not shown that chiropractic treatments in excess of the guidelines are reasonably and necessarily required by the nature of the injury or for the process of recovery.

CONCLUSIONS AND OPINION

Claimant is entitled under ORS 656.245(1) to payment for medical services for his compensable condition for as long as the nature of the injury or the process of recovery requires. OAR 436-10-040 establishes guidelines for the number of office visits following a compensable injury. Treatments may exceed the guidelines if claimant can show that they are reasonable and necessary. James v. Kemper, 81 Or App 80 (1986).

The Referee found the treatments in excess of the guidelines reasonable and necessary. She reasoned that the treating chiropractor's opinion was detailed and that it told why claimant needed continued treatment. For that reason, she deferred to Dr. Apple, the treating physician, and gave his opinion greater weight than the examining physicians. As further support for claimant's need for continued treatment, the Referee referred to the "frequent treatments of Dr. Noall immediately following claimant's injury on August 31, 1985 and through December 1986." We find the Referee's reliance on Dr. Apple's opinion and her rationale for finding the treatments reasonable and necessary to be flawed.

Although we generally defer to the opinion of the treating physician, in this case we find persuasive reasons not to do so. First, we do not characterize claimant's treatments with Dr. Noall as "frequent" as did the Referee. Dr. Noall's chart notes show that claimant returned to him for follow-up only one time per month in 1986. This was during the time claimant was improving and gradually increasing his hours at work. That is significantly different from the three times per week claimant has been receiving chiropractic treatments for almost 16 months after medical treatment was first sought and almost three months after claimant was declared medically stationary.

Additionally, in Dr. Apple's December 16, 1987 letter, he provided a history of claimant's situation to indicate that claimant was going through an on-going condition related to his back. Dr. Apple's recitation of the history was inaccurate. Claimant did not first see him on December 19, 1985, but on December 19, 1986, after monthly follow-ups with Dr. Noall and after being declared medically stationary. The June 10, 1986 report of the Orthopaedic Consultants does say, as Dr. Apple states, that claimant had sustained a right rhomboid and trapezius muscle strain. However, contrary to the point Dr. Apple was trying to make, the Consultants then stated that claimant was stationary at that time, that he could return to his previous occupation without limitation, and that there was not significant permanent impairment. This was more than six months before claimant first saw Dr. Apple. Finally, what Dr. Apple was treating was stiffness and soreness in the upper back; claimant can also get relief from hot packs and use of the hot tub at home.

We are not persuaded by Dr. Danis' report of evaluation. He included all areas of claimant's spine in his diagnosis, including the lumbosacral area where claimant had never had symptoms.

We find the medical opinion of Dr. Noall, claimant's treating physician most contemporaneous with the date of injury and treatment through recovery, to be more persuasive than that of Dr. Apple. Dr. Noall's opinion is bolstered by that of the Orthopaedic Consultants and of Dr. Duncan, all of whom opine that there is no objective basis for continued treatment.

We conclude that claimant has not established that treatments in excess of those allowed under the guidelines are compensable under ORS 656.245.

Penalties and Fees

OAR 436-10-040(2)(a) states in relevant part:

"...[P]hysicians requesting reimbursement for visits in excess [of two visits per month] must submit upon request a report documenting the need for such services. Insurer shall notify the physician within 30 days of receipt of the report whether or not the report justifies treatment in excess of the guidelines or justification will be assumed."

We read this rule to require a carrier to request a report of a treating physician when requested services exceed the suggested guideline. The report provides a basis for making a decision within 30 days as to need for services, as required by the rule. Here, the employer did not request a report from Dr. Apple before denying the services. We find that conduct unreasonable and therefore agree with the Referee's assessment of penalties and attorney fees for unreasonable denial of medical services. Because we are reversing the Referee's order as to compensability, there will be no "amounts then due" and therefore no penalty may be assessed. The Referee assessed an attorney fee of $750 based on both the penalty issue and the denial issue. Because the denial is now upheld, we set aside that award and find that $250 is a reasonable attorney fee on the penalty issue. See OAR 438-15-010 (6); Barbara Wheeler, 37 Van Natta 122 (1985).

ORDER

The Referee's order dated January 29, 1988 is reversed in part and affirmed in part. Those portions of the Referee's order which set aside the self-insured employer's April 30, 1987 partial denial of chiropractic treatments in excess of those allowed under the OAR guidelines are reversed. The denial is reinstated and upheld. In lieu of the Referee's $750 attorney fee award, claimant's attorney is awarded $250, to be paid by the employer. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,000.50, is approved.

Board Member Ferris, concurring:

I join in the majority opinion, but write separately to address the concerns expressed by the dissent. The denial in this case is proper for the reasons explained in my concurrence in Gordon D. Garrett, 41 Van Natta 334 (Issued this date).

Board Member Crider, dissenting:

The denial in question read, in part, as follows:

"[W]e are denying treatment in excess of two office visits per month in accordance with the Oregon Administrative Rules. Any billing statements from Dr. Apple received after the date of this denial, will be reduced accordingly. . . ."

The denial is purely prospective in nature and, for that reason, is void. The majority errs in reinstating the denial. I dissent for the reasons stated in my dissenting opinions in June Jelen, 40 Van Natta 1175 (1988) and Gordon D. Garrett, 41 Van Natta 334 (Issued this date).

RICHARD E. CORSON, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 85-07125
February 23, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Quillinan's order that: (1) declined to grant any permanent disability compensation, either scheduled or unscheduled, in addition to that granted by Determination Order; (2) declined to alter the rate of temporary disability benefits; and (3) declined to assess penalties and related attorney fees.

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

On review, claimant's counsel requests that the Board either consider Dr. Misko's January 6, 1987 report, which claimant never submitted before the hearing record was closed, or remand claimant's case to the Referee for further development of the record.

On November 13, 1987, at the close of claimant's hearing, the Referee left the record open until mid-January in order to receive diagnostic tests and any opinion voiced by Dr. Isaacson regarding claimant's possible need for surgery. On January 27, 1987, the Referee closed the record after having received no further medical evidence from either party.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

Claimant's counsel had approximately three weeks from the time Dr. Misko issued his January 6, 1987 report until the record was closed on January 27, 1987. On Board review, claimant's counsel gives no explanation for this failure to submit additional evidence. After de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we find that the additional evidence presented by claimant's counsel was obtainable with due diligence. Accordingly, we conclude that remand is not warranted.

Our second comment pertains to claimant's request that we award him an award of scheduled disability. Claimant presented no claim for scheduled permanent disability either before or at the time of hearing. Claimant's December 10, 1985 Request for Hearing form did not include "Scheduled Disability" as an issue. Also, when the Referee asked to clarify the issues at hearing, and specifically listed "unscheduled" disability as the only permanent disability issue, claimant's counsel assented. When an issue is not properly raised before a Referee at hearing, and the record is closed, that issue will not subsequently be considered. Randy L. Johnson, 39 Van Natta 463 (1987). Therefore, the Board declines to address the issue on appeal.

ORDER

The Referee's order dated February 27, 1987 is affirmed. The Board approves a client-paid fee not to exceed $160.

GORDON D. GARRETT, Claimant
Velure & Yates, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 86-11631
February 23, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of Referee Neal's order that: (1) increased claimant's unscheduled permanent disability award for a low back injury from 5 percent (16 degrees), as awarded by a Determination Order, to 15 percent (48 degrees); and (2) upheld the self-insured employer's partial denial of claimant's chiropractic treatments for a low back condition which were in excess of the Medical Director's Guidelines. The issues on review are extent of permanent disability and medical services.

FINDINGS OF FACT

Claimant, a 43-year-old mechanic, injured his low back in March 1984 during a lifting incident. Prior to the injury, he had experienced periodic problems with his back causing him to miss occasional days of work each year. Following the March 1984 injury, he began treating with Dr. Hoppert, orthopedic surgeon, who diagnosed chronic lumbosacral strain. He was off work for a few days immediately following the injury.

In September 1985, he used his seniority status to move from his mechanic job to an upholstery repair job which does not require as heavy work. Since then, he has had two periods of exacerbation. The first exacerbation occurred in late December 1985, when he filled in temporarily as a mechanic. He was off work for approximately two weeks. He then went for one year without any episodes of back spasms. The second exacerbation occurred one week before the hearing. He had been off work for the week prior to hearing and was receiving daily treatment from Dr. Buttler, chiropractor.

Claimant began treating with Dr. Buttler in early January 1986, just after his first exacerbation. Dr. Buttler took claimant off work until January 15, 1986, when he released him for modified work. Claimant returned to his upholstery job because it was light enough to comply with the restrictions imposed by Dr. Buttler. Claimant was then receiving treatments from Dr. Buttler three times per week.

In May 1986, Dr. Buttler reduced claimant's treatments to two times per week. He also released claimant for his regular work.

Claimant's claim has been reopened several times. The only award of permanent disability claimant has received resulted from a February 7, 1985 Determination Order that granted him 5 percent unscheduled permanent disability.

On January 30, 1987, the employer denied responsibility for chiropractic treatment in excess of two times per month.

Dr. Buttler examined claimant on April 21, 1987. In a report dated one week prior to hearing, Dr. Buttler found claimant medically stationary and able to do modified work with no heavy lifting or repetitious bending or twisting from the waist. He noted a reduced range of motion in claimant's back. He nevertheless felt that claimant's condition had improved

sufficiently to warrant reduction in treatment. He opined that claimant was now in need of periodic "as-needed" palliative care.

Claimant has always relied upon Dr. Buttler to determine the frequency of treatments. The maximum period between treatments has been two weeks.

The employer had claimant examined by different chiropractic panels in February 1986 and January 1987. Those panels opined in April 1987 that claimant's condition did not support treatments in excess of twice per month, except during periods of exacerbation.

Claimant testified to a persistent backache. He can sit for approximately one-half hour before experiencing pain. As of the date of hearing, claimant's back felt better than it had two years earlier.

Claimant has a high school education with additional course work in electronics. He retains the ability to do medium work, but he is no longer capable of performing the mechanics job he did at the time of his 1984 injury. We rate his physical impairment as mild. In addition to work as a mechanic and upholsterer, claimant has also worked as a mechanic training supervisor for two years and as an emergency medical technician for nine years.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that he is entitled to additional unscheduled permanent disability beyond the 15 percent awarded by the Referee. He asserts that his ability to "obtain and hold gainful employment in the broad field of general occupations" is moderately, if not severely, impaired. In addition, he argues that his physical impairment is in the mildly moderate range.

In rating the extent of unscheduled permanent disability for claimant's low back condition, we consider his impairment as reflected in the medical record and the testimony at hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Dr. Hoppert, claimant's initial treating physician, rated claimant's impairment in the mild range in 1984. In April, 1987, Dr. Buttler opined that claimant had "mild to moderate permanent impairment . . . dependent upon physical activity." We would normally give greater weight to Dr. Buttler's more recent opinion. We conclude, however, that Dr. Buttler's findings support a mild, rather than moderate, impairment. This conclusion is supported by claimant's testimony that his back is in better shape now than it was two years earlier. Furthermore, we do not consider claimant's age of 43 as a serious impediment to future employability.

Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that the Referee's award of 48 degrees for 15 percent unscheduled permanent partial disability

Turning to the medical services issue, claimant contends that the Referee arbitrarily limited the number of chiropractic treatments to two per month. We do not agree.

The workers' compensation statutes do not authorize any limitation on the number of treatments a claimant may receive. ORS 656.245; Kemp v. Worker's Comp. Dept., 65 Or App 659 (1983), modified on other grounds, 67 Or App 270, rev den 297 Or 227 (1984). Claimant, however, has the burden of proving that treatments are reasonable and necessary. James v. Kemper Ins. Co., 81 Or App 80, 84 (1986). Here, Dr. Hoppert opined that, as of May 6, 1985, claimant needed no further treatment. Two independent chiropractic consultants opined that it was not reasonable or necessary for claimant to have chiropractic treatments in excess of two treatments per month except in the event of an exacerbation of symptoms. One week prior to hearing, Dr. Buttler himself opined that claimant was in need of only periodic as-needed palliative care. We conclude that claimant has not met his burden of proving that at this time more than two treatments monthly are reasonable and necessary.

ORDER

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

Board Member Crider, concurring in part and dissenting in part:

I concur in that portion of the order which affirms the Referee on the extent of disability question. I dissent, however, from that portion of the order upholding the employer's denial of future treatment for the compensable injury in excess of the Director's Guidelines.

The denial reads as follows:

> "Your treating physician for this injury is presently Brian Buttler, D.C. We have received additional information indicating your condition is medically stationary, and the care and treatment provided at this time is palliative in nature. . . . Based on the above information, we are denying treatment in excess of two times per month in accordance with the Oregon Administrative Rules. This decision does not affect your right to receive treatment for your injury of March 1, 1984. Under OAR 436-10-090(5), you cannot be held responsible for the treatment which is in excess of the guidelines after the date of this letter." (Emphasis added.)

The denial is misleading as to its effect insofar as it suggests that it does not effect claimant's right to treatment. Moreover, it is addressed to no service rendered for which reimbursement has been sought. It simply denies all future medical services in excess of two treatments per month. It should, therefore, be set aside for the reasons stated in my dissenting opinion in June Jelen, 40 Van Natta 1175 (1988).

treatment in a compensable claim. See Robert M. Bryant, 41 Van Natta 324 (issued this day); Frances M. Mead, 40 Van Natta 1878 (1988). At the same time, the Board will uphold a denial of all future treatment in a compensable claim in excess of two treatments per month. I am at a loss to understand the legal significance of the distinction. Developments in claimant's condition the day after the denial issues or the day after the hearing is conducted may just as realistically result in the need for treatment in excess of the guidelines, as within the guidelines. To permit a denial addressed to the future is therefore equally inappropriate in the two cases.

As I understand it, also, the Board will continue to declare that a denial is addressed only to billings rendered to the date of the denial. Robert M. Bryant, supra; Arlene S. Pettit, 40 Van Natta 1610 (1988); Billie J. Eubanks, 35 Van Natta 131 (1983). Nevertheless, the Board will uphold a denial issued although all requests for reimbursement for medical services have been granted -- at least where the denial is addressed to the extent of chiropractic treatment to be rendered in the future. Again, I am unable to grasp the legal principle which permits us to uphold a denial of medical services that is issued with respect to no request for reimbursement when frequency of treatment is at issue, but leads us to set aside all other denials that are addressed to no claim for reimbursement.

Consistent with our decisions in Robert M. Bryant, supra, and Arlene S. Pettit, supra, the denial should be set aside.

Board Member Ferris, concurring:

I join in the majority opinion, but write separately to address the concerns expressed by the dissent. The dissent states that the majority has upheld "a denial of all future treatment in a compensable claim in excess of two treatments per month." This is incorrect. The majority simply holds that claimant has failed to prove that more than two treatments per month were reasonable and necessary for his condition as it existed at the time of the denial. See James v. Kemper Insurance Co., 81 Or App 80, 84 (1986). Any impact that the majority decision may have on future treatment is limited to that permitted by the res judicata rule of issue preclusion. See William E. Anderson, 40 Van Natta 1798 (1988). Should claimant's compensable condition change and more frequent treatment or another kind of treatment be required, the majority decision would not preclude such treatment.

As for the dissent's objection to the form of the employer's denial, the dissent reads the denial as "purely prospective in nature" because it is "addressed to no service rendered" and alludes to treatment that claimant might receive after the date of the denial. The dissent reads the denial out of its procedural context. Prior to the denial, claimant had been receiving two or more chiropractic treatments per week for more than a year. A few weeks before the denial, claimant was examined by a panel of the Independent Chiropractic Consultants. The Consultants reported that claimant was medically stationary, that the treatment he had been receiving was palliative and that the frequency of the treatments had been excessive. (See Ex. 43-4). The employer issued its denial of "treatment in excess of two times per month" on January 30, 1987. The denial recites the information received from the Independent Chiropractic Consultants. Given this context, the employer clearly

contemplated the pattern of treatments claimant had received prior to the denial and denied the reasonableness and necessity of at least a portion of those treatments. The denial thus was not "purely prospective in nature." Even assuming, as the dissent apparently does, that the employer paid for all treatments rendered through the date of the denial, merely paying or providing compensation is not acceptance of a claim or an admission of liability. ORS 656.262(9). That fact, therefore, (if it is one) does not preclude the employer from contesting the reasonableness and necessity of the treatments.

The allusion to future treatment must also be read in the context of claimant's continuing course of treatment. It was nothing more than a warning to claimant and to his treating doctor of what the employer's policy would be toward future treatments. This allowed claimant and his doctor to reconsider and, if necessary, modify their course of treatment before incurring expenses which would not be reimbursed by the employer. The employer's warning was not intended to and did not have any prospective legal effect. It was not improper in any way.

THERESA L. HOWARD, Claimant
Malagon & Moore, Claimant's Attorneys
Nelson, et al., Defense Attorneys
Fenner, et al., Attorneys
H. Thomas Andersen (SAIF), Defense Attorney

WCB 87-06763, 86-15767 & 86-15861
February 23, 1989
Order on Reconsideration

Claimant requested reconsideration of that portion of the Board's November 3, 1988 Order on Review that did not award her counsel an attorney fee for services rendered on Board review. In order to fully consider the matter, we abated our prior order and granted both SAIF and Liberty Northwest an opportunity to respond. After receiving responses from the insurers, and further considering this matter, we make the following conclusions.

At the outset, we note that in its response to our Order of Abatement, SAIF included a copy of a ".307" order issued in this matter, dated June 22, 1987. Although our decision in regard to an insurer-paid attorney fee for services rendered at the hearing level rested in large part on the absence of ".307" order, the existence of such an order does not effect our decision. We reach this conclusion because the ".307" was not issued until June 22, 1987, approximately one month after the hearing had taken place. Since claimant's compensation was at risk at the time of hearing, her attorney is still entitled to an insurer-paid fee for services rendered in connection with the hearing. See Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). We now turn to the issue of an insurer-paid attorney fee for services at the Board level.

Under ORS 656.382(2), 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." Here, SAIF initiated Board review and sought to shift responsibility to Liberty Northwest. SAIF was ultimately successful. Because Liberty Northwest did not seek Board review, this case does not fall within ORS 656.382(2), as it allows for attorney fees against an employer or insurer who initiates an appeal. Anfora v. Liberty Communication, 88 Or App 30, 31 (1988).

The only remaining statutory provision applicable to attorney fees for services on review is ORS 656.386(1). That provision provides for an insurer-paid fee where a claimant finally prevails on review "from an order or decision denying the claim for compensation." Shoulders v. SAIF, 300 Or 606, 611 (1987).

As noted above, a ".307" order has been issued in this case. Although it was issued subsequent to the hearing, it was in effect prior to issuance of the Referee's order. The ".307" order was not submitted as part of the record, however, the Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(2) (OER 201(b)); Susan K. Teeters, 40 Van Natta 115 (September 7, 1988). Accordingly, we conclude that an order issued by the Workers' Compensation Department pursuant to ORS 656.307 is a document we can take administrative notice of and consider in resolving this case. Dwane Kester, 38 Van Natta 1417 (1986); Dennis Fraser, 35 Van Natta 271, 274 (1983).

In sum, we conclude that neither ORS 656.382(2) nor ORS 656.386(1) entitles claimant to attorney fees for services rendered on Board review. Shoulders v. SAIF, supra; Anfora v. Liberty Communication, supra. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

Board Member Crider, concurring in part and dissenting in part:

I concur in that portion of the Order on Reconsideration that rejects SAIF's contention that issuance of a .307 order following the hearing suggests that claimant was not entitled to an insurer-paid attorney fee for services at hearing. I dissent from that portion of the order that rejects claimant's contention that she is entitled to an insurer-paid fee for services on Board review.

The issues at hearing were compensability and responsibility. The Referee set aside SAIF's denial and upheld Liberty's denial. SAIF requested review. On review, claimant argued that the Referee was wrong -- that Liberty's denial should have been set aside and SAIF's upheld. Claimant had a stake in the proceeding in that her temporary disability benefits would be higher if Liberty were held responsible. We held Liberty responsible -- setting aside its denial on review. Claimant is entitled to a fee under 656.386 (1). SAIF v. Phipps, 85 Or App 436 (1987). For the reasons stated in my dissenting opinion in Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989), the majority errs in denying a fee.

COY D. KELLER, Claimant
Michael B. Dye, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney

WCB 86-06554
February 23, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Daron's order that: (1) upheld the SAIF Corporation's aggravation denial; and (2) affirmed a Determination Order award of unscheduled permanent disability for a back injury of 30 percent (96 degrees). On review, the issues are aggravation or, in the alternative, extent of permanent disability. We reverse.

FINDINGS OF FACT

We adopt Paragraphs 1 through 7 and Paragraph 11 of the Referee's findings of fact with the following supplementation.

Claimant, a 57-year-old lifelong painter with an 11th grade education, sustained several injuries to his back before December 20, 1984. A 1969 low back injury in Oregon resulted in an ultimate award of 15 percent unscheduled permanent disability; 1977 and 1984 low back injuries in Oklahoma resulted in total permanent disability awards of 14 percent to the body as a whole. Following the January 1984 injury, claimant was released for work on February 20, 1984 with a diagnosis of muscle sprain and strain to the paravertebral muscles.

Since claimant's April 1985 laminectomy at L4-5 and L5-S1 on the right, he has experienced continuous low back and left leg pain. Claimant was noted to have left leg pain in July 1985, September 1985, April 1986 and again in September 1986.

On October 11, 1986, claimant tripped and fell while on his way to an independent medical examination by BBV Medical Services. This fall caused a temporary increase in his low back and left leg symptoms. The December 1984 compensable injury remains a material cause of those continuing symptoms.

On October 31, 1986, claimant was examined by his treating physician, Dr. Poulson, for an acute episode of low back pain, resulting primarily from the October 11, 1986 fall. In his chart note, Dr. Poulson reported that walking, sitting, lifting and bending increased claimant's pain. He prescribed Darvon, Soma and some physical therapy and took claimant off work until February 11, 1987. SAIF received that chart note on November 14, 1986. When claimant last saw Dr. Poulson on February 11, 1987, he continued to be in an off work status with considerable pain.

CONCLUSIONS OF LAW

Aggravation

The Referee dismissed claimant's aggravation claim by concluding that: (1) his left leg pain did not appear until after claim closure in May 1986; and (2) the October 11, 1986 fall that occurred while claimant was on his way to an independent medical examination had no compensable relationship to his compensable injury of December 20, 1984. We disagree on both counts.

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 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). If a waxing and waning of symptoms was anticipated in the prior permanent disability award, claimant must show that the worsening was greater than that contemplated by the last award. Gwynn v. SAIF, 304 Or 345 (1987). However, if a worsening of the compensable condition results in either inpatient hospitalization for treatment of the condition or total disability for more than 14 consecutive days, then the claimant has established an aggravation as a matter of law.

The last award of compensation for claimant's back was the award of 30 percent (96 degrees) unscheduled permanent partial disability granted by the May 1986 Determination Order. Based upon the evidence available to the Evaluation Division at the time it granted the award, we conclude that the award anticipated ongoing and periodically fluctuating low back and leg pain. To prove an aggravation, therefore, claimant must show either: (1) that he experienced an increase in the symptoms of his compensable condition which required in-patient hospitalization or resulted in more than 14 consecutive days of temporary total disability; or (2) that he experienced disabling symptoms in portions of his body other than his back that were causally related to his compensable condition. The question of whether claimant's reported increase in low back and left leg symptoms in October 1986 was causally related to his compensable back condition presents 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).

Causal relationship of left leg pain

Claimant's left leg pain is well documented in the record. Dr. Poulson, claimant's treating physician, first noted left leg pain in July 1985, approximately three months after the laminectomy and foraminotomy at L4-5 and L5-S1 on the right. In September 1985 Dr. Corrigan noted complaints of low back and left lower extremity pain and weakness with slight hypesthesia on the lateral aspect of the left calf and foot to light touch. In April 1986 Dr. Poulson found that whenever claimant began to ambulate, sit, stand, or walk for a few minutes, or twist or turn, he experienced excruciating low back and left leg pain. After claim closure in May 1986, claimant continued to experience low back and left leg pain.

In March 1987 Dr. Poulson opined that claimant's lumbar and left lower extremity pain was caused by the December 20, 1984 injury. He further stated that the October 1986 fall aggravated those symptoms, although the increase in symptoms thereafter subsided and claimant returned to his pre-aggravation status.

BBV Medical Services examined claimant on October 11, 1986 and they believed that claimant's left leg pain was unrelated to his compensable 1984 injury. They relied, however, upon the erroneous belief that claimant's low back pain had completely resolved following the April 1985 surgery. Accordingly, we are more persuaded by the opinion of Dr. Poulson, claimant's longtime treating physician, who was well aware of the development of low back and left leg pain following the April 1985 surgery. We conclude that, at the time of hearing, claimant's low back and left leg condition was causally related to his compensable 1984 injury.

Causal relationship of the October 11, 1986 fall

The fact that claimant exacerbated his compensable condition as the result of a fall on his way to an independent medical examination for that condition does not defeat his claim for a compensable aggravation. The court in Fenton v. SAIF, 87 Or App 78, 83 (1987) held that "when a worker is injured in an accident which occurs during a trip to see a physician for treatment of a compensable injury, the new injury also is

compensable." Therefore, not only is claimant's left leg and low back condition compensably related to his 1984 injury, but any increased disability as a result of the October 1986 fall is also compensable if a valid aggravation claim was made by claimant.

Worsening of the compensable condition

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

On October 31, 1986, Dr. Poulson examined claimant and reported in his chart note of that date that claimant was suffering from a rather acute episode of low back pain. Dr. Poulson also reported the following:

> "Such things as walking, sitting, lifting and bending increases the pain. Any activity increases it. He moves very slowly. He is taking Tylenol 3 and Percodan with relief. He is staying about the same but improving a little. His best position is on his right side."
>
> "For this last problem, he was seen at the Salem Memorial Hospital and was evaluated. X-rays were taken [on October 13, 1986] and he was given Tylenol 3."
>
> "Past History: On 12/20/84, he had an on the job injury. So he has had a continuation of his old problem and aggravated by this fall."
>
> * * * *
>
> "We gave him some Darvon, Soma and also some physical therapy. He is to return again in a week."

SAIF received Dr. Poulson's October 31, 1986 chart note on November 14, 1986. Since the chart note indicated that claimant was in need of further medical services, it constituted a valid claim for aggravation and should have been treated as such by SAIF.

On May 6, 1987, Dr. Poulson indicated that claimant was on an off-work status until February 11, 1987, his last visit with the doctor.

We are persuaded by the opinion of Dr. Poulson that claimant's condition worsened following the October 1986 fall, causing total disability for a period of at least four months. Because claimant was totally disabled for more than 14 consecutive days, we conclude that he has established an aggravation as a matter of law. See Gwynn v. SAIF, supra. Claimant is entitled to temporary disability benefits beginning November 14, 1986, the date SAIF received medical verification of claimant's need for medical services.

Since claimant has established a compensable aggravation claim, we decline to address the issue of the extent of his permanent disability. That matter will be addressed by the Evaluation Division upon claim closure.

ORDER

The Referee's order dated August 13, 1987 is reversed. The SAIF Corporation's denial of claimant's aggravation is set aside and the claim is remanded to SAIF for processing according to law. Claimant's counsel is awarded an assessed fee of $750 for his efforts in setting aside the aggravation denial, to be paid by SAIF.

ALICE C. LADELLE, Claimant
Coons & Cole, Claimant's Attorneys
David C. Force, Attorney
Charles Lisle (SAIF), Defense Attorney

WCB 86-00676
February 23, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Seymour's order that awarded claimant only an attorney fee payable out of her increased permanent partial disability compensation. We modify claimant's attorney fee award.

ISSUE

1. Whether claimant's counsel is entitled to a reasonable assessed fee for his efforts at hearing in setting aside SAIF's denial of claimant's aggravation claim.

2. Whether claimant is entitled to a reasonable attorney fee on Board review.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplement.

On November 3, 1986, SAIF denied claimant's aggravation claim, stating that medical information indicated that claimant's condition had not worsened since her claim was previously closed.

On November 4, 1986, claimant's counsel informed SAIF that claimant's treating physician had reduced her working hours from eight to six due to increased headaches, back and neck pain. Along with that letter to SAIF, claimant's counsel attached a "Petition to Reopen" claimant's claim.

On December 8, 1986, SAIF indicated in a 1502 Insurer's Report that claimant had been paid temporary disability compensation on her accepted claim at the rate of $115.54 from July 9, 1986 through October 22, 1986.

At hearing on June 10, 1987, claimant was medically stationary and did not contend that she was entitled to additional temporary disability benefits. The only issue at hearing was whether claimant's condition had worsened to the extent that she was more disabled than at the prior arrangement of compensation, thereby entitling her to additional permanent partial disability benefits.

CONCLUSIONS OF LAW

Attorney fee on denied claim

The Referee concluded that the sole issue was the extent of claimant's unscheduled permanent disability and therefore

awarded an attorney fee out of that increased compensation. We disagree and modify the attorney fee award.

On November 3, 1986, SAIF denied that claimant's compensable condition had worsened. Although SAIF subsequently paid temporary disability benefits and claimant alleged no entitlement to increased temporary disability benefits at hearing, SAIF did not withdraw its aggravation denial prior to or at hearing. Therefore, it was claimant's burden to overcome that denial by proving that she had in fact suffered a worsening of her condition since the prior award of compensation in order that she be entitled to a rating of her permanent disability. Claimant successfully carried that burden of proof. Because she was medically stationary at the time of hearing, the Referee went on to rate the extent of disability due to claimant's compensable aggravation claim.

Former ORS 656.386 provides that:

> "(1) In all cases involving accidental injuries where a claimant finally prevails . . . from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee . . . then the referee . . . shall allow a reasonable attorney fee.
>
> "(2) In all other cases attorney fees shall continue to be paid from the claimant's award of compensation except as otherwise provided in ORS 656.382."

SAIF denied claimant's claim for compensation. Since the Referee found at hearing that claimant had suffered an aggravation of her compensable condition and was therefore entitled to additional compensation, claimant's counsel is entitled to a reasonable attorney fee, to be paid by SAIF. This award is in addition to, and not in lieu of, the Referee's award of 25 percent of the additional compensation made payable by his order.

As previously discussed, claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney for services rendered at hearing. See ORS 656.386(1). 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.

Attorney fee on Board review

Claimant is not entitled to an additional attorney fee on Board review because an attorney fee ordered to be paid by the insurer is not an element of "compensation" as the term is used in ORS 656.382(2). Dotson v. Bohemia, Inc., 80 Or App 233, 235 (1986).

ORS 656.386(1), supra, provides for an attorney fee in all cases involving accidental injuries where a claimant finally

prevails from an order or decision denying the claim for compensation.

"'Compensation' includes all benefits, including medical services, provided for a compensable injury to a subject worker . . . " ORS 656.005(8). The term "compensation" refers to those benefits set forth in ORS 656.202 to ORS 656.258. Dotson v. Bohemia, Inc., supra at 236. Those benefits do not include attorney fees. Id.

ORDER

The Referee's order dated June 16, 1987 is modified in part. Claimant's attorney is entitled to a reasonable attorney fee for counsel's efforts at hearing in setting aside the SAIF Corporation's aggravation denial. This assessed fee is payable in addition to the Referee's award of an attorney fee of 25 percent of the additional compensation made payable by his order. However, this assessed fee cannot be awarded at this time because no statement of service has been filed. The remainder of the Referee's order is affirmed.

DOROTHA L. McDARMENT, Claimant
Malagon & Moore, Claimant's Attorneys
Richard D. Barber (SAIF), Defense Attorney

WCB 86-09858
February 23, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Nichols' order which: (1) declined to award temporary disability benefits from October 28, 1986 to February 11, 1987; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable refusal to pay temporary disability benefits. On review, the issues are temporary disability benefits and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

Claimant originally injured her right knee in August 1981 while working as a bartender/waitress for the SAIF Corporation's insured. Claimant has not worked as a bartender/waitress, her job at the time of the injury, since a shoulder injury in 1983. She has not looked for work in this field since that time, but rather has helped her husband run a family owned service station of which she is the co-owner.

In March 1986, she was seen by Dr. Carlsen for complaints of worsened symptoms over the last several months. In October 1986, claimant was examined by Western Medical Consultants, who diagnosed a possible tear of the median meniscus, and recommended an arthroscopic exam on claimant's right knee.

Claimant's surgery was approved by SAIF in December 1986 and scheduled for January 1987, but was postponed until February 1987, partly because claimant had the flu. Prior to the surgery, in December 1986, SAIF asked Dr. Carlsen if claimant was able to do bookkeeping up until the time of the surgery and he agreed that she could perform such duties because of the sedentary nature of those duties. Dr. Carlsen released claimant to regular work on February 26, 1987.

There was not a medically verified inability to perform claimant's duties at the service station until February 11, 1987, the date of the surgery. SAIF paid time loss benefits from that date through the time of the hearing.

FINDINGS OF ULTIMATE FACT

Since 1983 claimant has been involved in operating a family-owned service station.

Claimant was able to perform her work at the service station until February 11, 1987, the date of the surgery.

CONCLUSIONS OF LAW

We adopt the "conclusions and reasonings" of the Referee with the following supplementation.

In adopting the Referee's opinion, we wish to emphasize the fact that the Referee found claimant's testimony unreliable. Following our de novo review of the record, we agree with this finding, and therefore have rejected her testimony that she did not abandon her efforts to work in her at-injury job well before her condition came to require surgery. We have found that, by October 28, 1986, claimant had become involved in the family-run service station in place of her former occupation.

The evidence establishes that claimant was able to do her tasks connected with the service station until the time of her February 11 surgery. She was not required to leave that work due to her need for medical services. She was thus not temporarily disabled and not entitled to temporary disability benefits until February 11. We observe that, contrary to the implication of the Referee's order, the lack of medical verification of inability to work is not dispositive of the question of claimant's entitlement to temporary disability benefits. Although her physician's opinion that she was able to do her service station-related work until the date of surgery is evidence that she was not disabled, other evidence may establish that she was disabled at an earlier date. Claimant is entitled to temporary disability benefits for the entire period of her disability. Botefur v. City of Creswell, 84 Or App 627 (1987); Silsby v. SAIF, 39 Or App 555, 562 (1979). On review of all the credible evidence, however, we do not find that claimant was temporarily disabled prior to surgery.

The lack of medical verification of inability to work pre-surgery, however, does preclude the assessment of a penalty and attorney fee for failure to commence payment of temporary disability compensation at an earlier date; for the duty to commence payments does not mature until the insurer receives medical verification of inability to work due to a worsening of the compensable injury. Silsby v. SAIF, supra, 39 Or App at 563.

ORDER

The Referee's order dated July 30, 1987 is affirmed.

CRAIG M. TOLONEN, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 87-02169
February 23, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer, requests review of Referee Menashe's order that set aside its denial of claimant's occupational disease claim for his anxiety condition. We affirm.

ISSUE

The issue on review is compensability.

FINDINGS OF FACT

Claimant is a 35 year old glazier for the employer, a school district. He has worked for the employer for fourteen years.

Claimant has a long history of alcohol and substance abuse. He has maintained his sobriety since 1983, with the help and support of his family. Additionally, he has a personality disorder which predisposes him to suffer from anxiety-related conditions, including headaches and depression.

Claimant's usual work assignment was on the day shift. Periodically, he was transferred to the swing shift (3:00 to 11:00 p.m.). The transfer was based entirely on the seniority system, as dictated by the union contract.

In 1985, claimant was transferred to the swing shift, due to a change in work load. He resisted the transfer and filed a grievance. He sought exemption from the assignment due to medical problems. Claimant believed that working swing shift would infringe on the time he spent with his family and interfere with his ability to maintain his sobriety. Finding no violation of the union contract, the grievance committee denied his grievance. The shift change was based on seniority in accordance with the union contract. Because claimant had low seniority he was required to work the shift.

Claimant continued to work the swing shift occasionally through March 1986. During this period he was treated for depression. He was reassigned to the day shift in April.

Claimant suffered from acute anxiety attacks in June and July 1986. He sought emergency treatment. These anxiety attacks produced symptoms which included paresthesias in the left arm, left sided headaches, weakness, chest discomfort, and hyperventilation.

Following his July 1986 emergency treatment, he was referred to a neurologist for further studies, which were normal. In August 1986, he began treating with Dr. Harburg, internist. Dr. Harburg prescribed Librium to control his anxiety with hyperventilation and subsequent neurologic symptoms.

Claimant continued to work the day shift. In the fall he was told that the swing shift would be reinstituted. The anticipated change in shift required him to seek further medical treatment because of his increased anxiety. On September 9, 1986 and on November 14, 1986, claimant presented his foreman with a medical release stating that he could not work the night shift as it would exacerbate his nervous condition .

Claimant appeared to be doing better, having only occasional anxiety episodes, until November 1986. He then experienced another anxiety attack. Claimant was treated with antidepressants on a trial basis. Because he was unable to tolerate the drug he was retreated with Librium. Claimant experienced one more anxiety attack in December of 1986. His librium was increased.

On January 5, 1987, claimant was once again assigned to the swing shift. Two days later, during his shift, he experienced another anxiety attack. On January 16, 1987, Dr. Harburg released claimant from work, indefinitely, due to his preexisting anxiety condition which was worsened by the move to swing shift.

On January 16, 1987, claimant filed a claim for job related stress. The employer denied on the basis that unrelated employment activities and personal reasons were the cause of claimant's anxiety condition.

On February 19, 1987, Dr. Turco, psychiatrist, performed an independent examination. Dr. Turco diagnosed chronic alcoholism (in good remission) and adult adjustment reaction regarding his concerns about shift work.

Dr. Harburg referred him to Dr. Winkler, a clinical psychologist. Dr. Winkler performed both an objective test of personality and the MMPI. The test results revealed that claimant was under rather severe stressful conditions and his disorder appeared to fall within the neurotic range of behavior, fear being a primary component. His personality profile indicated elevated hypochondriasis, anxiety, depression and mania. Dr. Winkler treated claimant with Xanax and psychotherapy. Claimant was retested in April, 1987. The results indicated claimant had benefited from the treatment regime. He continues to complain of tension headaches, irritability, loss of sleep and other anxiety associated symptoms.

Claimant returned to day shift work on March 22, 1987.

CONCLUSIONS OF LAW

The Referee concluded that claimant's condition was compensable. We agree.

The medical evidence establishes that claimant had a preexisting anxiety condition. Thus, for claimant to establish his claim for job stress, he must prove by a preponderance of the evidence that he suffered a worsening of his anxiety condition and that his work exposure was the major contributing cause of that worsening and his resulting disability. Weller v. Union Carbide, 288 Or 27, 35 (1979). The exacerbation need not be a permanent worsening of the condition, so long as it is a worsening. Wheeler v. Boise Cascade, 298 Or 452, 457 (1985). In the absence of a satisfactory medical explanation of a distinction between symptoms and the condition, the symptoms are the condition. Adsitt v. Clairmont Water District, 79 Or App 1, 7 rev den 301 Or 338, 301 Or 666 (1986); SAIF v. Varner, 89 Or App 421 (1988).

Stress caused claims for benefits arising out of mental and physical disorders are compensable if they flow from objectively existing conditions of the worker's employment and those work conditions, when compared to non-employment conditions, are the major contributing cause of claimant's mental disorder. McGarrah v. SAIF, 296 Or 145, 166 (1983). Claimant's reaction to the work events need

not have been reasonable or rational. If claimant reacted to real events, he has a basis for a stress claim. See Leary v. Pacific Northwest Bell, 67 Or App 766 (1984).

The stressful conditions must be objective in that they must be real, however, the medical effect on the worker is measured by the worker's actual reaction, rather than by an objective standard of whether the conditions would have caused disability in the average worker. Peterson v. SAIF, 78 Or App 167, 170 (1986); SAIF v. Shilling, 66 Or App 600 (1984).

The Referee found that the school district had the authority to alter claimant's work schedule. Claimant's fear and anxiety concerning his alcoholism and ability to maintain his sobriety due to schedule change was genuine and deeply felt. The situation he faced was real; conform to the work schedule or seek employment elsewhere. We conclude that claimant reacted to a real work event and has established the basis for a stress claim.

We generally accord greater weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810. When there is a dispute between medical experts, more weight will be given to the medical opinion which is both well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Claimant's treating doctors, Dr. Harburg and Dr. Winkler, found that his shift change was the major contributing cause of exacerbating his anxiety disorder. Further, Dr. Winkler opined that if claimant were not working or under the stress of the swing shift his anxiety symptoms would subside.

Dr. Turco, psychiatrist and independent examiner, found claimant's condition developed due to the change in work hours. His review of outside stresses and issues of his personal life were found to be noncontributory. At hearing, Dr. Turco testified that the work change aggravated claimant's anxiety and other symptoms. He attributed claimant's problems to his underlying alcoholism, somatoform disorder, and dependent personality.

The employer argues, however, that claimant's overuse of librium and underlying adjustment disorder caused his problems in January, 1987. In support of its argument, the employer relies on the testimony of Dr. Larsen. Dr. Larsen, psychiatrist, testified at hearing that claimant was addicted to librium and was suffering from withdrawal. He opined, in the alternative, that claimant's condition was due to manipulation. Dr. Larsen performed a medical file review; he did not examine or interview claimant. In addition, the employer argues that claimant suffered the same symptoms in June and July 1986 while working the day shift. Therefore, his symptomatology was not related to the swing shift and not the major cause of his problem, but instead his preexisting conditions.

We find that the weight of the medical evidence establishes that claimant's preexisting anxiety condition and associated symptoms were worsened by his shift change. The altered work schedule was the major contributing cause of the worsening of his anxiety condition and resulting disability. Therefore, his claim for occupational disease is 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 June 29, 1987 is affirmed.

RICK L. KASSEBAUM, Claimant
Merrill Schneider, Claimant's Attorney
Scheminske & Lyons, Defense Attorneys

WCB 86-10070
February 24, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Thye's order that declined to award interim compensation and penalties and attorney fees for nonpayment of interim compensation. We reverse.

ISSUES

Interim compensation for an aggravation claim, penalties and attorney fees.

FINDINGS OF FACT

We adopt the findings of the Referee and set forth the relevant portions thereof:

Claimant is a 38-year-old production worker who struck his right elbow at work on May 22, 1985. The claim was closed by Determination Order of March 10, 1986, awarding temporary disability through February 5, 1986, and 10 percent scheduled permanent disability for loss of use of the right arm.

On March 21, 1986, claimant was examined by Dr. Wisdom, M.D. He complained of soreness in his elbow. Wisdom diagnosed chronic lateral epicondylitis. He signed an 827 form, a First Medical Report, indicating claimant was not medically stationary and was not released for work. The insurer received this form on April 24, 1986. The insurer had received chart notes from Dr. Wisdom prior to receiving this form which indicated clamant's condition was about the same as ever. The insurer never responded to this form as an aggravation claim and did not pay claimant interim compensation for the following relevant periods: April 24, 1986 to April 29, 1986; May 6, 1986 to July 22, 1986; September 10, 1986 to November 12, 1986.

The claim was reclosed by a Determination Order dated January 6, 1987, which awarded additional temporary disability only. The claim was reopened for aggravation February 19, 1987, and was still open at the time of hearing.

ULTIMATE FINDINGS OF FACT

Claimant filed an aggravation claim sufficient to put the insurer on notice to begin interim compensation or deny the claim within 14 days. The insurer did not deny the claim within 14 days and did not pay interim compensation after receiving medically verified information that claimant was not medically stationary and not released for work. The insurer unreasonably

delayed paying interim compensation and either accepting or denying the claim.

CONCLUSIONS

The Referee analyzed the evidence as whether claimant submitted sufficient documents to the insurer to constitute an aggravation claim. He found that claimant did not. We disagree.

On March 28, 1986, Dr. Wisdom signed a "First Medical Report" based on his March 21, 1986 examination indicating claimant was not medically stationary and that he was not released for work. The report indicates that the injury is work related. The insurer received this report on April 24, 1986. On these facts alone, we conclude that claimant filed an aggravation claim sufficient to satisfy ORS 656.273(2). The report itself does not need to prove a worsened condition. Rather, its purpose is to put the insurer on notice that treatment for more than continuing conditions is indicated. Krajacic v. Blazing Orchards, 84 Or App 127 (1987).

It is true that when the insurer received the March 28 report, it was also in receipt of chart notes of Dr. Wisdom made upon examinations after claimant had been in a fight. These chart notes detail the injuries claimant suffered in the fight and note that his elbow was scraped. The insurer argues on appeal that the First Medical Report must be read with these chart notes and, therefore, does not constitute an aggravation claim. We disagree.

When the insurer received the First Medical Report, it could tell that the report was based on information from the March 21, 1986 examination. This examination took place before the fight, and the report states that claimant is not medically stationary. We believe that when an insurer receives this information from a doctor, the insurer should be on notice that more than a continuing complaint may be involved.

The real issue in this case is the insurer's obligation to pay interim compensation after receiving the aggravation claim. Under ORS 656.262 and 656.273(6), the insurer must either begin paying interim compensation within 14 days or deny the claim. Here it did neither. We note that this is the prohibited "third choice" described in Jones v. Emanuel Hospital, 280 Or 147, 151 (1977). The insurer delayed, neither accepting nor denying the claim, and also did not pay interim compensation.

We find that the insurer has unreasonably delayed either accepting or denying the aggravation claim and did not make interim payments for certain periods of time. Consequently, we award claimant interim compensation for those periods of time set forth in our findings of fact. In addition, a 25 percent penalty and a reasonable attorney fee is assessed. See ORS 656.262(10).

ORDER

The Referee's order dated August 26, 1987 is reversed. Claimant is awarded temporary total disability for the following periods: April 24, 1986 through April 29, 1986; May 6, 1986 through July 23, 1986; September 10, 1986 through November 12, 1986. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. As a penalty for its unreasonable claims processing, the insurer shall

pay claimant an additional 25 percent of the aforementioned temporary total disability payments. Claimant's attorney is also awarded an attorney fee of $500 on the penalty issue, to be paid by the insurer. A client-paid fee, not to exceed $858.50, is approved.

LEROY MILLAGE, Claimant
Kulongoski, et al., Claimant's Attorneys
Williams, et al., Defense Attorneys

WCB 87-05147
February 24, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Menashe's order which upheld the self-insured employer's denial of claimant's right wrist/hand injury claim. On review, the sole issue is whether claimant's injury arose out of the course and scope of his employment. We affirm.

FINDINGS OF FACT

On March 5, 1987, claimant received a phone call while at work. Claimant's supervisor told claimant he could take the call in the supervisor's office. When claimant answered the phone call, his family physician informed claimant that his 15-year old daughter was pregnant. This was the first time, claimant learned of his daughter's pregnancy.

Following the phone call, claimant returned to his work station. In route to his work station, claimant became upset and punched a stack of containers with his right hand. Shortly thereafter, he began to experience pain in his right hand. He then asked for and was granted permission to leave work.

Claimant's condition was diagnosed as a sprain/strain of the right wrist. On March 18, 1987, the self-insured employer denied compensability of claimant's right hand/wrist condition.

Claimant's right hand/wrist condition did not arise out of, or in the course and scope of his employment.

CONCLUSIONS OF LAW

The Referee concluded that claimant's injury did not arise out of, or in the course and scope of, his employment. We agree.

In Rogers v. SAIF, 289 Or 633 (1980), the Supreme Court adopted a unitary "work-connection" approach which poses the following question: "Is the relationship between the injury and the employment sufficient that the injury should be compensable?" 289 Or at 642. In applying this approach, it is first necessary to determine whether the injury occured while claimant was at work or engaged in work-related activity, taking into consideration time, place, and circumstances surrounding the injury. Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983). There must also be a showing that a causal link exists between the occurrence of the injury and a risk connected with the particular employment. 296 Or at 29.

In the instant case, claimant received purely personal information which understandably upset him, causing him to vent his

anger by striking the containers. Yet, this information lacked any connection to claimant's work. Rather, the information concerned a personal matter. While the injury did occur at work, it cannot be said that claimant was engaged in a work-related activity. Further, there is no causal relationship between claimant's injury and a risk connected with his employment. The only connection between claimant's injury and his employment is the fact that it occurred while he was at work. This single factor is not enough to make the injury compensable. Rogers, supra. Accordingly, the injury is not compensable.

ORDER

The Referee's order of October 7, 1987 is affirmed. A client-paid fee, not to exceed $289, is approved.

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

WCB 86-03204
February 24, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Myers' order which: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition; (2) declined to assess penalties and related attorney fees for an alleged unreasonable denial; and (3) increased claimant's unscheduled permanent disability award for a low back condition from 20 percent (64 degrees), as awarded by a Determination Order, to 50 percent (160 degrees). On review, the issues are aggravation, penalties and related attorney fees and extent of unscheduled disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "findings of fact."

FINDINGS OF ULTIMATE FACT

Due to his compensable injury, claimant was disabled from work from November 25, 1985 through March 9, 1986, at which time he began a vocational training program.

SAIF's denial of claimant's aggravation claim was not unreasonable.

CONCLUSIONS OF LAW

The Referee concluded that claimant's prior permanent disability award contemplated a "waxing and waning" of his condition, therefore he found that claimant had not sustained an aggravation. We disagree based upon the Supreme Court's holding in Gwynn v. SAIF, 304 Or 345 (1987), a decision issued subsequent to the Referee's order.

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 disability 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, supra at 352-53; see also International Paper Co. v. Turner, 304 Or 354, 358 (1987).

Claimant received a total of 20 percent (64 degrees) unscheduled permanent partial disability for his low back condition. In November 1985, he experienced a symptomatic worsening of his compensable condition and temporarily became totally disabled. We agree with the Referee that this prior award did anticipate that claimant would experience temporary exacerbations of his compensable condition. However, regardless of the fact that temporary exacerbations were anticipated at the time of the last award, claimant's temporary total disability exceeded 14 days. Therefore, claimant, has proven a compensable aggravation. Gwynn v. SAIF, supra at 353. Consequently, he is entitled to temporary total disability benefits from November 25, 1985, the date he became disabled, through March 9, 1986, the day before he began an authorized training program.

In regard to the issue of penalties and related attorney fees, we adopt the Referee's conclusion with the following supplementation.

At the time SAIF issued its denial, the caselaw suggested that "waxing and wanings" anticipated at the time of the last arrangement of compensation did not constitute an aggravation. See Jimmie B. Hill, 37 Van Natta 728, 729 (1985). Given this, Dr. Silver's report which notes that claimant had suffered intermittent attacks of low back pain for a number of years and recommends against surgery due to a lack of significant nerve compression, was reasonable grounds on which to issue a denial. Furthermore, claimant's increased back complaints were preceded by an off-work activity, i.e., chopping firewood. Under these circumstances, we conclude that SAIF's denial was not unreasonable. Accordingly, penalties and related attorney fees are not warranted.

In regard to the remaining issue of extent of permanent disability, we adopt the Referee's conclusions and reasoning.

Claimant's attorney is entitled to an assessed fee for services at hearing for prevailing against SAIF's denial. However, no Statement of Services for the hearing level was submitted, only a Statement of Services for Board review. Therefore, we are unable to award an attorney fee for services rendered at the hearing. OAR 438-15-010(5).

ORDER

The Referee's order dated August 12, 1987 is reversed in part and affirmed in part. That portion which upheld SAIF's denial of an aggravation claim for claimant's low back condition is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for the payment of temporary total disability benefits from November 18, 1985 through March 9, 1986. The remainder of the Referee's order is affirmed. For services on Board review concerning the aggravation issue, claimant's attorney is awarded an assessed fee not to exceed $510, to be paid by the SAIF Corporation.

TIEN VU, Claimant
Jack Ofelt, Jr., Claimant's Attorney
Acker, et al., Defense Attorneys

WCB 86-04849
February 24, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of Referee Tenenbaum's order which set aside its partial denial of claimant's right eye amyloidosis condition. On review, the sole issue is compensability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to his right eye when some cleaning solution splashed in his face and right eye. The injury was diagnosed as a right eye corneal abrasion. The eye was treated immediately with washing and patching. Claimant was released for regular work on the day following the accident.

Approximately six days after the accident, claimant experienced blurred vision, tearing, and pain in his right eye. This condition was diagnosed as amyloidosis of the conjunctiva of the right eye. The insurer denied this condition on the basis that it was not related to claimant's compensable eye injury.

Claimant is permanently restricted to wearing glasses when at his work, and he has been advised to wear glasses all the time.

FINDINGS OF ULTIMATE FACT

Claimant's compensable right eye injury is not causally related to his right eye amyloidosis.

CONCLUSIONS OF LAW

The Referee concluded that claimant's compensable right eye injury was causally related to his right eye amyloidosis.

The Referee's conclusion was based upon the temporal relationship between the right eye injury and the subsequent development of right eye amyloidosis. In reaching this conclusion, the Referee relied on International Paper Co. v. Tollefson, 86 Or App 706 (1987) and Collins v. Hygenic Corp. of Oregon, 86 Or App 484 (1987), for the proposition that the amyloidosis was compensable as there was no explanation, other than the compensable injury, for the condition. We find, however, that the medical evidence does not correspond with the Referee's conclusion.

Dr. Fraunfelder, a treating opthamologist, opined that claimant's solvent-chemical exposure to his right eye was inconsequential to the development of the amyloidosis as the location of that condition was inconsistent with the chemical exposure. Dr. Fraunfelder further felt that it was medically improbable that the amyloidosis was secondary to the compensable injury and that it was more probable that the condition was progressive.

Dr. Rosenbaum, an examining opthamologist, reported that he was unaware of any research that related amyloidosis to trauma or burns, but felt he could not exclude that possibility given the temporal relationship between the injury and development of the

condition. The mere possibility of a causal relationship, however, is insufficient to establish compensability. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Dr. Marquis, opthamologist, reported that he was unaware of any correlation between claimant's compensable right eye injury and the development of right eye amyloidosis. Dr. Marquis described amyloidosis as a "buildup of abnormal substance which is usually localized to the eyelid."

Given Dr. Fraunfelder's opinion that the amyloidosis was not causally related to the compensable injury and Drs. Rosenbaum and Marquis equivocal opinions as to causation, we find that claimant has not carried his burden of proving that a causal relationship exists between the compensable injury and the amyloidosis condition. Accordingly, we conclude that the amyloidosis condition is not compensable.

ORDER

The Referee's order dated September 10, 1987 is reversed. The insurer's denial of March 27, 1986 is reinstated and upheld. A client-paid fee, not to exceed $229.50, is approved.

WALTER L. ROWLEY, Claimant
Green, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 86-01653
February 28, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of that part of Referee Lipton's order that set aside its denial of claimant's myocardial infarction. On review, the sole issue is compensability.

We reverse.

FINDINGS OF FACT

Claimant, 61 years of age at the time of hearing, is employed as a night janitor at an elementary school. He has difficulty completing his work within his scheduled eight hour shift and often has to work overtime.

While working on the evening of October 14, 1985, claimant interrupted his work to go outside and confront two young boys who were on the roof of the school house. He was initially concerned with the boys' safety, and he directed them to come down off the roof and leave the property. Claimant was annoyed by their abusive manner and the fact that the interruption meant he would have to work faster in order to get his chores done by the end of his shift. The boys failed to leave the roof, and claimant confronted them a second time and eventually called the police when they did not respond to his warning.

A short time after the second confrontation, claimant experienced significant chest pains. His symptoms disappeared when he sat down and took a 10 minute break. He commenced working and experienced a recurrence of less severe pain shortly before the end of his shift. His symptoms again resolved after he rested for 10 to 15 minutes. He experienced further chest pains later that evening at his home and again the following morning. These pains

were more severe and of longer duration than his symptoms at work. He was hospitalized and diagnosed with preexisting coronary artery disease and an acute myocardial infarction.

Claimant filed a claim for his myocardial infarction. The insurer denied the claim, and claimant requested a hearing.

FINDINGS OF ULTIMATE FACT

Claimant's work environment on October 14, 1985 caused him to experience an acute episode of physical and emotional stress. The chest pains claimant experienced while he was at work on that day were attributable to angina, a condition which often proceeds but does not contribute to myocardial infarction. Claimant's actual myocardial infarction occurred after he left work. Although his work-related stress contributed to his angina, the record does not demonstrate that his stress materially contributed to his subsequent myocardial infarction.

CONCLUSIONS OF LAW AND OPINION

On review, the insurer contends that the Referee erred in setting aside its denial of claimant's injury claim for a myocardial infarction. In order to prevail on this issue, claimant must prove that his work activity was both the legal and the medical cause of the condition. In order to prove legal causation, he must demonstrate that his work resulted in physical or emotional stress. To establish medical causation, he must demonstrate that his work-related stress was, within reasonable medical probability, a material contributing cause of the infarction. Medical causation must be established by medical experts. Somers v. SAIF, 77 Or App 259, 262 (1986).

The Referee was persuaded that claimant's work activity on October 14, 1985 produced sufficient stress to satisfy his burden of proving legal causation. He also concluded that the medical evidence indicated that claimant's stress materially contributed to his subsequent heart attack. We agree with the Referee's conclusion that claimant has carried his burden of proving legal causation. However, we do not agree that claimant has demonstrated the requisite medical causation.

The Referee relied on the opinión of Dr. Giedwoyn, the cardiologist who began treating claimant several months after his infarction. Dr. Giedwoyn indicated that claimant's symptoms at work on October 14, 1985 were attributable to angina and that his actual myocardial infarction occurred after he left work. He believed that work-related stress contributed to the formation of blood clots which, in turn, contributed to claimant's subsequent heart attack. The Referee found that Dr. Giedwoyn's role as treating cardiologist put him in a better position to render an opinion on the cause of his heart attack. He further concluded that Dr. Giedwoyn's opinion was well-reasoned and sufficient to carry claimant's burden of proving medical causation.

We disagree, and instead rely on the contrary position of Dr. Kloster, cardiologist. He rendered an independent medical opinion based on claimant's file and the testimony at hearing. Dr. Kloster agreed that claimant's symptoms at work were characteristic of angina and that the hospital records and lab reports indicated that the actual myocardial infarction occurred after claimant left work. However, he did not believe that

claimant's work-related stress produced blood clotting or otherwise contributed to his subsequent myocardial infarction. He, instead, attributed claimant's heart attack to the natural progression of his underlying coronary artery disease.

In support of that position, he noted that there is no clear evidence that external stress contributes to blood clotting. Rather, studies indicate that stress contributes to heart attacks by obstructing oxygen flow, and he noted that major studies in this area have concluded that only episodes of severe emotional or acute physical stress contribute to the development of myocardial infarctions, as distinct from symptoms of angina. He did not believe that claimant's physical work activity or emotional stress rose to that level. He noted that the fact claimant failed to report that incident until shortly before hearing indicated that it had not been severely stressful.

We find Dr. Kloster's opinion to be well-reasoned and consistent with current medical research. Furthermore, we disagree with the Referee's finding that Dr. Giedwoyn is in a better position than Dr. Kloster to render an opinion on this issue. Dr. Giedwoyn did not examine claimant until two months after his attack. Furthermore, his knowledge of claimant's stressful work activity did not come from claimant but was, instead, based on a letter from claimant's attorney. Moreover, the causation issue in this case turns on expert analysis rather than personal observation. In this case, we are persuaded that Dr. Kloster's opinion provides the better-reasoned analysis.

We, therefore, defer to his opinion and conclude that claimant has not carried his burden of proving medical causation. Accordingly, we reverse the Referee on this issue.

ORDER

The Referee's order dated May 26, 1987 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's myocardial infarction and awarded an insurer-paid attorney fee concerning this issue is reversed. The insurer's denial is reinstated and upheld. We affirm the remainder of the order.

DANNY M. RUSK, Claimant
David Hollander & Assoc., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-12348
February 28, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Zucker's order that: (1) upheld the insurer's denial of further chiropractic care; (2) found that his back and neck injury claim was not prematurely closed by a Determination Order; and (3) affirmed a Determination Order that did not award any unscheduled permanent disability.

The Board reverses in part and affirms in part.

ISSUES

1. Whether the insurer's denial of further chiropractic care was an impermissible prospective denial.

2. Whether claimant's neck and back injury claim was prematurely closed by a Determination Order.

3. Whether claimant is entitled to an award of unscheduled permanent disability.

FINDINGS OF FACT

The Board adopts the Referee's factual findings with the following supplementation.

Claimant has minimal physical impairment and disabling headache pain as a result of his compensable injury of May, 1986.

CONCLUSIONS OF LAW

Medical Services

The insurer's September 8, 1987, denial stated:

> "This letter is to notify you of the denial of further chiropractic care for your injury of the above date. Independent medical examinations have shown that further chiropractic care is not needed at this time, and that you could get equal benefit from doing exercises at home. Because of these circumstances, I am denying further chiropractic care from this date forwared [sic]." (Emphasis added.)

At the hearing, the Referee discussed the parties positions on the scope of the above denial, stating, inter alia:

> "The employer states that it [i.e., the denial] is intended only to apply to current treatment, to be a denial of current treatment. Claimant states that, in any case, he was not advised of that until today and is, therefore, entitled to a penalty and attorney fee."

We recently addressed the propriety of a prospective denial of medical services in Robert M. Bryant, 41 Van Natta 324 (February 23, 1989), stating, inter alia:

> "A denial of care in the future is void; and any denial of treatment in reliance on such a denial must be set aside."

Here, as in Bryant, the employer denied further chiropractic care beyond the date of its denial. Accordingly, pursuant to Bryant, we conclude that the insurer's denial is an impermissible denial of claimant's right to future medical services, see ORS 656.245(1), and, therefore, must be set aside.

Premature Claim Closure

To establish premature claim closure, a worker must prove, by a preponderance of the evidence, that he was not medically stationary on the effective date of claim closure.

Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985). "Medically stationary" is defined as "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Whether or not claimant was medically stationary on June 2, 1987, is, in our view, largely a medical question to be resolved by expert testimony. See Uris v. Compensation Dept., 247 Or 420 (1967).

Here, claimant was examined by Dr. Olmscheid, M.D., and Dr. Hopkins, M.D., on November 26, 1986. Olmscheid reported that he expected claimant's condition to become medically stationary in six-to-eight weeks. Hopkins recommended physical therapy treatment for approximately three weeks and then further evaluation for a "possibl[e]" return to work. On June 2, 1987, Dr. Gatterman, D.C., examined claimant and reported that he was medically stationary. The Determination Order, which issued on July 23, 1987, found that claimant was medically stationary effective June 2, 1987. In January, 1988, Dr. Powers reported that he had not yet declared claimant medically stationary and was not stationary -- solely on the ground that he still suffered from headaches and neck pain. He stated no reason for believing claimant's condition would improve.

On this record, we are not persuaded that the Determination Order prematurely closed claimant's compensable neck and back claim.

Unscheduled Permanent Disability

The Referee found that claimant's headache condition was not causally related to his compensable injury of May, 1986. She, therefore, concluded that he had no permanent disability. We disagree.

Claimant testified that he had no headache condition prior to his compensable injury. On the day of his injury, he began to experience headaches. A few months later, he reported his frequent headaches to his family physician, Dr. Gebbie. Drs. Powers and Wilson are of the opinion that claimant's headaches are causally related to his compensable injury. The only contrary opinion in the record is that of Dr. Gatterman. However, Gatterman only stated that claimant's headaches were due to muscle tension, which is "not necessarily" related to his compensable injury.

Given claimant's testimony and the lack of persuasive expert medical testimony to rebut the opinions of Drs. Powers and Wilson, we conclude that claimant's headaches are causally related to his compensable injury.

In rating the extent of unscheduled permanent disability for claimant's neck and back condition, we consider his physical impairment, as reflected in the medical record, the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380, et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

Here, claimant is 25 years of age. He is educated through the 10th grade and has no vocational training. His job history consists primarily of work as a fiberglass maintenance

worker and a quality control inspector of steel pipes. He has remained out of work since his compensable injury, except for a brief and unsuccessful return to light duty work in June, 1987. Although the frequency and duration of his painful headaches has diminished, he still experiences disabling headache pain.

There is near unanimity among the medical experts, save for Dr. Powers, that claimant's subjective complaints exceed his objective examination findings. Dr. Olmscheid reported "no evidence of permanent impairment as a result of the injury of May, 1986." Dr. Hopkins stated that "[claimant's] disability is probably minimal and . . . he will completely recover with adequate physical therapy treatment." Dr. Gatterman reported: "[O]bjectively, there are no positive orthopedic or neurologic findings . . . ."

In light of claimant's disabling headache pain, which prevented his successful return to light duty work in March 1987, we find that he has minimal physical impairment. Accordingly, after considering the aforementioned social and vocational factors, we conclude that an award of 5 percent (16 degrees) unscheduled permanent disability appropriately compensates claimant for his permanent loss of earning capacity due to his compensable injury.

ORDER

The Referee's order dated January 27, 1988 is reversed in part and affirmed in part. The insurer's denial of further chiropractic care is set aside. Claimant is awarded 5 percent (16 degrees) unscheduled permanent disability for his compensable injury of May, 1986. All remaining portions of the Referee's order are affirmed. For services at hearing and on review concerning the denial issue, claimant's attorney is awarded an assessed fee of $1,800, to be paid by the insurer. In addition, claimant's attorney is awarded an approved fee of 25 percent of claimant's increased permanent disability compensation awarded by this order. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,755.

Board Member Ferris, dissenting:

I dissent from those portions of the majority's opinion that dispose of the insurer's denial of medical services on procedural grounds and award claimant unscheduled permanent partial disability for "disabling headaches."

The reasons for my dissent from the majority's conclusion concerning the insurer's denial of further chiropractic care are similar to those expressed in my concurrence in Gordon D. Garrett, 41 Van Natta 334 (February 23, 1989).

As for the award of permanent partial disability for claimant's headaches, the majority relies upon the opinions of Drs. Powers and Wilson and the lay opinion offered by claimant. Dr. Powers' opinion is conclusory and should be disregarded for that reason. Dr. Wilson expressly rejects Dr. Powers' opinion and states that he does not know how claimant's headaches are related to his compensable injuries, but nonetheless attributes the headaches to the injuries in the absence of an alternative explanation. This equivocal and logically inconsistent opinion is of no probative value. As for claimant's lay opinion, the

question of the cause of claimant's headaches is a medically complex one. Claimant is not a medical professional. His opinion, therefore, cannot be relied upon. On this record, I would conclude that claimant has failed to establish that his headaches are causally related to his compensable injuries and would not award any permanent disability on account of them. I would affirm the order of the Referee.

JAMES R. VonRICHTER, Claimant
David Hollander, Claimant's Attorney
David Smith (SAIF), Defense Attorney

WCB 86-13859
February 28, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Leahy's order which upheld the SAIF Corporation's partial denial of claimant's claim for medical services for his current low back condition. On review, the sole issue is compensability of medical services. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury to his low back in November 1969. The injury was diagnosed as an acute lumbosacral strain. Claimant received 10 percent unscheduled permanent partial disability, pursuant to a February 1, 1972 Referee's order. This order was affirmed by the Board.

Between 1978 and 1986, claimant sought treatment at the Oregon Health Sciences Center for multiple complaints, including low back pain. It was recommended that claimant seek psychiatric care on numerous occasions during this time period. In April 1986, claimant began treating with Dr. Colleson, chiropractor, who diagnosed claimant's condition as an exacerbation of lumbar strain/sprain.

In August 1986, claimant was examined by the Orthopaedic Consultants. The Consultants recommended that no treatment, diagnostic testing, or surgery was necessary for claimant's low back condition.

FINDINGS OF ULTIMATE FACT

Claimant's current need for medical services for his low back condition is not causally related to the November 1969 industrial injury.

CONCLUSIONS OF LAW

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1987). Accordingly, claimant must prove that the industrial injury of November 1969, materially contributed to his current low back condition and need for treatment.

Following our de novo review of the medical and law evidence, we find that a preponderance of the evidence does not establish that the November 1969 industrial injury materially contributed to claimant's current low back condition and need for treatment. Claimant's treating chiropractor, Dr. Colleson, did not

treat claimant until approximately 17 years after the original injury. Further, as the Referee noted, Dr. Colleson relied solely on claimant's version of the history, which is not supported by the record. Accordingly, we are not persuaded by Dr. Colleson. Thomas L. Whittlinger, 40 Van Natta 399, 400 (1988).

Conversely, the Orthopaedic Consultants opined that claimant needed no treatment, testing, or surgery in relation to his low back condition. The Consultants had a more complete history of claimant's numerous complaints, and offer a well-reasoned opinion which we find persuasive. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, medical services for claimant's current low back condition are not compensable.

ORDER

The Referee's order dated June 4, 1987 is affirmed.

PAUL WHITE, Claimant
Emmons, et al., Claimant's Attorneys
SAIF, Insurance Carrier

Own Motion 87-0596M & 88-0628M
February 28, 1989
Own Motion Order

It has come to the Board's attention that two orders have been issued recently which perform the same function; i.e., reopen the above entitled claim for the payment of temporary disability compensation. We conclude our error should be corrected.

Own Motion Order (88-0628M) dated October 20, 1988 was published in error and, therefore, is vacated in its entirety. The Own Motion Order on Reconsideration published on November 16, 1988 was issued under the correct own motion number.

IT IS SO ORDERED.

ELDEN E. ATKINSON, Claimant
Cummins, et al., Defense Attorneys

WCB 88-09150
March 2, 1989
Order Denying Motion to Dismiss

The insurer has moved for an order dismissing claimant's request for Board review on the ground that a copy of the request was not mailed to all parties to the proceeding. We deny the motion.

FINDINGS

The Referee's order issued December 30, 1988. On January 12, 1989, the Board received claimant's request for review of the Referee's order. Claimant indicated that he was no longer represented by legal counsel. The request did not include an acknowledgment of service or a certificate of personal service by mail upon the parties to the proceeding before the Referee. Neither the employer nor its representatives have received a copy of claimant's request.

On January 18, 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 January 20, 1989.

ULTIMATE FINDINGS

Claimant requested Board review within 30 days of the

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

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

"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). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance Co. v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Here, the Board received claimant's request for review of the Referee's December 30, 1988 order on January 12, 1989. Consequently, the request for review is timely. See ORS 656.289(3). However, claimant neglected to mail copies of the request for review to the remaining parties to the proceeding. Thus, in order for the Board to retain jurisdiction, the parties must have received actual notice of the request within the statutory period. Argonaut Insurance Co. v. King, supra. We so find.

Since the Board's acknowledgment letter was mailed to the remaining parties to the proceeding within 20 days following the Referee's order, we conclude that it is more probable than not they received actual notice of claimant's request for review within the statutory 30-day period. See John D. Francisco, 39 Van Natta 332 (1987). Even if neither the employer nor its insurer received the acknowledgment letter within 30 days of the Referee's order, the insurer's counsel concedes that he received the letter on January 20, 1989, which is within the statutory period. Moreover, assuming that the employer and its insurer did not timely receive the acknowledgment letter, no contention has been made that they have been prejudiced by their counsel's timely actual notice of the request for review. Absent such a finding, we hold that the insurer's counsel's timely actual notice is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. ORS 656.295(2); Argonaut Insurance Co. v. King, supra; Nollen v. SAIF, supra; Paul E. Dillman, 40 Van Natta 489 (1988).

Accordingly, the motion to dismiss is denied. As a result of this motion, it will be necessary to implement a revised briefing schedule. See OAR 438-11-025. Therefore, claimant's appellant's brief shall be due 14 days from the date of this order. The insurer's respondent's brief shall be due 14 days from

the date of mailing of claimant's brief. Claimant's reply brief, if any, shall be due 7 days from the date of mailing of the insurer's brief. If claimant submits a brief or any other material on review, he is reminded to simultaneously provide copies to the insurer's counsel. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

TIMOTHY J. BALBI, Claimant
SAIF, Insurance Carrier
Tom Ewing, Assistant Attorney General

WCB 88-14380
March 2, 1989
Order of Dismissal

The SAIF Corporation has moved the Board for an order dismissing 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 issued December 8, 1988. Claimant's request for review, contained in a letter carrying a postmark date of January 5, 1989, was received by the Board on January 6, 1989. The request, which was mailed by certified mail, did not include an acknowledgment of service or a certificate of personal service by mail upon SAIF, its insured, or its legal counsel.

On January 9, 1989, the Board mailed a computer-generated letter to the parties acknowledging the request. SAIF received the acknowledgment on January 10, 1989. The receipt of the Board's acknowledgment letter constitutes SAIF's and its insured's first notice of claimant's request for Board review.

ULTIMATE FINDINGS

Claimant's request for review was mailed to the Board within 30 days of the Referee's December 8, 1988 order. However, the remaining parties to the proceeding 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 December 8, 1988 order was January 7, 1989, a Saturday. Thus, the last day to timely file a request for Board review was Monday, January 9, 1989. See ORS 174.120. Claimant's request for Board review was filed January 5, 1989, the date he mailed the request by certified mail. See OAR 438-05-046(1)(b). Consequently, claimant's request for review was timely submitted to the Board. 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, pursuant to SAIF's counsel's affidavit, the remaining parties' first notice of claimant's request occurred on January 10, 1989, when SAIF received the Board's January 9, 1989 acknowledgment letter. January 10, 1989 is more than 30 days after the Referee's December 8, 1988 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 v. King, supra.

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.

CLARK W. BUCHANAN, Claimant
Pozzi, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys
Kate Donnelly (SAIF), Defense Attorney

WCB 86-05237 & 86-11799
March 2, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Argonaut Insurance Company requests review of those portions of Referee Foster's order that: (1) set aside its denial of claimant's aggravation claim for a back condition; (2) upheld a denial of claimant's aggravation claim for the same condition issued by the SAIF Corporation; and (3) directed Argonaut Insurance Company to pay claimant's attorney a $1,700 fee for prevailing on the responsibility issue. If the Board decides that claimant is entitled to an attorney fee, Argonaut contends that the Referee's award is excessive.

On review, the issues are responsibility and attorney fees.

We affirm.

FINDINGS OF FACT

Claimant initially injured his back in 1975 while working for SAIF's insured. His symptoms included low back and posterior left leg pain. He was eventually diagnosed with a herniated disc and Dr. Adams, orthopedic surgeon, performed surgery in June 1980. SAIF accepted responsibility for the herniated disc, and claimant received post-surgery treatment through July 1981. At his closing examination, Dr. Adams noted that claimant's subjective leg pain had disappeared, but that he continued to complain of left leg weakness and numbness and some low back discomfort on rising from a sitting position. Dr. Adams' examination findings included full range of lumbar motion, no lumbar tenderness on palpation and a lateral band of paresthesia and numbness in the left thigh. Claimant's injury claim was ultimately closed with an award of 30 percent permanent partial disability.

Over the next two years, claimant sought no further medical care but experienced mild intermittent back and left leg pain. These symptomatic flare-ups would occur every two to three weeks and last two to four days. He went to work for a new employer insured by Argonaut, and in September 1983 he experienced a significant symptomatic exacerbation of left leg and back pain related to his work activity. His increased symptoms occurred after he lifted a heavy automotive bumper and then spent the following day working bent over a car hood.

Claimant credibly and reliably testified regarding his symptomatic history following the work incident in September 1983. He continued working, but his symptoms persisted. In November 1983, he sought further treatment from Dr. Adams, who reported pain on extension and mild tenderness in the lower lumbar spine. Claimant then filed a new injury claim for back and left leg pain with Argonaut's insured which was accepted as a nondisabling injury. The exact condition accepted by Argonaut is not apparent from the record.

A CT scan performed in December 1983 revealed an irregularity at the site of claimant's previous disc surgery which was interpreted as either a fibrosis related to that surgery or a disc reherniation. A subsequent myelogram performed in January 1984 revealed no significant extradural defects and was interpreted as essentially normal. Claimant's symptoms abated somewhat following the myelogram but increased again the following March. He was treated conservatively through April 1984, and his claim with Argonaut apparently was closed with no award of permanent disability.

Claimant sought no further medical care over the next 18 months, but he continued to experience intermittent back and left leg symptoms which gradually worsened over time. Then, in November 1985 he experienced severe back and left leg pain when he reached across a table at his home over the Thanksgiving holiday. His pain resolved somewhat with bed rest during the weekend and he was able to continue working. However, his symptoms continued to worsen, and he sought chiropractic treatment in January 1986. He returned to Dr. Adams the following month and reported the November 1985 incident and a history of gradually worsening back pain dating back to the September 1983 injury. A subsequent myelogram performed in April 1986 provided definite evidence of a disc reherniation at the site of the 1980 surgery. Dr. Adams performed a second disc surgery in June 1986.

Argonaut and SAIF both denied responsibility for claimant's current condition, but Argonaut issued its denial without waiving other issues of compensability. Claimant requested a hearing concerning Argonaut's denial and filed a request for Own Motion jurisdiction in regard to SAIF's denial. An order designating a paying agent pursuant to ORS 656.307 was not issued because of the Own Motion request.

At hearing, claimant's attorney actively and successfully litigated the position that Argonaut was responsible for claimant's back condition. Claimant's attorney assisted in pre-hearing case preparation and represented claimant at two significant post-hearing depositions involving more than 11 hours of travel time. He made substantial opening remarks at hearing but did not conduct direct or cross-examination. Claimant will receive a lower rate of temporary disability compensation if Argonaut prevails on the responsibility issue on Board review.

FINDINGS OF ULTIMATE FACT

Claimant's injury with Argonaut's insured in 1983 resulted in either a bulging disc or a mild disc herniation which progressively worsened to the point claimant required surgery in June 1986.

Claimant's entitlement to compensation was at issue at hearing. His compensation will be reduced if Argonaut prevails on the responsibility issue on Board review.

CONCLUSIONS AND OPINION

Responsibility

We adopt the Referee's opinion on the responsibility issue, subject to the following comment.

In cases involving successive work-related injuries, responsibility rests with the carrier at risk at the time of the most recent injury that independently contributed to a worsening of the claimant's condition. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986); Smith v. Ed's Pancake House, 27 Or App 361 (1976). Where successive injuries are to the same body part, a rebuttable presumption exists that the last accepted injury contributed to the worsened condition and that the insurer at that time is responsible. That insurer can then rebut the presumption by showing that its accepted injury caused only symptoms or involved a different condition affecting the same body part. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984).

The condition in the present case is a herniation of a lumbar disc. Claimant's herniation occurred after two accepted low back claims. Argonaut was on the risk at the time of the last accepted claim. Accordingly, it has the burden of proving that claimant's September 1983 injury with its insured did not independently contribute to a worsening of claimant's disc herniation. See Kearns, supra.

We note Argonaut's argument on review that the Kearns presumption is not applicable because it accepted responsibility for a nondisabling back strain, not a disc herniation. However, the cases cited by Argonaut in support of its contention are not on point. They concern acceptance of a condition for purposes of determining whether an insurer has issued a prohibited "backup denial". Furthermore, the record contains no information to support Argonaut's assertion that its acceptance was limited to back strain. Moreover, even if that were the case, the Kearns presumption was triggered by Argonaut's acceptance of an injury to the same body part, i.e., the low back. There is no requirement that the acceptance also be for the same condition for which claimant is currently seeking compensation. Rather, Argonaut has the opportunity to rebut the presumption by showing that its accepted injury involved a different condition affecting the same body part.

The record contains conflicting medical opinions on the causation issue. Claimant's treating orthopedic surgeon, Dr. Adams, opined that the September 1983 injury resulted in a mild disc herniation which progressively worsened until claimant required surgery in June 1986. Dr. Crist, M.D., gave a similar opinion based

on an independent file review in July 1986. He reported that claimant's September 1983 injury had resulted in a bulging disc which progressively worsened until the disc fully herniated in November 1985.

A differing opinion was rendered by Dr. Baker, who performed an independent orthopedic examination in September 1986. At one point in his report, Dr. Baker stated that the initial injury in 1975, the 1980 surgery, the 1983 injury and the off-work incident in November 1985 all contributed a certain amount to claimant's need for surgery in July 1986. However, in the same report he attributed claimant's need for surgery in June 1986 to the off-work incident in November 1985 and opined that the 1983 injury did not materially contribute to the current condition.

We conclude that Argonaut has not carried its burden of proving that claimant's work activities with its insured did not independently contribute to his current condition. This conclusion is consistent with Dr. Adams' opinion that the September 1983 injury resulted in a mild disc herniation. There are a number of persuasive reasons to defer to his opinion.

First, the causation issue in this case depends on both external observation and expert analysis of diagnostic studies. As Dr. Adams is both a specialist in disc conditions and a treating physician with significant opportunity to observe claimant, his opinion is entitled to considerable weight. See Taylor v. SAIF, 75 Or App 583 (1985); Donald L. Oxford, 38 Van Natta 1297 (1986).

In addition, he persuasively explained that his opinion was consistent with the medical record, including the heavy activity engaged in at the time of the 1983 injury, the December 1983 CT scan suggesting a possible disc reherniation, his examination findings in November 1983, the fact that claimant's increased symptoms did not resolve following the injury but continued to progressively worsen, and additional diagnostic studies demonstrating the occurrence of a full disc reherniation on or before April 1986. Furthermore, Dr. Adams' opinion is consistent with Dr. Crist's opinion and the latter's observation that the normal myelogram conducted in January 1984 did not, necessarily, rule out a new disc herniation as myelograms fail to reflect bulging discs in a substantial number of cases.

In relying on Dr. Adams' opinion, we are aware that he has fluctuated somewhat on the causation issue in this case. After he initially opined that claimant had probably sustained a new or recurrent disc herniation, repeat diagnostic studies failed to demonstrate a definite herniation. Based on these studies, Dr. Adams reversed his initial position and, instead, attributed claimant's ongoing problems and need for treatment to waxing and waning symptoms related to the June 1980 surgery. However, he stated that he would revert to his initial opinion if further diagnostic studies definitely demonstrated a disc herniation. When a subsequent myelogram and repeat disc surgery provided definite evidence of a disc reherniation, Dr. Adams reverted to his initial opinion. Under these circumstances, we conclude that his revised opinion was both reasonable and consistent with currently available medical evidence.

Moreover, there is no persuasive contrary opinion. See Somers v. SAIF, 77 Or App 259 (1986); Partridge v. SAIF, 57 Or App 163 (1982). Dr. Baker's report is internally inconsistent. On the one hand, he opined that the 1983 injury contributed a certain amount to the current condition. Then, in the same report, he stated that the

1983 incident was not a material contributing cause of the need for surgery in June 1986. Furthermore, his opinion is based on an inaccurate symptomatic history. He reported that claimant's symptoms returned to their pre-injury status after the 1983 incident, whereas claimant testified that his symptoms progressively worsened following that injury. We find claimant's testimony credible in light of the Referee's finding that his testimony had been "quite straightforward," and the fact that his testimony is consistent with Dr. Adams' contemporaneous medical records.

We, therefore, conclude that Argonaut has not produced sufficient evidence to rebut the presumption that it is responsible for claimant's current condition. To the contrary, we are persuaded that the September 1985 injury materially contributed to claimant's disc reherniation. As a result, the fact that claimant's subsequent non-work incident in November 1985 also contributed to the condition does not relieve Argonaut of responsibility. See Grable v. Weyerhaeuser Co., 291 Or 387 (1981). Accordingly, we agree with the Referee's decision to assign responsibility to Argonaut.

Attorney Fee at Hearing Level

The Referee awarded claimant's attorney a $1,700 assessed fee for services at hearing. On review, Argonaut contends that claimant is not entitled to an assessed fee and, alternatively, that the fee awarded is excessive.

We agree with the Referee's award of an assessed fee at hearing. Assessed fees for services at the hearing level are authorized under ORS 656.386(1). Under that provision, claimant is entitled to a reasonable carrier-paid fee for finally prevailing in a "rejected case," defined as a case in which entitlement to receive compensation, as opposed to the amount of compensation, is at issue. Short v. SAIF, 305 Or 541, 545-546 (1988); Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989).

Here, Argonaut issued its responsibility denial without waiving other issues of compensability, and no ".307" order issued prior to hearing. The absence of a ".307" order placed the claimant's entitlement to receive compensation at risk. Even though Argonaut did not amend its initial denial to include compensability as an issue, claimant did not actually prevail on that issue until the issuance of the Referee's order. See Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). Accordingly, claimant prevailed at hearing over a "rejected case" within the meaning of ORS 656.386(1), and the Referee properly awarded an assessed fee. See Ronald L. Warner, supra. Compare Rhonda L. Bilodeau, supra.

Furthermore, the $1,700 fee awarded by the Referee is not excessive. Claimant's attorney was present at the hearing and provided substantial opening remarks. He also assisted in pre-hearing case preparation and participated in two lengthy post-hearing depositions involving more than 11 hours of travel time. He has practiced workers compensation law for 11 years, devotes 50 to 75 percent of his time to such cases, and provided legal services on a contingency basis. In light of these factors, we conclude that a $1,700 fee is reasonable.

Attorney Fee at Board Level

ORS 656.382(2) authorizes an assessed fee on review when a carrier initiates Board review and the Board determines that "the

compensation awarded to a claimant should not be disallowed or reduced." Here, Argonaut initiated Board review on the responsibility issue, and claimant would have received a lower rate of temporary disability if Argonaut had prevailed on review. As a result, Argonaut's request for review has resulted in a decision that claimant's compensation "not be disallowed or reduced" within the meaning of ORS 656.382(2). See Rhonda L. Bilodeau, supra. Moreover, despite Argonaut's failure to raise the issue on Board review, claimant's entitlement to receive compensation remained at risk because no .307 order had issued. See Dale Tichenor, 41 Van Natta 179 (January 26, 1989). Accordingly, claimant is entitled to a reasonable assessed fee on Board review, payable by Argonaut.

ORDER

The Referee's order dated February 12, 1987 is affirmed. Claimant's attorney is awarded a $700 assessed fee for services on Board review regarding the responsibility issue, to be paid by Argonaut Insurance Company.

Board Member Crider, commenting separately:

I agree with the conclusions reached on all issues. However, I disagree with the statement on Page 6, Paragraph 2, that states that claimant is only entitled to a reasonable carrier-paid fee for finally prevailing at hearing in a "rejected case," which is defined as a case in which entitlement to receive compensation, as opposed to the amount of compensation, is at issue. I continue to adhere to the reasoning expressed in my dissenting opinion in Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989).

JOHN A. CALDER, Claimant
Michael Dye, Claimant's Attorney
David Fowler, Assistant Attorney General

WCB 88-14307
March 2, 1989
Order Denying Motion to Dismiss

Claimant has moved the Board for an order striking the "Appellant's Brief", which was recently filed by the Department of Justice, Inmate Injury Fund (Fund). Inasmuch as the "brief" is the first document received by the Board since the issuance of the Referee's December 5, 1988 order, we have interpreted claimant's motion as one for dismissal of the Fund's request for review on the ground that it is untimely. The motion is denied.

FINDINGS

The Referee's order issued December 5, 1988. On January 4, 1989, the Board received an "Appellant's Brief," which had been submitted by the Fund. Accompanying the brief was a certificate of personal service by mail upon claimant's counsel.

In its brief, the Fund questions the Referee's authority to assess penalties and attorney fees in this case. Contending that the Referee lacks such authority, the Fund seeks reversal of that portion of the Referee's order.

ULTIMATE FINDINGS

The Fund's appellant's brief was received by the Board within 30 days of the Referee's December 5, 1988 order. A copy of the brief was mailed to claimant's counsel within 30 days from the date of the Referee's order.

CONCLUSIONS

Review of inmate injury claims shall be as provided by ORS 656.283 to 656.304. See ORS 656.525. Pursuant to 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. 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).

"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). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

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(1). Here, although the Fund's "appellant's brief" does not expressly request Board review, its intentions are clearly expressed; i.e., it is objecting to, and seeks reversal of, a portion of the Referee's order. Under such circumstances, we conclude that the brief can also be considered as a request for Board review. See generally, Rochelle M. Gordon, 40 Van Natta 1808 (1988).

The 30th day after the Referee's December 5, 1988 order was January 4, 1989. The Fund's request was received by the Board on January 4, 1989. See OAR 438-05-046(1)(a). Thus, the request was timely submitted to the Board. See ORS 656.289(3).

Furthermore, the record establishes that the Fund also mailed a copy of its request to claimant's counsel on January 4, 1989, again within the statutory 30-day period. There is no contention that claimant has been prejudiced by not receiving personal notice of the Fund's request. Absent such a finding, we conclude that timely service of a request for review on claimant's counsel is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra; Nollen v. SAIF, supra; Robert C. Jaques, supra.

Accordingly, the motion to dismiss is denied. Therefore, a hearing transcript shall be ordered. Upon receipt of the transcript, copies will be provided to the parties and a briefing schedule implemented. Inasmuch as the Fund's appellant's brief has already been submitted, claimant's respondent's brief shall be due 14 days from the date of mailing of the transcript. The Fund's reply brief, shall be due 7 days from the date of mailing of claimant's respondent's brief. Thereafter, the case will be docketed for review.

IT IS SO ORDERED.

DONNA M. HOOPER, Claimant
BJL Video, Inc., dba
ADVENTURELAND VIDEO AND JIMMIE LOU AQUINO, INC., Employer
Stunz, Fonda, et al., Claimant's Attorneys
Davis & Bostwick, Attorneys
W.F. Schroeder, Attorney
Terri Borchers, Assistant Attorney General

WCB 87-13181, 87-02763 & 87-09367
March 2, 1989
Order Denying Motion to Dismiss

Farmers Insurance Group has moved for an order dismissing the alleged noncomplying employer's request for Board review of Referee Wasley's order insofar "as it involves any questions of coverage, of the employer's non-compliance and insofar as it involves Farmers' letter of January 15, 1987 advising employer of no coverage." We deny the motion.

FINDINGS

The Compliance Division found: (1) the alleged noncomplying employer to be a subject employer; (2) claimant to be a subject worker at the time of his injury; and (3) the employer to be noncomplying. Thereafter, the claim was referred to the SAIF Corporation for processing.

The alleged noncomplying employer requested a hearing, objecting to SAIF's acceptance of claimant's injury claim, on its behalf. The employer also contended that Farmers was estopped from denying workers' compensation coverage as a result of representations allegedly made by an insurance agent.

The Referee concluded that: (1) claimant suffered a compensable injury; (2) claimant's injury claim was never properly denied by the employer; (3) the employer was subject to the Workers' Compensation law; and (4) the employer was noncomplying. Consequently, the Referee: (1) affirmed the Compliance Division's finding that the employer was noncomplying; (2) upheld SAIF's acceptance of the claim; and (3) upheld Farmers' denial of coverage.

The Referee's conclusions were contained in one order, which carried WCB Case Nos. 87-13181, 87-02763, and 87-09367. The employer requested Board review within 30 days of the Referee's order.

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 request for review by the Board of an order of the Referee need only state that the party requests a review of the order. ORS 656.295(1). Although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. William E. Wood, 40 Van Natta 999 (1988).

When a Referee issues an order concerning a Director's order of noncompliance or any other matters unrelated to a claim, the Referee's order becomes a final order of the Director and must be appealed directly to the Court of Appeals. ORS 183.480(1), (2); Denise K. Rodriguez, 40 Van Natta 1788 (1988). However, when an order declaring a person to be a noncomplying employer is

contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim. ORS 656.740(4)(c). Matters concerning a claim are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3).

Here, the hearing before the Referee was not limited to the Compliance Division's noncompliance order. Instead, the order also concerned the employer's objections to SAIF's acceptance of the claim and Farmers' refusal to accept coverage. Since the Referee's order directly involved claimant's right to receive compensation, review shall be conducted as provided for a matter concerning a claim. See ORS 656.704(3); 656.740(4)(c). Such a procedure necessarily involves Board review of the Referee's order pursuant to ORS 656.289(3) and 656.295.

Furthermore, the Referee's order does separately address the compensability and coverage/noncompliance issues. Yet, the Referee's findings and conclusions concerning these issues are contained in one final order. Inasmuch as the employer has timely requested Board review of the Referee's order, we have jurisdiction to consider all matters contained therein. Wood, supra.

Accordingly, the motion to dismiss is denied. Once a transcript is obtained and copies are distributed to the parties, a briefing schedule will be implemented. Upon completion of the briefing schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

ROBERT S. LITTLETON, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-04258
March 2, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Littleton v. Weyerhaeuser Co., 93 Or App 659 (1988). The court has concluded that claimant is entitled to an award of attorney fees for prevailing, at the Board level, against the self-insured employer's cross-appeal concerning the compensability of certain medical services.

The attorney fee to which claimant is statutorily entitled is defined as an "assessed fee." OAR 438-15-005(2). Our present rules became effective January 1, 1988 and are applicable to all cases pending before us on and after that date. See OAR 438-05-010; 438-15-003(2). In accordance with these rules, we cannot award such a fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5).

Here, no statement of services has been submitted. Consequently, no assessed fee can be awarded at this time. Once a statement of services is received, we shall proceed with this matter.

IT IS SO ORDERED.

JOHN O. MEALUE, Claimant
Olson Law Firm, Claimant's Attorney
John Motley (SAIF), Defense Attorney

WCB 86-00763
March 2, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Howell's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability for a hip and low back condition from 45 percent (144 degrees), as previously awarded, to 75 percent (240 degrees). We reverse.

ISSUE

Whether claimant is permanently totally disabled.

FINDINGS OF FACT

Claimant, 56 at hearing, suffered a prior compensable injury to his left leg and right foot in 1955. Subsequently, surgeries were performed resulting in the insertion of a rod into claimant's left femur and wires into his right foot. As a result his prior injury, claimant received scheduled awards totaling 35 percent for the left leg and 35 percent for the right foot.

In November 1974 claimant compensably strained his left leg. This injury eventually resulted in an October 1975 osteotomy of the left hip and, in April 1976, a total hip replacement.

A June 22, 1979 Determination Order awarded 20 percent unscheduled permanent partial disability for the left hip and low back condition. A September 1979 Stipulated Order awarded an additional 25 percent unscheduled permanent disability.

In March 1984, the claim was was reopened as claimant underwent a total hip revision. After surgery claimant continued to have moderate symptoms consisting primarily of pain in the thigh. Trochanteric bursitis was diagnosed due to the hip revision. In January 1985 further surgery was performed to remove the trochanteric wires from the hip.

In August 1985, Dr. Fitch, claimant's treating orthopedic surgeon, determined claimant was medically stationary. Claimant complained of continued symptoms of stiffness and soreness with walking or physical activity. He was unable to walk on uneven ground, jump, lift more than a few pounds, and stand or walk for protracted periods.

On January 3, 1986, claimant's claim was reclosed by a Determination Order. No additional permanent partial disability was awarded.

In November 1986, claimant was examined by Dr. MacCloskey, an orthopedist.

Claimant has primarily worked as a logger/timber faller. He has a GED and was involved in a vocational rehabilitation program where he received an associates degree in Real Estate Appraisal. Claimant also studied auto-parts for one term, but could not complete the program due to the required amount of sitting.

Claimant made substantial efforts to locate gainful employment but has been unsuccessful. He provided a list of 54 employers that he had personally contacted. In addition, he contacted approximately 40 additional employers in search of custodial, sales, and security guard work. His job search efforts extended from Hillsboro to Willamina, Silverton, McMinville, and Newberg.

Claimant experiences considerable pain and stiffness in the left hip and low back; particularly in the mornings. Prolonged sitting or walking increases these symptoms. When walking he must stop and rest every five minutes. Although he can drive a car, he must stop frequently to alleviate pain in his left thigh.

Mr. Reese, a vocational counselor, testified at the hearing on behalf of SAIF.

CONCLUSIONS OF LAW

There are two types of permanent total disability: one arising entirely from medical or physical incapacity and the other arising from conditions of less than total medical or physical incapacity. The second type takes into consideration additional conditions such as age, education, aptitude, adaptability to nonphysical labor, mental and emotional conditions, and the state of the labor market. Shaw v. SAIF, 78 Or App 558, 561 (1986). These factors are considered the "odd-lot" doctrine. The import of the doctrine is that a disabled worker capable of performing work of some kind, may still be permanently totally disabled due to these other factors. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). Lastly, under ORS 656.206(3), the worker is required to make reasonable efforts to obtain regular gainful employment, unless it would be "futile" to do so. Butcher v. SAIF, 45 Or App 318 (1983).

The Referee found that claimant was not permanently totally disabled. We disagree.

Upon reviewing the medical and lay evidence, we conclude that claimant is not permanently totally disabled solely from a medical standpoint. However, we must also determine whether he has satisfied the "odd-lot" requirements for permanent total disability. We conclude that he has.

Claimant was 56 years old at the time of the hearing. His education and training are limited to a GED certificate and an associates degree in Real Estate Appraisal. Except for a brief period of employment as a construction worker, he has primarily worked as a logger. Because of his physical limitations, he cannot return to either of those occupations. Additionally, he has previously sustained a 35 percent loss of use or function of both his left leg and right foot. Although Dr. MacCloskey felt that claimant could perform sedentary work, he also found that claimant was "functionally disabled."

Moreover, we are not persuaded by Mr. Reese's opinion that claimant was capable of performing work in sedentary and light-duty occupations. First, prior to the hearing, Reese had neither observed claimant nor offered any vocational assistance. Second, Reese's opinion was based, in part, on the fact that

claimant had worked for one year as an army supply clerk in the early 1950's. Last, Reese identified no jobs that had been offered to or refused by claimant.

We turn to whether claimant made reasonable efforts to obtain regular gainful employment. ORS 656.206(3). Claimant personally contacted numerous employers and looked for a variety of positions in several geographic areas. In fact, Mr. Reese testified, inter alia:

> "I would agree that [claimant] has done a very nice job in looking at a number of different areas? [sic] He hasn't restricted himself to just one particular community nor looking at one particular type of employment or geographical areas and three or four different occupations."

The Referee found that claimant's inability to find work was due, in large part, to the apparent "depressed nature" of the general labor market. We do not agree. On this record, we find no persuasive evidence that the general labor market was depressed.

Accordingly, based on our de novo review of the medical and lay evidence, and taking into consideration claimant's age, education, aptitude, adaptability to nonphysical labor, mental and emotional conditions, and the state of the labor market, we find that claimant is permanently and totally disabled.

ORDER

The Referee's order dated December 29, 1986 is reversed in part. Claimant is granted permanent total disability as of November 25, 1986. The SAIF Corporation is authorized to offset the permanent partial disability benefits paid pursuant to the Referee's order against the permanent total disability award. Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation created by this order. However, the total of fees approved by the Referee and the Board shall not exceed $6,000. All remaining portions of the Referee's order are affirmed.

Board Member Ferris, dissenting:

I dissent. I would affirm the Opinion and Order of the Referee.

JAMES PEACOCK, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF, Insurance Carrier

Own Motion 87-0062M
March 2, 1989
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on February 9, 1989 whereby claimant's temporary disability benefits were terminated as of September 21, 1988 and he was granted an additional award for 15 percent unscheduled disability for injury to his low back. Claimant has requested that the Board reconsider its order. He asks that his claim be kept open pending the outcome of his request for hearing currently before the Board on Board review or, in the alternative, that he be granted an award of permanent total disability. His attorney seeks a reasonable fee for his services on claimant's behalf.

After careful consideration, the Board declines to grant the relief claimant seeks. We are persuaded that claimant's condition is medically stationary and closure is appropriate at this time. The Board does often postpone action on own motion requests for reopening when there is litigation pending which bears a direct relationship to the own motion issues. However, rarely, if ever, has the Board postponed action on a request for own motion closure in cases in which temporary disability benefits would continue to be paid, perhaps indefinitely. The possibility of a large unrecoverable overpayment renders this type of action by the Board inappropriate. The request for abatement of the recent Own Motion Determination and the continuance of temporary disability benefits must be denied.

Claimant's claim is in a closed status and, as such, all requests for further disability must be considered under the current own motion law. The law, which took effect January 1, 1988, has significantly limited the Board's own motion authority. Although temporary disability benefits can be granted under certain pre-determined circumstances, there is no provision for the granting of further permanent disability. Orville D. Shipman, 40 Van Natta 537 (1988). Therefore, claimant's request for permanent total disability benefits must be denied.

Claimant's attorney is entitled to a reasonable fee for his efforts on claimant's behalf. Claimant's attorney is awarded 25% of the additional compensation granted by the February 9, 1989 order, not to exceed $650 as a reasonable attorney's fee.

IT IS SO ORDERED.

GLENN L. PERRY, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-14031 & 82-10387
March 2, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Georgia-Pacific Corporation v. Perry, 92 Or App 56 (1988). The court has concluded that claimant is not entitled to an award of permanent total disability and that the Determination Order awards of 30 percent (96 degrees) unscheduled permanent disability for a neck injury and 40 percent (60 degrees) scheduled permanent disability for loss of use or function of the left leg are appropriate. Consequently, we have been instructed to reinstate the Determination Orders.

Accordingly, pursuant to the court's mandate, the Determination Orders dated April 7, 1983 and November 5, 1985 are reinstated and affirmed.

IT IS SO ORDERED.

KENNETH M. SIMONS, Claimant
Quintin B. Estell, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney
Cummins, et al., Defense Attorneys

WCB 87-02814 & 86-16762
March 2, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Quillinan's order that: (1) set aside its denial of claimant's aggravation claim for a back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. Claimant

cross-requests review of that portion of the order that upheld Liberty's partial denial of medical services. We reverse.

ISSUES

(1) Payment for diagnostic medical services;

(2) Compensability of claimant's back condition; and

(3) Responsibility for the same condition.

FINDINGS OF FACT

Claimant was compensably injured in January 1985, while working for Liberty's insured. He sprained his upper and low back and groin when a coworker slipped, leaving him holding a 175 pound motor. Claimant was treated conservatively by his family physician, Dr. Regier, osteopath. The claim was accepted, and closed by Determination Order on May 15, 1985, with no award for permanent disability.

Claimant continued to have low back and interscapular discomfort, and pain in his legs and feet. Neurological tests conducted by Dr. Brooks were normal. Dr. Brooks recommended that claimant have a complete rheumatological work-up to rule out the possibility of collagen vascular disease.

Claimant was examined by Dr. Zivin, neurologist, in January 1986. Claimant has a past history of Reiter's syndrome, a rheumatoid condition. Dr. Zivin felt examination by a rheumatologist would be appropriate, but that it was unrelated to the 1985 injury.

Dr. Regier considered claimant's 1985 sprain improved, but not resolved. He, too, recommended examination by a rheumatologist to clarify what was causing claimant's condition.

Claimant did not return to work for Liberty's insured. Instead, he began work for SAIF's insured. His duties included packing, loading, selling and delivering apples. He regularly moved boxes of apples weighing 40 pounds. His back was continually sore, and he took aspirin in quantities up to 30 per day.

In July 1986, claimant was examined by Dr. May, rheumatologist. Dr. May had previously diagnosed claimant's Reiter's syndrome. Dr. May conducted tests for synovitis, which were negative. He also drew blood for other diagnostic tests, the results of which are not in the record.

On September 19, 1986, while working for SAIF's insured, claimant bent over to pick up windfall apples from the ground when he had a sudden increase in low back pain identical to that experienced at the time of the 1985 injury. He sought treatment at the hospital emergency room for low back and interscapular pain. He suffered a sprain which produced spasms. Claimant missed two days of work. He then returned to light duty, and eventually resumed regular work. His back eventually returned to its prior state.

SAIF denied responsibility for a "new injury" on October 9, 1986. SAIF's denial was made on the basis that the claim should have been sent to Liberty Northwest as a

reaggravation of a prior injury. On February 7, 1987, Liberty denied the claim for aggravation on the basis of compensability and responsibility.

Claimant was reexamined by Dr. Zivin on June 11, 1987. He had no tenderness or muscle spasm, and full range of motion. Abduction and adduction of the shoulders against resistance produced interscapular pain.

CONCLUSIONS OF LAW AND OPINION

Diagnostic Test

Claimant has a past diagnosis of Reiter's syndrome, a rheumatoid condition which is sometimes active and sometimes in remission. Claimant's treating physician, Dr. Reiger, and several other physicians recommended a complete rheumatological examination to determine whether claimant's symptoms were causally related to Reiter's syndrome, and not recurrent sprain. Liberty has refused to pay for the diagnostic testing.

The Referee found no basis for either carrier to be responsible for the diagnostic testing and concluded that neither carrier had a duty to pay for such testing. We disagree.

ORS 656.245 extends to payment for diagnostic procedures even when the procedures ultimately reveal that claimant's condition is not compensable. Brooks v. D & R Timber, 55 Or App 688 (1982); Myrtle L. Thomas, 35 Van Natta 1093 (1983). An insurer must pay for diagnostic testing which is reasonable and necessary to determine a causal relationship, if any, between a compensable condition and a disease process. Clifford D. Howerton, 38 Van Natta 1425 (1986). We conclude that the insurer must pay for the rheumatology tests which may show whether claimant's symptoms are related to his noncompensable Reiter's syndrome.

We further conclude that the responsibility to pay for the diagnostic testing is Liberty's. The request for the test was made at a time when Liberty was the only insurer potentially responsible for claimant's medical services. SAIF has not been asked to provide the services.

Compensability

Claimant contends that his current back symptoms are either an aggravation of his 1985 sprain while working for Liberty's insured, or a new injury sustained in September 1986, while working for SAIF's insured. The Referee concluded that claimant had sustained an aggravation of his 1985 compensable injury. We disagree.

We interpret causation in this case to involve a complicated medical question, particularly because claimant suffers from a preexisting condition in addition to sustaining a prior back injury. We, therefore, feel that expert medical evidence is necessary for claimant to meet his burden of proof. Kassahn v. Publishers Paper, 76 Or App 105 (1985).

Claimant has suffered from ongoing back symptoms since his 1985 compensable injury. It is not clear, however, whether those symptoms were due to the 1985 compensable strain, the myofascitis, secondary to the compensable strain, or to a Reiter's

syndrome. The September 1986 incident did, however, cause claimant to experience a temporary period of acute pain.

Dr. Zivin could not relate this acute episode to the 1985 injury and felt that the incident appeared to be a new injury. Although the symptoms were similar, he suggested that the incident created a new strain/sprain superimposed on the underlying Reiter's condition. He described a new injury: an insult which produced spasm and other objective pathological changes and then subsided. We find Dr. Zivin's well-reasoned opinion persuasive. Somers v. SAIF, 77 Or App 259 (1986).

In light of the foregoing, we conclude that claimant's condition is not causally related to his 1985 strain for which Liberty is responsible. Instead, we are persuaded that claimant's current disability and need for medical treatment for his back condition is causally related to the September 1986 incident. Since this incident occurred while claimant worked for SAIF's insured, SAIF is the responsible insurer.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review, in regard to the medical services 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). 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 September 28, 1987, as reconsidered December 3, 1987, is reversed. Liberty Northwest Insurance Corporation's denial of claimant's medical services claim for rheumatological diagnostic testing is set aside. Liberty Northwest's February 5, 1987 denial is reinstated and upheld. The SAIF Corporation's October 9, 1986 denial is set aside and the claim is remanded to it for processing according to law. A client-paid fee, payable from Liberty Northwest to its counsel, is approved, not to exceed $2,175.50.

DAN ADAMS, Claimant

Own Motion 89-0076M
March 3, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his October 20, 1982 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim for the payment of temporary disability benefits.

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 is heat, massage and ultrasound. There is no need 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.

LARRY HOWLAN, Claimant
SAIF, Insurance Carrier

Own Motion 87-0221M
March 3, 1989
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on September 16, 1988 whereby claimant was granted an additional award of 50 percent loss of function of the right foot. We have been advised that our file was evidently incomplete as claimant already had 60 percent loss of the foot, resulting in a total of 110 percent disability. SAIF asked the Board to clarify its order. On October 14, 1988 we abated our order to allow claimant the opportunity to respond. Claimant did not respond to SAIF's request for reconsideration.

In Donald S. Wincer, Own Motion Determination on Reconsideration, September 28, 1988, we stated that when a claim is in closed status, further requests for own motion relief are subject to the current own motion law. We have previously ruled that our own motion authority is limited and does not allow for the awarding of permanent disability awards. Orville D. Shipman, 40 Van Natta 537 (1988). We concluded in Wincer, supra, that we are also precluded from reducing or eliminating such awards.

On reconsideration we adhere to and republish our September 16, 1988 Own Motion Determination in its entirety.

IT IS SO ORDERED.

PAUL J. WILLIAMS, Claimant
Francesconi & Assoc., Claimant's Attorneys
SAIF, Insurance Carrier

Own Motion 88-0439M
March 3, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his August 26, 1981 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's 1988 surgeries, but opposes reopening for the payment of temporary disability benefits as it contends claimant has removed himself from the work force and that, prior to the May 5, 1988 surgery, claimant's condition did not worsen.

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 surgery on May 5 and August 22, 1988 for his compensable condition. SAIF contends that the May 5, 1988 surgery was anticipated prior to the issuance of a Referee's August 13, 1987 Opinion and Order which was the last arrangement of compensation in this claim. Therefore, it feels claimant's condition did not worsen after the last arrangement of compensation and would not qualify for claim reopening. We find that when claimant underwent surgery on May 5, he became more disabled than he was before the surgery and temporarily unable to work. Therefore, his condition worsened.

SAIF also objects to claim reopening as it feels claimant has not been a part of the work force since 1981.

Claimant has advised the Board that he has, in fact, looked for work and has taken part in training programs. He also has advised us that he is currently working. We conclude claimant has shown sufficient participation in the work force to justify claim reopening.

Accordingly, claimant's claim is reopened with temporary disability benefits to commence May 5, 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 $450 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.

TRUDY E. HUGHES, Claimant
Malagon & Moore, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 87-00429
March 7, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of that portion of Referee Mongrain's order which upheld the insurer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. On review, the sole issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer in May 1986. She worked on the raimann machine, dry chain, feeding dryer, and near the end of September 1986, began doing "cleanup" duties. The "cleanup" duties required relatively frequent use of a long rake, weighing approximately 25 pounds, to push and pull debris.

During the latter part of the 1986 summer, claimant experienced minor aching in her hands. By November 1986, she began experiencing burning, numbness, and swelling in her hands. Thereafter she consulted a physician.

Claimant's condition was diagnosed as bilateral carpal tunnel syndrome. On November 19, 1986, she filed an "801" form with the insurer. Claimant left work on December 10, 1986 as a result of her condition and consulted Dr. Young, orthopedic surgeon, the same day. Dr. Young diagnosed bilateral carpal tunnel syndrome, took claimant off work, and noted that he would contact the insurer in regard to a proposed bilateral carpal tunnel release.

In January 1987, Dr. Young performed bilateral carpal tunnel release surgery. He noted that claimant had tight carpal tunnels bilaterally with extensive synovial hypertrophy adherent to both the flexor tendons and the nerve.

In February 1987, the insurer denied claimant's claim for bilateral carpal tunnel syndrome.

Claimant's off-work activities, both prior to and after working for the employer, were mostly housework-type chores, such as

washing dishes, doing the laundry, basic cleaning, and some yard-work. Claimant experienced no symptoms of burning, swelling, or pain in her hands prior to beginning work for the employer. Following the bilateral carpal tunnel release, claimant returned to work for the employer.

FINDINGS OF ULTIMATE FACT

Claimant had not experienced carpal tunnel symptoms in her hands, or missed any work due to such symptoms, prior to her work with the employer.

Claimant's work activities, as compared to her non-work activities, are the major cause of her bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW

The Referee concluded that claimant's work activities may have caused bilateral carpal tunnel symptoms, but were not the major cause of her bilateral carpal tunnel condition. He therefore found the condition noncompensable. We disagree.

In order to prevail on an occupational disease claim, claimant must show that the work activity either caused the condition or, in the the case of a preexisting condition, that the work activities caused a worsening of the underlying condition. Wheeler v. Boise Cascade, 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979). In addition, a claimant must prove that the work activities were the major contributing cause of the condition or its worsening. Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985).

In the present case, there is no evidence that claimant's bilateral carpal tunnel syndrome preexisted her employment. Further, claimant had not experienced carpal tunnel symptoms or missed any work due to such symptoms, prior to her employment. Her bilateral hand and forearm difficulties commenced only after she began work for the employer. Accordingly, the evidence does not establish that claimant had preexisting bilateral carpal tunnel syndrome, therefore, she must show that her work activities were the major cause of the development of the condition. Devereaux v. North Pacific Ins. Co., 74 Or App 388, 391-92 (1985).

The only medical evidence in the record in regard to the causation aspect of claimant's condition are reports from her treating orthopedist, Dr. Young. In a report dated December 29, 1986, Dr. Young opined that claimant's symptoms appeared to be related to her employment and noted that he would request the insurer to authorize a bilateral carpal tunnel release procedure.

Following receipt of a letter from claimant's attorney, Dr. Young reiterated his position as to causation, and stated inter alia:

> "In reply to your letter of March 31, 1987, I continue to stand behind my initial statement which is never given lightly. I therefore reconfirm that I feel that this is industrially related and that her industrial insurance carrier is clearly responsible and that denial of this claim in my opinion is totally unjustified..."

Although Dr. Young's opinion might be read to suggest that claimant's symptoms, and not her bilateral carpal tunnel syndrome is related to her work activities, he makes no distinction between symptoms and disease. His opinion relates claimant's condition, disability, and need for medical treatment, to her work. Parenthetically, we note that "magic words" are not required if a physician' opinion supports compensability and is accompanied by other persuasive evidence. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). We find that Dr. Young's opinion, in conjunction with the fact that claimant had no prior diagnosis of carpal tunnel syndrome, nor had she experienced carpal tunnel symptoms prior to her employment, leads to the conclusion that claimant's work activities were the major cause of her bilateral carpal tunnel syndrome. Accordingly, the condition is compensable.

ORDER

The Referee's order dated August 28, 1987, is reversed in part and affirmed in part. That portion which upheld the insurer's denial is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. For overcoming this denial, claimant's attorney is awarded a reasonable assessed fee of $3,062.50, to be paid by the insurer. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $451, is approved.

ANDY E. WEBB, Claimant
Hayner, et al., Claimant's Attorneys
Thomas Andersen (SAIF), Defense Attorney

WCB 86-06882
March 7, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

The SAIF Corporation requests review of Referee Brown's order that set aside its partial denial of claimant's current back condition. The issue on review is compensability. We reverse.

FINDINGS OF FACT

Claimant was approximately 54 at hearing. He suffered a noncompensable back injury in 1970, for which he underwent surgery. His back was asymptomatic when he began working for the employer in 1976 as a corrections officer. In 1979, he suffered a compensable accident when someone struck him in the abdomen. He underwent six hernia operations in the next five years. In December 1983, claimant terminated his employment because of his hernia condition.

Arond January 1984, claimant began to have low back pain. No specific event triggered the onset of his symptoms. The pain worsened gradually through the next year. In January, 1985, claimant fell down his front steps when his leg gave way. Although the pain continued to worsen, he did not see anyone for his back condition until January, 1986.

In January, 1986, claimant was examined by Dr. Bert, an orthopedist. Dr. Bert diagnosed acute and subacute disc syndrome at L4-5. Dr. Quinn, a radiologist, reported that claimant's x-rays revealed mild degenerative disc disease with spurring and possible mild spinal stenosis.

When asked whether claimant's condition was related to his 1979 injury, Dr. Bert said:

> "I do feel that the back problem is multifactorial. . .It is my feeling that with an ongoing hernia it is difficult to have a patient do the . . .exercises he needs to do to keep his back in condition. . . [T]he hernia he had . . . was a contributing factor . . . I would still have to state that his fall . . . was perhaps the major factor."

CONCLUSIONS OF LAW

The Referee ruled that claimant had proven that his compensable hernia injury was a material contributor to his back condition. We disagree.

Claimant contends that his back condition is related to his compensable hernia injury. Under this theory, the compensable injury must be a material factor in the condition. "Material" is something more than de minimus, but less than the major cause. Summit v. Weyerhaeuser, 25 Or App 851 (1976).

Dr. Bert, who was claimant's treating physician for his back condition, but not for his hernias, suggested that patients in general cannot do the exercises necessary to strengthen their backs, but did not report whether that was true in this claimant's case. Neither did Dr. Bert report to what extent he felt claimant's hernia affected his back condition. No other doctors gave opinions as to causation. Claimant has the burden of establishing the probability that a material relationship is present, and not just the possibility of a causal connection. Gormley v. SAIF, 52 Or App 1055 (1981). Dr. Bert's equivocal statement alone is not sufficient evidence that the accident was a material factor in claimant's back condition.

Because claimant has not met the burden of proof of causation, we reverse the Referee's order and reinstate the denial.

ORDER

The Referee's order dated September 29, 1987 is reversed. The SAIF Corporation's denial is reinstated and upheld.

MICHAEL T. ALIOTH, Claimant
C. David Hall, Claimant's Attorney
Rankin, et al., Defense Attorneys

WCB 86-07369
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Jacobson's order that: (1) rejected his request for temporary total disability compensation for the period from January 21 through July 13, 1987; and (2) awarded him 25 percent (33.75 degrees) scheduled permanent partial disability for his left foot in lieu of an award by Determination Order of 15 percent (20.25 degrees). On review, the issues are temporary total disability and extent of permanent disability.

We conclude that claimant is entitled to temporary total disability compensation for the period from January 21 through April 3, 1987, but otherwise affirm the order of the Referee.

FINDINGS OF FACT

Temporary Disability Compensation

Claimant compensably injured his foot on August 20, 1982 in the course of his employment as a boilermaker with the self-insured employer. He subsequently underwent five surgical operations, the last of which was performed on February 15, 1985. After recovering from this operation, claimant began an on-the-job training plan of vocational assistance on January 22, 1986. The training plan was in automotive mechanics.

Claimant became medically stationary on January 23, 1986. On April 11, 1986, the Workers' Compensation Department issued a Determination Order pursuant to former ORS 656.728(3). Claimant's on-the-job training plan ended on January 20, 1986. The training plan employer offered to continue claimant's employment, but claimant refused the offer, apparently because he wanted to repair transmissions and the employer was assigning him other kinds of tasks. The self-insured employer did not resume temporary disability payments after claimant left work on January 20, 1987. On March 8, 1987, Dr. Grewe, claimant's treating neurosurgeon, opined that claimant was capable of performing the employment he had refused.

The Workers' Compensation Department issued a Determination Order pursuant to former ORS 656.268(4) on April 3, 1987. The Determination Order awarded temporary disability compensation from the date of claimant's injury through January 20, 1987, the date upon which his on-the-job training plan ended.

In June 1987, the employer authorized further vocational assistance for claimant. He began drawing unemployment compensation in July 1987. On August 23, 1987, claimant began a second vocational training plan. Claimant was unemployed from January 20 to August 23, 1987 and remained medically stationary during that period.

Extent of Disability

The Board adopts the Referee's findings of fact on the extent issue.

CONCLUSIONS OF LAW

Temporary Disability Compensation

The Referee concluded that claimant was entitled to no temporary disability compensation after January 20, 1987 because a Determination Order had been issued in April 1986, the on-the-job training plan had ended and claimant had not established a worsening of his condition within the meaning of ORS 656.273. On Board review, claimant contends that he is entitled to temporary total disability for the period between his two training programs pursuant to Bold v. SAIF, 60 Or App 392 (1982). We fail to see how Bold has any application in the present case, but have other difficulties with the Referee's analysis.

A carrier must continue paying temporary total disability compensation until claim closure pursuant to ORS 656.268 unless the claimant has been released to return to his regular work, former ORS 656.268(2), has returned to his regular work, Jackson v. SAIF, 7 Or App 109, 115 (1971), or has refused wage earning employment. ORS 656.325(5). In the last of these three circumstances, the carrier must pay temporary partial rather than temporary total disability until claim closure pursuant to ORS 656.268.

As noted in our findings of fact, the April 1986 Determination Order was issued pursuant to former ORS 656.728(3), not ORS 656.268. The purpose of this determination was to authorize the employer to receive reimbursement from the Rehabilitation Reserve for temporary disability compensation paid to claimant during his on-the-job training plan. It was not a determination pursuant to former ORS 656.268 or the equivalent of such a determination. Claimant's claim remained open, therefore, after the issuance of the April 1986 Determination Order.

Claimant completed his on-the-job training plan on January 20, 1987. He was medically stationary at that time, but was not released to return to his regular work as a boilermaker and did not return to his regular work. His claim was open and remained open until April 3, 1987, when the Determination Order pursuant to former ORS 656.268 was issued. Under these circumstances, the employer should have paid claimant some form of temporary disability compensation for the period from January 21 through April 3, 1987. If the employer satisfied all of the requirements of ORS 656.325(5) and the associated administrative rules, it should have paid temporary partial disability compensation. Otherwise, it should have paid temporary total disability.

Without attempting an exhaustive discussion of the requirements of ORS 656.325(5) and the associated administrative rules, we note that the self-insured employer in this case failed to satisfy OAR 436-60-030(5)(c). That provision authorizes the employer to cease paying temporary total disability and begin paying temporary partial disability only after:

> "the employer has provided the injured worker with a written offer of [wage earning] employment which states the beginning time, date and place; the duration of the job, if known; the wage rate payable; an accurate description of the job duties and that the attending physician has said the offered employment appears to be within the worker's capabilities."

The self-insured employer provided claimant with no such written offer. The employer was not authorized, therefore, to pay claimant temporary partial disability for the period at issue and should have paid temporary total disability.

In view of the above discussion, the employer shall be ordered to pay claimant temporary total disability compensation for the period from January 21 through April 3, 1987. Given the fact that claimant was medically stationary during this period, the employer shall be authorized to offset this payment against any future awards of permanent partial disability on this claim.

Extent of Disability

The Board adopts the Referee's conclusions of law on the extent issue.

ORDER

The Referee's order dated December 21, 1987 is reversed in part. The self-insured employer shall pay claimant temporary total disability compensation for the period from January 21 through April 3, 1987. The employer is authorized to offset this payment against any future awards of permanent partial disability on this claim. Claimant's attorney is awarded a fee of 25 percent of the increased compensation granted by this order, not to exceed $3,800. A client-paid fee of $599.50 for services on Board review is approved.

JOSE L. ALTAMIRANO, Claimant
Steven C. Yates, Claimant's Attorney
Lester Huntsinger (SAIF), Defense Attorney

WCB 86-14286
March 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Garaventa's order that: (1) declined to find claimant's back injury claim prematurely closed; (2) awarded 20 percent (64 degrees) unscheduled permanent disability for a back injury, whereas a December 30, 1986 Determination Order had awarded no permanent disability; (3) upheld the SAIF Corporation's partial denial of claimant's current bilateral knee condition; and (4) declined to assess a penalty and attorney fee for an allegedly unreasonable denial. SAIF cross-requests review, contending that claimant's permanent disability award should be eliminated. We affirm in part and reverse in part.

ISSUES

1. Whether claimant's condition was medically stationary on November 20, 1986.

2. The extent of claimant's unscheduled permanent disability.

3. Whether SAIF's October 10, 1986 partial denial of bilateral knee condition should be upheld.

4. Was SAIF's October 10, 1986 denial unreasonable.

FINDINGS OF FACT

On October 11, 1985, claimant, a 26 year old laborer with a 9th grade Mexican education, sustained a compensable acute thoracic sprain with associated lumbosacral sprain and cervical strain while digging trees for a nursery. To relieve palpable muscle spasms and pain, he was treated with chiropractic manipulation, physiotherapy, exercises, and rest by Dr. Buttler. Chiropractic treatment provided temporary relief.

Claimant continued to treat with Dr. Buttler one time per week. In early May, 1986 he drove by car to Mexico and stayed there for one month. He sought no medical treatment until he returned to Dr. Buttler, who continued to consider him not medically stationary and in need of further curative treatment.

On June 26, 1986, Dr. Buttler released claimant to modified work. Limitations included no heavy lifting, no repetitious light to moderate lifting and no repetitious bending or twisting from the waist.

Vocational services were initiated on March 7, 1986. Claimant's work history is limited to outdoor nursery and farm labor in the medium to heavy range. The vocational counselor identified transferable skills in outdoor professions. Dr. Buttler also approved a gas station attendant position. On June 27, 1986, however, claimant declined further vocational services, choosing instead to pursue seasonal farm labor jobs.

On September 29, 1986, the Orthopaedic Consultants examined claimant. Following review of claimant's extensive history and a physical examination, they diagnosed a resolved lumbosacral strain, declared claimant medically stationary and indicated no further treatment was necessary. The Consultants noted that claimant had some episodes of soreness in the front of both knees. Finding no significant permanent back impairment, they recommended that claimant return to his previous occupation without limitations.

Dr. Buttler began treating claimant's knee problems in June 1986. Due to his knee pain, he was restricted from kneeling or squatting. Claimant had no knee problems prior to his October 11, 1985 back injury. On October 3, 1986, Dr. Buttler advised SAIF that claimant was suffering secondary bilateral knee sprain due to overuse, of which the major contributing cause was the lack of low back strength and motion. Dr. Buttler concluded that these restrictions prevented claimant from bending at the waist. There is no medical opinion to the contrary. SAIF received Dr. Buttler's report on October 6, 1986. SAIF issued its denial of the bilateral knee condition on October 10, 1986.

Dr. Gambee, orthopedist, examined claimant on November 20, 1986. He diagnosed a low back strain but found no objective evidence of impairment. He saw no indication for further medical management or therapeutic treatment. In fact, further treatment was felt to be deleterious from a psychological standpoint. Dr. Gambee opined that claimant had no permanent residual and recommended a return to either modified work or his regular job with initial sheltering.

A December 30, 1986 Determination Order declared claimant medically stationary as of November 20, 1986. Claimant was awarded periods of temporary disability, but no award of permanent disability.

Dr. Buttler declared claimant medically stationary as of January 19, 1987. He described moderate permanent impairment manifested as pain and stiffness, dependent on physical activity. Claimant was released for modified work, subject to his previous physical restrictions. Additionally, claimant was restricted from kneeling and squatting due to the pain in his knees.

Claimant was referred to Dr. Poulson, orthopedist, on February 3, 1987. Upon examination, claimant exhibited full ranges of motion of both the cervical and dorsolumbar spine. Dr. Poulson diagnosed chronic cervical and lumbar strain with no impairment. However, it was felt that claimant had a mild

disability based on tolerable, recurrent back pain. Dr. Poulson recommended that claimant return to regular employment following a work hardening program.

Claimant's compensable low back injury caused him to become more reliant on his knees. This overuse materially contributed to his bilateral knee sprain and myalgia.

CONCLUSIONS OF LAW

Premature Claim Closure

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 would reasonably 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); Austin v. SAIF, 48 Or App 7, 12 (1980); Dennis Kurovsky, 35 Van Natta 58, 60 (1983).

We generally defer to a treating physician's opinion on the medically stationary question unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

Here, Dr. Buttler was the treating physician from beginning to end. He was in the best position to express an opinion regarding claimant's medically stationary date. There is, however, a conflict in medical opinion regarding the medically stationary date which requires us to weigh the evidence. On September 29, 1986, the Orthopaedic Consultants, composed of two orthopaedic surgeons and a neurologist, stated that claimant's condition was stationary. On November 20, 1986, Dr. Gambee, orthopedist, reached the same conclusion. Finally, on January 19, 1987, Dr. Buttler stated that claimant's condition was stationary.

The persuasiveness of the medical evidence depends largely upon the reasons given in support of their respective position. Dr. Buttler did not indicate why claimant's condition was not medically stationary until January 19, 1987. The work restrictions were the same in January 1987 as they were in June 1986. There is no evidence that further material improvement was reasonably expected from medical treatment, or the passage of time after November 20, 1986. Although Dr. Buttler was in the best position to express an opinion regarding the medically stationary date, he gave no reasons to support that opinion.

On the other hand, Dr. Gambee found no indication of any permanent residual. This opinion supported the Orthopaedic Consultants prior conclusions. Furthermore, Dr. Gambee found claimant medically stationary because there was: (1) no objective evidence to support his subjective complaints; and (2) no indication for further medical treatment. We agree with the Referee and are more persuaded by the opinions of the Orthopaedic Consultants and of Dr. Gambee that claimant was medically stationary on November 20, 1986, at the latest.

Extent of Permanent Partial Disability

The criteria for rating permanent disability is the permanent loss of earning capacity due to the compensable injury. Earning capacity is defined as "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." ORS 656.214(5); Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). A claimant is a competent witness to testify as to the pain he suffers and his impaired ability to perform physical labor as a result of that pain. Harwell v. Argonaut Ins. Co., supra.

At hearing, claimant was a 26 year old laborer with a ninth grade Mexican education, who had rejected vocational assistance in favor of returning to his regular work of farm labor.

There is a marked discrepancy between the evaluations of Dr. Buttler, claimant's treating chiropractor, and the remaining three examiners: The Orthopaedic Consultants, Dr. Gambee and Dr. Poulson. Dr. Buttler repeatedly described rather significant impairment and the need for continued treatment. The remaining physicians, however, found no objective impairment. All agreed that claimant could return to his regular work.

Claimant's month long excursion to Mexico in May 1986 without treatment demonstrated that he was not as physically disabled as described by Dr. Buttler. Also, claimant terminated his vocational assistance, choosing to return to farm labor. These actions suggest that claimant considered himself physically capable of performing the work activities of his former occupation.

After considering the medical and lay testimony, we find claimant's physical impairment to be minimal, based on subjective pain.

Following our review of the medical and lay evidence, and considering claimant's physical impairment, young age, limited education and work experience , we conclude that an award of 20 percent unscheduled permanent disability appropriately compensates claimant for his compensable injury. Accordingly, we agree with the Referee's award of permanent disability.

Compensability of Knee Condition

When a compensable injury creates "spreading disability," the employer responsible for the original injury will also be responsible for any subsequent condition which arises as a direct consequence of the original injury. Florence v. SAIF, 55 Or App 467 (1981). Claimant must show that the original injury materially contributed to the symptomatology of the subsequent condition before he is entitled to receive medical services for that subsequent condition. Florence v. SAIF, supra.

In the present case, Dr. Buttler found that the major contributing cause of claimant's knee condition was the lack of low back strength and ranges of motion caused by the original compensable injury. The resulting low back pain prevented claimant from using his back to bend over. Increased reliance on

the knees caused bilateral knee sprain and myalgia. Dr. Buttler began treating this knee condition in June 1986. There is no opinion that such treatment was unnecessary. As a result of this condition, claimant was restricted from kneeling or squatting. There is no medical evidence contrary to Dr. Buttler's opinion.

We conclude that the compensable back injury caused claimant to become more reliant on his knees. This overuse materially contributed to the bilateral knee sprain and myalgia. Inasmuch as claimant's compensable back injury materially contributed to his current bilateral knee condition, SAIF is responsible for his current knee treatment.

Therefore, we disagree with the Referee and set aside SAIF's partial denial.

Penalties and Attorney Fees for Unreasonable Denial of Bilateral Knee Condition

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. ORS 656.262(10). If SAIF's October 10, 1986 denial was unreasonable, claimant is entitled to penalties and attorney fees under ORS 656.262(10). See Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985); Nelson v. SAIF, 49 Or App 111 (1980); Mavis v. SAIF, 45 Or App 1059 (1980).

On September 29, 1986, the Orthopaedic Consultants reviewed x-rays of claimant's knees and found no bony abnormalities. Dr. Buttler's October 3, 1986 report was received by SAIF on October 6, 1986. That report documented the material relationship between the compensable low back condition and subsequent symptomatology in both knees. Work restrictions included no kneeling or squatting due to knee pain.

SAIF issued its denial on October 10, 1986. It was unable to accept responsibility for the knee condition for the reason that there was no documented relationship between the work injury occurring October 11, 1985 and the knee problems. Based on the Orthopaedic Consultant's September 29, 1986 report, we find that SAIF's October 10, 1986 denial was not unreasonable. Therefore, claimant is not entitled to a penalty and attorney fee.

Attorney Fee for Services on Review

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered at hearing and on Board review concerning the partial denial issue. 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 May 11, 1987 is affirmed in part and reversed in part. The SAIF Corporation's October 11, 1986 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.

STANLEY B. BENSON, Claimant
Welch, et al., Claimant's Attorneys
Thomas Sheridan (SAIF), Defense Attorney

WCB 86-12926
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of Referee Fink's order that granted claimant an award of permanent total disability for an injury to his low back and left leg, in lieu of an award by Determination Order of 25 percent (80 degrees) unscheduled permanent partial disability for the low back, 80 percent (120 degrees) scheduled permanent partial disability for the loss of the use or function of the left leg, and 15 percent (22.5 degrees) scheduled permanent partial disability for the loss of the use or function of the right leg. Further, SAIF requests authorization to offset permanent partial disability paid subsequent to the date claimant was deemed permanently and totally disabled against permanent total disability benefits payable pursuant to the Referee's order. We affirm.

ISSUES

The issues on review are permanent total disability, and when the insurer must request authorization for offset.

FINDINGS OF FACT

Claimant, age 64, sustained a compensable low back and leg injury on March 18, 1977, following a logging accident at a lumber mill. Claimant had worked for the employer since 1951 as a log scaler.

Claimant initially treated with Dr. Staver, orthopedist. Dr. Staver diagnosed fractures of the tibia and fibula. After attempts at closed reduction, the fracture was realigned with open reduction and plate fixation.

On April 20, 1977, Dr. Hauge, surgeon, operated and performed a pedicle graft, right leg, and lumbar laminectomy, L5-S1. Claimant was afforded good relief by the laminectomy.

In May 1977, Dr. Grossenbacher, orthopedist, removed the plate and performed a skin graft.

On January 16, 1978, Dr. Grossenbacher noted that claimant's leg fracture had not healed and estimated the possibility of union without additional surgical intervention at 30 percent. On April 17, 1978, claimant underwent an iliac bone graft to his nonunion left tibia.

On July 24, 1978, Dr. Grossenbacher reported that claimant's leg fracture and right leg wound were healing. He noted that claimant exhibited incomplete nerve deficit, secondary to his back injury. Dr. Grossenbacher advised that claimant was actively treating and not medically stationary.

On October 27, 1978, Dr. Grossenbacher reported incomplete healing of the tibia. He noted that claimant had slipped and fallen while shoveling snow, and had fractured his left femur. On December 4, 1978, Dr. Grossenbacher performed an osteotomy of claimant's left fibula.

On October 10, 1979, Dr. Grossenbacher reported that claimant's tibia had probably healed after the bone graft. An active rehabilitation program for his lower extremity was instituted.

On June 4, 1980, the Orthopaedic Consultants performed an independent medical examination. They found claimant was not medically stationary. A "below-knee" amputation was suggested due to claimant's considerable deficit in his leg and ankle. Dr. Grossenbacher concurred, but stated that claimant would never consider, nor would he recommend an amputation. On July 14, 1980, claimant underwent a surgical electrostimulation implant designed to promote the healing of his fracture.

In December 1980, claimant had a massive myocardial infarction. Dr. Grossenbacher reported that claimant was totally disabled and not employable due to his tibia, back injury, and heart attack.

On March 24, 1981, Dr. Grossenbacher reported that claimant was having drainage at the fracture site, due to chronic sepsis. Treatment for his nonunion fracture now consisted of ambulation with compression weightbearing.

On July 9, 1981, Dr. Hauge performed a skin graft and debridement of claimant's lower extremity ulcer.

On January 25, 1982, Dr. Grossenbacher reported that claimant's tibia was healing. He noted a quarter sized area of skin breakdown exposing the tibia. Dr. Grossenbacher stated that claimant was not employable.

On September 13, 1982, claimant underwent surgical debridement of devitalized tissue and ulcer, and sequestrum and debridement of bone to his left lower extremity.

In January 1984, with Dr. Grossenbacher's permission, claimant began receiving vocational assistance. Thereafter, claimant continued to experience medical problems and his case was closed.

On October 16, 1984, Dr. Grossenbacher reported that claimant's tibia had achieved early healing. Claimant was taken out of a cast and put into a permanent leg brace. Claimant's ulcer had not healed. His condition improved, but he was not medically stationary.

On April 30, 1985, claimant was deemed orthopedically stable and medically stationary. Dr. Grossenbacher noted that claimant continued to have osteomyelitis with a draining wound.

On June 16, 1985, claimant sought treatment from Dr. Griffith, cardiologist, and Dr. Carlsen, surgeon. Dr. Carlsen performed an irrigation and debridement, and skin graft of claimant's leg ulcer. Claimant was treated with a high dose of parenteral antibiotic therapy. Dr. Griffith found claimant to have atherosclerotic coronary vascular disease, status post myocardial infarction, hypothyroidism, hypercholesterolemia, atherosclerotic peripherovascular disease, and pleuritic chest pain.

On October 14, 1985, Dr. Berry, surgeon, performed a

debridement and skin graft to claimant's left ankle. During his hospitalization, Dr. Carroll found claimant to have a probable rotator cuff tenosynovitis, and mild impingement syndrome. He was treated conservatively.

On November 26, 1985, SAIF partially denied claimant's artherosclerotic coronary artery disease, hypothyroidism, and hypertension.

On June 2, 1986, claimant was found ineligible for vocational assistance, based upon a determination that he had declined assistance or had retired.

On June 24, 1986, Dr. Grossenbacher reported that claimant was again medically stationary and orthopedically stable. Dr. Grossenbacher reported claimant was not employable due to his leg injury, arteriosclerotic heart disease with previous myocardial infarction, presumptive bacterial endocarditis, and probable peripheral vascular disease with claudication of one block.

On July 9, 1986, the Orthopaedic Consultants performed another independent medical examination. They recommended no further treatment. Claimant's left lower extremity impairment was rated as moderately severe. His lumbar impairment was found to be mild. They found no evidence of a functional disturbance.

The claim was closed by Determination Order dated September 4, 1986, awarding claimant 25 percent unscheduled disability for his back injury, 80 percent loss of his left leg, and 15 percent loss of his right leg.

Claimant has an eleventh grade education. His work history involved 26 years of work in a lumber mill. At the time of his injury he was performing medium work as a lumber scaler. Claimant has not received retraining. He is fit only for sedentary work. Claimant has a moderately-severe leg impairment and a mild back impairment. It is futile for claimant to seek work.

CONCLUSIONS OF LAW

The Referee found that claimant was permanently and totally disabled. He also found claimant credible. Additionally, he found that claimant was not impeached by surveillance films showing him doing limited gardening.

To prove entitlement to permanent total disability, claimant must establish that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant is not totally incapacitated on a physical or medical basis. Consequently, claimant can prevail only by proving that he falls within the so-called "odd-lot" doctrine. Under that doctrine, a disabled person, with some residual physical capacity, may still be permanently and totally disabled due to a combination of his 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 Co., 72 Or App 397 (1985). Lastly, under the "odd-lot" doctrine, claimant must demonstrate that he is willing to re-enter the work force and that he has made reasonable efforts to do so. Failure to look for work may be considered reasonable when such attempts

would obviously be futile. See Butcher v. SAIF, 45 Or App 318 (1983).

The medical evidence establishes that claimant suffered moderately severe injuries to his legs and a mild back injury. The injury to his lumbar spine was surgically corrected with a laminectomy. He continues to suffer pain from the resulting peripheral nerve injury to his leg. The compound fracture to his tibia eventually healed following multiple operative procedures. As a result of the surgeries, claimant's left leg is one and one-half inches shorter than his right leg, in turn affecting his overall posture. He is required to wear a leg brace. Dr. Grossenbacher, claimant's treating physician, rated his impairment as moderately severe. He described the left leg impairment as equal to a below the knee amputation. Dr. Grossenbacher did not separately rate claimant's low back condition. The staff of Orthopaedic Consultants opined that claimant's left lower extremity impairment was moderately severe and his back impairment was mild.

Claimant testified that he is limited in walking, and must utilize his leg brace at all times. He has difficulty climbing stairs, sitting, standing, and bending. Claimant suffers from pain if he overexerts during physical activity. He takes medication to control his pain. Further, he requires assistance with activities of daily living. Additionally, driving long distances causes him to suffer from low back pain.

SAIF contends that claimant's testimony should be afforded little weight because surveillance films show him gardening. It argues that gardening involves all activities which claimant testified that he was limited in or unable to perform because of pain.

After viewing the films, we agree with the Referee and find that they did not impeach claimant's testimony. The films show claimant on his hands and knees pulling weeds while frequently changing positions. He was able to push a wheelbarrow a short distance and used a shovel only to break ground, a task he testified he could have done with his hands.

SAIF also contends that claimant is precluded from an award of permanent total disability because he failed to establish that a job search would be futile, has made no effort to seek work, and refused vocational assistance. Alternatively, it argues that claimant is not entitled to such an award because he voluntarily retired, as evidenced by Social Security disability and retirement benefits. We disagree.

The mere fact that claimant has been receiving Social Security disability benefits since 1977 when he was injured is not dispositive in determining whether he has withdrawn from the workforce. Chapel of Memories v. Davis, 91 Or App 232 n. 3 (1988). Furthermore, claimant's receipt of retirement benefits or decision to retire does not preclude him from an award of permanent total disability. See Grace L. Stephen, 39 Van Natta 1045 (1987), affirmed SAIF v. Stephen, 93 Or app 217 (1988).

Claimant has not looked for work on the advice of his treating doctor who has repeatedly stated that he was not employable and could not return to his former employment. Further, claimant has severe physical limitations and restrictions

on his activities. Further, despite being a retired worker, the evidence supports the conclusion that any attempt by claimant to participate in vocational assistance or to locate work would have been futile. See Butcher v. SAIF, 45 Or App 318 (1983). As a result, we find that claimant has satisfied the seek work requirement of ORS 656.206(3).

Considering claimant's moderately severe impairment, advancing age, limited education, and lack of transferable skills, we conclude that the lay and medical evidence preponderates in favor of an award of permanent and total disability within the meaning of ORS 656.206.

SAIF seeks authorization for an offset for permanent partial disability paid subsequent to the date of hearing, when claimant was deemed permanently and totally disabled. We decline to grant SAIF authority for an offset as the issue was not raised at hearing. See Elsie L. Hobkirk, 40 Van Natta 778 (1988); Jack D. Easley, 40 Van Natta 775 (1988).

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 April 23, 1987 is affirmed.

RAYMOND R. BIRD, Claimant
Olson Law Firm, Claimant's Attorney
Stafford Hazelett, Defense Attorney

WCB 87-16838
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Myers' order that upheld the insurer's partial denial relating to his left thumb and wrist. The Referee upheld the denial on the ground that claimant's claim was barred by res judicata. If the Board reverses the Referee on the res judicata issue, claimant requests that we remand the case to the Referee for a decision on the merits. We conclude that res judicata does not bar claimant's claim, but reject his request for remand. On the merits, we set aside the insurer's partial denial.

ISSUES

1. Whether claimant's current left thumb and wrist condition is noncompensable as a matter of law by reason of res judicata.

2. Whether the case should be remanded to the Referee.

3. The compensability of claimant's current left thumb and wrist condition.

FINDINGS OF FACT

Claimant injured his left thumb and wrist in the course of his employment on July 16, 1986 when he tripped and fell. Claimant treated initially with Dr. Wessels, a family practitioner, who diagnosed a sprain of the left thumb and wrist. The insurer accepted claimant's claim for the injury on August 8, 1986.

Claimant continued to experience pain and began treating with Dr. Burdell, a chiropractor. Dr. Burdell later referred claimant to Dr. Ellison, a hand specialist. Dr. Ellison diagnosed a left "trigger thumb" and carpal tunnel syndrome and requested that the insurer authorize surgery on the thumb. The insurer arranged independent medical examinations with Dr. Button, a hand specialist, and Dr. Turco, a psychiatrist. Both opined that claimant's symptoms were functional in origin. Dr. Button recommended against surgery.

On February 17, 1987, the insurer denied authorization of the surgery proposed by Dr. Ellison. The reasons stated in the denial letter were:

> "1. Medical evidence states that surgery to your left hand is neither reasonable nor necessary.
>
> "2. Your present disability is a direct result of an unrelated psychological condition which was not caused by, or worsened by, your July 16, 1986 injury and/or employment with [the employer]." (Ex. 30).

Claimant continued to receive chiropractic treatments for his hand from Dr. Burdell. On May 26, 1987, the insurer denied payment of medical bills it had received from Dr. Burdell. The basis of the denial was that "[m]edical evidence states that your present treatment is not a direct result of your accepted left thumb and wrist strain." (Ex. 37). Claimant timely filed requests for hearing on both of the insurer's denials. The requests were later consolidated. For reasons not disclosed in the record, claimant subsequently withdrew his requests for hearing and an Order of Dismissal was issued by Referee Gary Peterson on August 6, 1987.

Claimant continued to experience pain in his left thumb and wrist. On August 26, 1987, he was examined by Dr. Lafrance, a neurologist. Dr. Lafrance diagnosed "trigger thumb, left hand" and possible carpal tunnel syndrome and recommend further diagnostic tests. Nerve conduction studies performed a short time later confirmed the diagnosis of carpal tunnel syndrome. Dr. Lafrance then referred claimant to Dr. Henshaw, an orthopedic surgeon. Dr. Henshaw subsequently requested authorization for left "trigger thumb" and carpal tunnel release surgeries.

The insurer issued a partial denial of claimant's current left thumb and wrist conditions on October 12, 1987. Claimant requested a hearing on the partial denial and a hearing was held by Referee Myers on January 6, 1988. In his order, the Referee upheld the insurer's denial on res judicata grounds. He expressed no opinion on the merits.

FINDINGS OF ULTIMATE FACT

1. The insurer's February 17 and May 26, 1987 denials were denials of medical services which became final by operation of law. The causation issues raised in the denials were never actually litigated.

2. The Referee allowed full development of the record.

3. There is a material causal connection between claimant's current left thumb and wrist conditions and his July 16, 1986 industrial injury.

CONCLUSIONS OF LAW

Res Judicata

In upholding the insurer's denial of claimant's current left thumb and wrist conditions, the Referee reasoned that claimant's failure to litigate the insurer's first two denials rendered them final by operation of law and "established as a matter of law that claimant's condition [at that time] was not caused by the compensable injury." He then found that claimant's condition had not changed since the prior denials became final and thus concluded that claimant's current condition must be deemed noncompensable under the doctrine of res judicata.

We disagree with the Referee's analysis. The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). "Claim preclusion" is the name given to the preclusive effect of a prior adjudication on a claim and "issue preclusion" to the preclusive effect of a prior adjudication on an issue. Id. Neither rule precludes litigation of the insurer's most recent denial in this case.

The rule of claim preclusion is that if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same cause of action or any part thereof. Restatement (Second) of Judgments §§ 17-19, 24 (1982); see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986). A cause of action is an aggregate of operative facts which compose a single occasion for judicial relief. Id. at 310.

Each request for prospective medical services and each bill for rendered medical services associated with an accepted claim is a separate cause of action. See Leonard A. Chambers, 40 Van Natta 969, 971 (1988); Billy J. Eubanks, 35 Van Natta 131, 135 (1983). When such services are denied, therefore, the scope of the cause of action affected by the denial is limited to those services requested or rendered on or before the date of the denial. See Arlene S. Pettit, 40 Van Natta 1610 (1988); Leonard A. Chambers, supra, 40 Van Natta at 971.

The insurer's February 27, 1987 denial was a denial of a request for prospective medical services. Its May 26, 1987 denial was a denial of rendered medical services. Neither was a "back-up" denial of claimant's original claim. Under the rules stated above, the scope of the cause of action associated with the February 27 denial was limited to requests for surgery submitted on or before February 27. The scope of the cause of action

associated with the May 26 denial was limited to medical services rendered on or before that date. Subsequent requests for surgery or bills for rendered medical services, therefore, represent separate causes of action which are not barred by the rule of claim preclusion.

The rule of issue preclusion is that if an issue of fact is actually litigated and determined by a valid, final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different cause of action. See North Clackamas School District v. White, supra, 305 Or at 53.

Although both of the insurer's denials raised the issue of the causal relation between claimant's accepted claim and his then-current condition, that issue was never actually litigated. The rule of issue preclusion, therefore, does not preclude current litigation of the causal relation issue. The Referee erred in concluding that res judicata required affirmation of the insurer's most recent denial.

Remand

The Board may remand a case to the Hearings Division if it determines that the case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). Claimant has requested remand in the event that the Board reverses the Referee on the res judicata issue. Our review of the record, however, reveals no basis for concluding that development of the record in this case was lacking. Claimant has pointed to nothing which would support such a conclusion. Consequently, remand is denied.

Compensability

To overcome the insurer's partial denial, claimant has the burden of proving a material causal relation between his current left thumb and wrist conditions and his compensable industrial injury. See Harris v. Albertson's, Inc., 65 Or App 254, 257 (1983). We conclude that claimant has carried his burden.

A total of nine medical professionals offered opinions bearing on the causal relation between claimant's ongoing complaints and his industrial injury. Dr. Ellison, claimant's longtime treating hand specialist, and Dr. Burdell, his longtime treating chiropractor, have consistently opined that there is a causal relation.

Dr. Button, the consulting hand specialist, and Dr. Turco, the consulting psychiatrist, both opined that there was no material causal relation between claimant's current condition and his industrial injury. Dr. Button opined that claimant was either consciously feigning or unconsciously exaggerating his symptoms because of psychological factors. His opinion was based primarily upon early normal nerve conduction studies and a single physical examination. Dr. Wessels, the family practitioner who treated claimant immediately after the industrial injury, and Dr. Cronk, an orthopedic surgeon who participated in claimant's early treatment, both summarily concurred with Dr. Button's opinion. Dr. Turco opined that claimant's symptoms were related to an underlying passive-aggressive personality disorder and strong somatic fixation rather than the industrial injury. His opinion was based upon a single personal interview of claimant.

In July 1987, claimant was examined by a psychologist, Dr. Garfunkel. Dr. Garfunkel conducted a personal interview of claimant and also administered a Minesota Multiphasic Personality Inventory (MMPI) and a Million Behavioral Health Inventory (MBHI). Based upon the information obtained from the MMPI and MBHI, Dr. Garfunkel opined that psychological factors played no significant role in claimant's ongoing pain complaints.

Claimant began treating with a neurologist, Dr. Lafrance, in August 1987. Dr. Lafrance ordered new nerve conduction studies which confirmed that claimant had carpal tunnel syndrome on the left. He also diagnosed "trigger thumb, left hand" based upon his physical examination of claimant. Dr. Henshaw, an orthopedic surgeon, subsequently arrived at the same diagnoses. Based upon the history received from claimant, their examinations of claimant and the new nerve conduction studies, both Lafrance and Henshaw opined that claimant's ongoing symptoms were related to his 1986 industrial injury.

Dr. Button offered another opinion in December 1987. He continued to believe that claimant was either consciously feigning or unconsciously exaggerating his symptoms. He did not think that there was sufficient objective evidence of left "trigger thumb" or carpal tunnel syndrome. He appeared to be ignorant of the recent nerve conduction studies ordered by Dr. Lafrance, stating that "electrical testing had never specifically documented carpal tunnel symptomatology." (Ex. 52).

Claimant sustained a significant sprain of his left thumb and wrist. He testified that he has experienced symptoms in those areas ever since. We find claimant's testimony credible.

In evaluating the above evidence, we give the greatest weight to those medical opinions which are based upon complete information and are well-reasoned. See Somers v. SAIF, 77 Or App 259, 263 (1986). Under these criteria, the opinions of Drs. Ellison and Burdell are due considerable weight because both doctors observed claimant's condition over a long period of time, beginning relatively early in the life of the claim. The opinions of Drs. Garfunkel, Lafrance and Henshaw are also due considerable weight because they were based upon more complete information than that relied upon by the others. The opinions of Drs. Button and Turco are due less weight because they were based upon very limited, incomplete and even erroneous information. The summary concurrences of Drs. Wessels and Cronk are subject to the same criticisms. The history and testimony provided by claimant are credible and are consistent with the opinions of Drs. Ellison, Burdell, Garfunkel, Lafrance and Henshaw. Under these circumstances, we conclude that the evidence preponderates in claimant's favor and hence that the insurer's partial denial should be set aside.

ORDER

The Referee's order dated January 26, 1988 is reversed. The insurer's denial dated October 12, 1987 is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $1,750 for services rendered at hearing and on Board review, to be paid by the insurer.

CARL L. BOHRER, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-07993 & 87-03010
March 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee McCullough's order that upheld the self-insured employer's denial of claimant's aggravation claim regarding a low back injury. On review, the sole issue is the compensability of claimant's aggravation claim. We reverse.

FINDINGS OF FACT

Claimant, age 56, injured his low back on June 15, 1984 as a result of his employment as a sander operator with the employer, where he had been employed for about 20 years. The injury occurred when he jumped out of the way of some falling beams and twisted his back. Following his injury, claimant received conservative treatment for a few weeks and then, on July 13, 1984, he underwent surgery for a left L4-5 herniated nucleus pulposus.

Following his surgery, claimant continued to have pain in his back and legs and he received further conservative treatment. His claim was closed by a Determination Order issued on October 24, 1985. He was awarded temporary total disability from June 18, 1984 through September 10, 1985 and 20 percent unscheduled permanent partial disability.

On October 7, 1985, claimant returned to his sander operator job in a part-time, modified capacity. He stopped working after October 29, 1985. During this period of modified employment, claimant's attendance was irregular. The reason he left work in late October 1985 was because he fell and experienced increased back pain symptoms. Claimant subsequently received further conservative treatment for his symptoms. This included an evaluation and period of treatment at the Northwest Pain Center in March 1986.

On May 19, 1986, claimant returned to his sander operator job in the part-time, modified capacity. Claimant continued working in this capacity until May 30, 1986. During that time his attendance, as before, was irregular. He stopped working after May 30, 1986 because of increased back pain.

On May 27, 1986, claimant had a hearing regarding his appeal of the October 24, 1985 Determination Order. One of the issues raised at the hearing was whether he was entitled to an award of permanent total disability. On June 26, 1986, a prior Referee awarded claimant an additional 55 percent unscheduled permanent partial disability in addition to the 20 percent that he had previously received, for a total of 75 percent. Claimant was dissatisfied with this award and timely appealed the order to the Workers' Compensation Board. On March 12, 1987, the Board issued an Order on Review which affirmed the prior Referee's order regarding the permanent disability issue. The Oregon Court of Appeals has affirmed the Board's order. Bohrer v. Weyerhaeuser Company, 93 Or App 75, (1988).

On July 28, 1986, claimant again returned to the employer, performing the sander operator job on a half-time, modified basis. The job basically involved operating buttons on three control panels. He was restricted regarding any twisting, pulling, bending

or lifting. Further, there was another person available to take care of problems involving the sander belts. Claimant's work situation in July/August 1986 was essentially the same as it had been when he returned to work in late 1985. Between July 28, 1986 and August 19, 1986, claimant missed several days of work. On August 19, 1986, his leg gave way and he fell, injuring his head, shoulder and right arm. As a result of claimant's falling episodes, Dr. Hockey took claimant off work. Because of this left leg problem, claimant had fallen on numerous previous occasions, including at least one occasion during the return to work period in July/August 1986. Subsequent to August 19, 1986, claimant has fallen a number of times.

Claimant filed a new injury claim based upon that August 19, 1986 fall and also filed an aggravation claim, requesting that his 1984 injury claim be reopened. The employer denied both the new injury and aggravation claims.

Claimant has not returned to work since August 1986. He has had additional medical evaluations and conservative treatment, including an evaluation in June 1987 by Dr. Smith, neurosurgeon. Following the June evaluation, Dr. Smith ordered an MRI examination of claimant's lumbar spine. Based upon lower lumbar and lumbosacral defects evidence by the MRI study, Dr. Smith recommended surgery and requested authorization for it. Also, in June 1987 claimant began treating with Dr. Radmore, psychiatrist. At that time, claimant's depression condition was contributing to his disability status.

CONCLUSIONS OF LAW

The Referee concluded that claimant's condition had not changed nor was he less able to work than at the time of the last award of compensation. Therefore, he found that claimant had not proven a compensable aggravation claim. 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 must show that 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). If 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). In the absence of indications to the contrary, we assume that all evidence relevant to anticipated symptomatic flare-ups was considered by the agency or tribunal which granted the last award of compensation. See International Paper v. Turner, 91 Or App 91, 93 (1988).

On July 28, 1986, claimant was released to the part-time, modified sander operator position. On August 11, 1986, Dr. Hockey, claimant's treating physician, noted that claimant had recently fallen twice and thought it was questionable how much longer he would be able to continue working for the employer. Claimant was taken off work the remainder of the week and then returned to his modified position. On August 19, 1986, however, he again fell when his leg collapsed. Dr. Hockey took him off work at that time. As Dr. Hockey stated on August 22, 1986:

"[u]nder the circumstances, I do not see how we can have the patient continue working. Apparently he has fallen several times at work and if this keeps happening, he will continue to aggravate the problem."

On November 6, 1988, he elaborated on claimant's status, reporting that:

"[t]he patient states he fell yesterday and this seemed to aggravate his problem. He continues to do this and when he returns to work, I am sure he will do the same. I feel [claimant] should get early retirement and will not be able to return to his work."

After claimant's two previous unsuccessful attempts to return to work on a modified, half-time basis, Dr. Hockey finally believed that claimant was not capable of continuing in that position. Claimant has not returned to work since August 1986.

Although claimant's last award of 75 percent unscheduled permanent disability anticipated that he would experience short periods of future disability, the combination of claimant's physical and psychological waxing of symptoms since that time has caused an indefinite temporary disability status. In any event, claimant has been totally disabled since August 19, 1986 for greater than 14 consecutive days. Therefore, he has established an aggravation as a matter of law. Gwynn v. SAIF, 91 Or App 84, 88 (1988).

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered at hearing and on Board review. See ORS 656.386(1). 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 23, 1987 is reversed in part. That portion of the Referee's order that upheld the self-insured employer's denial of claimant's claim for aggravation is reversed. The claim is remanded to the self-insured employer for processing according to law. The Board approves a client-paid fee, not to exceed $721.75.

ROBERT E. DERBY, Claimant
Bottini, et al., Claimant's Attorneys
Stafford Hazelett, Defense Attorney

WCB 87-09707
March 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Neal's order that upheld the insurer's partial denials of his degenerative back condition on the basis that claimant's hearing request was untimely. Claimant argues that he had "good cause" for his failure to timely request a hearing on the denials. See ORS 656.319(1)(b). The issue is timeliness. The insurer did not submit a respondent's brief on review. We affirm the Referee's order.

FINDINGS OF FACT

Claimant injured his back in a falling incident on August 28, 1986, while employed as a log loader. The insurer initially deferred acceptance or denial of the claim. Then, on February 3, 1987, the insurer issued a letter accepting a back strain but denying a preexisting degenerative condition. Claimant received a check for temporary disability benefits at the same time he received the insurer's "partial" denial.

The claim remained in open status for several months with the insurer continuing to periodically pay temporary benefits. Then, on April 17, 1987, the insurer mailed a second denial to claimant. This letter denied responsibility for claimant's "current disability and need for treatment" on the ground that they were related to the denied degenerative condition rather than the accepted back strain. The insurer discontinued temporary benefits at the same time but did not close the claim administratively or submit the claim for closure.

The insurer sent this second denial to claimant's last known address in Napa, California. Claimant moved from California to Washington prior to the date upon which the insurer mailed its second denial letter. As a result of this move, claimant did not receive the April 17, 1987 denial until May 1, 1987.

On an unknown date between May 1, 1987 and June 16, 1987, claimant consulted an attorney in Seattle, Washington concerning the two denials. Claimant believed that the Seattle attorney would handle the matter for him. However, on or about June 16, 1987, claimant was referred by the Seattle attorney to his present Oregon counsel.

Claimant contacted his Oregon counsel that same day. Counsel prepared a request for hearing, an attorney retainer agreement, and an authorization to release medical information. These materials were mailed to claimant. Claimant signed the attorney retainer agreement and the authorization to release medical information on June 18, 1987. He mailed the materials back to his Oregon counsel, who then sent them by first class mail to the Board. They were received by the Board on June 24, 1987.

Claimant's hearing request was filed 141 days after mailing of the first denial and 68 days after mailing of the second denial.

CONCLUSIONS OF LAW AND OPINION

A request for hearing from a denied claim must be filed within 60 days after claimant is notified, unless good cause for failure to file within that time is shown. ORS 656.319(1). Claimant concedes that he failed to request a hearing within 60 days of either denial. He contends, however, that the insurer's April 17, 1987 denial resulted in an improper termination of his temporary benefits in contravention of the dictates of Roller v. Weyerhaeuser Co., 67 Or App 583, rev den 297 Or 601 (1984) and Bauman v. SAIF, 295 Or 788 (1983). He concludes that the denials are void and that late appeal therefrom does not bar him from receiving a hearing on the merits.

We do not agree. We have previously determined that the propriety of a denial may not be litigated unless a hearing is

timely requested on the denial. Charles E. Martin, 37 Van Natta 1102, 1104 (1985). In the absence of a timely hearing request, the Referee is without jurisdiction to consider the matter. John E. Russell, 36 Van Natta 678 (1984).

Claimant argues in the alternative that he had good cause for his failure to request a hearing within 60 days of notification of each denial. Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). "Good cause" as used in ORS 656.319(1)(b) means the same kind of "mistake, inadvertence, surprise or excusable neglect" that permits relief from a default judgment under former ORS 18.160, now ORCP 71(B)(1). Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986).

With regard to the February 3, 1987 denial, claimant argues "good cause" for two related reasons. First, claimant notes that he received a check for temporary benefits at the same time he received the partial denial and he continued to receive temporary benefits thereafter. Claimant contends that he, therefore, did not feel there was anything from which to appeal. Second, claimant asserts that the insurer confused him by accepting the claim in the form of a partial denial letter.

In Cowart v. SAIF, 86 Or App 748 (1987), the Court of Appeals mandated that we make the decision concerning "good cause" on the basis of the considerations in ORCP 71(B)(1) or cases decided under former ORS 18.160. Claimant cites no authorities in support of his position. Our independent review of the cases discloses no authorities sufficiently analogous to the instant case to be helpful. We note, however, that the language of the February 3, 1987 denial is not ambiguous. Furthermore, claimant was properly informed of his appeal rights.

Claimant alleges that he was confused by the denial because the insurer continued to pay temporary benefits and to process his medical bills. The confusion alleged by claimant is inherent in any partial denial situation. However, the courts have expressly recognized partial denials. As noted by the Supreme Court in Johnson v. Spectra Physics, 303 Or 49, 58 (1987), partial denials promote timely closure of the accepted aspects of the claim. In addition,

> "[i]f insurers could not partially deny claims, they might routinely deny entire claims to protect their interests, rather than accepting conditions or injuries that are clearly compensable." Ibid.

The insurer has issued a partial denial unambiguous on its face which includes a proper recitation of claimant's appeal rights. We conclude that claimant has not proven the same kind of "mistake, inadvertence, surprise or excusable neglect" that permits relief from a default judgment under former ORS 18.160, now ORCP 71(B)(1).

With regard to the April 17, 1987 denial, claimant first notes that the denial was not received until approximately two weeks after mailing by the insurer. Claimant's hearing request from his denial was received sixty-eight days after the date of mailing. Although claimant did not receive the denial until May 1, 1987, he received it well before the expiration of 60

ORDER

The Referee's order dated August 28, 1987 is affirmed.

DONALD R. DURRANT, Claimant
Heiling & Morrison, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 86-13970, 86-13971, 86-14498 & 86-14499
March 8, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

Western Employers Insurance Company requests review of those portions of Referee Brown's order that: (1) set aside its denial of claimant's claim for his current cervical condition; and (2) upheld United Pacific Insurance Company's denial of claimant's "new injury" claim for the same condition. We affirm.

ISSUE

Responsibility for cervical condition.

FINDINGS OF FACT

Claimant, a millwright, compensably injured his neck and right shoulder in December, 1985, when he fell 15 feet and fell on his right shoulder. A myelogram revealed disc herniation at C6-7. Dr. Golden, a neurosurgeon, performed a cervical laminectomy in April, 1986, removing free disc tissue from C6-7. Subsequently, claimant's symptoms resolved except for mild pain in the neck, right shoulder and arm. Western Employers accepted the claim for a disabling injury. Dr. Golden released claimant for regular work in May, 1986. Claimant returned to lighter, full-time work, occasionally working overtime. On July 1, 1986, the employer changed its insurance carrier from Western Employers to United Pacific.

On July 14, 1986, claimant experienced a numbing and "burning" sensation extending from the right side of the neck to the right shoulder and arm, while welding in a sitting position on the floor. The symptoms were similar to those he experienced after the original injury in 1985. Prior to welding, he had been lifting steel plates weighing 25 to 30 pounds and placing them on a plywood press. However, we do not find that any activity or occurrence precipitated the recurrence of symptoms.

A CT scan on September 8, 1986, revealed no evidence of disc herniation. The next day, Dr. Golden performed a repeat cervical laminectomy at C6-7 and removed scar tissue and an osteophytic spur which were decompressing the C7 root. In his operation report, Golden did not record any observation of a recurrent disc herniation. We do not find that claimant suffered a recurrent disc herniation on or after July 14, 1986.

Claims for the symptomatic recurrence were filed with Western Employers and United Pacific. On September 4, 1986, Western Employers denied responsibility for the cervical condition beyond July 14, 1986. United Pacific denied responsibility for the "new injury" claim on September 25, 1986. On October 1, 1986, an order issued pursuant to ORS 656.307, designating Western Employers as paying agent.

FINDINGS OF ULTIMATE FACT

We do not find that work activities while United Pacific was on the risk independently contributed to any worsening of claimant's cervical condition.

CONCLUSIONS OF LAW AND OPINION

In successive injury cases, we apply the last injury rule which provides that the insurer on the risk at the time of the original injury remains liable for the second injury if the second injury did not independently contribute even slightly to the causation of the disabling condition, i.e., to a worsening of the underlying condition. Hensel Phelps Const. v. Mirich, 81 Or App 290, 293-94 (1986). Here, claimant's original disabling injury claim remained in open status at the time of his symptomatic flare-up in July, 1986. Hence, this case does not present a true "aggravation/new injury" question as in the line of successive injury cases. See, e.g., Mirich, supra. Nevertheless, with the issuance of the .307 order, the only question before the Board is responsibility. Because this issue presents a complex medical question, resolution of this case turns largely on the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical evidence on the responsibility issue was generated by Dr. Golden, claimant's treating neurosurgeon. By check-the-box response, Golden concluded that the work activity on July 14, 1986 independently contributed to and materially worsened claimant's cervical condition. We are not persuaded by that opinion, however, because the factual bases supporting it are unreliable. First, Golden based his conclusion on a finding that claimant suffered a recurrent disc herniation after the July 14 work activity. That finding is inconsistent with the September, 1986 CT scan, which revealed no evidence of herniation, and is not substantiated by Golden's own report of the repeat laminectomy. In that operation report, Golden only reported the removal of scar tissue and a spur; he did not record any observation of a herniation. Although Golden's discharge summary and subsequent reports refer to a recurrent disc herniation at C6-7, those reports issued several days after the laminectomy and, for that reason, are less reliable than the operation report itself.

Second, in reaching his conclusion, Dr. Golden apparently relied on history that, on July 14, 1986, claimant felt an immediate onset of severe neck pain while lifting 80-pound steel plates over his head. That history is inconsistent with claimant's testimony that the symptoms appeared while he was welding and that he could not identify a specific activity or occurrence which precipitated the flare-up. Although claimant testified that he had been lifting steel plates prior to welding, he estimated the weight of each plate at 25 to 30 pounds. We are mindful that the history provided to Dr. Golden merely reflects the history that claimant provided to the employer's investigator in an August, 1986 interview. However, claimant explained at hearing that, prior to the interview, he was informed that Western Employers would deny his claim, and, for that reason, he felt pressured into identifying a specific activity which precipitated his symptoms. Hence, we are most persuaded by claimant's testimony at hearing that his symptomatic flare-up did not coincide with a specific lifting incident.

The lay evidence supports a finding that the July 14 incident was merely a recurrence of the original injury. Claimant testified that he had mild residual pain when he returned to work in May, 1986, indicating that the original cervical condition persisted prior to the symptomatic flare-up. He further testified that his symptoms were the same as those he suffered after the original injury and that there were no new symptoms. After reviewing the medical and lay testimony, we are unable to find that the work activity while United Pacific was on the risk independently contributed to any worsening of claimant's cervical condition. Accordingly, we conclude that claimant's cervical condition beyond July 14, 1986 is the continuing responsibility of Western Employers.

ORDER

The Referee's order dated May 11, 1987 is affirmed. The Board approves a client-paid fee not to exceed $105, to be paid to United Pacific Insurance Company's counsel, and a client-paid fee not to exceed $1,000, to be paid to Western Employers Insurance Company's counsel.

MARY J. GATES, Claimant
Rankin, et al., Defense Attorneys
Moscato & Byerly, Defense Attorneys

WCB 86-16302, 86-17922 & 87-00191
March 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant, pro se, requests review of those portions of Referee St. Martin's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for carpal tunnel syndrome; (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for the same condition; and (3) declined to award interim compensation, penalties and attorney fees for the self-insured employer's alleged unreasonable claims processing. We affirm.

ISSUES

(1) Compensability of claimant's carpal tunnel syndrome as either an aggravation or an occupational disease claim;

(2) Entitlement to interim compensation; and

(3) Penalties for the self-insured employer's alleged failure to timely process a claim.

FINDINGS OF FACT

Claimant, 32 years of age at hearing, suffered a compensable back injury on February 1, 1980. At that time, the employer was self-insured. Liberty Northwest Insurance Corporation came on the risk beginning February 1, 1984.

Claimant returned to work, as a cashier for the employer in 1982. The claim for the original injury was closed by Determination Order, dated July 13, 1982. Claimant received no permanent disability. The Determination Order was affirmed at the hearing's level and upon Board review. Claimant continued to experience some low back pain after her return to work.

Claimant became pregnant with her second child late in 1982. She continued to experience low back pain and also began to notice neck and right shoulder discomfort. On March 29, 1983, in addition to claimant's compensable lumbar strain, the Orthopaedic Consultants diagnosed cervical and dorsal strain which they believed was brought on by tension, unrelated to the original injury. The panel specifically noted that claimant complained of no numbness, tingling or other radicular symptoms in her upper extremities. Claimant's treating physician, Dr. Berselli, M.D., concurred with the panel's opinion.

Claimant continued working for the employer until August 1983, when she took maternity leave to have her second child. She returned to work in October 1983. In April 1984, claimant again sought treatment for right hip, back and neck pain, shoulder and bilateral leg and arm pain. Dr. Duckler, M.D., diagnosed chronic pain syndrome and possible fibromyositis.

Dr. Berselli saw claimant in October 1984 for neck pain. Claimant also complained of occasional right arm numbness. The doctor conducted a neurologic exam of claimant's upper extremities. The findings were normal. Nerve conduction tests were also normal. The doctor noted claimant was again pregnant. Claimant left work in October 1984 and has not returned to work since.

Claimant next sought treatment from Dr. Berselli, in May 1986, complaining of right arm and hand pain and numbness. On May 29, 1986, the self-insured employer received Dr. Berselli's May 9, 1986 report requesting claim reopening. On May 20, 1986, Dr. Berselli forwarded an 827 to Liberty Northwest, diagnosed carpal tunnel syndrome and restricted claimant from work. EMGs conducted in September 1986 revealed definite carpal tunnel syndrome on the right and a borderline condition, on the left. The diagnosis was later confirmed by nerve conduction studies performed by Dr. Stolzberg, M.D. On September 19, 1986, the employer, in its self-insured capacity, denied claimant's aggravation claim.

ULTIMATE FINDINGS OF FACT

(1) Claimant's February 1, 1980 compensable back injury has not worsened since the last arrangement of compensation. Her carpal tunnel syndrome is not causally related to the compensable back condition.

(2) Claimant's work exposure with the employer was not the major contributing cause of her carpal tunnel syndrome condition.

(3) The employer in its self-insured status received notice of Dr. Berselli's May 9, 1986 request for claim reopening on May 29, 1986. The employer issued a denial of the aggravation claim on September 19, 1986.

(4) Claimant has not been employed since she left the employer in October 1984.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to show a causal relationship between her carpal tunnel syndrome condition and her work exposure with the employer. He relied upon Dr. Berselli's conclusion that claimant's employment did not cause the condition. He discounted Dr. Long's opinion, as it was primarily based on claimant's history,

which the Referee found unreliable. He also discounted the testimony of claimant's friends and found they simply supported "each other's entrenchment in disability." We agree with the Referee.

In order for claimant to establish her carpal tunnel syndrome claim under an aggravation theory, she must prove by preponderant evidence that her compensable condition has worsened since the last arrangement of compensation and that there is a material relationship between the worsening and her compensable injury. Johnson v. Argonaut Insurance Co., 79 Or App 230 (1986).

Claimant failed to establish a relationship between her compensable back injury and the carpal tunnel syndrome condition. Whether there is a relationship between claimant's compensable back injury and the carpal tunnel syndrome condition is a complex medical question that requires expert opinion to establish. See Kassahn v. Publishers Paper, 76 Or App 105 (1985). There is no expert opinion establishing a connection between claimant's back condition and the carpal tunnel syndrome. In fact, Dr. Long specifically ruled out any such relationship. He stated: " I do not believe that there is a direct relationship between the upper and lower trunk pain dating from February 1, 1980 and the median compression neuropathy evident in both wrists now."

Claimant has also presented an occupational disease claim for the carpal tunnel syndrome condition. To prevail under this theory, she must prove a causal connection between her employment and the condition. ORS 656.802(1)(a). She must also show that her work activities were the major contributing cause of the condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). Claimant fails on both counts.

Claimant's carpal tunnel syndrome arose after she left work with the employer in October 1984. Although claimant did have some right arm pain complaints in 1984, those complaints were diagnosed and treated as related to the cervical and dorsal spine discomfort she experienced during that time and diagnosed as chronic pain syndrome.

Absent persuasive reasons not to, we ordinarily defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Based on the neurologic exams that treating physician, Dr. Berselli, conducted on claimant's upper extremities in October 1984, he concluded that claimant was not suffering from carpal tunnel syndrome when she left work in October 1984. He opined that there was no relationship between claimant's job activities with the employer and the development of the condition in 1986. We also note that Dr. Berselli advised that claimant's pregnancy may have played a role in the development of the condition.

Dr. Nye also opined that the development of the carpal tunnel condition was unrelated to claimant's employment. He concluded claimant's activities as a cashier would not likely produce the condition. He also noted that her symptoms seemed to correspond to her pregnancies and that the condition had worsened after claimant left work. For these reasons, Dr. Nye determined the onset of the carpal tunnel syndrome was probably ideopathic.

We discount Dr. Long's contrary opinion. We find his opinion less persuasive than the well reasoned opinions of Drs. Berselli and Nye. See Somers v. SAIF, 77 Or App 259 (1986). His conclusion that claimant experienced carpal tunnel syndrome symptoms as early as 1982, is based solely on the history she provided

him. We agree with the Referee that claimant's history is not particularly reliable. Therefore, Dr. Long's opinion based upon reliance of that history is flawed. See Frank E. Battaglia, 40 Van Natta 842 (1988).

We also note that Dr. Long is unable to account for the discrepancy between claimant's history of carpal tunnel complaints, since 1982, and the lack of objective findings of the condition as documented by the normal nerve conduction studies taken in 1984. Dr. Long's opinion is particularly confusing given his opinion that if claimant's nerve conduction studies were normal in 1984, she should not have been experiencing carpal tunnel symptoms, at that time.

Claimant is not required to use expert opinion to establish a causal relationship between her employment and the carpal tunnel condition. Lay testimony may be sufficient to establish that the condition arose during the time claimant worked for the employer. See Garbutt v. SAIF, 297 Or 148 (1985). However, as mentioned above, we agree with the Referee that claimant's account of the onset of carpal tunnel symptoms is inaccurate and unreliable.

For example, claimant testified at hearing that in December 1982, she experienced pain and weakness in her right hand, that caused her to drop a coffee pot. This was essentially the same account of the incident that she provided Dr. Stolzberg, neurologist, on August 23, 1986. Dr. Long relied on this story in concluding claimant had carpal tunnel syndrome as early as November or December, 1982. However, these later accounts are not in harmony with claimant's initial report of the incident to Dr. Heatherington, on January 5, 1983. At that time, she informed him the coffee pot incident caused pain in her back and neck. There was no report of hand or arm pain.

Claimant's inaccurate history is insufficient of itself to establish a causal relationship between her employment and the carpal tunnel syndrome condition. In addition, the medical evidence preponderates against compensability. Claimant has failed to meet her burden of proof.

Interim Compensation

Claimant contends that she is entitled to interim compensation, from the self-insured employer, due from the fourteenth day after she filed her claim for carpal tunnel syndrome, until the claim was denied. See ORS 656.273(6). We disagree. ORS 656.273(6) does not mandate payment of interim compensation until the employer has notice or knowledge of claimant's "medically verified inability to work" as a result of a worsening of her compensable back injury.

Dr. Berselli's May 9, 1986 report, to the self-insured employer, requesting reopening for treatment and diagnostic work-up of claimant's carpal tunnel condition does not document claimant's inability to work, nor does it substantiate that claimant's inability to work is due to her compensable back injury. Dr. Berselli's May 20, 1986 827 sent to the insurer, while restricting claimant from work, does not attribute claimant's inability to work to a worsened back condition. At most, the report can be read as a request for authorization for additional conservative treatment and EMG diagnostic work ups. The self-insured employer had no duty to pay interim compensation under these circumstances.

Penalties

Claimant also contends that she is entitled to penalties and attorney fees for the employer's failure to timely process her claim. We agree that the employer issued an untimely denial. The employer received notice of "aggravation" reopening requests from Dr. Berselli in May 1986. The employer, in its self-insured status, issued a denial of the aggravation claim and of Dr. Berselli's later request for surgery authorization, on September 19, 1986. Clearly, the employer did not issue a timely denial. ORS 656.262(6); 656.273(6).

Penalties can only be assessed on amounts "then due." ORS 656.262(10). Because we found that claimant's condition is not compensable, and she was not entitled to interim compensation, there are no amounts "then due" on which to assess penalties.

ORDER

The Referee's order dated August 28, 1987, is affirmed. The Board approves a client-paid fee, not to exceed $1,006, payable from the self-insured employer to its counsel.

JOSEPH HLAVKA, Claimant
Royce, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 87-12588 & 87-06234
March 8, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

EBI Companies requests review of those portions of Referee Podnar's order that: (1) set aside its "de facto" partial denial of claimant's claim for medical services; (2) upheld a denial of claimant's "new injury" claim for his back condition issued by CNA Insurance Company; (3) assessed penalties and attorney fees for EBI's failure to notify claimant in its partial denial of his statutory hearing rights; and (4) recommended that claimant's claim be reopened pursuant to the Board's Own Motion authority. We reverse the assessment of penalties and attorney fees and affirm the remainder of the Referee's order.

ISSUES

1. Whether claimant sustained an aggravation of his compensable July 14, 1980 injury or a "new injury" on January 20, 1987.

2. Whether EIB's procedurally defective denial of April 17, 1987 was unreasonable, thereby entitling claimant to penalties and attorney fees.

a. If the procedurally defective denial was unreasonable, what amount was "then due" upon which to base the penalty.

FINDINGS OF FACT

Claimant, a 29 year old carpenter, compensably injured his low back on July 14, 1980 while lifting concrete forms at EBI's insured. A lumbosacral strain was diagnosed and he received conservative treatment through the March 24, 1981 claim closure with no permanent disability award.

On July 29, 1981, the claim was reopened. Following additional conservative treatment, the claim was closed on June 15, 1982 with an award of 10 percent unscheduled permanent disability. That award was increased to 20 percent unscheduled permanent disability by Opinion and Order of February 11, 1983.

In December 1983 claimant was hospitalized for traction. On February 13, 1984, Dr. Rosenbaum, neurological surgeon, performed an unsuccessful Chymopapain injection at the L4-5 level. On June 12, 1984, due to the continuing nature of claimant's low back and bilateral leg pain, Dr. Rosenbaum performed a lumbar laminectomy and diskectomy at L4-5 on the left.

As of August 1985 claimant continued to experience significant low back and bilateral leg pain, worse on the left. In September 1985 a myelogram revealed a moderate diffuse bulging disc at L4-5 on the right.

On October 22, 1985, Dr. Nash, neurological surgeon, performed a lumbar laminotomy, medial facetectomy for root release, and diskectomy at L4-5 on the right. Although the surgery reduced claimant's low back and bilateral leg pain, his symptoms continued to wax and wane.

On May 1, 1986, the claim was again closed by Determination Order with no additional award of permanent disability. A request for hearing resulted in a stipulation which granted claimant an additional 11.76 percent unscheduled disability, giving him a total of 31.76 percent unscheduled permanent disability.

Claimant subsequently obtained employment as a light industrial employee for CNA Insurance Companies' insured. On January 20, 1987, he attempted to lift a plastic tub from a stack of tubs; as he jerked, the suction resisted and he experienced an immediate increase in low back and left leg pain. At no time between May 1, 1986 and January 20, 1987 had claimant been completely free of the low back and leg pain. Claimant has not returned to work since the January 1987 incident.

On January 20, 1987, he was hospitalized for traction for approximately two weeks and came under the care of Dr. Thomas, orthopedic surgeon. He was released to bed rest at home, but did poorly there and, on February 7, 1987, was readmitted to the hospital.

On February 9, 1987, Dr. Quilici, radiologist, reviewed an MRI of claimant's lumbar spine and diagnosed degenerative disc disease at L4-5 with a broadbased disc bulge and probable focal disc herniation on the right.

On February 16, 1987, Dr. Thomas wrote to EBI and informed it of claimant's off work status and injury. On March 12, 1987, Dr. Thomas requested permission from EBI to perform surgery. Dr. Nash concurred in this request.

On April 17, 1987, EBI wrote to the Workers' Compensation Board to explain its position that injuries subsequent to the accepted July 14, 1980 injury were responsible for claimant's current need for treatment. A copy of this letter was sent to claimant. The letter, however, neither notified claimant that his claim had been denied nor that he could challenge its denial by exercising his statutory hearing rights.

On April 22, 1987, Dr. Nash wrote to CNA, requesting authorization to perform an L4-5 diskectomy.

On May 18, 1987, the Orthopaedic Consultants examined claimant and diagnosed degenerative disc disease at L4-5 and recurring lumbosacral strain by history. They did not see sufficient clinical evidence to warrant surgery.

On April 20, 1987 and again on June 10, 1987, claimant's counsel filed a request for hearing and application to schedule with the Workers' Compensation Board, alleging, inter alia, issues involving medical services, an aggravation claim, and penalties and attorney fees.

On June 8, 1987, claimant was shot twice in the chest at his home by a police officer who was investigating a domestic disturbance complaint. He was hospitalized for three months and underwent six operations before being released.

On August 17, 1987, claimant's counsel filed a supplemental request for hearing specifically contesting EBI's "de facto" denial of the claim and attached thereto a "Motion to Make Denial More Definite and Certain Pursuant to OAR 436-60-140."

Although the January 20, 1987 lifting incident did cause an increase in claimant's low back and leg symptoms, it did not independently contribute to a worsening of his condition.

From January 20, 1987 through September 24, 1987, the time of hearing, claimant had accrued an outstanding medical bill for his back condition in the amount of $7,292.92.

CONCLUSIONS OF LAW

Responsibility

The Referee relied upon the opinion of Dr. Thomas in concluding that, although the January 1987 event caused an increase in symptoms, it did not materially affect the progression of claimant's condition. We agree.

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

Despite two diskectomies performed at the L4-5 level, both right and left sides, claimant has had constant low back and leg pain since his compensable 1980 injury. Subsequent to the January 20, 1987 incident, claimant was found to have a recurrent disc protrusion at the L4-5 level on the right.

Dr. Nash examined claimant in April 1987 and opined that he had sustained a new injury which had produced new findings on the site opposite from that which was corrected during the 1985 diskectomy. Dr. Nash, however, failed to note that the initial 1984 diskectomy had been performed to correct an L4-5 disc herniation on the right, the same area which was found to be protruding in 1987.

The Orthopaedic Consultants also believed that claimant had sustained a new injury in January 1987. They based their opinion, however, on the assumption that following the 1985 diskectomy claimant was greatly improved and did not experience any further leg pain until January 20, 1987. Although claimant's low back and leg symptoms did decrease following the 1985 surgery, they did not resolve; he continued to experience a waxing and waning of symptoms up to the January 1987 incident. Since the basis for the Orthopaedic Consultants' opinion that claimant suffered a new injury at that time was not accurate, we give little weight to the opinion.

In May 1987 claimant's treating physician, Dr. Thomas, opined that the January 1987 lifting incident increased claimant's back symptoms but did not pathologically worsen his back. He further opined that claimant's present problem was a continuation of his 1980 injury. Although in September 1987 Dr. Thomas stated that the January 1987 incident was a factor in claimant's present "problems," we interpret "problems" to indicate "symptoms."

Dr. Rosenbaum, who performed the 1984 diskectomy, concurred with the opinion of Dr. Nash and opined that, if one were to assume the January 1987 incident created a temporary flare-up of claimant's symptoms, then the incident would not likely have materially affected the progression of his condition.

We rely upon the more persuasive opinions of Drs. Thomas and Rosenbaum and conclude that the January 1987 incident did not independently contribute to a worsening of claimant's condition. Therefore, EBI remains responsible for claimant's continuing low back and leg condition.

Penalties and attorney fees

The Referee assessed claimant a 25 percent penalty and a $500 attorney fee for EBI's procedurally defective denial, characterized as unreasonable claims processing. We agree that EBI's claims processing was incorrect, but conclude that it was not unreasonable.

On April 17, 1987, EBI mailed a letter to the Own Motion section of the Workers' Compensation Board advising it that claimant had suffered a new injury while employed with CNA's insured and that the new injury was the cause of his current need for medical treatment. A copy of that letter was mailed to claimant. Although the letter was intended to notify claimant and the Own Motion section that EBI would no longer be responsible for claimant's medical benefits, it did not specifically state that it was denying claimant's claim for medical services; nor did it notify claimant of his statutory hearing rights. Therefore, the April 17, 1987 letter did not constitute a denial. Instead, we construe EBI's actions to be a "de facto" denial of claimant's medical services. See Syphers v. K-W Logging, Inc., 51 Or App 769 (1981).

However, on April 20, 1987, and again on June 10, 1987,

claimant's counsel filed a request for hearing and application to schedule with the Board, alleging, inter alia, issues involving medical services, aggravation, and penalties and attorney fees. EBI did not subsequently issue a formal denial of compensation.

ORS 656.262(10) states that:

> "[i]f 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."

EBI relied upon our decision in Joyce A. Morgan, 36 Van Natta 114 (1984) in arguing that a penalty and attorney fee should not be imposed because claimant suffered no prejudice as a result of its procedurally defective denial. In Roger C. Prusak, 40 Van Natta 2037 (1988), however, we relied upon the Court of Appeals decision in Lester v. Weyerhaeuser Co., 70 Or App 307, 311, rev den 298 Or 427 (1984), and expressly disavowed our holding in Joyce Morgan, supra. Because prejudice is no longer an element of a claims processing violation, the theoretical basis of the Morgan decision is gone. Roger C. Prusak, supra.

Although EBI's procedurally defective denial was wrong, the Board's decisions in Morgan and subsequent cases provided a reasonable basis for EBI to conclude that, when claimant's attorney filed a request for hearing three days after its April 17, 1987 de "facto denial", no basis for a penalty or attorney fee for unreasonable claims processing existed. It could reasonably assume that, under the existing caselaw, it was unnecessary to subsequently issue a formal denial. Under these circumstances, while EBI's claims processing was incorrect, it was not unreasonable. Therefore, claimant is not entitled to a penalty and attorney fee.

ORDER

The Referee's order dated October 8, 1987 is reversed in part and affirmed in part. That portion of the Referee's order that assessed penalties and attorney fees is reversed. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $1,200 for his services on Board review, to be paid by EBI Companies. The Board approves a client-paid fee, from CNA Insurance Companies to its counsel, not to exceed $785.53. The Board also approves a client-paid fee, from EBI Companies to its counsel, not to exceed $1,269.50.

JOSEPH HLAVKA, Claimant
Royce, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Own Motion 87-0184M
March 8, 1989
Own Motion Order

Claimant requested that the Board exercise its own motion authority and reopen his claim for a 1980 injury. Claimant's aggravation rights have expired. On August 26, 1987, the Board deferred acting upon claimant's request since he had requested consolidation with proceedings which were presently pending.

(WCB Case Nos. 87-06234 and 87-12588). The hearing concerned the issues of medical services, responsibility and penalties and attorney fees.

The litigation proceeded to hearing. On October 8, 1987, Referee Podnar found that claimant's current low back and leg condition had required hospitalization and continued to be related to his 1980 injury. Consequently, Referee Podnar recommended that we exercise our own motion authority pursuant to ORS 656.278. On Board review, we agreed that claimant had sustained an aggravation of his 1980 compensable low back injury and affirmed that portion of the Referee's order. See Joseph Hlavka, 41 Van Natta (Issued this date).

Following our review of the record, we also agree with the Referee's recommendation that we exercise our own motion authority pursuant to ORS 656.278. Accordingly, the claim should be reopened with temporary disability to commence January 20, 1987 and continue until claimant returns to his regular work at his regular wage or becomes medically stationary, whichever is earlier.

At hearing, the parties raised a question concerning the applicability of the new administrative rules and their effect on the time period for the payment of temporary disability.

The new Own Motion rules adopted by the Board, effective January 1, 1988, apply to claims actually reopened after that date. OAR 438-12-018. Therefore, the new Own Motion rules apply to the present case.

ORS 656.278 provides that the Board may authorize temporary total disability benefits "from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary . . . "

Claimant was first hospitalized for traction on January 20, 1987. Therefore, claimant is entitled to temporary disability benefits from that date until he returns to his regular work at his regular wage or becomes medically stationary.

As a reasonable attorney's fee, claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $1,050.

Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

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

WCB 86-17402
March 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requested review of those portions of Referee Daron's order that: (1) set aside its partial denial of chiropractic care; (2) set aside its partial denial of claimant's spinal biomechanical aberration condition; (3) assessed penalties and related attorney fees for its unreasonable denial of that biomechanical aberration condition; and (4) found that claimant's back injury claim was prematurely closed. The insurer, however,

withdrew its request for review and this case comes before us on claimant's cross-request for review of the Referee's order. No briefs were filed by either party. We modify in part and affirm in part.

ISSUES

1. Whether claimant's claim was prematurely closed.

2. If claimant's claim was not prematurely closed, what is the extent of claimant's permanent disability, if any, resulting from her compensable injury of June 7, 1986.

3. Whether the insurer's pre-closure partial denial of claimant's thoracolumbar biomechanical aberration condition was procedurally proper.

4. If the insurer's pre-closure partial denial of claimant's biomechanical aberration condition was procedurally proper, whether that condition is compensable.

5. Whether claimant's chiropractic care was reasonable and necessary.

6. Whether claimant is entitled to penalties and related attorney fees for the alleged unreasonable partial denials.

FINDINGS OF FACT

On or about June 7, 1986, claimant sustained a compensable injury when she tripped and fell, landing on her buttocks. Following her fall, claimant visited the Salem Hospital emergency room on three successive days, June 9, 10 and 11, 1986, with varying back complaints each day. The first day's diagnosis was acute cervical and dorsal spine strain, but was thereafter diagnosed as paraspinal muscle strain or muscle spasm.

On June 11, 1986, claimant saw Dr. Tiley, who diagnosed mild paraspinal muscle spasm, and prescribed rest and heat. On July 7, 1986, Dr. Tiley indicated that claimant was released for regular work as of June 26, 1986.

Claimant then consulted with Dr. Romanick, chiropractor. After a short period of treatment, Dr. Romanick released claimant to regular work with the restriction that she should be allowed to rest as necessary to prevent severe low back pain.

On August 1, 1986, claimant again changed treating physicians and began seeing Dr. Palmer, another chiropractor. Dr. Palmer diagnosed: (1) pain in the thoracic spine; (2) lumbar disc syndrome; (3) coccydynia; and (4) myalgia of her lower extremities. He did not release claimant for work and recommended conservative chiropractic care.

On August 12, 1986, Dr. Wei, chiropractor, reviewed x-rays and diagnosed: (1) transitional lumbosacral vertebra with synostosis on the left and mild reactive sclerosis at the left sacroiliac joint; (2) loss of the mid and lower cervical lordosis; and (3) moderately accentuated lumbar lordosis emphasized at the L4-5 junction.

The transitional lumbosacral vertebra with synostosis on the left and mild reactive sclerosis at the left sacroiliac joint

combined with the accentuated lumbar lordosis at the L4-5 junction accounted for the biomechanical dysfunction of claimant's low back.

On September 29, 1986, Dr. Hubbard, neurologist, examined claimant and diagnosed muscular stiffness in her low back as the source of the majority of claimant's back pain.

On October 15, 1986, Dr. Palmer issued a TENS unit to claimant on a trial basis in the hope that it would relieve some of her lingering lumbosacral pain.

On October 25, 1986, Dr. Bolin, chiropractor, examined claimant and found no evidence to support Dr. Palmer's diagnosis of intervertebral disc syndrome. Dr. Bolin diagnosed a thoracolumbar strain, by history. Based upon claimant's statements that the chiropractic treatments were of no benefit, he recommended that they be discontinued and claimant be referred to another discipline of medicine.

In the meantime, Dr. Palmer referred claimant to Dr. Lawton, a chiropractor with expertise in biomechanical aberrations.

On November 25, 1986, the insurer sent copies of Dr. Bolin's October 25, 1986 report to Drs. Palmer and Lawton, asking them if they concurred with Dr. Bolin's findings and recommendations.

On December 5, 1986, Dr. Lawton responded to the insurer's request with an extensive narrative report in which he diagnosed: (1) lumbar intersegmental dysfunction (subluxation) characterized by aberrant kinetics; (2) lumbosacral sprain/strain; (3) lumbar sprain/strain; (4) thoracic intersegmental dysfunction (subluxation) characterized by aberrant motor unit kinetics; (5) sciatica; (6) thoracic sprain/strain; (7) cervicobrachial syndrome; and (8) sacroiliac ligamentous sprain/strain.

At that time, claimant's condition was responding positively to Dr. Lawton's chiropractic treatments, which were designed to establish normal spinal biomechanics and increase spinal ranges of motion. Nonetheless, her condition remained highly unstable and she remained totally restricted from work.

On December 9, 1986, the insurer notified Dr. Lawton that it had not yet received his reply to its letter of November 25, 1986.

On December 10, 1986, the insurer denied all chiropractic treatment in claimant's claim.

On December 12, 1986, Dr. Palmer informed the insurer that he did not concur with Dr. Bolin's October 25, 1986 report.

On February 17, 1987, Dr. Duncan, chiropractor, examined claimant and diagnosed: (1) a congenital transitional lumbosacral junction with sacralization of the right transverse process of L5; (2) lumbar hyperlordosis apex at L4-5; and (3) thoracolumbar strain by history, resolved. He recommended that, due to the lack of objective findings, further curative or palliative care was not necessary.

On February 23, 1987, the insurer issued a partial denial of claimant's claim for benefits since medical information indicated that her current medical treatment was for a preexisting

biomechanical aberration that was not worsened or related to her industrial injury.

On March 18, 1987, a Determination Order issued which awarded claimant temporary disability benefits from June 7, 1986 through February 3, 1987.

On June 12, 1987, Dr. Lawton released claimant to work on a trial basis, working three hours per day every other day.

Claimant's June 7, 1986 industrial injury caused a worsening of her congenital L5 sacralization. The industrial injury was also a material contributing cause of her thoracolumbar biomechanical aberration.

Chiropractic treatments were reasonable and necessary medical services since they were likely to be of significant curative, palliative, preventive or restorative benefit to claimant's compensable back condition.

CONCLUSIONS OF LAW

Premature claim closure

Based upon Dr. Lawton's persuasive opinion that claimant's condition was not medically stationary, the Referee concluded that claimant's claim had been prematurely closed. We agree.

Dr. Lawton opined that claimant's condition was not medically stationary when her claim was closed, when her disability compensation was terminated, or at hearing. On June 12, 1987, he described her condition as guarded but improving and continued to treat her on a three times per week basis.

We are also persuaded by Dr. Lawton's opinion and find that claimant's claim was prematurely closed. Therefore, the March 18, 1987 Determination Order is set aside and claimant's claim is remanded to the insurer for further processing consistent with this order.

Pre-closure partial denial of claimant's biomechanical aberration

The Referee concluded that the insurer should have pursued claim closure under the appropriate procedure before proceeding to issue a partial denial of claimant's biomechanical aberration condition. We agree and also conclude that claimant's biomechanical aberration condition is compensable.

The denial letter of February 23, 1987 does not deny claimant's claim ab initio, but attempts to deny responsibility for time loss, as well as medical benefits, relative to claimant's symptomatology from that day forward. Even assuming that such a denial might be appropriate where the evidence established that there was both a discrete, noncompensable biomechanical aberration and a compensable thoracolumbar strain, and claimant had fully recovered from the compensable injury, see Aquillon v. CNA Insurance, 60 Or App 231, 235, 653 P2d 264 (1982), rev den 294 Or 460 (1983), the medical testimony here establishes that claimant's symptoms are a continuation of the symptoms arising from her original compensable injury. The insurer's partial denial is essentially an attempt to terminate its liability for the original injury as of a specific

time. See Safstrom v. Riedel International, Inc., 65 Or App 728, 731 (1983). The courts have consistently disallowed such attempts to terminate future responsibility before the extent of claimant's permanent disability has been determined. See Roller v. Weyerhaeuser Co., 67 Or App 583, 586 (1984). To hold otherwise would be tantamount to authorizing the insurer to bypass claimant's hearing on the extent of disability and could preempt the resolution of an issue that is involved in determining the extent of that disability. Id. Therefore, the insurer's pre-closure partial denial of claimant's biomechanical aberration condition was improper.

Assuming arguendo that the partial denial was procedurally proper, we further conclude that claimant's biomechanical aberration condition is compensable.

To establish a compensable industrial injury, claimant has the burden of proving that a work event or series of events within a discrete time period was a material contributing cause of her disability or need for medical services. See Harris v. Alberton's, Inc., 65 Or App 254, 256-7 (1983); Valtinson v. SAIF, 56 Or App 184, 187-88 (1982).

Following our de novo review of the medical and lay evidence, we are persuaded that the June 7, 1986 industrial injury was a material contributing cause of claimant's thoracolumbar biomechanical aberration. We also conclude that the industrial injury was a material cause of the worsening of claimant's congenital sacralization of L5. Summit v. Weyerhaeuser Co., 25 Or App 851 (1976); Patitucci v. Boise Cascade Corp., 8 Or App 503 (1972).

We rely upon the persuasive opinions of Dr. Lawton in determining the compensability of these two conditions. On February 17, 1987, Dr. Duncan examined claimant and identified her biomechanical aberration but concluded that the condition preexisted the industrial injury. Dr. Lawton persuasively rebutted Dr. Duncan's report through both his detailed reports and well reasoned testimony at hearing. Dr. Lawton noted that even though Dr. Duncan had elicited clear objective signs of pelvic instability, he refused to acknowledge that instability. Dr. Lawton also commented that, although claimant's congenital sacralization of L5 was worsened by her industrial injury, that congenital abnormality was clearly not responsible for her thoracolumbar symptoms. He correctly noted that Dr. Duncan failed to address the abnormal thoracic biomechanics or the upper extremity symptoms and he concluded that those problems did not preexist the industrial injury but were materially caused by the fall.

Based upon Dr. Lawton's persuasive medical opinions we find that the industrial injury: (1) materially worsened claimant's congenital sacralization at L5; and (2) was a material cause of claimant's thoracolumbar biomechanical aberration.

Reasonableness and necessity of chiropractic treatments

The Referee concluded that the chiropractic treatments were in fact reasonable and necessary medical services and set aside the partial denial. We agree.

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

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, 197-98 (1986).

Dr. Lawton persuasively opined that the chiropractic treatments rendered in connection with claimant's compensable back condition, including the biomechanical aberration, were likely to be of curative benefit at the time when they were rendered. Therefore, they were reasonable and necessary.

Penalties and related attorney fees

The Referee concluded that the partial denial of the biomechanical aberration was procedurally improper and therefore unreasonable. Accordingly, he awarded a penalty and related attorney fee only for the unreasonableness of the latter partial denial. We agree that claimant is entitled to such a penalty and fee and adopt the Referee's conclusions in this regard.

We disagree with the Referee, however, regarding the amount due upon which to base the penalty. Instead of awarding claimant a penalty based upon the amount due between the insurer's denial and the date of hearing, claimant is entitled to a penalty based on 25 percent of the amount of Dr. Lawton's services for treatment of the biomechanical aberration, due as of the time of the denial. Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (June 22, 1988).

ORDER

The Referee's order dated August 13, 1987, as amended on September 11, 1987, is modified in part and affirmed in part. That portion of the Referee's order that awarded a penalty for the unreasonable partial denial of claimant's biomechanical aberration and based that penalty on 25 percent of Dr. Lawton's services for treatment of claimant's biomechanical aberration from the time of denial until the date of the hearing is modified. The 25 percent penalty is based upon the aforementioned amounts due as of the time of the denial. The remainder of the Referee's order is affirmed.

JUNE L. LINGARD, Claimant
Doblie & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-10166
March 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Lawrence's order that: (1) upheld the insurer's denial of claimant's aggravation claim for lumbar and cervical spine conditions; (2) declined to assess penalties and attorney fees for an alleged unreasonable denial; and (3) declined to require the insurer to pay the expert witness deposition fee of claimant's treating physician. Claimant also moves the Board to strike evidence relating to the reason for claimant's termination as irrelevant and, therefore, inadmissible. The insurer cross-requests review of that portion of the order which set aside its denial of claimant's carpal tunnel syndrome. We affirm in part and reverse in part.

ISSUES

1. Whether the testimony regarding the reason for claimant's termination from employment is admissible.

2. Whether the insurer was required to close the nondisabling claim.

3. Whether the insurer was permitted to deny claimant's low back and cervical conditions and carpal tunnel syndrome.

4. Whether claimant's current low back and cervical conditions and carpal tunnel syndrome are compensable.

5. Whether the insurer's denial was unreasonable, so as to justify a penalty and attorney fee.

6. Whether the insurer is required to pay expert witness fees for the deposition of claimant's treating physician.

FINDINGS OF FACT

Claimant sustained a compensable injury on July 8, 1984, when the car she was driving was rear-ended by another vehicle. On July 10, 1984, she signed a claim for lower back injury suffered in the accident.

Claimant reported to the hospital emergency room on July 12, 1984, and complained of pain in the neck and left knee. Diagnosis was of mild cervical strain and minor contusion to the left knee. Claimant thereafter treated with Dr. Berovic, chiropractor, who diagnosed an acute lumbosacral sprain/strain with radiculopathy and cervical strain.

The insurer indicated its acceptance of the claim for low back injury on November 12, 1984 by checking the appropriate box on the claim form.

Claimant had treated regularly with Dr. Berovic since November, 1982, for low back complaints, and occasionally for headaches and cervical spine complaints. She hesitated to have her cervical spine adjusted because she had previously undergone a cervical spinal fusion.

Claimant had also treated previously with Dr. Berselli, orthopedist, beginning in November, 1983, primarily for a valgus deformity of the left knee which had resulted from childhood polio. In August, 1984, she described low back pain and advised Dr. Berselli of her July, 1984 motor vehicle accident. In October, 1984, claimant was admitted to the hospital for treatment of thrombophlebitis, and was subsequently placed on an anticoagulant for that condition. In April, 1985, she complained to Dr. Berselli of swelling of the hands and feet, which the doctor attributed to fluid retention. On October 30, 1985, she was treated for an infection after complaining of swollen lymph nodes. Claimant did not complain of low back pain again or of cervical pain or symptoms in her hands and wrists until June 3, 1986.

Dr. Berselli related the low back condition and the carpal tunnel syndrome to the July, 1984 motor vehicle accident by

history. He originally felt that the cervical condition was related, but later stated that, had that bothered claimant after the 1984 injury, she probably would have related the symptoms to him at some point prior to June 3, 1986.

Claimant's employment was terminated in February, 1986, for reasons not made clear in the record.

Dr. Berovic first documented complaints of tingling and numbness in claimant's hands on February 27, 1986.

By letter dated July 18, 1986, the insurer reiterated its acceptance of the nondisabling low back and neck strain, but denied claimant's bilateral carpal tunnel syndrome and her current low back and neck conditions.

Claimant had an extensive history of low back, left leg, and cervical problems beginning in the 1960's. A 1978 motor vehicle accident resulted in extended treatment for cervical and low back complaints. Claimant had a cervical diskectomy in 1980. In 1984, she fell and injured her low back.

Claimant has been treated for depression since before the July, 1984 injury. She first complained of carpal tunnel symptoms in 1986.

On October 23, 1986, Dr. Berovic was deposed by the insurer for the purpose of determining what records relating to his treatment of claimant were contained in his file. The insurer had previously subpoenaed the doctor's entire file, but had not received any chart notes in response. After a follow-up letter was unsuccessful, counsel for the insurer arranged for a deposition. In a letter to Dr. Berovic, counsel for the insurer stated that it would pay expert witness fees, provided that it asked a question of the doctor requiring his expertise. The insurer's counsel further stated that it did not intend to ask any such questions.

At the deposition, the insurer's counsel asked questions regarding the contents of Dr. Berovic's file. However, the insurer's counsel also posed questions that required the physician to read from, and interpret, his chart notes. In addition, the insurer's counsel also inquired into the duration and location of claimant's complaints concerning areas other than her low back.

CONCLUSIONS AND OPINION

Preliminary Matters

1. The Referee rendered credibility findings based on the witnesses' attitude, appearance, demeanor, and testimony at hearing. The Referee found claimant credible with regard to her testimony as to her "medical condition," but not credible with regard to her "other testimony." He found all other witnesses unreliable and not credible. We defer to the Referee's credibility findings relating to the "other witnesses." Miller v. Granite Const. Co., 28 Or App 473 (1977). We find his credibility finding of claimant ambiguous, however, and, therefore, turn to the record. Based on our review of the documentary and testimonial evidence, we find claimant not credible.

2. In reviewing the transcript of hearing, we observe that Exhibits 1-63 were not technically received into evidence by the Referee. However, it is clear from the actions of the Referee and of

the parties that Exhibits 1-68 were intended and understood to comprise the entire record. We, therefore, overlook the technical oversight and consider the exhibits to have been admitted by the Referee.

3. In her brief, claimant renews her motion to exclude testimony relating to the reason for claimant's termination from employment on the ground that it is irrelevant.

Claimant's credibility is at issue in this case. Her statements to various medical providers regarding the reason for her termination differs from that elicited in testimony at hearing from other witnesses. We find the testimony relevant and overrule the objection.

Compensability

Claim Closure

On the date of injury, ORS 656.268(3), required carrier closure of nondisabling claims. Or Laws 1979, Ch 839, SS4(3) and (33). See Webb v. SAIF, 83 Or App 386 (1987). Such closure could be accomplished by either Notice of Closure or by Determination Order. Dena M. Smith, 38 Van Natta 1011 (1986). A denial of continuing responsibility for a compensable condition prior to closure and determination of extent of permanent disability resulting from that condition was prohibited. Roller v. Weyerhaeuser Company, 67 Or App 583 (1984). The court reasoned that, in a nondisabling case, once a Notice of Closure issued, the claimant would be able to request a Determination Order, allowing for the determination of extent. Following closure, the insurer could deny subsequent claims for medical benefits for aggravation on grounds allowed under the statute, but still the orderly process of claim closure and determination of extent would have been accomplished. Roller, 67 Or App at 587.

The claim in this case was filed in July, 1984, within the period that nondisabling claims were required to be closed. The claim was accepted as a nondisabling injury and appropriate benefits were paid. Contrary to the requirement under ORS 656.268(3), the claim was never closed. Because it was not, the subsequent denial of the conditions accepted under that claim was prohibited. Bauman v. SAIF, 295 Or 788 (1983).

The focus then turns to the question of what was formally accepted in November, 1984.

The only formal written acceptance appears on the original claim form. The injury claimed on that form was for the lower back. It is that condition that cannot be denied prior to closure, and the insurer remains responsible for that condition until closure is accomplished.

Claimant argues that the denial letter, which stated, "As you know, we have accepted your claim for a nondisabling low back and neck strain incurred in an industrially related motor-vehicle accident on July 8, 1984," functions as an acceptance of the neck condition. The Court of Appeals has rejected that argument in a case with similar facts. U.S. Bakery v. DuVal, 86 Or App 120 (1987). In that case, the claimant described a back strain on the 801 form which the insurer indicated acceptance by checking the appropriate box.

Later, the insurer partially denied compensability of Paget's Disease which the claimant contended was related. In its partial denial, the insurer indicated that it had accepted the claim for back strain and related Paget's Disease. The court stated that the term "accepted" precludes the interpretation of the letter itself as an acceptance of the disease at the time it was sent. DuVal, 86 Or App at 127. That is precisely the case here. The 801 form indicated acceptance of injury to the lower back. The partial denial does not serve as a formal acceptance of any condition. There is no formal acceptance of the cervical condition in the record. Bauman v. SAIF, supra, does not apply, and the insurer was not precluded from later partially denying that condition.

Neither is there a formal acceptance of the bilateral carpal tunnel condition. In fact, it was not even mentioned until the spring of 1986. The insurer was not precluded from denying the compensability of that condition.

On the Merits

We find that claimant has not established that her current cervical condition is compensable. Drs. Berselli and Berovic both treated claimant before and after the July, 1984 injury, so are in the best position to determine the relationship of claimant's cervical complaints to the July, 1984 injury.

Dr. Berselli stated that he related the condition to the 1984 injury because claimant had had a prior cervical fusion which would ordinarily leave proximate levels of the spine more susceptible to injury. He found it strange, however, that claimant never mentioned her cervical problems to him until June 3, 1986, observing that, through experience, he had determined her to be the type of person to relate complaints of any nature to him. He had also forgotten that claimant, concerned that the cervical fusion had not taken, had asked him to review her cervical spine x-rays more than 6 months prior to the July, 1984 injury, fearing that the cervical fusion had not taken. Dr. Berselli's opinion, when read as a whole, does not support compensability of claimant's current cervical condition.

Dr. Berovic related the 1986 cervical complaints to the July, 1984 injury, stating that claimant had had no cervical complaints prior to the motor vehicle accident. His own chart notes, read at deposition, dispute that understanding. He notes cervical spine complaints and/or headache on November 3, 1982, November 22, 1982, November 29, 1982, and early January, 1983. Claimant had had a cervical fusion in 1980, and continued to have related complaints thereafter. Dr. Berovic reported cervical complaints on the Form 827 in July, 1984, but the record is devoid of continuing cervical complaints between the date of injury and February, 1986.

We also find the evidence insufficient to establish the compensability of the carpal tunnel syndrome. The only medical opinions to attribute the condition to the compensable injury are based on inaccurate histories. All treating and consulting physicians were under the impression that claimant received a traumatic blow to the median nerve in the motor vehicle accident and that the symptoms of tingling and numbness began within a few days or at least weeks following the injury. There is no persuasive evidence that such was the case. Claimant reported that history to doctors when she was evaluated in 1986, yet there is no documentation of such

trauma or complaints anywhere in the extensive contemporaneous medical record. Dr. Berovic reported that claimant complained of symptoms off and on following the injury, but there is no record of such complaints in his chart notes and we are not persuaded by his testimony.

Dr. Berselli stated that a delay of 1-1/2 years in the appearance of symptoms following the incident would indicate to him that the incident was not a precipitating cause of the condition. We are persuaded by his opinion and conclude that claimant has not shown that her bilateral carpal tunnel syndrome was caused in material part by the compensable July 8, 1984 injury.

Penalties and Attorney Fees

Claimant seeks penalties and attorney fees for the insurer's alleged unreasonable denial of the low back and cervical conditions and the carpal tunnel syndrome. Because we find that only the denial of the low back condition was improper, we address the issue only with regard to the denial of that condition.

Claimant's low back injury was accepted and was later denied prior to closure. The insurer has offered no justification for its denial in the face of the statute to the contrary. We find the denial unreasonable, justifying penalties and fees. However, claimant has not identified any "amounts then due" upon which a penalty can be based. See Kosanke v. SAIF, 41 Or App 17 (1979). We, therefore, decline to assess a penalty. An attorney fee for prevailing on that issue is, nevertheless, proper. Spivey v. SAIF, 79 Or App 568 (1986).

Expert Witness Fees

The insurer paid witness fees in the amount required in civil cases, but refused, because of the nature of the deposition, to pay Dr. Berovic's billing as an expert witness. The question is whether the doctor is entitled to an expert witness fee for his appearance at the deposition. We hold that he is.

OAR 438-07-020 provides that witness fees and mileage in workers' compensation cases shall be paid as in civil actions. ORS 40.410 allows $5 per day and $.08 per mile as witness fees. OAR 438-07-005(3) deals with an insurer's right to subpoena a claimant's physician for cross-examination, and provides that the cost shall be paid by the insurer. Surgical, hospital, and vocational reports are also allowed in the record as substantive evidence, provided the author is available for cross-examination. We interpret OAR 438-07-005 to contemplate that deposition of physicians for cross-examination of medical opinions necessarily involves the expertise of those witnesses.

Here, in scheduling the deposition, the insurer's counsel expressly noted that it did not intend to ask any question of the doctor that required his expertise. Yet, counsel acknowledged that the insurer would pay an expert witness fee if it asked Dr. Berovic questions that required his expertise to answer. Thus, the insurer's intention was not to conduct a cross-examination, but rather to merely obtain discovery. Had the insurer's counsel remained within the confines of this expressed intention, Dr. Berovic would not be considered an expert and the insurer would be required to pay only those fees dictated by statute in civil cases.

However, during the deposition, the insurer's counsel posed questions that required Dr. Berovic to not only read from, but interpret, his chart notes. Furthermore, questions were posed concerning the duration and location of claimant's complaints concerning areas other than the low back pain. We consider such inquiries, which could be answered by no one other than the treating physician, to involve more than merely the completion of the discovery process. Moreover, it was only after these questions were asked that claimant's counsel delved further into claimant's medical history.

Under these circumstances, we conclude that the questioning by the insurer's counsel involved the expertise of Dr. Berovic. Consequently, in accordance with the aforementioned administrative rule, as well as the insurer's counsel's prior assurance, Dr. Berovic is entitled to an expert witness fee, to be paid by the insurer.

Attorney Fees

The insurer's counsel has submitted a statement of services, seeking Board authorization of a client-paid fee. However, we cannot provide such authorization unless an executed retainer agreement or attorney referral letter has been filed. See OAR 438-15-010(1).

ORDER

The Referee's order dated January 13, 1987, is affirmed in part and reversed in part. The insurer's denial of claimant's continuing low back condition is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review concerning this issue, claimant's attorney is awarded a reasonable attorney fee of $2,000, to be paid by the insurer. The insurer's denial of claimant's bilateral carpal tunnel syndrome is reinstated and upheld. The Referee's attorney fee award concerning this issue is reversed. For services at the hearing and on Board review concerning the claims processing issue, claimant's attorney is awarded a reasonable fee of $500, to be paid by the insurer. The insurer is directed to pay to Dr. Berovic an expert witness fee for his appearance at the October 23, 1986 deposition. The remainder of the Referee's order is affirmed.

JOHN LOSINGER, Claimant
Royce, et al., Claimant's Attorneys
Tooze, et al., Defense Attorneys

WCB 82-10633
March 8, 1989
Order Approving Request

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered which culminated in our March 17, 1988 Order of Dismissal. The request is approved.

FINDINGS

On January 8, 1988, the Court of Appeals granted claimant's motion to remand this case to the Board for approval of a disputed claim settlement. On March 7, 1988, the Board advised the parties that the proposed agreement was unapprovable in that it did not comply with the Board's rules.

On March 10, 1988, a revised agreement was submitted, complying with the Board's rules. That same day, the insurer's

counsel sought authorization of a client-paid fee for services rendered in this case. The request included an attorney referral letter and a statement of services.

On March 17, 1988, the Board approved those portions of the agreement that pertained to matters pending review. 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 February 11, 1988, the administrator for the Board had notified all practitioners with cases currently pending review that executed retainer agreements or referral letters, 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 to receive such approval a statement of services should be filed within 15 days after the submission of stipulations and disputed claim settlements.

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, 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. Harry N. Hunsley, 40 Van Natta 972 (1988); Jane E. Stanley, 40 Van Natta 831 (1988). We have concluded that to receive authorization, the request must be in compliance with the Board rules. Hunsley, supra; Stanley, supra. Consequently, requests must be accompanied by an executed retainer agreement and a statement of services, which shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-010(1); 438-15-010(5); 438-15-027(1)(d).

Here, the authorization request has been accompanied by an attorney referral letter. Such a submission constitutes an executed retainer agreement pursuant to the administrator's directive. Furthermore, the request was submitted within 15 days of the submission of the revised disputed claim settlement. Consequently, again in accordance with the administrator's directive, such a submission is timely.

After reviewing the statement of services and the attorney referral letter, submitted by the insurer's counsel, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, payable from the insurer to its counsel, not to exceed $2,099.21. In so doing, we note that costs incurred by the attorney are not included in fees paid to an attorney and, as such, Board approval for reimbursement of such costs is not required. OAR 438-15-005(4), (5), (7); Janelle I. Neal, 40 Van Natta 359 (1988).

IT IS SO ORDERED.

STEPHEN D. McELROY, Claimant
Bennett, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-13564
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Blevins' order which upheld the self-insured employer's denial of an aggravation claim. We reverse.

FINDINGS OF FACT

Claimant compensably injured his pelvis on April 26, 1986. He subsequently returned to regular work. The claim was closed by Determination Order on September 4, 1986.

The employer laid claimant off in November 1986. Claimant worked part-time as a janitor during the winter of 1987. Claimant began complaining of increased pain in March 1987.

On April 13, 1987, claimant's pain had increased to the point that he could do only light work. Dr. McLean wrote a letter on that date which is the aggravation claim at issue here.

The employer denied the aggravation claim on August 3, 1987.

ULTIMATE FINDING OF FACT

As of April 13, 1987, claimant's compensable condition had worsened to the point that he was less able to work than he had been at the time of the Determination Order.

CONCLUSIONS

The medical experts agree that claimant's compensable condition has not objectively worsened. However, they also agree that his subjective complaints have worsened so that he can no longer do his regular work. A subjective worsening which renders a claimant less able to work is sufficient to prove an aggravation claim.

The employer argues that claimant has failed to sustain his burden of proof because the medical opinions are based on claimant's subjective reports and the Referee found claimant not credible. We would agree if we were to accept the Referee's credibility finding; however, we do not.

The Referee stated without explanation that claimant was not a credible witness. There is no basis for inferring that the Referee's credibility finding is based on demeanor. We find nothing in the record which supports a finding that claimant was not credible. We have no obligation to defer to a credibility finding which is not based on demeanor because we are in as good a position as the Referee to decide credibility based on the record. Accordingly, we find that claimant was credible. We rely on his testimony that his condition has worsened to the point that he cannot do his regular work.

ORDER

The Referee's order dated November 13, 1987 is reversed

in part. That portion of the Referee's order which upheld the employer's aggravation denial is reversed. The employer's denial is set aside and the claim is remanded to the employer for processing according to law. Claimant's attorney is awarded a reasonable attorney's fee of $1,400, to be paid by the employer. A client-paid fee, not to exceed $1,596, is approved.

BETRE A. MELLES, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Williams, et al., Defense Attorneys

WCB 86-06072
March 8, 1989
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of Referee Mulder's order that upheld the insurer's denials of claimant's depression and asthma conditions. We reverse.

ISSUES

1. Whether claimant's depression condition is compensable.

2. Whether the aggravation of claimant's preexisting asthma condition is compensable.

FINDINGS OF FACT

Claimant is a highly independent, achievement-oriented African male who was accustomed to success in educational, leisure and vocational activities throughout his life. He does not have a preexisting personality disorder. He has, however, suffered an unusual number of minor physical illnesses during the last seven years. In 1981, he was found to have occasional sinusitis and already existing exercise-induced asthma. In 1982, he experienced epigastric discomfort associated with nausea. In 1983, he was diagnosed with reactive airway disease. He had smoked cigarettes in the past but attempted to quit around that time. In 1985, claimant complained of wheezing and inability to sleep. Throughout 1985, claimant continued to be plagued by a variety of minor bodily symptoms. On December 17, 1985, Dr. Bagwell advised claimant to cut back to part-time work until the symptoms subsided.

In 1981 claimant began working for the employer as a customer service representative. Claimant was quickly promoted to assistant manager and by late 1981 to branch manager of the employer's Clackamas office. Initially, two assistant managers worked under claimant's direction. During 1983 and 1984 claimant was the top performing branch manager in terms of both growth and income. Claimant's performance was supervised by the district manager. Prior to 1984, claimant had never received a reprimand for inadequate performance. In April 1984, however, a new district manager replaced the prior district manager who was demoted due to poor documentation of compliance with state and federal regulations as well as company, area and regional policy. Until that time, claimant's branch had outperformed all other branches in terms of productivity. Thereafter, however, claimant's productivity began to deteriorate. During 1985, claimant's branch wrote the fewest number of loans of all the employer's branches.

On August 31, 1984, the district manager gave claimant his first official letter of reprimand due to certain exceptions to company policy. Those exceptions were reviewed with claimant and the

letter of reprimand was placed in his personnel file as a permanent addition. Specific exceptions included: (1) consistently arriving for work late and leaving early; (2) disbursing funds on real estate loans on the date signed, not waiting for the recission period to elapse; (3) destroying or failing to provide the borrower with right of recission documents; (4) destroying customer copies of credit rejection letters; (5) holding payoffs on loans received prior to the end of the month until after the first of the following month; and (6) adjusting credit and payment information in order to make real estate loans look more attractive. Claimant received numerous additional reprimands which he refused to sign.

On December 3, 1984, one of claimant's two assistant managers quit. He was replaced with another full-time assistant manager. Claimant's branch office continued to have three full-time managerial positions until May 23, 1985. At that time, another assistant manager quit her position due in part to what she described as claimant's overbearing managerial style. A part-time employee was hired to fill the position. The decision to forego the hiring of another full-time assistant manager was based upon the low productivity of claimant's branch office. During the last half of 1985 claimant continued to miss significant hours from work during the day due to doctors' appointments.

Without explanation, claimant failed to arrive for work from April 29 through May 1, 1985. Those absences, however, did not appear on claimant's timesheet, which claimant signed.

On May 20, 1985, the district manager advised the regional manager of claimant's alleged misconduct and fired claimant due to his three day unexplained absence. On the same day, however, the regional manager rescinded that decision and claimant returned to his job as branch manager.

At that time, the assistant manager position again turned over. A new assistant manager was hired in May 1985 to help claimant. That assistant stayed until November 15, 1985. He subsequently quit because of his perception of the employer's unethical practices as well as overwork. During that period of time, claimant and the assistant manager were the only two full-time employees at the Clackamas branch. Occasionally, part-time help was hired on a limited basis.

On September 28, 1985, the district manager sent claimant a memo indicating that some of claimant's actions were in violation of company policy. Claimant was advised that if he did not reach a loan gain goal of $50,000 per month, he would be terminated.

In October 1985 claimant sought medical treatment for constant frontal headaches and expressed his concern that job-related stress and anxiety was the cause of the headaches and sweating. He was diagnosed with chronic sinusitis.

On November 21, 1985, a memo from the district manager to claimant advised claimant that the employer was disappointed with the performance of his branch office during the past six months. A salary increase for claimant was therefore postponed.

Throughout 1985 claimant became increasingly rude and angry with clients. On one occasion, claimant was charged by a client with sexual harassment.

Claimant began to miss many hours from work in 1985 due to doctors' appointments for various depression-related symptoms. He attempted to make up this lost time by concealing his absences from the district manager as well as working during lunch and after hours. When claimant was on the job during regular hours, there were many times when he was understaffed due to illness of his assistant manager or a heavy workload.

In December 1985 claimant was admitted in a completely exhausted state to a hospital with pneumonia and aggravated reactive airway disease. Dr. Rudin diagnosed an autonomic nervous system dysfunction brought on by stress.

On January 21, 1986, Dr. Colistro, psychiatrist, diagnosed claimant as suffering from work-related major depression with melancholia. Claimant's symptoms included sleep disturbance, tension headaches, loss of appetite and weight, vomiting blood, dizziness, elevated blood pressure, restlessness, backaches, social withdrawal, irritability, impairment of memory and concentration, and sweating. The symptoms began in approximately April 1984 and gradually intensified throughout 1985.

In January 1986 claimant also developed pneumonia which aggravated his asthma condition. Claimant's asthma condition worsened as a result of work-related mental stress.

The position of branch manager involved constant pressure to be more and more productive. Claimant worked long hours, not uncommonly in excess of 60 hours per week. Constant pressure for greater productivity along with the tension between claimant and his subordinates and claimant and the district manager also created a stressful environment in which to work. Reprimands concerning poor productivity also contributed to the stressful conditions.

Claimant had no financial problems until Dr. Colistro took him off work in January 1986. Subsequent to the insurer's denial, however, claimant was forced to declare bankruptcy. Claimant's financial difficulties developed due to his inability to work and receive a regular salary. Also, in 1983 claimant separated from his wife and eventually obtained an amicable divorce in 1986.

On April 10, 1986, the insurer denied the compensability of claimant's stress claim. Work-related stress, however, was the major contributing cause of claimant's mental disorder.

Neither claimant nor the district manager were entirely credible witnesses. Claimant's witnesses, however, were credible in their testimony that they observed claimant working long hours during 1985.

CONCLUSIONS OF LAW

Psychiatric condition

1. Whether claimant's employment duties were a major contributing cause of his depression condition?

The Referee concluded that, although the medical evidence established that claimant had a mental disorder, the real events and conditions of claimant's employment with the employer were not of

sufficient magnitude to have made his work a major contributing cause of his mental disorder. We disagree.

In determining the compensability of a mental stress claim, there are four relevant questions: (1) What were the "real" events and conditions of claimant's employment? (2) Were those real events and conditions capable of producing stress when viewed "objectively," even though an average worker might not have responded adversely to them? (3) Did claimant suffer a mental disorder? (4) Were the real stressful events and conditions the "major contributing cause" of claimant's mental disorder? Leary v. Pacific Northwest Bell, 67 Or App 766 (198); see Elwood v. SAIF, 67 Or App 134, 137 (1984); McGarrah v. SAIF, 296 Or 145 (1983), SAIF v. Gygi, 55 Or App 570, 574, rev den 292 Or 825 (1982).

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., 767 Or App 105, 109 (1985). The instant case involves a complex medical question requiring expert medical opinion. Therefore, the lay testimony presented by both parties is not persuasive evidence of causation. Compensability must be proven by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 25 Or App 851, 856 (1976).

There were four real events or conditions of claimant's employment which were objectively capable of producing stress. They included: (1) long working hours; (2) pressure from the district manager for greater and greater productivity; (3) tension between claimant, his subordinates and the district manager; and (4) claimant's reprimands for poor job performance.

At hearing, claimant contended that the stress of managing a branch office, particularly the hours involved, caused his depression condition. He testified that he worked over lunch hour, in the evenings and on weekends; 60 to 70 hours per week was not uncommon. Various witnesses called by claimant corroborated the fact that he worked at all hours of the day and night.

On the other hand, witnesses for the employer indicated that claimant repeatedly missed large amounts of time during regular hours and attempted to conceal those absences from the employer.

The record, in fact, was replete with inconsistent and contradictory testimony. For example, claimant testified that the district manager: (1) refused to allow claimant to take a holiday on Martin Luther King's birthday; (2) frequently called claimant at home with regard to company business when he was sick; and (3) made a racial remark against him on one occasion. Claimant also testified that personnel cuts had been made at his branch in the fall of 1984. The district manager denied all of claimant's allegations. Further, he stated that: (1) claimant had indicated to him that he had a "tough" time because of the break-up of his marriage; (2) claimant had been observed smoking on a number of times in the branch office during 1985, although claimant testified that he quit two years previously; (3) the turnover rate for employees in claimant's branch was the highest he had ever experienced; and (4) no personnel cuts had been made at claimant's branch until May 1985. Also, the district manager indicated that he did not recall observing claimant "going downhill" in 1985.

In exercising our de novo review, we generally defer to the Referee's determination of credibility, when it is based on the Referee's opportunity to observe the witnesses. Humphrey v. SAIF, 58 Or App 360, 363 (1982). However, when the Referee's conclusion is based not on demeanor, but on an objective evaluation of the substance of a witness's testimony, the Referee has no greater advantage in determining credibility than we do. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Davies v. Hanel Lumber Company, 67 Or App 35, 38 (1984).

Although we find neither claimant nor the district manager to be entirely credible, based upon the substance of the witnesses' testimony, we disagree with the Referee that claimant was not sufficiently credible to convince us that he worked long stressful hours on the job. Beside claimant's own testimony that he worked extraordinarily long hours, he presented a number of witnesses who testified that he worked at all hours of the day and night. We found no persuasive reason not to rely on that testimony. The district manager even testified that the branch manager position is stressful and performance-based, thereby leading us to conclude that long hours were necessary in order to adequately perform claimant's job duties.

The medical evidence is in agreement that claimant suffered a mental disorder during the period in question. Many lay witnesses who observed claimant during the period in question, both on and off the job, perceived his stress manifestations. Drs. Colistro, Parvaresh, Harrison, and Rudin all found a depressive disorder. All of the doctors believed that an accurate history was essential to a determination of whether claimant's job was the major contributing cause of the stress-induced disorder. They all were correctly led to believe that claimant had in fact worked 60 to 70 hours per week.

Claimant's responsibilities as a branch manager caused stress. The evidence established that there were times when the branch was understaffed. Claimant also worked longer hours on occasion to make up for his absences during regular working hours. There was constant tension between the staff, claimant, and the district manager. The branch was, during the pertinent period, a low producer and claimant was the subject of multiple stress-producing reprimands.

The weight of the medical evidence established that claimant had a stress-related mental disorder. Based upon the totality of the medical and lay evidence, we conclude that the real events and conditions of claimant's employment as branch manager, including long hours, pressure for productivity, tension between claimant, his employees and the branch manager and the numerous reprimands, were of sufficient magnitude to constitute the major contributing cause of his mental disorder. Therefore, claimant's mental disorder is compensable.

2. Whether the employer's reprimands of claimant's misconduct were by themselves the major contributing cause of claimant's depression condition?

Our primary analysis concerning the compensability of claimant's depression condition rests upon the assumption that claimant worked long hours in a highly stressful position where constant friction existed between claimant and the district manager. We found that the persuasive medical evidence established that the

totality of those stressful conditions was the major contributing cause of claimant's depression condition. At hearing, however, Dr. Parvaresh opined that the major contributing cause of claimant's depression was stress caused by reprimands alone. The insurer argues that claimant may not establish a compensable condition if the condition results from stress caused by a wilful violation of company policy and State and Federal regulations. We disagree and find, in the alternative that, even if claimant did not work long hours, the reprimands alone were sufficient, when compared to off work stressors, to be the major contributing cause of claimant's depression condition.

Dr. Parvaresh testified at hearing that of the numerous potentially stress causing work conditions, only the reprimands would constitute the major cause of claimant's depressive condition. In order to determine the compensability of claimant's depression condition resulting solely from reprimand-caused anxiety, there are two questions we must answer: (1) whether claimant's misconduct deviated sufficiently from the scope and course of his employment to render his depressive condition noncompensable; and (2) if his misconduct was within the scope and course of his employment, whether the reprimands were the major contributing cause of his depressive condition.

Stress which arises out of a deliberate disregard of the employer's rules but which does not overstep the boundaries defining claimant's ultimate job responsibilities will be found compensable. Patterson v. SAIF, 64 Or App 652, 656 (1983). In other words, misconduct which involves a violation of the employer's rules governing the method of accomplishing his ultimate work remains within the scope of claimant's employment. Id. But see Terese L. Panecaldo, 36 Van Natta 1353 (1984).

In Patterson v. SAIF, supra at 654, claimant, a hospital security guard, had been instructed to take patients who did not wish to leave the hospital "off the hill," meaning that the patient was to be taken to the edge of the employer's premises and released. On the day in question, however, claimant took an unruly patient off the premises and into downtown Portland where claimant injured himself while trying to restrain the patient. Since claimant's misconduct amounted to nothing more than disobedience to specific instructions designating the method of execution of his ultimate job duty, the resulting injury was found to be sufficiently work-related to be compensable. Id. at 656.

In the present case, claimant's reprimands concerned certain business practices which, although contrary to company policy, were intended to generate more income. The sole exception was the reprimand regarding claimant's absences from work. However, when we take into account the fact that claimant was making up those lost hours on evenings and weekends, we see that even this pattern of misconduct represented only another "method of accomplishing the ultimate work." Therefore, although claimant engaged in repeated misconduct, he remained within the scope of his employment.

Dr. Parvaresh testified at hearing that the reprimands which claimant received for his misconduct would, in the absence of outside stressors, be a major contributing cause of claimant's depression condition. There was no contrary medical evidence in the record.

Thus, even had we found that claimant had not suffered

stress due to long working hours, we would conclude that the stress produced by the reprimands alone was the major contributing cause of claimant's depression condition and that his condition was compensable.

Compensability of claimant's asthma condition

The Referee concluded that claimant's employment stress was not of sufficient magnitude to have caused a worsening of claimant's preexisting asthma condition. We disagree.

To establish compensability, claimant must prove that work activities caused a worsening of his underlying condition producing disability or the need for medical services. Weller v. Union Carbide, 288 Or 27, 35 (1979). He must also establish that his work conditions were the major contributing cause of the worsening of his preexisting condition. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); SAIF v. Gygi, 55 Or App 570, 574, rev den 292 Or 825 (1982). A mere recurrence or exacerbation of symptoms is insufficient to establish a compensable condition. Wheeler v. Boise Cascade, 298 Or 452, 457-58 (1985).

Claimant's asthma condition (reactive airway disease) was diagnosed as early as 1981. Around that time, Dr. Rudin, claimant's treating pulmonologist, prescribed an alupent inhaler. Prior to 1985, claimant's asthma condition had never been disabling.

In December 1985 claimant developed pneumonia which aggravated his asthma condition, and as a result, required hospitalization. On July 18, 1986, Dr. Harrison opined that claimant's pulmonary and gastrointestinal problems were caused by work-related stress. Dr. Rudin agreed that the work-related stress which claimant was subjected to during the fall of 1985 was the major contributing factor in aggravating his preexisting asthma condition and requiring claimant's hospitalization in December 1985. She elaborated upon this opinion in her testimony at hearing. She explained that when claimant entered the hospital in December 1985,

> "he was totally exhausted. He was emotionally bankrupt. He was psychologically bankrupt, and he was a sitting duck for any infection that happened to walk down the pathway and happened to land in the hospital with a pneumonia. That would have aggravated his asthma acutely, but the asthma continued to be a problem as did just stress in general."

On the other hand, Dr. Patterson examined claimant in October 1986 and opined that claimant did not have any occupational lung disease or asthma. He believed that claimant's symptoms of chest tightness were not a manifestation of asthma, but rather of anxiety or stress. Regarding claimant's pneumonia condition, he opined that such infections are common in people with asthma.

We find that Dr. Rudin, claimant's treating pulmonologist, is more persuasive in this matter. She has treated claimant for a long period of time and expressed her opinions in articulate fashion. Based upon her testimony that claimant's pneumonia and worsened asthma condition was caused by work-related stress, we find that claimant's asthma condition did worsen. Therefore, the aggravation of claimant's asthma condition is compensable.

ORDER

The Referee's order dated June 29, 1987 is reversed. The insurer's denials are set aside and the claims are remanded to the insurer for processing according to law. Claimant's attorney is awarded an assessed fee of $5,000 for his services both at hearing and on Board review, to be paid by the insurer. The Board approves a client-paid fee not to exceed $178.50.

Board Member Ferris, dissenting:

I dissent from the majority's position. Claimant was not a credible witness, did not work long hours on the job, and did not experience stress as a result of receiving reprimands from his district manager. Therefore, I would affirm the Referee's order.

The Referee specifically found that:

> "[C]laimant was not sufficiently credible to convince me that he has proven a compensable occupational disease. This case was replete with conflicts in evidence, both on major areas of concern, and on collateral and minor elements. Claimant's credibility is the key."

Since the Referee did not clearly indicate that his credibility finding was based on an observation of claimant's demeanor, the majority was not bound by that finding. See Coastal Farm Supply v. Hultberg, supra. Nonetheless, I agree with the Referee that the inconsistencies in the record cast grave doubts on claimant's credibility as a witness. Therefore, I would not rely on his testimony.

There were many illustrations of conflict between claimant's assertions and other witnesses' assertions at hearing. Claimant stated that he did not have reprimands because he refused to sign them and they were "dropped." Claimant denied being rude and angry with customers. The employer persuasively refuted that testimony. Claimant claimed mileage reimbursement he was not entitled to. He asserted frequent and harassing phone calls at home from the district manager, who testified to the contrary. Claimant asserted that he had quit smoking cigarettes sometime prior to 1985. Many people, however, observed him smoking subsequent to that time. Claimant asserted that a co-worker quit his job because of overwork. The co-worker testified that he left for a better job and for "moral" reasons. Claimant's testimony attempted to downplay the impact of the separation and divorce from his wife in 1986. Other evidence indicated that claimant had said that the effect was substantial. Claimant's brother-in-law testified that claimant had no financial problems during the period in question. The fact that claimant filed bankruptcy in 1986 would appear to indicate a much different financial picture.

The only evidence in the record that claimant worked long hours (i.e. 60-70 hours per week) came from claimant himself. The majority mischaracterized the testimony of claimant's witnesses in this regard. No one, other than claimant, testified that claimant worked 60-70 hour weeks; the corroborating testimony merely indicated that claimant worked irregular hours. In fact, the employer's witnesses testified to the contrary, that claimant missed significant

amounts of time from work during 1985 and attempted to conceal those absences. For example, claimant discovered that his supervisor would be out of the office for three days from April 29 to May 1, 1985. Therefore, without explanation, he failed to arrive for work during those three days and subsequently attempted to conceal that absence by falsifying his timesheet. Although claimant did attempt to make up some of his lost hours over lunches, and on evenings and weekends, his constant attempts to minimize regular working hours and subsequently conceal those absences directly contradicted his testimony of 60-70 hour work weeks. I would rely on claimant's deeds, not his words. Although he worked irregular hours, he did not work long hours during the period in question.

Claimant's credibility is the cornerstone of any decision on the merits. The basis of the medical opinions regarding both claimant's depression and asthma conditions overwhelmingly concentrated on claimant's presumed long working hours. However, since claimant, in fact, did not work long hours, those opinions were based on an inaccurate history and are not persuasive.

For two reasons, Dr. Parvaresh's opinion regarding the effect which the reprimands had on claimant's depressive condition is also not persuasive. First, it assumed that claimant did experience stress as a result of those reprimands. Second, it was not directed specifically to claimant's circumstances. The majority wrongly assumes to the contrary. First, they assume that claimant did experience stress as a result of receiving reprimands due to misconduct. Nowhere in the record, however, did claimant testify that this was the case. Second, they assume that Dr. Parvaresh's opinion, that reprimands were a major contributing cause of claimant's depressive condition, specifically concerned claimant. It did not. Dr. Parvaresh's opinion was based upon a general observation of the effect of a reprimand on the average worker. If he had understood claimant's testimony, that claimant felt no stress or anxiety due to the reprimands, I am confident that Dr. Parvaresh would not have opined as he did. I would give his opinion little weight. For the above reasons, I would find claimant's depression and asthma conditions not compensable.

STEPHEN W. MILES, Claimant
Merrill Schneider, Claimant's Attorney
Judy Johnson (SAIF), Defense Attorney

WCB 87-06984
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Knapp's order that: (1) upheld the SAIF Corporation's "de facto" denial of claimant's chiropractic treatment in excess of two visits per month; and (2) declined to assess a penalty and attorney fee for SAIF's failure to issue a formal denial of treatment.

ISSUES

1. Reasonableness and necessity of chiropractic treatment in excess of two visits per month.

2. Penalty and attorney fee for SAIF's failure to issue a formal denial.

We affirm and adopt on the medical services issue, and modify on the penalty and attorney fee issue.

FINDINGS OF FACT

Claimant treats regularly with Dr. Bolera, a chiropractor, for the effects of an accepted low back injury sustained in July, 1984. From July, 1986, through the Summer of 1987, the frequency of treatment was thrice weekly. The frequency was then reduced to once per week.

SAIF paid the medical bills in full until January 20, 1987. Thereafter, it paid for only two office visits per month. No formal denial was issued to claimant. By letter of April 16, 1987, SAIF advised Dr. Bolera that it would pay for only two treatments per month.

CONCLUSIONS OF LAW AND OPINION

The Referee declined to consider the issue of whether SAIF should be assessed a penalty and related attorney fee for its failure to issue a formal denial of treatment, finding that the issue was not raised by claimant at hearing. We disagree.

The Referee's scope of review is limited to issues raised by parties at hearing. Allen B. Cooper, 40 Van Natta 1915 (1988); Sylvia M. Evy, 35 Van Natta 89 (1983). In his hearing request, claimant raised the issue of penalties and attorney fees for SAIF's "unreasonableness" in refusing to pay medical bills. At hearing, claimant's counsel reiterated the statement that he was seeking penalties and attorney fees. Tr. 2. Although not clarified further at hearing, the Referee was vested with authority to review not only SAIF's refusal to pay the medical bills but also its processing of those bills under the "reasonableness" standard in ORS 656.262(10). Accordingly, the issue of whether a penalty and attorney fee should be assessed for SAIF's failure to issue a formal denial was properly before the Referee.

On the merits, claimant argues that SAIF's failure to issue a formal denial requires that it pay for the disputed medical services. That is incorrect. Ellis v. McCall Installation, 93 Or App 188 (1988).

Furthermore, even assuming that SAIF's conduct was unreasonable, a penalty can only be measured by "amounts then due." ORS 656.262(10). Here, there were no "amounts then due," because the unpaid medical services were not reasonable and necessary. No penalty can be assessed. See Ellis v. McCall Installation, supra. However, irrespective of whether there were any "amounts then due," we may assess a penalty-related attorney fee pursuant to ORS 656.262(10) and 656.382(1). Mischel v. Portland General Electric, 89 Or App 140, 143 (1987). SAIF's conduct in failing to furnish claimant a written notice of the denial pursuant to ORS 656.262(6) was unreasonable. Claimant is entitled to a reasonable, insurer-paid attorney fee. ORS 656.262(10), 656.382.

ORDER

The Referee's order dated January 21, 1988 is modified in part and affirmed in part. Claimant is awarded a penalty-related attorney fee of $200, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

LAWRENCE W. MILLER, Claimant
Elton T. Lafky, Claimant's Attorney
Rick Barber (SAIF), Defense Attorney
Phillip L. Nyburg, Defense Attorney

WCB 86-09172 & 86-09651
March 8, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance v. Miller, 93 Or App 38 (1988). The court has concluded that neither the Board's order nor the Referee's order, which the Board affirmed, adequately applied the two-part test for "successive injury" cases announced in Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984) and Hensel Phelps Const. v. Mirich, 81 Or App 290, 294 (1986). We have been instructed to do so on remand. On reconsideration, we affirm the Referee's order.

ISSUE

Whether claimant's employment after July 1, 1984, while Liberty Northwest was on the risk, independently contributed to a worsening of his underlying back condition.

FINDINGS OF FACT

The Board adopts the Referee's findings as its own and makes the following additional findings.

This case involves one employer insured by two carriers. The SAIF Corporation provided coverage to July 1, 1984, when Liberty Northwest Insurance Corporation commenced coverage.

Claimant's employment after July 1, 1984, independently contributed to a worsening of his underlying back condition.

CONCLUSIONS OF LAW

In Mirich, supra, the court found, inter alia:

> "The weight of the medical evidence is that claimant's work activities at [the later employer] did not independently contribute to the causation of the disabling condition, i.e., to a worsening of the underlying condition." (Emphasis in original).

81 Or App at 294.

Here, the Referee stated, inter alia:

> "Hensel Phelps Const. v. Mirich, [citation omitted] held that worsening of the underlying condition is required to shift responsibility from first employer to a second employer (or first insurer to second insurer). * * * I conclude that the greater weight of evidence is that claimant's underlying condition has worsened since July 1, 1984, when [the later insurer] assumed coverage."

The Court of Appeals has instructed us to determine whether claimant's employment after July 1, 1984, independently

contributed to his underlying back condition. We conclude that it did.

In reaching this conclusion, we find the opinion of the treating physician, Dr. Warner, to be persuasive. Dr. Warner acknowledged that claimant's original injury and sequela, for which SAIF was responsible, predisposed him to future damage. In addition, Warner conceded that, had claimant not suffered from this predisposition, his post-July 1984 work activities, while Liberty Northwest was on the risk, would have produced much less disability. Yet, Dr. Warner concluded that claimant's back condition had worsened and that his work activities after July 1984 had "indeed significantly contributed" to a worsening of his underlying condition.

Absent persuasive reasons to the contrary, we generally give great weight to the conclusions of the treating physician. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no reasonable basis to discount the opinion of Dr. Warner, the physician who has treated claimant both before and after his condition worsened, as well as before and after his work activities while Liberty Northwest was on the risk began. On the contrary, we find Dr. Warner to have been in a particularly advantageous position to address the pivotal responsibility issues of causation and independent contribution.

Consequently, on reconsideration, we agree with the Referee that claimant's post-July 1, 1984 work activities while Liberty Northwest was on the risk independently contributed to a worsening of claimant's underlying back condition. Accordingly, the Referee's order dated February 13, 1987, which found Liberty Northwest to be responsible, is affirmed.

IT IS SO ORDERED.

CHARLES P. MITCHELL, Claimant
Pozzi, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 85-07024
March 8, 1989
Order on Review

Reviewed by Board Members en banc.

The insurer requests review of that portion of Referee Leahy's order that granted claimant permanent total disability. Claimant cross-requests review of that portion of the order regarding the effective date of the award.

The Board modifies that portion of the Referee's order that found claimant permanently totally disabled as of the date of his Opinion and Order. All remaining portions of the Referee's order are affirmed.

ISSUES

1. Whether claimant is permanently totally disabled.

2. Whether the Referee erred in finding that claimant was permanently totally disabled as of the date of his Opinion and Order.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

Claimant's physical condition, age, education, and adaptability to lighter work, have permanently incapacitated him from regularly performing work at a gainful and suitable occupation.

Claimant successfully sought employment as a metal fabricator, without vocational assistance, in May 1985. While so employed, he was motivated and demonstrated a cooperative work attitude. (11/19/86 Tr. 251-52, 270). After that job ended, he unsuccessfully sought continued employment with several other employers.

CONCLUSIONS OF LAW

Under the "odd-lot" doctrine, a worker's physical impairment combined with his age, education, adaptability to nonphysical labor, and emotional conditions can establish permanent total disability. Clark v. Boise Cascade Co., 72 Or App 397 (1985). However, a worker is required to make reasonable efforts to obtain work, unless such efforts would be futile. Butcher v. SAIF, 45 Or App 318 (1983); see ORS 656.206(3).

Here, claimant is 53 years of age. He is educated through only the seventh grade. Although a skilled ironworker, he is permanently disabled from working in that field. He has few transferable skills to lighter occupations.

Repeated vocational testing revealed below average skills and limited opportunities for training or employment. In April 1985, Floyd Yoder, a vocational counselor, opined, inter alia:

> "Because of the [claimant's] limited formal education and significant restrictions associated with his injury, [he] would not appear to be either a candidate for formal training or any work planning situation that required complex steps for task completion."

In August 1986, Richard Ross, vocational evaluator, found that claimant had below average abilities in reading, mathematics, reasoning, and language. Despite those findings, Ross concluded that claimant was employable. At the hearing, Hank Lageman, vocational evaluator, disagreed with Ross' conclusion that claimant was employable:

> "Q. Mr. Lageman, did you reach any conclusions after your assessment of [claimant] concerning his employability?
>
> "A. Yes, I did.
>
> "Q. And what were those conclusions?
>
> "A. That he was not employable.
>
> * * * * *
>
> "Q. Did you consider jobs that are listed appropriate under the Ross report?
>
> "A. Yes, I did.
>
> "Q. What's wrong with those jobs.

"A. They don't match the profile that he outlined."

We are persuaded by Lageman's exhaustive testimony concerning claimant's employability. See Somers v. SAIF, 77 Or App 259, 263 (1986). His conclusions are well reasoned and supported by claimant's vocational aptitude test results.

In addition, we conclude that claimant has proven that he was willing to seek regular gainful employment and that he made reasonable efforts to obtain such work. See ORS 656.206(3). In May 1985, he landed a job as a metal fabricator through his own job search efforts. His employer, Mr. Burke, testified that he was an excellent worker. After that job ended, he made further efforts to find continued employment.

Accordingly, we agree with the Referee's conclusion that claimant is permanently totally disabled.

Lastly, we turn to the question of the proper effective date for claimant's award of permanent total disability. The Referee awarded permanent total disability "as of the date of [his] order." We modify.

In Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370 (1988), the court stated, inter alia: "The effective date of a modification of a permanent disability award is the earliest date when a claimant proves all elements necessary to his claim existed."

Here, claimant's return to work motivation was at issue. See ORS 656.206(3). As we assess the evidence, claimant did not prove that he had satisfied ORS 656.206(3) until he and Mr. Burke testified on November 19, 1986 (i.e., the day of the hearing). The hearing record closed November 19, 1986. Accordingly, on this record, we conclude that claimant's permanent total disability payments should commence as of November 19, 1986.

Contrary to the dissent's view, we do not view Adams, supra, as precluding an award of permanent total disability effective as of the date of the hearing. Rather, in our view, Adams simply provides, as the dissent points out, that the effective dates should be set at the earliest date in which a worker "proves all the elements necessary to his claim . . . ." 90 Or App at 370.

As of this date, claimant's attorney has not submitted a Statement of Services for services on Board review. OAR 438-15-010(5); see ORS 656.388(1). Accordingly, an assessed fee, OAR 438-15-005(2), shall not be awarded at this time.

ORDER

The Referee's order dated December 10, 1986, is modified in part and affirmed in part. That portion of the Referee's order that found claimant permanently totally disabled as of the date of his Opinion and Order, is modified. The effective date of claimant's permanent total disability award is November 19, 1986. Claimant's attorney is awarded an approved fee equal to 25 percent of claimant's increased compensation created by this order, provided that the total of fees approved by the Referee and the Board does not exceed $3,800. The insurer is authorized to offset any permanent partial disability compensation paid after November 19, 1986 against claimant's permanent total disability compensation. the remainder of the Referee's order is affirmed.

Board Member Crider concurring in part and dissenting in part.

I concur in that portion of the Board's Order affirming the referee's conclusion that claimant is permanently and totally disabled. I dissent from that portion of the Order making the award effective on November 19, 1986, the date of hearing.

The evidence establishes that claimant was permanently and totally disabled effective no later than the last day of October, 1985. Payments should commence as of that date. It is of no consequence that the Board, in reaching its decision, relied on testimony at hearing. The question is not when all the facts supporting the award were laid out before this tribunal but rather when in the course of human history it became clear that claimant was permanently unable to obtain and hold gainful employment in a hypothetically normal labor market. Wilke v. SAIF, 49 Or App 427 (1980).

The majority's reliance on Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365 (1988) to support its approach is error. In Adams, the court relied on vocational testimony at hearing to conclude that claimant became permanently and totally disabled and yet made the award effective on a date some six months before, at the time all the factors underlying the expert's opinion were fixed. The court did not make the award effective on the date of hearing.

On April 24, 1985, claimant's vocational counselors, after assessing claimant's skills, academic training, and expected residuals of his injury, observed that to find suitable employment would be "a challenge". Ex. 91-4. The following month, claimant was declared medically stationary. Despite the counselors' skepticism, claimant, in a display of initiative, obtained work with his employer at injury. The employer did not expect claimant to work as quickly as other employees; claimant was permitted to work at his own pace and to determine what tasks available were within his limitations and which were not. When claimant was laid off by this sympathetic employer in October, 1985, he was unable to find other work.

After another surgery, claimant again sought work. In July, 1986, a battery of tests were performed by a vocational evaluator. They indicated that claimant's academic skills, dexterity and motor skills were far below average. It was these characteristics, coupled with claimant's serious physical impairment, that led the counselor to testify, at hearing, that claimant was unemployable.

The record suggests that claimant's physical condition has not worsened since May, 1985 nor is there any evidence that the academic and vocational factors have changed since that date. The job claimant held after that date was tailor made for him and does not represent a type of job available in the labor market generally. Claimant became permanently and totally disabled as of May, 1985. The cross-request seeks modification of the referee's order to commence permanent total benefits effective at the end of October, 1985. The cross-request should be granted.

At the time of hearing, claimant's back injury claim with Weyerhaeuser remained in open status, and claimant had not become medically stationary.

CONCLUSIONS OF LAW AND OPINION

Entitlement to Interim Compensation/ Penalties and Attorney Fees for Failure to Pay Interim Compensation

We adopt the Referee's opinion on these issues with the following comment.

Claimant's filed a new injury claim with EBI on August 15, 1986. EBI paid no compensation on the claim and did not issue a written denial until November 14, 1986. The Referee, therefore, awarded temporary total disability, in the form of interim compensation, from the date of injury through October 30, 1986, the date claimant returned to light-duty work. On review, claimant contends that he is entitled to benefits through November 14, 1986, the date of EBI's denial.

An insurer may suspend payment of temporary disability benefits when a claimant accepts and commences wage-earning employment paying a wage equal to or greater than the wage at injury. See OAR 436-60-030(3). In awarding interim compensation through October 30, 1986, the Referee apparently found that claimant had not demonstrated that he received less than his wage at injury when he returned to work on that date.

We agree with the Referee's finding. The only indication in the record that claimant received less than his wage at injury is his testimony that Weyerhaeuser continued to pay him temporary partial disability benefits after he returned to work in October 1986. This, alone, is not sufficient to establish that he received less than his regular wage when he returned to work. Accordingly, we conclude that the Referee correctly awarded interim compensation through October 30, 1986.

Propriety of the Referee's Extent Ruling

The Referee found Weyerhaeuser responsible for claimant's current condition. The Referee then proceeded to rate the extent of claimant's permanent disability based on his condition immediately prior to the May 1986 aggravation. Claimant contends that the Referee should not have rated his disability because he was not medically stationary at the time of hearing. We agree.

A Referee should not rate permanent disability if the claimant is not medically stationary at the time of hearing or the claim is in open status. ORS 656.268(1); Kociemba v. SAIF, 63 Or App 557 (1983); Harmon v. SAIF, 54 Or App 121 (1981). The Board has followed this rule where the claimant was medically stationary when the claim was initially closed but, at the time of hearing, the claim was in open status or the claimant was not medically stationary because of a subsequent aggravation. See Theresa Skoyen, 39 Van Natta 462 (1987); Andrew Simer, 37 Van Natta 154 (1985); Gary A. Freier, 34 Van Natta 543 (1982). Furthermore, disability ratings should be based on a claimant's condition at the time of hearing. Gettman v. SAIF, 289 Or 609, 614-615 (1980). It is error to exclude information bearing on a claimant's condition at the time of hearing and rate disability as of a prior date. See Norton v. SAIF, 86 Or App 447, n. 2 (1987).

maintenance, repair, remodelling or similar work in or about the private home of the person employing the worker.

"(3)A worker whose employment is casual and either:

"(a)The employment is not in the course of the trade, business, or profession of the employer;

* * *

"(b)For the purpose of this subsection, 'casual' refers only to employment where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200.

It is not clear from the Referee's opinion whether he found claimant not to be a subject worker under section (2) or section (3) of ORS 656.027. We find that claimant was hired by Dan Parker to do maintenance, repair, and remodelling at Dan Parker's private home. Therefore, we find claimant is not a subject worker pursuant to ORS 656.027(2).

Having found claimant not to be a subject worker under ORS 656.027(2), we need not determine if his employment was casual pursuant to ORS 656.027(3).

Claimant sought below to introduce evidence of Dan Parker's activities since the injury in question. A determination of the relevance of such evidence is within the discretion of the Referee. On review, we find no abuse of discretion in not admitting this evidence.

ORDER

The Referee's order dated May 15, 1987, is affirmed.

RAUL SALDANA, Claimant
Michael L. Spencer, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 87-06155
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Leahy's order that: (1) found that claimant's back injury claim was not prematurely closed; (2) declined to assess penalties and related attorney fees for the insurer's alleged unreasonable failure to contact claimant's treating chiropractor regarding his medical status prior to closure; and (3) declined to award claimant any unscheduled permanent disability. We affirm.

ISSUES

1. Whether claimant's back injury claim was prematurely closed.

2. Whether claimant is entitled to penalties and related attorney fees due to the insurer's failure to solicit a preclosure report from claimant's treating chiropractor.

3. Whether claimant is entitled to an award of unscheduled permanent disability.

FINDINGS OF FACT

On August 21, 1986, claimant, 54 years old, fell to the ground on his left side when a backhoe moved some earth beneath his feet and he was caught by a water line. He initially experienced some minor pain below his bottom rib in a "V"-shaped area down to his navel and up to his heart. Shortly thereafter, he developed left hip pain. Claimant was first treated by Dr. Kleeman, M.D., who diagnosed mild low back pain resulting from a muscle pull. He treated claimant conservatively with muscle relaxants and physical therapy. When it became apparent that claimant's condition was not improving, Dr. Kleeman referred him to Dr. Klump, neurosurgeon, who performed a myelogram and CT scan. Both of these studies were within normal limits. Dr. Kleeman also referred claimant to Dr. Balme, orthopedic surgeon, who examined him on December 16, 1986.

By December 30, 1986, claimant had developed significant symptoms in his left low back, left hip and left leg. Dr. Kleeman last examined claimant on January 27, 1987. At that time, he was unable to ascertain any objective findings that would support claimant's complaints and had been unable to find any specific physical therapy that was of benefit to claimant. He indicated, however, that claimant still had some complaints but seemed to be improving.

On February 12, 1987, claimant changed attending physicians to Dr. Davis, chiropractor. As a result of chiropractic treatment, claimant's left hip pain disappeared immediately. Since that time, however, claimant's low back and left leg pain has waxed and waned without material improvement.

On February 25, 1987, claimant was seen by Dr. Howell on behalf of the insurer who found claimant medically stationary with no objective evidence of physical impairment. Dr. Kleeman concurred with Dr. Howell's opinion that he could not locate any specific medical diagnosis or prescribe any specific therapy that would be of benefit to claimant.

In determining whether or not claimant was medically stationary, the insurer did not seek Dr. Davis' opinion. Instead, it provided the Evaluation Division with reports from Drs. Kleeman, Klump, Balme and Howell. Evaluation did not request further medical evidence prior to claim closure.

On April 15, 1987, a Determination Order awarded claimant temporary disability from August 25, 1986 through February 25, 1987 but no permanent disability benefits.

Since June 8, 1987, claimant has been working 30 hours per week for the City of Klamath Falls. His duties include raking asphalt, driving trucks and cutting weeds with a 25 pound gas weedeater strapped to his back.

Throughout the spring and early summer of 1987, claimant continued to receive what Dr. Davis termed "palliative" treatments on a once a week basis. On July 8, 1987, however, Dr. Davis stated that claimant was not medically stationary. At the time of hearing,

claimant still experienced occasional low back and left leg pain when bending, lifting or twisting.

Claimant's job history consists of almost 20 years of construction labor and truck driving. He attended school through the 5th grade and has difficulty reading and writing.

At the time of closure on February 25, 1987, no further material improvement of the claimant's condition was reasonably expected from medical treatment, or the passage of time.

CONCLUSIONS OF LAW

Premature claim closure

The Referee concluded that the insurer was under no duty to seek a preclosure report from claimant's treating chiropractor to submit to the Evaluation Division. He also concluded that Dr. Davis' opinion in July 1987 that claimant was not medically stationary was conclusory and inconsistent with his prior reports and therefore not persuasive. The Referee relied upon the well- reasoned opinions of Dr. Howell to find that claimant's claim had not been prematurely closed. 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 reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). The term "medically stationary," however, does not mean that there must be a lack of variation in claimant's medical condition or that there is a lack of need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984).

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).

Claimant had been seen by a number of physicians at the time of closure. On December 16, 1986, Dr. Balme, orthopedic surgeon, found that claimant had negative straight leg raising, normal sensory and motor exams, no atrophy and entirely normal x-ray findings. He diagnosed "left hip pain" and encouraged an early return to work.

On February 12, 1987, Dr. Kleeman, still claimant's treating physician at the time, was unable to make any more specific diagnosis than low back strain. He noted that claimant's treatment consisting of anti-inflammatories, physical therapy, muscle relaxants and traction had been of little benefit and his pain had continued to wax and wane. He recommended that claimant continue with strengthening and stretching exercises and opined that he should be able to return to regular work.

On February 26, 1987, Dr. Howell saw claimant and was unable to diagnose anything other than complaints of low back, left

leg, and left upper quadrant abdominal pain. In the absence of any objective findings, he felt that claimant was medically stationary and in need of no further medical treatment.

Dr. Davis did not voice an opinion regarding claimant's medical status until June 15, 1987. At that time he informed claimant's counsel that claimant had returned to work on June 8, 1987 and was being treated palliatively once each week. On July 8, 1987, Dr. Davis opined that claimant was not yet medically stationary and was still making gradual improvement.

When there is a dispute between medical experts, we give more weight to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

In the present case, Dr. Kleeman, claimant's former treating physician, last examined claimant on January 27, 1987. Although he concurred with Dr. Howell's lack of diagnosis or treatment plan, he declined to discuss whether or not claimant's condition was medically stationary.

Dr. Davis, claimant's treating chiropractor, offered one conclusory report a week before hearing in which he opined that claimant was not medically stationary. He did not, however, indicate why that was so. In fact, less than a month earlier, he had authored another report stating that claimant had returned to work and was receiving only palliative, not curative, treatments. The fact that claimant was receiving weekly chiropractic treatments to alleviate occasional pain does not mean that claimant was not medically stationary.

In contrast to the detailed, consistent and well-reasoned reports of Dr. Howell, we find Dr. Davis to be unpersuasive and decline to rely upon any aspect of his opinion.

The medical evidence is persuasive that at the time of closure on February 25, 1987, 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 February 25, 1987.

Penalties and attorney fees

Although the Referee did not specifically respond to the issue of penalties and attorney fees, we presume that he declined to assess them because he believed that the insurer's failure to seek a preclosure report from claimant's treating chiropractor was not unreasonable. We agree.

ORS 656.262(10) states that:

> "[i]f 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."

Claimant argues that the insurer had a duty to seek a

preclosure report from Dr. Davis and submit it, along with other medical evidence, to the Evaluation Division. Claimant cites no authority to support this position. While we believe it to be good practice for the insurer to seek a preclosure report from the treating physician, neither the statute nor the rules require it. On the contrary, when an insurer requests claim determination, it must provide only those medical records which have not previously been provided to the Department. OAR 436-30-030(5). Since the insurer had no affirmative duty to procure a medical report from claimant's treating chiropractor prior to closure, it was not unreasonable conduct to decline to do so. Therefore, penalties and related attorney fees are not warranted.

Unscheduled permanent disability

The Referee did not award claimant any permanent disability benefits, but failed to offer more than a conclusory explanation of the basis of his decision. We agree with the Referee's conclusion but add the following explanation.

In rating the extent of claimant's unscheduled permanent disability, we consider his 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).

Loss of earning capacity must reflect claimant's handicap in obtaining and holding gainful employment in the broad field of general occupations and not just in relationship to his occupation as a construction laborer or truck driver. Ford v. SAIF, 7 Or App 549, 552 (1972). Return to prior work does not necessarily justify a reduction, much less an elimination, of permanent partial disability. Howerton v. SAIF, 70 Or App 99 (1984).

In the present case, however, claimant's return to similar preinjury employment does suggest that he should not receive an award of permanent disability. At the time of hearing, claimant's job duties included raking hot asphalt, driving trucks and cutting weeds with a 25 pound "weedeater" strapped to his back. Although he experienced occasional pain in his low back and left leg when bending, lifting or twisting, the record neither indicates that the pain caused him to miss work nor limits the extent of his job duties. These were heavy labor job duties. Also, the record does not indicate that claimant sustained any handicap in obtaining and holding gainful employment in fields other than construction labor and truck driving.

The only suggestion that claimant suffered any permanent physical impairment came from Dr. Davis, who opined in July 1987 that, when claimant became medically stationary, he would end up with a permanent partial disability of from 20 to 30 percent. As previously stated, Dr. Davis' opinion was not persuasive.

Consequently, after conducting our de novo review of the medical and lay evidence, we are not persuaded that claimant has suffered permanent disability as a result of his compensable injury. Claimant's pain symptoms do not appear to be disabling. We conclude that he has not sustained a permanent loss of earning capacity resulting from the compensable injury. Accordingly, he is not entitled to an award of permanent disability.

ORDER

The Referee's order dated July 22, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $544.

DORIS N. THOMPSON, Claimant
Amrat and Jeliben Patel, dba
SUNDOWNER MOTEL & CAFE, Employer
A. Duane Pinkerton, II, Claimant's Attorney
Steven Finlayson, Attorney
Rick Barber (SAIF), Defense Attorney
Terri Borchers, Assistant Attorney General

WCB 85-10539 & 85-11343
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The noncomplying employer requests review of that portion of Referee Thye's order which set aside a denial of claimant's low back injury claim, which was issued by the SAIF Corporation on the employer's behalf. We also interpret the employer's brief on review to request remand for the taking of further evidence. Claimant's counsel seeks reimbursement for costs incurred in presenting the case at hearing. On review, we deny the motions to remand and for reimbursement and affirm the Referee's order.

ISSUES

1. Whether the case should be remanded for the taking of additional evidence.

2. Whether claimant's injury is compensable.

3. Whether SAIF should reimburse claimant's counsel for litigation costs.

FINDINGS OF FACT

We adopt as findings those facts set forth in the section entitled "Evidence" on Pages 1 through 4 of the Referee's order.

ULTIMATE FINDINGS OF FACT

(1) The hearing record was properly developed.

(2) The noncomplying employer failed to timely submit the transcripts of his witness' testimony for inclusion in the record.

(3) The noncomplying employer failed to subpoena an available witness to hearing.

(4) Claimant fell and injured her back while performing duties arising out of and within the course of her employment with the noncomplying employer.

(5) Claimant's fall was not attributable to intoxication.

(6) Claimant's on-the-job fall was a material contributing cause of her need for treatment of the resulting back injury.

CONCLUSIONS AND OPINION

Remand

On the issue of remand, the employer requests that the case be remanded to require admission of the prior testimony of a witness not present at hearing. In the alternative, the employer requests that a deposition of the witness be allowed.

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for further evidence taking, the requesting party must show that the evidence is material and that it was not obtainable with due diligence at the time of hearing. Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

We are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. At the commencement of the hearing, there was discussion among the parties and the Referee regarding the admission of transcripts of prior testimony of two witnesses, Barbara McKnight and Karen Dinsmore. The Referee noted that the transcripts had not been submitted timely for inclusion in the record and that the noncomplying employer also failed to show good cause why the transcripts could not have been submitted in a timely fashion. See OAR 438-07-005. The Referee found that the two witnesses were available to testify and that they could have been subpoenaed to testify at hearing. We conclude that the Referee properly exercised his discretion in excluding the proffered exhibits.

The noncomplying employer also indicated, at the beginning of the hearing, that he wished to take the testimony of Barbara McKnight by telephone. At the time of hearing, testimony by telephone was not prohibited and its authorization was within the Referee's discretion. See Elsie Lumpkins, 40 Van Natta 1571 (1988). We note, however, that presently telephone testimony is authorized only under certain limited circumstances. See OAR 438-07-022. Claimant did not object to the employer's request and the testimony of that witness was taken. However, after testimony from claimant's five witnesses, the noncomplying employer also requested that he be able to call Karen Dinsmore as a witness and have her testimony taken by telephone "in light of the testimony that's been presented." After claimant's counsel objected, the Referee declined the noncomplying employer's request on the grounds that the employer had failed to subpoena the witness to the hearing.

The Court of Appeals has discouraged this type of "two bite" approach attempted by the noncomplying employer, stating that proceedings must reach some state of repose. See Russell v. A & D Terminals, 50 Or App 27 (1981). We interpret this remand request to be such an approach. Furthermore, we uphold the Referee's decision to deny the noncomplying employer's request to take the nonsubpoenaed witness' testimony by telephone.

Compensability

On the issue of compensability of the low back injury, we affirm and adopt the "Compensability" section of the Referee's "Opinion."

Reimbursement of Claim Costs

Claimant, in the form of an "Affidavit and Application for Extraordinary Attorney Fees," has requested reimbursement by SAIF of $131 to cover costs incurred in presenting her case at hearing. In Patricia M. Anderson, 35 Van Natta 1718 (1983), we stated that, "It is well settled that a claimant's litigation costs are not compensable." Accordingly, the request for reimbursement is denied.

ORDER

The Referee's order dated December 31, 1986, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $800, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

MARVIN J. TRUE, Claimant
Brian Whitehead, Claimant's Attorney
Kevin Mannix, Defense Attorney

WCB 86-09264
March 8, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Peterson's order that set aside a denial of current chiropractic care for claimant's neck condition. The issue on review is compensability of medical services. We affirm.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Board adopts the order of the Referee with the following comment:

The only issue on review is whether the present claim for chiropractic services is barred by the principle of res judicata.

A 1983 denial by the insurer for similar services became final in 1983 when claimant's request for hearing was dismissed. In 1986, claimant sought further chiropractic treatments for increased neck pain from Dr. Palmer, chiropractor. Dr. Butler, chiropractor, opined that further improvement could be expected with regular treatment.

On July 14, 1986, the insurer denied further chiropractic treatment on the grounds that the condition described and the treatment proposed were identical to that covered in its 1983 denial. On review, the insurer's brief makes it clear that res judicata is the only issue.

We find that the insurer's 1983 denial is final only as to whether claimant's chiropractic treatments were reasonable and necessary in 1983, and cannot be a bar to any subsequent claims for chiropractic care. See, Leonard A. Chambers 40 Van Natta 969 (1988); Patricia Dees 35 Van Natta 120 (1983).

ORDER

The Referee's order dated June 8, 1987, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer. A client-paid fee, not to exceed $2,087, is approved.

ALVIN L. VAN ARNAM, Claimant
Galton, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 87-01074
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer has requested review of Referee Podnar's order which granted claimant permanent total disability, whereas a Determination Order had awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left leg in addition to the 65 percent (208 degrees) unscheduled disability for a low back injury claimant had previously received. On review, the issue is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

Claimant, 55 years of age at hearing, sustained a compensable low back injury in April 1981. Prior to this incident, claimant had sustained five compensable low back injuries, all of which resulted in no award of permanent disability. Claimant's condition was diagnosed as lumbar strain superimposed on preexisting degenerative lumbar arthritis. The claim was closed by a January 1982 Determination Order which awarded claimant 45 percent unscheduled permanent disability.

Claimant's claim was reopened, and subsequently closed again by a Determination Order of July 1, 1983. This Determination Order awarded claimant temporary disability benefits and affirmed the award of 45 percent unscheduled permanent disability. Claimant appealed this Determination Order and a prior Referee found claimant to be permanently and totally disabled. On review, the Board reversed the Referee finding of permanent total disability and increased claimant's unscheduled permanent disability award to a total of 65 percent. Alvin L. Van Arnam, 36 Van Natta 1641 (1984) (Board Member Lewis dissenting). The basis for the Board's reversal was that claimant had not satisfied the "seek work" requirement of ORS 656.206(3). Id. at 1645. The Board's order was affirmed without opinion by the Court of Appeals. See Van Arnam v. EBI Companies, 74 Or App 151 (1985).

In October 1985, claimant was referred for vocational and work evaluation. Claimant participated in an authorized training program through which he earned his GED. The authorized training program was completed in May 1986. Following completion of his academic training, claimant received job placement assistance, and submitted applications to numerous employers in the area of retail sales. Claimant secured a sales position at a sporting goods store in September 1986, through the assistance of a wage subsidy contract.

After working at the sporting goods store for 3 days, claimant left the job as he was unable to tolerate the pain in his back and both legs.

In January 1987 a Determination Order issued awarding claimant temporary disability benefits, as well as 5 percent (7.5 degrees) scheduled permanent disability for the left leg (thigh). No additional unscheduled permanent disability was awarded. In May 1987, claimant's vocational services were terminated pursuant to OAR 436-120-090(12).

Claimant's current diagnosis is: degenerative arthritis or spondylosis of the lumbar spine; and multiple level disc problems with spurring manifested by recurrent lumbar spasm.

FINDINGS OF ULTIMATE FACT

As a result of his compensable injury, as well as relevant nonmedical factors, claimant is unable to obtain and hold employment in the normal labor market.

Claimant has made reasonable efforts to obtain employment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was permanently and totally disabled. We agree.

At the outset, the insurer argues that claimant must prove a permanent worsening in order to obtain additional permanent disability benefits. We note, however, that the determination order challenged here issued not after reopening for increased permanent disability under ORS 656.273, but rather after reopening for vocational services. Accordingly, the insurer's argument is without merit. See Hanna v. SAIF, 65 Or App 649, 652 (1983).

To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful, suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant may prove permanent total disability by a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984). In addition, claimant has the burden to establish that he is willing to seek regular, gainful employment and has made reasonable efforts to obtain such employment. ORS 656.206(3).

Claimant is 55 years old and the majority of his work experience is in medium to heavy labor work. He can no longer do such work. Claimant has recently obtained his GED, however, his return to work as a salesperson was cut short due to disabling pain.

Dr. Post, claimant's treating physcian since 1981, has consistently opined that claimant is permanently and totally disabled. He feels that claimant's back impairment is in the moderately-severe range, and that claimant could not work an eight-hour day without suffering severe pain.

Claimant's vocational counselor felt that he did not possess the necessary transferable skills to secure suitable employment, and felt sedentary work could be feasible, provided there was a highly flexible work environment and decreased pain symptoms. Further, as of May 1987, the vocational counselor was of the opinion that vocational assistance would not be able to resolve claimant's lack of suitable employment.

Claimant actively participated in a work training program, and received his GED. Following this, he actively participated in job placement assistance, and, in fact, did find employment. The employment, however, was terminated due to claimant's physical disability. We find this to be a reasonable effort to obtain employment as required by ORS 656.206(3).

Claimant is no longer able to obtain and hold gainful employment in the broad field of occupations. His efforts to obtain employment to have been reasonable. Accordingly, we conclude that

claimant has sustained his burden of establishing that he is permanently and totally disabled.

ORDER

The Referee's order dated July 28, 1987 is affirmed. Claimant's attorney is awarded a reasonable attorney fee of $750, for services on review, payable by the insurer.

DARLENE L. VAUGHN, Claimant
Tamblyn & Bush, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-07743
March 8, 1989
Order on Review (Remanding)

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Leahy's order that: (1) declined to find that her back claim was prematurely closed by a Determination Order; (2) upheld the insurer's aggravation denial; and (3) declined to award unscheduled permanent disability. In addition, claimant argues that the Referee "abused his discretion" in declining to reconvene the hearing.

The Board remands this case to the Referee for further proceedings consistent with this order.

ISSUES

1. Whether remand is appropriate.

2. Whether claimant's back claim was prematurely closed by a Determination Order.

3. Whether claimant sustained an aggravation.

4. The extent of claimant's unscheduled permanent disability.

FINDINGS OF FACT

This case proceeded to hearing on September 1, 1987. At the beginning of the hearing, the following colloquy took place between the parties and the Referee:

"REFFEREE: Okay. Anything else?

"[CLAIMANT'S ATTORNEY]: That's all we have. Well, there's the -- we had already talked on the phone, the three of us, about keeping the record open to get some more diagnostic information on a thoracic outlet syndrome.

"REFEREE: It was an IME [i.e., Independent Medical Examination] wasn't it?

"[INSURER'S ATTORNEY]: Yes.

"[CLAIMANT'S ATTORNEY]: An IME, yes.

"REFEREE: Has that been scheduled yet?"

"[INSURER'S ATTORNEY]: Yes.

"REFEREE: When?

"[INSURER'S ATTORNEY]: It's set with Dr. John Porter for September 16, [1987,] which was his first available date.

"* * * * *.

"REFEREE: All right. We agreed in advance on 8-24-87 that we would hold the hearing today and continue it for an IME and for claimant's then perusal of the IME, so I presume you [i.e., claimant's attorney] get a chance to get more medical. I guess that was our agreement.

"[CLAIMANT'S ATTORNEY]: I believe the record wil [sic] be held open just for that." (Emphasis added).

Later, the insurer's attorney called Dr. Duris, claimant's treating physician, to the witness stand. Duris apparently did not bring all of his chart notes to the hearing. Consequently, at the end of Duris' direct examination, claimant's attorney requested the Referee to admit all of Duris' chart notes after copies were obtained. After ruling that all of Duris' chart notes would be admitted, the Referee stated, inter alia:

"There's plenty of time. We don't have to decide anything today. You've [claimant's attorney] got more medical coming, more testimony or doctors' depositions or whatever you're going to take in the future, and if you want to straighten this chart note thing out in the meantime, that's all right with me." (Emphasis added).

Lastly, at the close of the hearing the Referee stated:

"Most of the people have left, but counsel and the Referee and the court reporter are still here. We're terminating for today, and we will reconvene after all these additional medical depositions and other exhibits are gathered together, so the case is not closed." (Emphasis added).

Dr. Porter's IME took place on September 16, 1987, as scheduled. The insurer did not depose Porter until December 28, 1987.

Without reconvening the hearing, the Referee issued an Opinion and Order in this matter on January 27, 1988. In that order, he stated, inter alia:

"Prior to the hearing it was agreed that this hearing would be held open for defendant to obtain an IME. It has been

scheduled for September 16, 1987 with Dr. Porter, a vascular surgeon. It was admitted as Ex. 37 [sic] (74 pp.) on January 13, 1988. The parties could not convene again before March 1, 1988. The file was therefore closed without closing remarks, with no 1988 activity."

The transcript of the hearing shows that the Referee admitted Exhibits 1 through 34. In addition, the Referee's order stated that Exhibit 37, which is the deposition of Dr. Porter, was admitted. We note, however, that the record contains additional documents marked and identified as Exhibits 35 and 36.

CONCLUSIONS OF LAW

Remand

The Board may remand a case should it determine that the record has been improperly, incompletely or otherwise insufficiently developed or heard by a Referee. ORS 656.295(5).

Here, the parties and the Referee reached an agreement on the record that the hearing would be "reconvene[d]." Moreover, the Referee stated on the record that after the insurer had obtained Dr. Porter's IME report, claimant would be allowed to "get a chance to get more medical." In fact, the Referee assured claimant that "there's plenty of time" to admit additional medical documents.

In his Opinion and Order, the Referee misstated the agreement reached on the record: "[I]t was agreed that this hearing would be held open for defendant to obtain an IME." In fact, however, the parties and the Referee agreed that after Dr. Porter's IME, claimant would have an opportunity to submit further medical documents. Thereafter, the hearing was to reconvene.

The Referee further stated in his order that he was unwilling to leave the record open through March 1, 1988. He, therefore, closed the record, without reconvening the hearing, on January 27, 1988.

Under such circumstances, we do not agree with the Referee's closure of the record, without reconvening the hearing as agreed on the record. We wish to make clear, however, that we do not favor the practice of a Referee agreeing on the record to reconvene the hearing at some later unspecified date.

Regarding Exhibits 35, and 36, the Referee did not make any ruling on their admissibility. Although they are part of the file before us on Board review, we are not certain that those exhibits are, in fact, part of the record.

Furthermore, we note that claimant has attached a certain medical report, which he identifies as Exhibit 38, to his Appellant's Brief. That report is not part of the record, however, and we do not consider it because our review is confined to the record. ORS 656.295(5).

Accordingly, we conclude that the record is insufficiently developed and that remand is appropriate. The

Referee is directed to: (1) reconvene the hearing, as agreed on the record, and to allow further testimony and/or closing arguments; (2) rule on the admissibility of additional medical documents that claimant may wish to submit; (3) rule on the admissibility of Exhibits 35, and 36; (4) rule on the admissibility of Exhibit 38; and (5) issue a final, appealable Opinion and Order.

ORDER

The Referee's order, dated January 27, 1988, is vacated. This case is remanded to the Referee for further proceedings consistent with this order. A client-paid fee, not to exceed $1,044, is approved.

CONNIE R. WALKER, Claimant
Carney, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-06330
March 8, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests, and claimant cross-requests, review of Referee Mulder's order that directed the employer to pay claimant an additional sum of money under the terms of a disputed claim settlement (DCS). We reverse.

ISSUE

Whether the employer paid claimant the full sum owed under the terms of the DCS.

FINDINGS OF FACT

Claimant terminated her employment due to stress in February, 1985. She subsequently filed an occupational stress claim with the self-insured employer. It was denied. Claimant filed a request for hearing on the denial. On April 25, 1986, after more than a day at hearing, the parties began settlement negotiations which eventually resulted in the DCS in question. The DCS was signed by the parties in June, 1986, and approved by Referee St. Martin on July 9, 1986. In addition to resolving other contested matters, the DCS provides that the disputed stress claim shall remain in denied status and that claimant shall receive various lump sum payments. One of the provisions for lump sum payment provides:

> "2. The Employer shall indemnify Claimant from recourse for all related medical, hospital, psychiatric and pharmaceutical expenses incurred, or for treatment rendered through and including April 25, 1986; and shall further pay Claimant twenty-five percent (25%) of amounts owing to (approximately the sum of $10,000) Portland Adventist Hospital which have not been paid by the Employer's group health insurance carrier and which shall be payable to Claimant's counsel, Carney, Buckley, Kasameyer & Hays, to be held in Trust for Claimant to cover future medical expenses related to her psychological

condition in excess of amounts covered by her continuing health insurance coverge [sic] through the Employer's long term disability plan." (Emphasis added.).

The parties now disagree over the amount to which claimant is entitled under the emphasized portion of the provision above. The employer paid claimant $559.27; however, claimant asserts entitlement to a greater sum.

The employer provides its workers with a group health insurance plan. The plan is self-insured. It is administered by The Travelers, which bills the employer a percentage of the total sums paid on claims. The employer also provides a Long-Term Disability (LTD) Plan, which is administered by another insurance company. That plan provides wage-replacement benefits to workers who must leave employment due to disability. It does not provide medical benefits. However, former employes covered under the LTD plan continue to receive medical benefits under the employer's group health insurance plan, administered by The Travelers.

During pre-DCS negotiations in this case, claimant's attorney secured an agreement by Portland Adventist Hospital (PAH) to compromise 25 percent of the outstanding portion of claimant's hospital bills that was not paid by The Travelers. It was anticipated that the employer would pay the compromised portion (25 percent) to claimant to help pay for future medical expenses. PAH estimated that the oustanding bills for hospital services rendered through April 25, 1986, would total approximately $10,000. That estimate was based on the mistaken assumption that, after claimant began receiving LTD benefits, health insurance coverage would no longer be provided under the group plan administered by The Travelers. Claimant began receiving LTD benefits on February 12, 1986.

Before the DCS in question was signed, the employer sent claimant's attorney a booklet describing the LTD plan. The booklet stated that the "Medical Expense Plan (MEP) will continue at Company expense as long as the individual continues to be covered under provisions of the LTD Plan." Before signing the DCS, both claimant and her attorney knew that she would continue to receive medical insurance coverage while receiving LTD benefits. However, they apparently were not aware that the coverage would be provided under the group health insurance plan administered by The Travelers.

Meanwhile, The Travelers made several payments on PAH bills in May, 1986. Claimant and her attorney were not aware of these payments when they signed the DCS. After approval of the DCS, the employer sent claimant's attorney a check for $559.27, representing 25 percent of the PAH bills left outstanding after payments by The Travelers. The remainder of the PAH bills were paid by the employer. When claimant's attorney protested the amount of the check, the employer advised him that The Travelers continued to cover claimant's medical expenses even after she began receiving LTD benefits.

Claimant requested a hearing on the DCS, asserting entitlement to an additional sum under its terms.

FINDING OF ULTIMATE FACT

The sums paid PAH by The Travelers after February 12,

1986 were amounts paid by the employer's "group health insurance carrier" as that term is used in the DCS.

CONCLUSIONS OF LAW AND OPINION

The Referee agreed with claimant and ordered the employer to pay her "25% of the amount which was payable to PAH from [the employer] under the health insurance aspect of the Long Term Disability Plan through April 25, 1986." Stated differently, the employer was ordered to pay claimant 25 percent of the sums paid PAH by The Travelers after February 12, 1986, for hospital services rendered through April 25, 1986. The Referee essentially found that those sums were not amounts paid by the "group health insurance carrier" and, therefore, may not be considered in reducing the 25 percent sum owed claimant under the DCS. We disagree.

The DCS may be viewed as a private contractual agreement between the parties, and the clear and unambiguous language of the contract controls. Fidela O. Durgen, 39 Van Natta 316, 318 (1987); Steve W. Burke, 37 Van Natta 1018, 1019 (1985); Mary Lou Claypool, 34 Van Natta 943, 946 (1982). Here, the disputed terms of the DCS are clear and unambiguous, with the exception of the term "group health insurance carrier." Technically, the employer has no "health insurance carrier" because it is self-insured. However, the Referee found, and the parties agree, that "carrier" refers to The Travelers, the administrator of the employer's group health insurance plan. We adopt that undisputed interpretation.

The Referee found, nevertheless, that amounts paid PAH after February 12, 1986, were "[a]mounts paid by [the employer] under the health insurance aspect of the Long Term Disability Plan" and were not amounts paid by the "group health insurance carrier." That finding is not supported by the record. First, payments to PAH were made by The Travelers, as administrator of the employer's group health insurance plan. Second, there is no "health insurance aspect" of the LTD plan. The LTD plan does not provide medical benefits, and it is administered by another insurance company. Claimant was provided continuing coverage under the same group health insurance plan that was provided her during employment. Contrary to claimant's assertion, there was no conversion of medical insurance coverage when she began receiving LTD benefits. We are persuaded that the amounts paid PAH by The Travelers after February 12, 1986, were amounts paid by the "group health insurance carrier."

Claimant contends that, to comply with the terms of the DCS, the employer should have prevented The Travelers from making further payments after February 12, 1986. We disagree. No such duty was created by the DCS. The clear and unambiguous language of the DCS is devoid of any expression of intent to alter the contractual relationship between the employer and The Travelers. Moreover, the DCS does not mention the date of February 12, 1986, nor refer to any alleged "conversion" date.

Finally, claimant argues that the meaning she attaches to the DCS terms should be operative, because the employer had exclusive knowledge that The Travelers would continue to administer group health insurance coverage after she began receiving LTD benefits. We disagree. Claimant knew, or should have known, that coverage under the group health insurance plan administered by The

Travelers would not cease. In May, 1986, claimant received an LTD plan booklet which explained that the "Medical Expense Plan (MEP) will continue" while she receives LTD benefits (Emphasis added.). Although the booklet did not expressly identify the administrator as The Travelers, that specific information was readily obtainable had claimant been so inclined. Moreover, at about the same time, The Travelers made several substantial payments on PAH bills. Again, had claimant inquired, she could have discovered these payments prior to execution and approval of the DCS. She did not do so, and is now bound by that agreement. We conclude that the employer paid claimant the full amount owed under the terms of the DCS.

ORDER

The Referee's order dated December 10, 1987, as amended January 8, 1988, is reversed. The Board approves a client-paid fee not to exceed $2,500.

EBERET WILLIAMS, Claimant
Tamblyn & Bush, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 87-10555
March 8, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of Referee Menashe's order that set aside its denial of claimant's low back aggravation claim. The issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Summary of Facts."

ULTIMATE FINDINGS OF FACT

On June 12, 1987, claimant suffered a flare-up or worsening of his compensable back condition that left him less able to work since the last arrangement of compensation, on October 7, 1986 stipulation.

CONCLUSIONS OF LAW

We adopt the Referee's "Opinion" with the following comments. Claimant was unable to personally appear at hearing. Claimant's counsel requested to have his client testify by telephone. Upon the employer's motion, the Referee denied the request. The employer did not move to dismiss the hearing. The employer contends that claimant failed to establish his aggravation claim by a preponderance of the evidence. The employer argues that the medical opinion offered in support of claimant's aggravation claim is suspect since it is based on the untested credibility of claimant's history.

We have previously held that there is no jurisdictional requirement for claimant to personally appear at hearing. Warren F. Stier, 36 Van Natta 334 (1984). However, substantial justice may give the employer the right to confront and cross examine claimant, especially in cases, such as this one, where much of the expert opinion in the case is based on claimant's subjective complaints and history. Edwin R. Cantrell, 36 Van Natta 312 (1984). We agree with the employer that if claimant's testimony had proven to be noncredible, the value of the expert opinion which relied on claimant's history would have diminished. Nevertheless, in this case, we find that employer waived its right to

confrontation with claimant by failing to request dismissal of the hearing after the Referee rejected claimant's request to offer testimony by telephone.

On June 25, 1987, Dr. Lewis indicated claimant was temporarily totally disabled as of June 12, 1987. The record does not establish a date, after June 25, 1987, that claimant was authorized to return to work. However, the record establishes that claimant was temporarily totally disabled in excess of 14 days. Inasmuch as claimant was temporarily disabled as a result of increased symptoms attributable to his compensable condition, he has established a worsening of his condition for aggravation purposes, as a matter of law. See Gwynn v. SAIF, 304 Or 345 (1987); Van Woesik v. Pacific Coca-Cola Co., 93 Or App 627 (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." 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 13, 1987, is affirmed.

RICHARD J. DIXSON, Claimant
Cox, et al., Claimant's Attorneys
Thomas Sheridan (SAIF), Defense Attorney
Roberts, et al., Defense Attorneys

WCB 86-05692 & 85-14216
March 9, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee Knapp's order that declined to award a carrier-paid attorney fee for services at the hearing level. Santry Trucking (Santry), a self-insured employer, cross-requests review of that portion of the Referee's order that: (1) set aside its denial of claimant's aggravation claim for a neck condition; and (2) upheld a denial of claimant's "new injury" claim for the same condition issued by the SAIF Corporation.

On review, the issues are responsibility and attorney fees.

We affirm on the responsibility issue and modify the Referee's award of attorney fees.

FINDINGS OF FACT

We adopt the Referee's findings of fact and make the following additional findings.

Claimant's symptoms continued after his initial 1984 injury up to the time of his fall in February 1986. These symptoms included constant neck and shoulder pain and right arm weakness.

Claimant sustained a cervical strain in his February 1986 fall. His symptoms temporarily increased after the fall but resolved to their prior status after a short period of conservative

treatment. Dr. Smith's subsequent treatment was related to claimant's initial 1984 injury rather than his February fall.

SAIF and Santry issued their responsibility denials without waiving other issues of compensability. Claimant's attorney joined in SAIF's request for an order designating a paying agent under former ORS 656.307, and he filed a request for hearing on the denials prior to issuance of the ".307" order on April 24, 1986. At hearing, he actively and successfully litigated the position that Santry was responsible for claimant's neck condition. Claimant received a higher rate of temporary disability compensation as a result of the Referee's decision to assign responsibility to Santry. Conversely, claimant will receive a lower rate of temporary disability compensation if Santry prevails on the responsibility issue on Board review.

FINDINGS OF ULTIMATE FACT

Claimant's fall in February 1986 did not independently contribute to a worsening of the disc rupture and arthritic spur diagnosed in May 1986. These conditions were the result of claimant's initial 1984 injury.

Claimant's attorney rendered services to protect claimant's right to compensation prior to the issuance of the April 24, 1986 ".307" order. Claimant's entitlement to compensation was not at issue at hearing. However, he received additional compensation under the Referee's order, and his compensation will be reduced if Santry prevails on the responsibility issue on Board review.

CONCLUSIONS AND OPINION

Responsibility

We adopt the Referee's opinion on the responsibility issue.

Attorney Fee at Hearing Level

At hearing, claimant actively and successfully litigated the position that Santry was responsible for his current condition. Claimant contends that the Referee erred in not awarding an assessed fee at hearing regarding the responsibility issue. We disagree.

Assessed fees for services at the hearing level are authorized under ORS 656.386(1). Under that provision, claimant is entitled to a reasonable carrier-paid fee for finally prevailing in a "rejected case," defined as a case in which entitlement to receive compensation, as opposed to the amount of compensation, is at issue. Short v. SAIF, 305 Or 541, 545-546 (1988); Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989). Here, claimant's entitlement to compensation was resolved prior to hearing through the issuance of an order designating a paying agent under ORS 656.307. This is, therefore, not a "rejected case" within the meaning of ORS 656.386(1), and claimant is not entitled to an assessed fee for services at hearing.

However, claimant's attorney is entitled to a carrier-paid fee under ORS 656.386(1) for services rendered to protect claimant's right to compensation prior to the issuance of

the ".307" order. See former OAR 438-47-015. SAIF and Santry issued their responsibility denials without waiving other issues of compensability. The issue of compensability was, therefore, not finally resolved until the order designating a paying agent was issued roughly one month after the denials. See Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). During this intervening period, claimant's attorney filed a request for hearing on the denials and joined in a request for issuance of the ".307" order. A fee payable by Santry for these services is appropriate under ORS 656.386(1).

Finally, claimant's attorney is also entitled to a fee payable out of the increased compensation awarded under the Referee's order. Claimant received a higher rate of temporary total disability compensation as a result of the Referee's decision to assign responsibility to Santry. His attorney was instrumental in establishing that Santry was responsible. Accordingly, we award a fee of 25 percent of the increased temporary disability compensation awarded under the Referee's order, not to exceed $750. See ORS 656.386(2); former OAR 438-47-030; Rhonda L. Bilodeau, supra.

Attorney Fee on Board Review

ORS 656.382(2) authorizes an assessed fee on review when a carrier initiates Board review and the Board determines that "the compensation awarded to a claimant should not be disallowed or reduced." Here, Santry initiated Board review on the responsibility issue, and claimant would have received a lower rate of temporary disability if Santry had prevailed on review. As a result, Santry's request for review has resulted in a decision that claimant's compensation "not be disallowed or reduced" within the meaning of ORS 656.382(2). See Rhonda L. Bilodeau, supra. Accordingly, claimant is entitled to a reasonable assessed fee on Board review.

However, we cannot authorize a carrier-paid fee unless claimant's attorney files a statement of services. See OAR 438-15-005(2) and 439-15-010(5). Because no statement of services has been received to date, a carrier-paid fee shall not be awarded.

ORDER

The Referee's order dated February 26, 1987 is modified in part. Claimant's attorney is awarded an assessed fee of $200 for services rendered prior to the issuance of the April 24, 1986 ".307" order. Claimant's attorney is also awarded a fee of 25 percent of the increased compensation resulting from the Referee's order, not to exceed $750. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee for counsel for Santry Trucking, not to exceed $150.

Board Member Crider, concurring:

I join in the Board's order regarding the issues of responsibility and attorney fees on Board review. I dissent from that portion of the order denying attorney fees at hearing. Claimant's counsel participated at hearing and sought to have responsibility assigned to Santry in order to achieve a higher rate

of temporary disability compensation. An attorney fee is thus required by SAIF v. Phipps, 85 Or App 436 (1987). I reject the majority's view that Phipps is dead for the reasons stated in my dissenting opinion in Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989) (dissent by Board Member Crider.)

HARVEY L. ELLIS, Claimant
Pozzi, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 87-01918
March 9, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Podnar's order which: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 35 percent (112 degrees), as awarded by Determination Order, to 60 percent (192 degrees). We affirm.

ISSUE

The issue is extent of permanent disability, including permanent total disability.

FACTS

Claimant is a 57 year old long haul truck driver. He compensably injured his low back in April 1984, while loading his truck. He has been employed in the trucking industry over 20 years. Claimant has an eighth grade education.

Claimant initially treated with Dr. Pace, chiropractor, who diagnosed left leg radiculopathy. Dr. Pace referred him to Dr. Bergquist, neurologist, due to claimant's back and leg pain. Dr. Bergquist diagnosed acute left L4 lumbar radiculopathy. Claimant was treated conservatively. He returned to regular work.

On December 30, 1986, claimant sought treatment from Dr. Pace due to periodic low back pain with left leg numbness and paresthesia sensations. Dr. Pace diagnosed intervertebral disc syndrome at L3-4. He referred him back to Dr. Bergquist.

On April 9, 1986, Dr. Bergquist reported that claimant was not medically stationary due to back and leg pain, but did not take him off from work. X-rays revealed severe disc narrowing at L5-6, mild preexisting degenerative disc disease, and a congenital condition of six lumbar vertebrae, non-contributory.

On August 8, 1986, the Orthopaedic Consultants performed an independent medical examination. They diagnosed L5-6 degenerative disc disease and found minimal permanent impairment.

Claimant's claim was closed by Determination Order dated September 25, 1986, which awarded 20 percent unscheduled permanent disability.

Approximately one month later, claimant sought treatment from Dr. Pace due to increasing low back pain and lower extremity radiculopathy. Again he was referred to Dr. Bergquist. Dr. Bergquist recommended a myelogram and CT scan. He noted that claimant was reluctant to consider surgery. He was taken off work.

Claimant's December 1986 myelogram revealed marked disc

space narrowing at L4-5, a disc protrusion at L3-4 and L4-5, mild bilateral encroachment on the lateral recesses at L3-4 and L4-5, and bilateral facet hypertrophy at L4-5 and L5-S1.

On January 23, 1987, Dr. Pace released claimant to medium work, noting his need for frequent changes in position.

On February 23, 1987, Dr. Pace restricted claimant to light duty. Claimant requested light-duty work from his employer. He was informed that no positions were available.

In March 1987, claimant began receiving vocational assistance. Claimant's vocational counselor wrote to his employer on March 20, 1987, and requested reinstatement based on his physical limitations.

On April 21, 1987, Dr. Pace reported claimant continued to experience moderate low back pain, left radicular pain, and loss of strength. He did not rate claimant's impairment. Claimant was deemed medically stationary.

Claimant's claim was closed by Determination Order dated June 25, 1987, awarding an additional 15 percent disability, for a total unscheduled award of 35 percent.

In August 1987, claimant actively began pursuing self-employment as a "hot-shot" truck driver. A "hot-shot" trucker transports partial loads on an expedited delivery basis. He purchased a truck and trailer, applied for and obtained ICC licensing and authority, and began soliciting jobs. In order to obtain ICC authority he had to demonstrate a need for his services. He met this requirement by soliciting trucker brokers who confirmed that the service was needed in their geographical area.

Claimant's business is licensed in 11 western states. He considers his business to be competitive in the industry. He has delivered at least one load. Claimant pursued self-employment as he felt it would afford him the flexibility in accepting only those jobs he wanted to perform. Additionally, he can hire laborers to do the tarping, and loading/unloading of his truck, as needed.

On September 3, 1987, claimant declined further vocational assistance.

Claimant has transferable skills in the trucking industry, and is utilizing those skills in his trucking venture.

CONCLUSIONS OF LAW

Claimant contends that he is permanently and totally disabled. In the alternative, he seeks an award of 90 percent unscheduled permanent partial disability.

The Referee found that claimant was not permanently and totally disabled. He increased claimant's unscheduled award from 35 to 60 percent. We agree with the conclusion of the Referee.

The extent of unscheduled permanent partial disability is measured by the permanent loss of earning capacity due to the compensable injury. Barrett v. D & H Drywall, 300 Or 325 (1985) aff'd on recon 300 Or 553 (1986). Earning capacity is defined as the "ability to obtain and hold gainful employment in the broad range of

general occupations." Surratt v. Gunderson Bros., 259 Or 65 (1971). It is claimant's burden to prove he has incurred a permanent loss of earning capacity as a result of his April 6, 1984 injury.

In rating the extent of claimant's unscheduled permanent partial disability, consideration is given to his physical impairment as reflected in the medical record and the testimony at hearing. Garbutt v. SAIF, 297 Or 148 (1984). Relevant social and vocational factors are considered in the totality of the circumstances. See OAR 436-30-380 et. seq The rules are merely guidelines used in the evaluation of the extent of permanent partial disability. They are not mechanically applied. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

A worker may prove permanent total disability by showing that he is totally physically or medically incapable of performing regular gainful and suitable employment. See Brech v. SAIF, 72 Or App 388 (1985). Permanent total disability need not, however, derive solely from the worker's medical or physical incapacity. Emerson v. ITT Continental Baking Co., 45 Or App 1089 (1980). Accordingly, under the "odd-lot" doctrine, a worker's physical impairment as well as contributing nonmedical factors such as age, education, adaptability to nonphysical labor, and emotional conditions can establish permanent total disability. Clark v. Boise Cascade Co., 72 Or App 397 (1985).

Generally, disability must be rated as it exists at the time of the hearing. Gettman v. SAIF, 289 Or 609 (1980). Lastly, under ORS 656.206(3), a worker is required to make reasonable efforts to obtain regular gainful employment, unless it would be "futile" to do so. Butcher v. SAIF, 45 Or App 318 (1983). The ability of a worker regularly to perform suitable and gainful work on a part-time basis may preclude an award of permanent total disability. Pournelle v. SAIF, 70 Or App 56 (1984).

Claimant testified that he has worked as a long-haul truck driver since 1956. He stated that as a result of his low back injury he is in constant pain. The pain is not unbearable but interferes with his physical activity. He does not utilize pain medication. Claimant testified that he usually is able to alleviate the pain by sitting, lying down, or performing back exercises.

Vocational Counselor, Byron McNaught, testified for claimant. He stated that claimant was employable outside of his self-employment, particularly when the vocational tools of wage subsidy, on-the-job training, and skills improvement were employed. Mr. McNaught opined that claimant was not vocationally permanently and totally disabled.

We conclude that claimant's condition has not precluded him from "regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a). The standard has been expressed as "whether the claimant is currently employable or able to sell his services on a regular basis in a hypothetically normal labor market." Harris v. SAIF, 292 Or 683 (1982).

> "The essence of the test is the probable dependability with which claimant can sell his services in a competitive labor market, undistorted by such factors as business

booms, sympathy of a particular employer or friends, temporary good luck, or the superhuman efforts of the claimant to rise above his crippling handicaps."

Id. at 695; 2 Larson Workman's Compensation Law, section 57.51 at 10-164.21 to 10-164.49.

We conclude that claimant is presently able to regularly perform a gainful and suitable occupation and is therefore precluded from permanent total disability.

A claimant's subjective testimony alone may be sufficient to sustain an award of permanent disability. Garbutt v. SAIF, supra. However, if the testimony is unpersuasive or insufficient, the Board is not bound by it, and may require expert medical opinion to resolve the issue. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Complex medical causation questions require expert medical analysis. Uris v. Compensation Dept., 247 Or 420 (1967). We conclude that claimant's testimony is unpersuasive.

The medical evidence does not support an award of 90 percent unscheduled disability. Dr. Pace opined that claimant suffered from moderate low back pain, left radicular pain, and loss of strength. He released claimant to light work. Dr. Nash opined that claimant had lumbar disc disease and lumbar radiculopathy. However, he did not rate claimant's impairment.

We find that claimant's impairment is in the moderate range. In so doing, we rely upon the restrictions recommended by Dr. Pace.

Following our de novo review of the medical and lay evidence and exercising our independent judgment in light of claimant's impairment and the relevant social and vocational factors, we agree with the Referee that an additional 25 percent unscheduled disability for a total award of 60 percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to his compensable low back injury.

ORDER

The Referee's order dated September 29, 1987 is affirmed.

DAVID A. HOWE, Claimant
Peter O. Hansen, Claimant's Attorney
Stafford Hazelett, Defense Attorney
Davis & Bostwick, Defense Attorneys

WCB 86-07451 & 86-06141
March 9, 1989
Order on Review

Reviewed by the Board en banc.

Argonaut Insurance Company requests review of Referee Leahy's order that: (1) set aside its denial of claimant's aggravation claim for his current right knee condition; (2) upheld Liberty Northwest Insurance Company's denial of claimant's "new injury" claim for the same condition; and (3) awarded claimant's attorney an insurer-paid fee for services at hearing, to be paid by Argonaut. On review, the issues are:

(1) responsibility for claimant's right knee condition following his December 5, 1985 injury;

(2) claimant's entitlement to an attorney fee for services at hearing; and

(3) whether the fee is payable by the responsible insurer, or out of claimant's compensation award.

We reverse.

FINDINGS OF FACT

Claimant, 23 at hearing, works as a parking lot attendant. On March 27, 1985, while Argonaut was on the risk, he compensably injured his right knee when he slipped and fell. The knee discolored and swelled. Claimant left work and sought treatment from Dr. Baum, osteopath, who diagnosed traumatic contusion to the prepatellar and medial aspects of the knee. He took claimant off work for a week, and treated conservatively.

Claimant saw Dr. Baum until June 27, 1985. He had continued pain symptoms in the knee, and two occasions of swelling. His knee, which had full range of motion, did not lock up or click. Describing claimant's condition as synovial irritation, Dr. Baum anticipated no permanent disability.

Claimant continued to have pain complaints. He returned to his regular work activities, which included parking cars in tight spots. Claimant had to squeeze into and out of the cars with their doors only slightly open. Entering and leaving cars in this configuration caused claimant regularly to bump his right knee on the steering wheels and doors. Each of these small traumas to claimant's injured knee prolonged the irritation and impeded healing. Before the March 1985 injury, these traumas did not affect claimant's knee.

On December 5, 1985, claimant reinjured his knee when it gave way while he was running up a parking ramp. At this time, Liberty Northwest had become the employer's insurer. Claimant had not experienced knee giveway prior to this incident. He left work and returned to Dr. Baum. The injury was again diagnosed as traumatic contusion. Claimant did not return to work until December 20, 1985.

On February 12, 1986, Dr. Baum requested permission from Argonaut to conduct arthroscopic surgery. In his request he reported that claimant had no clicking to indicate a meniscus tear. Instead, he indicated that claimant was suffering recurring injury with work activity, and so had developed a palpable synovial shelf which needed to be excised.

In a second report to Argonaut on February 24, 1986, Dr. Baum discussed claimant's reinjury of December 5, 1985. He reported that claimant's knee had materially worsened since the previous injury, and possibly had a torn medial meniscus, as well as synovial thickening.

On March 5, 1986, Argonaut denied responsibility for claimant's condition on the basis that it was materially worsened by the second injury. Noting that it would seek a ".307" order, Argonaut gave Dr. Baum permission to proceed with the requested surgery.

Dr. Baum performed arthroscopic surgery on March 11, 1986. No meniscus tear was detected. Dr. Baum did uncover and excise a thickening of the synovium. Although a possibility exists that a meniscus tear might have been overlooked, the record does not support such a finding.

On April 16, 1986, Liberty Northwest denied responsibility for claimant's "new injury" claim for his right knee condition.

A ".307" order issued on May 2, 1986, designating Liberty Northwest as paying agent on the claim. On that same day, claimant's attorney filed a hearing request on the denials issued by Argonaut and Liberty Northwest. The record does not demonstrate that claimant's attorney was instrumental in procuring the ".307" order. At hearing, claimant took the position that Argonaut was the responsible insurer. There is no evidence in the record to indicate that claimant received a higher rate of temporary disability compensation as a result of the Referee's decision to assign responsibility to Argonaut.

ULTIMATE FINDINGS OF FACT

The December 1985 incident independently contributed to a worsening of claimant's underlying condition. It constituted a new injury for which Liberty Northwest was responsible.

Claimant's entitlement to compensation was not at risk at hearing. Claimant has not demonstrated that he received any increased compensation under the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The insurer on the risk at the time of a compensable injury remains responsible for the injury unless work activity at a time when a subsequent insurer is on the risk independently contributes to a worsening of the underlying condition. Boise Cascade v. Starbuck, 296 Or 238 (1984); Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). In this case, Argonaut was on the risk at the time of claimant's first injury, March 27, 1985. It retains responsibility for this injury, unless claimant's work activity after Liberty Northwest came on the risk is shown to independently contribute to the worsening of his underlying condition.

The record does not reveal precisely when Liberty Northwest came on the risk. However, the parties seem to agree that it was on the risk at the time of the December 5, 1985 incident.

Claimant's treating physician, Dr. Baum, believed that claimant's daily work activities, which required him to bump the injury site repeatedly, contributed to claimant's condition. The bumping kept the injury irritated and inflamed, which led to an eventual thickening of the synovial lining of the knee. Claimant's testimony that his knee always hurt supports the doctor's finding that the knee never completely healed.

On December 5, 1985, claimant fell and struck his right

knee again, necessitating further medical treatment. He then returned to work on December 20, 1985, and remained at work until his surgery on March 11, 1986. His work activities during that time were the same as they had been prior to December 5, 1985. Dr. Baum reported that these work activities caused claimant to suffer recurrent injury, as he constantly contused the knee. This materially worsened the knee following the first injury. We conclude that claimant's work activities when Liberty was on the risk independently contributed to a worsening of claimant's underlying condition.

Liberty Northwest contends that the tear to claimant's medial meniscus, which was repaired in 1987 by Dr. North, was of uncertain vintage and could have dated back to claimant's March, 1985 injury. The evidence persuades us otherwise. Dr. Baum did posit the possibility of a meniscal tear before he performed surgery in 1986. However, there were no objective findings indicating a tear and his post-surgery report was that no tear was found. Subsequently, each doctor admitted the possibility that a tear might have been missed. Symptoms of a meniscal tear include McMurry's clicking of the joint. Claimant had no such clicking until after a subsequent injury, responsibility for which is not an issue currently before the Board.

Attorney Fee at the Hearing Level

Argonaut contends that claimant is not entitled to a carrier-paid fee for services at hearing. We agree and also conclude that he is not entitled to a fee out of compensation.

ORS 656.386(1) authorizes a reasonable carrier-paid fee when a claimant "finally prevails" in a "rejected case," defined as a case in which entitlement to receive compensation, as opposed to the amount of compensation, is at issue. Short v. SAIF, 305 Or 541, 545-546 (1988); Rhonda L. Bilodeau, 41 Van Natta 11 (January 4. 1989). In all other cases, attorney fees are paid from any increased award of compensation. ORS 656.386(2).

Here, claimant's attorney has not demonstrated that he is entitled to an assessed fee for services rendered in protecting claimant's compensation prior to issuance of the ".307" order. See former OAR 438-47-015. Compare Rhonda L. Bilodeau, supra. Furthermore, claimant took the position that Argonaut is the responsible party, whereas we have decided on review that responsibility rests with Liberty Northwest. As a result, claimant did not "finally prevail" on the responsibility issue within the meaning of ORS 656.386(1). Accordingly, he is not entitled to an assessed fee at the hearing level.

Moreover, assuming that claimant had finally prevailed on the responsibility issue, he would still not be entitled to an assessed fee for services at hearing. Claimant's entitlement to compensation was resolved prior to hearing through the issuance of an order designating a paying agent under former ORS 656.307. The case before the Referee was, therefore, not a "rejected case" within the meaning of ORS 656.386(1). See Rhonda L. Bilodeau, supra.

Finally, claimant was not entitled to a fee out of compensation under ORS 656.386(2) as he has not demonstrated that he received any increase in compensation as a result of the

Referee's assignment of responsibility to Argonaut. Compare Rhonda L. Bilodeau, supra. Claimant's brief on review suggests that he received a higher rate of temporary total disability as a result of the Referee's ruling. However, claimant has worked for the same employer during the course of this claim. His weekly wage was $213.75 at the time of the March 1985 injury while Argonaut was on the risk, whereas it was $225.63 at the time of the December 1985 incident after Liberty Northwest came on the risk. We, therefore, fail to see how the Referee's assignment of responsibility to Argonaut resulted in a higher rate of temporary disability compensation.

Accordingly, we reverse the Referee's award of attorney fees for services at the hearing level.

ORDER

The Referee's order dated May 29, 1987 is reversed. Argonaut Insurance Company's March 5, 1986 denial is reinstated and upheld. Liberty Northwest Insurance Company's April 16, 1986 denial is set aside, and the case is remanded to Liberty Northwest for processing according to law. Liberty shall reimburse Argonaut for its claim costs incurred to date.

Board Member Crider, concurring in the result:

I join in the Board's order regarding the responsibility issue. I agree that claimant's attorney is not entitled to an insurer-paid fee for services at hearing solely on the ground that claimant did not finally prevail on the only issue at hearing -- that is, responsibility. I do not rely on the rationale articulated in the majority opinion in Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989) for the reasons stated in my dissent therein.

DION A. PETERSEN, Claimant
Lonergan & Lonergan, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-12088
March 9, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of that portion of Referee Uffelman's order that set aside its denial of claimant's right knee injury claim. We reverse.

ISSUE

Whether claimant sustained a compensable injury to his right knee on July 31, 1986.

FINDINGS OF FACT

Claimant, 19 at the hearing, was a general laborer for the insured, a pickle processing plant. On July 31, 1986, he was teamed with a co-worker, Perry Davison, cleaning tanks. They punched out at the end of their shift, at 2:30 p.m.

At no time on July 31, 1986, did Davison observe an injury to claimant. Davison never observed claimant either limping or complaining of right knee pain.

On an uncertain date, claimant complained to Davison

about knee pain, while he and Davison were both at the bottom of a pickle tank.

On the morning of August 3, 1986, a Sunday, claimant went to a hospital emergency room for treatment of a painful right knee. He was examined by Dr. Bosker, M.D., who diagnosed a right posterior ligament strain. Later that day, he returned to the employer and completed an industrial injury claim form.

After July 31, 1986, claimant never returned to work for the employer. On August 15, 1986, the insurer issued a denial of his claim.

Claimant was examined by Dr. Post, M.D., on August 8, 1986, August 22, 1986, and September 5, 1986.

On October 21, 1986, claimant applied for work as a security guard. Shortly thereafter, he was hired. He was employed in that capacity until he was discharged in mid-June, 1986.

On June 23, 1986, claimant sought treatment from Dr. Olson, M.D. Olson referred him to Dr. Tilson, an orthopedic surgeon, who claimant saw on July 21, 1987.

ULTIMATE FINDING OF FACT

Claimant has failed to establish that he sustained an injury to his right knee, while cleaning the inside of a pickle tank on July 31, 1986.

CONCLUSIONS OF LAW

Procedure

The Referee erroneously assigned the burden of proof in this case to the insurer. This is not a case involving a "back-up" denial. See Bauman v. SAIF, 295 Or 788 (1983). Rather, the insurer issued a timely denial of compensability, stating, inter alia:

> "[W]e find insufficient evidence exists to substantiate your claim for [an] industrial related injury and/or condition arising out of and within the course and scope of your employment . . . ."

Throughout these proceedings, the insurer has taken the position that claimant did not sustain a right knee injury, while at work on July 31, 1986. Accordingly, claimant has the burden to prove the compensability of his claim. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

Compensability

Claimant must prove, by a preponderance of the evidence, that his right knee injury arose out of and in the course of his employment. Id.; former ORS 656.005(8)(a).

The Referee's statements concerning claimant's credibility are equivocal. Accordingly, the Referee stated, inter alia:

"Claimant testified in a credible manner with regard to the nature in which the injury occurred. However, his testimony is suspect with regard to his denial that the individual who appeared and testified as Perry Davison was [not] the individual working with him on July 31, 1986[,] and also with regard to matters that may affect extent of disability - i.e., that he expected a large recovery.

"* * * * *.

"I find that the insurer failed to prove by a preponderance that a fraudulent claim was made. Impeachment of claimant's credibility is not alone sufficient."

Generally, we defer to a Referee's credibility finding when based on the demeanor of a witness. Pinkerton, Inc. v. Brander, 83 Or App 671, 674 (1987). However, in this case, given the Referee's inconsistent statements concerning claimant's credibility, we will assess claimant's credibility based on the substance of his testimony. See Davies v. Hanel Lumber Co., 67 Or pp. 35, 38 (1984).

On August 3, 1986, claimant completed an industrial injury claim form, wherein he reported that Perry Davison had witnessed his alleged injury. That same day, however, Davison wrote and signed the following statement:

"I[,] Perry Davison[,] didn't see Dion [claimant] at anytime falling off ladder[.]"

At the hearing, claimant testified that he did not recognize Davison. (Tr. 16). Davison, however, recognized claimant and testified that they had worked together on July 31, 1986. (Tr. 73). In Davison's words, he and claimant "were like friends together." (Tr. 83).

According to claimant, the employer provided him with the name "Perry Davison." (Tr. 19). When questioned why he, himself, was unaware of his coworker's name, claimant testified, inter alia:

"Q. You [claimant] never found out a guy's name, worked with him two days? Is that your testimony under oath?

"A. Oh, yeah. I found out, but in time I forget people. I wasn't with him that long.

"Q. You forgot his name since Thursday, [July 31, 1986], you mean?

"A. Correct. Yes." (Tr. 19).

Claimant testified that immediately following his alleged injury, he was in pain and walked with a limp. (Tr. 7, 28). Davison, however, testified that he never observed claimant walking with a limp, while the two of them were putting equipment away and cleaning up on July 31, 1986. (Tr. 81).

Under cross-examination, claimant initially testified, inter alia:

> "Q. What time is your shift supposed to be over?
>
> "A. At 2:30.
>
> "Q. So you quit at 1:45?
>
> "A. Yes. I could not walk on my leg, so it took a little extra time." (Emphasis added). (Tr. 28).

Later, however, when reminded that he probably punched a time clock when quitting, he changed his testimony, stating, inter alia:

> "Q. "Do you punch a time clock when you leave?
>
> "A. "Yes, I do. That's in the lunchroom though.
>
> "Q. And you punched out early then?
>
> "A. No. No. I punched out on time.
>
> "Q. Punched out at 2:30?
>
> "A. Approximately.
>
> "* * * * *.
>
> "Q. I thought you said you put the equipment away. You'd finished putting it away by 1:45?
>
> "A. No. We were in the process of doing it then." (Tr. 29).

Claimant applied for a job as a security guard on October 21, 1986. On his application form, he was asked: "Were you ever injured?" He responded: "No." He also failed to provide any response to the question: "List Any Physical Defects[.]"

The employer who hired claimant for the security guard position, Mr. De Loretto, testified that claimant's work required walking, stair climbing, and frequent running. (Tr. 55). De Loretto further testified that he had observed claimant perform those activities without difficulty. (Tr. 59).

On June 23, 1987, shortly after claimant was discharged from his security guard job, he sought medical attention for his right knee from Dr. Olson. Olson reported, inter alia:

> "The patient came to the clinic with a knee brace and a cane. He did, however, seem to be walking normally."

In light of the above, we find that claimant is not a

credible witness. First, Davison was working with claimant on July 31, 1986, and he observed nothing in the way of an injury. Second, claimant failed to recognize Davison at the hearing, despite the fact that Davison clearly recognized him as a "friend." Third, claimant was at least less than forthright on his job application for the security guard position. Last, he went without medical attention for nearly 10 months, while performing a physically active security guard job without difficulty. Within a few days of his discharge, however, he presented to Dr. Olson with a knee brace and cane. After observing claimant, Olson noted that he seemed to be walking "normally."

Accordingly, on this record, we are not persuaded that claimant sustained an injury to his right knee on July 31, 1986, which arose out of and in the course of his employment.

ORDER

The Referee's order, dated January 5, 1988, is reversed. The insurer's denial of August 15, 1986, is reinstated. The Board approves a client-paid fee, payable from the insurer to its attorney, not to exceed $1,512.

JESSE W. TAYLOR, Claimant
Gatti, et al., Claimant's Attorneys
Bottini, et al., Defense Attorneys
Beers, et al., Defense Attorneys

WCB 86-03328 & 86-03329
March 9, 1989
Order on Review

Reviewed by the Board en banc.

EBI Companies requests review of Referee Wilson's order that: (1) set aside its denial of claimant's aggravation claim for a right knee condition; (2) upheld a denial of claimant's "new injury" claim for the same condition issued by the Safeco Insurance Company; and (3) awarded claimant a $1,000 carrier-paid attorney fee for prevailing on the responsibility issue.

On review, the issues are responsibility and attorney fees.

We reverse on the attorney fee issue.

FINDINGS OF FACT

We adopt the findings in the "Discussion" section of the Referee's order. We make the following additional findings.

EBI was on the risk when claimant sustained his initial injury in 1982. Arthroscopic surgery performed in March 1983 demonstrated undulations in the right medial meniscus, but no definite tear.

Following his initial injury, claimant returned to his regular job as a foreman with the same employer. This job involved welding and assembly work, and it required claimant to bend, squat and stand for significant periods of time. Safeco began insuring the employer in April 1984. Claimant was promoted to a supervisory position in September 1985. This new position required no lifting, bending or squatting and minimal physical activity.

Claimant credibly testified regarding his symptomatic history since his initial injury in February 1982. He sustained no further specific work injuries, but he continued to experience right knee symptoms, including pain, clicking and locking. He did not seek further medical care or miss any work until November 1985. At that time, he sought treatment for a nonwork related, spontaneous exacerbation of his knee symptoms. A repeat arthroscopic examination on November 27, 1985 revealed a complete meniscus tear which was surgically repaired.

At hearing, claimant took the position that EBI is responsible for his current knee condition. The record indicates that claimant did not receive a higher rate of temporary disability compensation as a result of the Referee's assignment of responsibility to EBI. Claimant's attorney was retained after claimant filed the request for hearing in this case. He was not instrumental in the issuance of the ".307" order. He made the opening and closing argument at hearing and conducted the direct examination of claimant. He was also responsible for significant pre-hearing case preparation.

FINDINGS OF ULTIMATE FACT

Claimant sustained a partial medial meniscus tear at the time of his initial injury with EBI's insured. The complete meniscus tear diagnosed in November 1985 was the result of the natural progression of that partial tear. Claimant's work activity during the period the employer was insured by Safeco did not independently contribute to the enlargement of claimant's meniscus tear and subsequent need for surgery in November 1985.

Claimant's entitlement to compensation was not at risk at hearing. Claimant did not receive any increase in compensation under the Referee's order.

CONCLUSIONS AND OPINION

Responsibility

We adopt the Referee's opinion on the responsibility issue.

Attorney Fee at Hearing Level

EBI contends that claimant is not entitled to a carrier-paid fee for services at hearing. We agree and also conclude that he is not entitled to a fee out of compensation.

The Referee awarded a carrier-paid fee because he was persuaded that claimant had actively litigated the prevailing position that EBI is responsible for his current condition. However, we have recently concluded that more is required to justify an award of carrier-paid fees. See Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989). Assessed fees for services at the hearing level are authorized under ORS 656.386(1). Under that provision, claimant is entitled to a reasonable carrier-paid fee for finally prevailing in a "rejected case," defined as a case in which entitlement to receive compensation, as opposed to the amount of compensation, is at issue. Short v. SAIF, 305 Or 541, 545-546 (1988); Rhonda L. Bilodeau, supra. In all other cases, attorney

fees are paid from any increased award of compensation. ORS 656.386(2).

Here, claimant's entitlement to compensation was resolved prior to the hearing through the issuance of an order designating a paying agent under former ORS 656.307. The case before the Referee was, therefore, not a "rejected case" within the meaning of ORS 656.386(1). See Rhonda L. Bilodeau, supra. Furthermore, claimant's attorney was retained after the hearing request in this case was filed, and there is no evidence that he was instrumental in obtaining the .307 order. See former OAR 438-47-015; Dennis S. Current 38 Van Natta 858, 859 (1986). Claimant's attorney, therefore, was not entitled to an assessed fee under ORS 656.386(1). Nor was he entitled to a fee out of compensation under ORS 656.386(2) as claimant did not receive any increase in compensation as a result of the Referee's assignment of responsibility to EBI. Compare Rhonda L. Bilodeau, supra.

Accordingly, we reverse the Referee's award of attorney fees.

ORDER

The Referee's order dated December 30, 1986 is affirmed in part and reversed in part. That portion which awarded a carrier-paid fee is reversed. The remainder of the Referee's order is affirmed.

Board Member Crider, concurring in the result:

I join in the Board's order regarding the responsibility issue. I concur in the decision regarding attorney fees solely on the ground that a .307 order issued prior to hearing and the evidence does not establish that claimant had a stake in the outcome of the responsibility dispute. I do not endorse the Board's reasoning on this issue articulated in the majority opinion in Rhonda L. Bilodeau, 41 van Natta 11 (January 4, 1989) for the reasons stated in my dissent therein.

DENNIS J. BLANCHARD, Claimant
Sellers & Jacobs, Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney

WCB 87-05652
March 10, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of Referee W. Smith's order that set aside its denial of claimant's back injury claim. In addition, the employer's counsel requests that the Board take "administrative notice" of an order, dated October 6, 1988, from the State of Oregon Department of Commerce, Insurance Division, which involved, inter alia, the employer and SAIF as adverse parties.

The Board affirms the order of the Referee.

ISSUES

1. Whether the Board should take administrative notice of an order from the Department of Commerce.

2. Whether claimant was a worker from another state at the time of his back injury.

3. Whether SAIF's insured was an employer from another state at the time of claimant's back injury.

4. Whether claimant should be compensated in Oregon, by SAIF, for his back injury, when he has received medical benefits and time loss compensation pursuant to an accepted out-of-state claim for that injury.

FINDINGS OF FACT

SAIF's insured, Power Master, Inc. ("PMI"), is an Oregon corporation with its corporate headquarters located in Portland, Oregon. It has field offices in the states of Washington, California, Utah, Texas, and Louisiana.

Claimant, an Oregon resident, began working as an asbestos remover for PMI in 1984. At that time, PMI had a field office located in Portland, Oregon. The operations manager at the Portland field office, Wayne Welty, hired claimant. When claimant was hired, he understood that he would temporarily be assigned to various out-of-state projects. On one or two occasions, he was temporarily assigned to projects in Washington. Otherwise, he worked exclusively in Oregon.

Sometime thereafter, claimant was laid off. In March, 1986, he was rehired by PMI. As before, he was told that he would occasionally be required to work out-of-state. From March, 1986, through September, 1986, he worked at a job site in Portland, Oregon. At the beginning and end of each work day, he reported to PMI's Portland field office. From that location, he and other workers punched a time clock and loaded and unloaded their trucks with various supplies.

In October, 1986, PMI relocated its Portland field office to Vancouver, Washington. As a result, claimant began reporting to the Vancouver field office. He typically spent about one hour of each work day at the Vancouver field office. Otherwise, he worked in Portland.

That same month, PMI terminated it workers' compensation coverage with SAIF for its employees, including claimant, who reported to the Vancouver field office. In lieu of SAIF's coverage for those employees, PMI began paying workers' compensation premiums to the Washington Workers' Compensation Fund. PMI continued to provide coverage through SAIF for its employees who worked at its corporate headquarters in Portland.

Shortly after PMI opened its Vancouver field office, claimant was temporarily assigned to a project in Potlach, Idaho. He worked on that project until November 24, 1986, when he sustained a back injury. A few days later, he returned to Oregon and was examined by Dr. Milam, a chiropractor. Milam completed a "First Medical Report" form and sent it to SAIF. On December 8, 1986, SAIF issued a denial, indicating that claimant was not an Oregon subject employee.

After Dr. Milam's examination, claimant rested a few days and then resumed work for PMI in Portland. Upon returning to work at PMI, Mr. Welty provided claimant with a Washington industrial injury claim form. Claimant completed the form and his claim was

subsequently accepted. After consulting an attorney, claimant protested the acceptance of his Washington claim and appealed SAIF's denial of his Oregon claim.

Claimant received medical benefits and time loss compensation pursuant to his Washington claim. At the hearing, the parties stipulated that claimant's Washington claim was accepted, but that he had filed a formal protest.

CONCLUSIONS OF LAW

Administrative Notice

The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2); see Groshong v. Montgomery Ward Co., 73 Or App 403 (1985).

Here, the employer requests that the Board take administrative notice of an order from the Department of Commerce, which involved itself and SAIF as adverse parties. We grant the employer's request, but only insofar as acknowledging that such an order from the Department of Commerce issued on October 6, 1988. We wish to make clear, however, that we in no way take notice of any of the Hearing Officer's findings or conclusions. Rather, we rely exclusively on the record as developed, in this case, in the hearing below. ORS 656.295(5).

Claimant's Status

ORS 656.126(1) provides:

> "If a worker employed in this state and subject to ORS 656.001 to 656.794 temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of employment, the worker, or beneficiaries of the worker if the injury results in death, is entitled to the benefits of ORS 656.001 to 656.794 as though the worker were injured within this state."

In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." Phelan v. H.S.C Logging, Inc., 84 Or App 632 (1988); Kolar v. B & C Contractors, 36 Or App 65 (1978). Under this test, "[t]he inquiry is focused on the extent to which claimant's work outside the state was temporary." Langston v. K-Mart, 56 Or App 709, 711, rev den, 293 Or 235 (1982).

PMI argues that claimant was a Washington worker at the time of his back injury and, therefore, not subject to Oregon's workers' compensation law. We are not persuaded.

Claimant was a continuous resident of Oregon at all times material to this case. When he was rehired by PMI in March, 1986, PMI had no offices or permanent employees in Washington. As before, claimant understood that his employment with PMI would require occasional out-of-state assignments. From March, 1986, through September, 1986, he began and ended each work day at PMI's field office in Portland, Oregon. He never worked outside of Oregon during that period. His paychecks were drafted at PMI's corporate headquarters in Portland, Oregon.

When PMI relocated its Portland, Oregon, field office to Vancouver, Washington, claimant continued to work in Portland. The only thing that changed for him, was that he began and ended each work day at the Vancouver field office. He spent only one hour each work day in Vancouver. PMI's Portland headquarters continued to draft his paychecks and to withhold Oregon income tax.

Shortly thereafter, claimant was assigned to an asbestos removing project in Idaho. He had worked there for less than two months, when he injured his back on November 24, 1986. Within a few days, he returned to Oregon, sought medical treatment, and resumed work for PMI in Portland.

After SAIF denied claimant's Oregon claim, it received a letter from Employers Unity, Inc. ("EUI"), a company hired by PMI to oversee the handling of its workers' compensation claims. In that letter, dated July 7, 1987, the EUI representative stated, inter alia:

> "On November 11, 1986, while temporarily out of state on assignment, [claimant] injured his back while carrying bags of asbestos at a job site in Lewiston, Idaho."

On this record, we conclude that claimant was a worker employed in Oregon and that his temporary duties in both Washington and Idaho were incidental to that employment. ORS 656.126(1).

PMI's Status

PMI argues that it is exempt from Oregon's workers' compensation laws under ORS 656.126(2), because it moved its field office to Vancouver prior to claimant's back injury of November, 1986. Again, we are not persuaded.

ORS 656.126(2) provides:

> "Any worker from another state and the employer of the worker in that other state are exempted from the provisions of ORS 656.001 to 656.794 while that worker is temporarily within this state doing work for the employer." (Emphasis added).

We concluded above that claimant was not a "worker from another state," inasmuch as he was permanently, not temporarily, employed in Oregon. Accordingly, we conclude that ORS 656.126(2) does not apply to cases, like here, involving a worker who is permanently employed in Oregon.

In our view, the question of whether PMI is exempt from Oregon's workers' compensation law is resolved by ORS 656.023, which defines subject employers as:

> "Every employer employing one or more subject workers in the state . . .

Here, PMI's corporate headquarters is located in Portland, Oregon. PMI does not dispute that its corporate headquarters is a subject employer. See 656.005(24). Nor does it dispute that its corporate headquarters has subject employees. See ORS 656.005(25). Accordingly, under ORS 656.023, we conclude that when claimant

injured his back in November, 1986, PMI was a subject employer and not exempt from Oregon's workers' compensation laws.

Preclusion of Benefits

The Referee did not address whether claimant should be compensated in Oregon, by SAIF, for his back injury, when he has received medical benefits and time loss compensation pursuant to an accepted out-of-state claim for that injury. We, therefore, proceed to do so.

In Kolar, supra, the worker sustained three compensable back injuries in California between 1973 and 1975. 36 Or App at 71. Thereafter, he moved to Bend, Oregon, and was hired by an employer that was licensed to do business in both Oregon and Washington. After working in Oregon for a few days, the worker was transferred to a project in Grand Coulee, Washington. While working in Grand Coulee, he reinjured his back. He filed claims in Washington, California, and Oregon.

The employer's carrier denied the Washington claim and the worker did not appeal. The worker then filed a claim in California, which was resolved by way of a "compromise and release" accepted by the California Workmen's Compensation Appeal Board. 36 Or App at 72. A few months later, the worker filed a claim in Oregon.

The Kolar court held that neither the Washington nor California claims estopped the worker from seeking benefits under Oregon's workers' compensation law. 36 Or App at 72. In so doing, the court provided, inter alia:

> "We have determined Oregon has jurisdiction to determine compensation for claimant's injury. The agreement [ORS 656.126(1) & (2)] provides if an Oregon worker is injured in Washington while temporarily in that state the exclusive remedy shall be provided under the Oregon Workers' Compensation Law. The fact that claimant selected the wrong jurisdiction in which to file his initial claim does not bar consideration of his claim in Oregon."

Here, like Kolar, claimant was permanently employed in Oregon, and injured while temporarily out-of-state. His exclusive remedy for his injury, therefore, is under Oregon's Workers' Compensation Law. ORS 656.126(1) & (2). Again like Kolar, the fact that claimant initially selected the wrong jurisdiction, i.e., the State of Washington, in which to file his claim, matters not. 36 Or App at 72. We have jurisdiction to consider his claim under Oregon's Workers' Compensation Law.

Accordingly, pursuant to Kolar, we conclude that SAIF is responsible for claimant's back injury of November, 1986.

ORDER

The Referee's order, dated December 21, 1987, is affirmed as supplemented by this order. For services on Board review, claimant's attorney is awarded a reasonable attorney fee of $640, to be paid by the SAIF Corporation.

MLADEN BLAZEVIC, Claimant
Vick & Gutzler, Claimant's Attorneys
Terrall & Miller, Defense Attorneys

WCB 87-02644
March 10, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee St. Martin's order that: (1) declined to award permanent partial disability; (2) upheld that portion of the insurer's denial of claimant's chiropractic treatments in excess of the Director's guidelines; and (3) upheld that portion of the insurer's denial of Cybex testing. We affirm in part and reverse in part.

ISSUES

1. Extent of permanent partial disability.

2. Whether claimant's chiropractic treatments in excess of the Director's guidelines were reasonable and necessary.

3. Whether Cybex testing performed on claimant was reasonable and necessary.

FINDINGS OF FACT

Claimant, 21 years old, was born in Yugoslavia and arrived in this country when he was 9 years old. He is 5'4" tall and weighs 110 pounds. Claimant has an eleventh grade education. His employment history includes work as car cleaner, painter's helper, restaurant bus boy, service station attendant and utility janitor. On review, we found him to be a credible witness.

On April 15, 1986, claimant compensably injured his low back while lifting and emptying 35 pound trash containers. He began treating with Dr. Gill, chiropractor. Dr. Gill diagnosed lumbosacral sprain with subluxation, facet syndrome and myofascitis. Chiropractic treatments averaged between 2 and 3 times per week. Claimant experienced only temporary relief of his low back pain following these treatments.

Although Dr. Bussanich, chiropractor, and Dr. Gill reported that claimant had sustained a 25 percent spinal impairment due to the compensable injury, the Independent Chiropractic Consultants, Dr. Duncan, chiropractor, and Dr. Duff, orthopedic surgeon, reported that claimant's injury had resulted in no permanent impairment.

On October 6, 1986, Dr. Gill assessed claimant's physical capacities as follows: (1) no lifting or carrying greater than 25 pounds; and (2) no bending, squatting or crawling.

In late October 1986 claimant began to receive vocational assistance. Soon thereafter, a modified janitorial position was proposed by claimant's employer-at-injury. This modified position required no lifting greater than 25 pounds and no carrying greater than 20 pounds on an occasional basis. It required stooping, instead of bending, and walking a vacuum cleaner, instead of pushing and pulling. The employer was more than willing to modify the position in any way which would allow claimant to work within his physical capacities. Dr. Gill, however, refused to approve the modified position and, on January 27, 1987, claimant, relying upon his treating chiropractor, refused the job offer.

On February 4, 1987, a Determination Order awarded claimant no permanent disability.

On February 9, 1987, claimant's vocational assistance ended as a result of his refusal to accept the suitable modified employment offered by his employer-at-injury. Throughout the course of his vocational assistance, claimant was difficult to contact and uncooperative.

On April 27, 1987, the insurer denied claimant's chiropractic treatments in excess of the Director's guidelines and denied Cybex testing performed by Dr. Bussanich as neither reasonable nor necessary.

Dr. Gill referred claimant to Dr. Bussanich for the Cybex testing in an effort to verify whether claimant had become medically stationary. It was also intended to further assist Dr. Gill in defining the restrictions which should be placed on claimant's activities. To those ends, the testing was both valuable and supportive.

Claimant's chiropractic treatments in excess of the Director's guidelines are neither reasonable nor necessary. Although claimant may suffer exacerbations of his low back injury, which will require periods of intensive chiropractic care above the guidelines at some time in the future, his condition at the time of the denial did not require such treatment.

As a result of his compensable injury, claimant is now unable to engage in heavy physical labor.

CONCLUSIONS OF LAW

Extent of permanent disability

The Referee concluded that the medical and lay evidence did not establish that claimant had suffered a loss of earning capacity due to his injury. We disagree.

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).

Claimant was examined by three independent medical examiners. The Independent Chiropractic Consultants opined that claimant displayed no characteristics suggestive of impairment. Dr. Duncan believed that claimant's lumbosacral strain had run a normal course and was resolved. He found no loss of function or measurable impairment attributable to claimant's compensable injury and exhibited no findings that would preclude him from returning to his previous occupation as a utility janitor. Dr. Duff, orthopedic surgeon, found no evidence of impairment resulting from claimant's back injury. He suggested, however, that due to claimant's small size and history of significant back injury at an early age, he was not well suited to very heavy physical work and recommended a maximum lifting restriction of 40 pounds.

Dr. Bussanich, chiropractor, tested claimant's spinal

ranges of motion and spinal motor impairment by using Cybex equipment. Based upon claimant's limited ranges of lumbar and joint motion, Dr. Bussanich concluded that claimant had suffered a 25 percent spinal impairment. Dr. Gill, claimant's treating chiropractor, concurred with Dr. Bussanich's impairment rating and eventually refused to release claimant to even modified janitorial work.

Although claimant relied upon Dr. Gill's judgment in regard to the modified janitorial position, we do not believe that claimant's refusal to take the job indicates a lack of motivation. In fact, regardless of the merit of Dr. Gill's decision, claimant deferred to what he believed was the well-reasoned recommendation of his treating doctor. Claimant's unavailability for vocational assistance, however, did reflect a certain lack of motivation to return to work. Nonetheless, this attitude does not convince us that claimant either lacks credibility or did not sustain some physical impairment as a result of his compensable injury.

Claimant credibly testified that he feels low back pain when he rides in a car for 15 to 20 minutes or when he attempts to engage in heavy physical labor.

Although we do not find, based on the evidence as a whole, that claimant has sustained a 25 percent impairment of his spine, the Cybex testing results which underlie Dr. Bussanich's impairment rating, are objective evidence that claimant has incurred some degree of physical impairment. We choose not to defer completely to the physician's impairment rating because: (1) it is unclear how the reported ranges of motion and spinal motor measurements justify the physician's impairment ratings; (2) claimant's own assessment of his physical impairment does not correspond to a 25 percent impairment rating; and (3) there is significant contrary medical evidence which indicates claimant has either very minimal or no permanent disability resulting from his compensable injury.

Following our review of the medical and lay evidence, and considering claimant's physical impairment which prevents him from engaging in heavy physical labor, young age, limited education and work experience, decreased adaptability to lighter occupations, mental capacity and emotional and psychological condition, we conclude that an award of 15 percent (48 degrees) unscheduled permanent disability appropriately compensates claimant for his compensable injury.

Chiropractic care in excess of the Director's guidelines

The Referee concluded that the evidence did not establish that claimant needs any chiropractic treatment in addition to the guidelines. We agree.

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 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, 197-98 (1986).

In October 1986 the Independent Chiropractic Consultants believed that during a graduated release to regular work, chiropractic treatment on a one time per week basis would be appropriate. In December 1986 Dr. Duncan believed that claimant had reached a stage of maximum benefit from chiropractic treatment and no ongoing treatment was reasonable or necessary. Furthermore, Dr. Duncan did not believe that such treatment was necessary to maintain claimant in a medically stationary status. In fact, Dr. Duncan expressed his concern that continued passive treatment bore a serious risk of perpetuating functional behavior. Dr. Duff also expected that claimant would receive no further benefit from continued chiropractic and/or medical treatment.

Dr. Gill, on the other hand, opined that claimant would suffer exacerbations of his low back injury in the future which would require periods of intensive care above the guidelines. Dr. Gill, however, did not address whether current chiropractic treatments are either reasonable or necessary. Accordingly, we conclude that claimant has not established that chiropractic treatments in excess of the Director's guidelines are either reasonable or necessary.

Cybex testing

The Referee concluded that the Cybex testing was not a procedure for curative treatment purposes and therefore upheld that portion of the insurer's denial. We disagree.

Claimant must show that at the time the services were rendered they were likely to be of significant curative, palliative, preventive or restorative benefit. West v. SAIF, supra at 320-21.

Subsequent to Dr. Duncan's opinion that claimant was medically stationary, Dr. Gill sent claimant to Dr. Bussanich for Cybex testing to aid Dr. Gill in his judgment regarding claimant's medically stationary status. It was also meant to further assist Dr. Gill in defining the restrictions which should be placed on claimant's activities. We conclude that such purposes were likely to be of significant preventive benefit to claimant since an accurate determination of claimant's physical capacities would likely prevent future exacerbations of his low back condition by providing information to set prophylactic restrictions. Therefore, the Cybex testing was compensable.

ORDER

The Referee's order dated September 2, 1987 is affirmed in part and reversed in part. That portion of the insurer's April 27, 1987 denial that denied payment of Cybex testing is set aside. Claimant's attorney is awarded an assessed fee of $800 for his efforts at the hearing level and on Board review in setting aside the insurer's denial of the Cybex testing, to be paid by the insurer. That portion of the denial that denied chiropractic treatments in excess of the Director's guidelines is affirmed. Claimant is awarded a total of 15 percent (48 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. The Board approves a client-paid fee, not to exceed $778.50.

HARRY R. BOSTWICK, Claimant
Myrick, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

Own Motion 87-0657M
March 10, 1989
Own Motion Order

By letter dated April 14, 1988, CIGNA closed the above claim under ORS 656.278. Shortly thereafter, claimant appealed the closure to the Board, contending his condition was not medically stationary and that he was entitled to compensation for permanent total disability. He also requested that CIGNA reopen his claim for the recommended total knee replacement surgery. CIGNA agreed to accept responsibility for the recommended surgery, but asked the Board to deny payment of temporary disability benefits as it contends claimant has removed himself from the work force.

After thorough review of the evidence, we conclude claimant was medically stationary as of March 28, 1988 and that temporary disability benefits were properly terminated as of that date. Dr. Gilsdorf indicated on April 26, 1988 that although claimant's examination was basically unchanged, his symptoms were increasing to the point where a total knee replacement was indicated. We conclude claimant's claim should be reopened for payment of benefits as of the date he is hospitalized for the proposed surgery. Claimant's entitlement to temporary disability benefits is not a significant issue to us at this time. Had we ruled that the claim was prematurely closed, he would have continued to receive disability benefits. The one month gap between claimant's medically stationary date and the recommendation for further surgery does not persuade us to resort to the decision in Cutright v. Weyerhaeuser Company, 299 Or 290 (1985) in determining claimant's entitlement to temporary disability benefits. We conclude the payment of temporary disability benefits is appropriate.

Claimant's request for permanent total disability must be denied as this claim was reopened under the new own motion law which significantly limits our authority under ORS 656.278. See Orville D. Shipman, 40 Van Natta 537 (1988).

CIGNA's April 14, 1988 closure of the claim is affirmed in all respects. Claimant's claim is hereby reopened with temporary disability benefits to commence the date claimant is hospitalized for the recommended 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 $750 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.

CINDY L. BROOKS, Claimant
Apaco, Inc., dba, SUNDAE'S WEST, Employer
Bill D. and Steven Amick, Employers
Brothers, Drew, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney
Carl Davis, Assistant Attorney General

WCB 86-09142 & 86-12672
March 10, 1989
Order on Review (Remanding)

Bill D. Amick, an alleged noncomplying employer, requests review of Referee Holtan's order that dismissed the employer's hearing requests concerning: (1) the Department's order finding him to be a noncomplying employer; and (2) the SAIF Corporation's acceptance, on Amick's behalf, of claimant's injury claim. We reverse and remand for hearing.

ISSUE

1. Whether the employer timely appealed the Workers' Compensation Department's order which found him to be noncomplying at the time of injury.

2. If the employer is ultimately found to be noncomplying, whether claimant's injury claim is compensable.

FINDINGS OF FACT

On January 31, 1986, claimant filed a workers' compensation claim, alleging that a work related injury had occurred on January 14, 1986. On May 20, 1986, by Proposed and Final Order of the Workers' Compensation Department, the employer was found to be noncomplying from June 2, 1985 to January 14, 1986. The record does not reflect when the employer received the Department's order. Subsequently, the SAIF Corporation was directed to process claimant's claim. The employer was notified that if he disagreed with the order, he had the right to request a hearing within 20 days. In a letter to the Workers' Compensation Department dated June 11, 1986, the employer requested a hearing on the issues of whether he was a complying employer and the compensability of the claim. That request for hearing was received by the Workers' Compensation Department on June 13, 1986.

On July 1, 1986, SAIF accepted claimant's claim. SAIF mailed a copy of the "Notice of Claim" acceptance to the employer on July 15, 1986. The attached cover letter informed him that he had a right to request a hearing within 60 days if he believed claimant did not sustain a compensable injury while in his employ. On September 10, 1986, the employer advised SAIF that he was requesting a hearing. His letter was received by the Board on September 12, 1986. The employer's two separate hearing requests were assigned separate WCB case numbers but were consolidated and set for hearing.

On April 3, 1987, prior to hearing, claimant filed a "Motion to Dismiss the Employer's Request for Hearing" on the compensability issue. Claimant did not raise the timeliness of the employer's request for hearing on the Department's order as an issue. The employer did not respond to that motion. The Referee concluded that claimant's motion accurately set forth the law and dismissed the employer's hearing request as to both WCB case numbers.

CONCLUSIONS OF LAW

Timeliness of employer's appeal

A party seeking dismissal has the burden of proving the

dismissal is warranted. Tim J. McAuliffe, 37 Van Natta 76 (1985). In the present case, the evidence is insufficient to sustain claimant's motion to dismiss.

ORS 656.740(1) states that:

> "A person may contest a proposed order of the director declaring that person to be a noncomplying employer, . . . by filing with the department, within 20 days of receipt of notice thereof, a written request for a hearing. Such a request need not be in any particular form, but shall specify the grounds upon which the person contests the proposed order or assessment." (Emphasis added).

On May 20, 1986, the Workers' Compensation Department found the employer to be noncomplying from June 2, 1985 to January 14, 1986. The record, however, fails to reflect when the employer received the Department's order. On June 13, 1986, the Department received the employer's June 11, 1986 request for hearing on the issue of whether he was a complying employer at the time of claimant's injury.

Since the record does not reflect when the employer received the Department's order, we cannot determine whether the employer timely appealed the Department's order of noncompliance. Therefore, we cannot determine whether the Referee had jurisdiction to review the propriety of that order. Accordingly, we remand for further evidence on this issue. ORS 656.295(5).

Compensability

Without a finding regarding the employer's status as either complying or noncomplying, we cannot address the issue of compensability since SAIF had authority to accept claimant's injury claim only if the employer was actually noncomplying during the period in question. Derryberry v. Dokey, 91 Or App 533, 536 (1988). On remand, the Referee should also address the issue of compensability in light of the court's decision in Derryberry v. Dokey, supra.

ORDER

The Referee's order of dismissal dated July 21, 1987 is vacated. This matter is remanded to Referee Holtan for a hearing on the issues of timeliness of the employer's hearing request from the Department's noncompliance order, the employer's compliance status, and the compensability of claimant's claim.

GLENN T. CALAWA, Claimant
Galton, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-16442 & 86-05075
March 10, 1989
Order Denying Motion to Abate

The insurer has moved the Board for an order abating our January 11, 1989 Order on Review, as amended February 9, 1989, that affirmed a Referee's order setting aside a partial denial of claimant's herniated disc and resulting need for medical treatment. Specifically, the insurer requests that we abate our prior orders to consider a proposed agreement designed to resolve this matter, as well as matters currently pending in WCB Case No. 87-02661.

FINDINGS

On January 10, 1989, the insurer mailed a proposed stipulation to the Board. On January 11, 1989, the Board issued its Order on Review affirming the Referee's order. Thereafter, the proposed stipulation was received.

On January 20, 1989, the Board received claimant's counsel's request for an insurer-paid attorney fee, accompanied by a statement of services. On February 1, 1989, the insurer petitioned for judicial review of the Board's order. The insurer has also moved the court for an order remanding the case to the Board. On February 9, 1989, the Board issued an amended order, adhering to the prior order and awarding an insurer-paid attorney fee for services on review.

CONCLUSIONS

Jurisdiction to consider this matter vested with the Court of Appeals upon the filing of the insurer's appeal. Inasmuch as the insurer had perfected its appeal prior to the issuance of our amended order, our February 9, 1989 order adhering to our January 11, 1989 order is a nullity.

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

Under these circumstances, we decline to withdraw our January 11, 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). Our approach is designed to enable the court to fully address the insurer's presently pending motion for remand. Should the court conclude that remand is an appropriate action, we stand ready to expeditiously proceed with our consideration of the proposed agreement.

IT IS SO ORDERED.

EDWARD T. CRUMLEY, Claimant
Burt, Swanson, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-12902
March 10, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Crumley v. Combustion Engineering, 92 Or App 439 (1988). The court has concluded that claimant is entitled to an award of permanent total disability. Consequently, we have been instructed to award permanent total disability benefits.

In accordance with the court's mandate, claimant is awarded permanent total disability, effective August 27, 1986. The insurer is authorized to offset any permanent partial disability benefits paid after August 27, 1986 against claimant's award of permanent total disability.

IT IS SO ORDERED.

ROBERT L. DIEHR, Claimant
Galton, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-15271
March 10, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of those portions of Referee Tuhy's order that: (1) found that claimant's compensable psychological claim was prematurely closed; and (2) declined to consider claimant's psychological aggravation claim. We affirm.

ISSUES

1. Whether claimant's compensable psychological claim was prematurely closed.

2. If claimant's compensable psychological claim was not prematurely closed, whether claimant sustained an aggravation of that condition.

FINDINGS OF FACT

On November 30, 1982, claimant compensably injured his low back while lifting 100 pound flour sacks. On February 24, 1983, Dr. Franks, neurological surgeon, performed a left L5-S1 discectomy. In June 1983 Dr. Franks found claimant medically stationary and on October 6, 1983, his claim was initially closed with an award of 15 percent unscheduled disability for injury to his low back.

Claimant was unable to return to his former employment due to a lack of any jobs within his physical restrictions, which included no lifting or carrying greater than 50 pounds. Therefore, in January 1984 claimant began an authorized training program in telephone repair and refurbishing. On February 22, 1984, however, that program was terminated following claimant's involvement in a motor vehicle accident in which he sustained lumbar and cervical strains. Subsequent to that accident, claimant began to drink alcohol more heavily. On May 10, 1984, a second Determination Order issued as a result of the termination of claimant's vocational assistance. It awarded him an additional 10 percent unscheduled disability for a total of 25 percent.

On July 2, 1984, claimant sustained a right knee injury while involved in a second training program in cooking. Claimant suffered a tear of the posterior horn of the right medial meniscus and underwent arthroscopy and a medial meniscectomy of the right knee. As a result of that injury, claimant sustained a minimal to mild impairment of his right knee.

During the early part of 1984 claimant began feeling severe depression as a result of his inability to find employment within his physical restrictions. This depression was worsened by his knee injury. Also at that time, claimant's use of alcohol and drugs increased. In September 1984, Dr. Pidgeon, psychiatrist, diagnosed anxiety and depressive neuroses. In January 1985, Dr. Parvaresh, psychiatrist, diagnosed generalized anxiety and substance abuse which preceded the accepted industrial injuries and recommended psychiatric care.

In December 1984 claimant's authorized training program was terminated since he was not enrolled and actively engaged in training.

On February 7, 1985, the insurer denied claimant's psychological claim.

On February 26, 1986, a Referee found that claimant's back injury and sequelae were a material contributing cause of claimant's psychological condition and set aside the insurer's denial of that condition.

On July 30, 1986, a Determination Order awarded claimant total awards of 30 percent (96 degrees) unscheduled permanent disability and 10 percent (15 degrees) scheduled permanent disability for loss of his right leg (knee).

On August 5, 1986, claimant was examined by Dr. Cotton, clinical psychologist. Dr. Cotton diagnosed: (1) atypical mixed personality disorder; (2) psychological factors affecting his physical condition; (3) major depressive episodes; and (4) alcohol and other drug dependencies. He reported that claimant was not psychologically stationary.

On October 28, 1986, the insurer denied claimant's psychological aggravation claim.

On December 9, 1986, the Board affirmed the prior Referee's decision that claimant's back injury and sequelae were a material contributing cause of his psychiatric condition.

On February 5, 1987, a hearing was convened to determine the issues of premature claim closure and the alleged aggravation of claimant's depressive and anxiety neuroses. That hearing was continued until April 27, 1987 for the purpose of receiving additional evidence.

On February 13, 1987, claimant was admitted to the Oregon Health Sciences University in a state of extreme delusional paranoia. The attending physician diagnosed: (1) psychotic depression; (2) amphetamine psychosis; and (3) schizophrenia.

On February 17, 1987, based on a two or three year history of paranoia, depressive affect and claimant's ongoing sense of disability from his back and knee injuries, Dr. Denney, psychiatrist, diagnosed an affective disturbance secondary to a psychotic syndrome. On March 7, 1987, Dr. Denney further articulated his diagnoses to include: (1) organic delusional disorder secondary to amphetamine abuse; and (2) adjustment disorder with depressed mood.

On April 17, 1987, Dr. Parvaresh stated that claimant's psychotic disorder was the sole product of drug abuse.

On July 30, 1986, when a Determination Order issued awarding claimant a total of 30 percent unscheduled and 10 percent scheduled permanent disability, his depressive and anxiety neuroses were expected to improve from further medical treatment or the passage of time.

CONCLUSIONS OF LAW

The Referee concluded that claimant's psychiatric claim had been prematurely closed. We agree with the Referee's ultimate decision; but before addressing the issue of whether or not claimant's compensable psychological condition was medically stationary at the time of closure, we first must decide what

constitutes claimant's compensable psychological condition. On review, the insurer argues that the doctrine of res judicata does not bar us from finding that claimant's psychological condition at the time of closure was not compensable. We disagree.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). "Claim preclusion" is the name for the preclusive effect of a prior adjucication on a claim and "issue preclusion" for the preclusive effect of a prior adjudication on an issue. Id.; Restatement (Second) of Judgments, introduction at 1-5 (1982).

The rule of claim preclusion is that if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Id. at section 17-19, 24; see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980).

The rule of issue preclusion is that if an issue of fact or law is actually litigated and determined by a valid and final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. North Clackamas School District v. White, supra, 305 Or at 53; Restatement (Second) of Judgments section 27 (1982).

On February 7, 1985, the insurer denied the compensability of claimant's psychiatric condition based upon medical evidence which indicated that the condition preexisted claimant's November 30, 1982 industrial injury.

That denial was supported by the opinions of Drs. Parvaresh and Zivin. Dr. Parvaresh diagnosed generalized anxiety and substance abuse and believed that these conditions preceded the accepted industrial injuries. He further opined that the February 1984 motor vehicle accident in which claimant was involved was a material contributing factor in the worsening of those preexisting psychological conditions. Dr. Zivin opined that the mental and emotional factors resulting from the motor vehicle accident pushed claimant into his intense anxiety and depressive reactions. He did not believe that claimant's low back injury produced the psychiatric picture, but rather that claimant's underlying personality features did so.

On February 26, 1986, however, a prior Referee set aside the insurer's psychiatric denial by Opinion and Order. He relied upon the persuasive opinions of claimant's treating physicians, Drs. Pidgeon and Franks, to conclude that claimant's back injury and its sequelae were a material contributing factor of his psychological condition. That psychological condition had previously been diagnosed by Dr. Pidgeon as depressive and anxiety neuroses.

The compensability of claimant's anxiety and depression neuroses was actually litigated to final order. By virtue of the Board's affirmance of the Referee's order, the compensability of the condition is the law of the case. Moreover, the Referee's finding that the injury and its sequelae were a material cause of the condition, called "depressive neurosis", was essential to the result. Therefore, that determination is conclusive in this subsequent action between the parties. The insurer cannot now

attempt to relitigate the compensability of claimant's anxiety and depressive neuroses.

The compensability of claimant's post-closure condition diagnosed as: (1) psychotic depression; (2) amphetamine psychosis; and (3) schizophrenia, however, is not before us. That issue was never raised by the insurer either prior to or at hearing. The issues raised by the parties at hearing before us are limited to premature claim closure and the aggravation of claimant's compensable psychological condition.

Having decided that res judicata bars the insurer from attempting to relitigate the compensability of claimant's depression and anxiety neuroses, we now turn to the question of premature claim closure.

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 reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). A claimant's psychological condition should be considered in determining whether the claim should be closed. Utrera v. Dept. of General Services, 89 Or App 114, 116 (1987), citing Rogers v. Tri-Met, 75 Or App 470 (1985).

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).

During the early part of 1984 claimant began feeling severe depression as a result of his inability to find employment within his physical restrictions. That depression was subsequently worsened by the knee injury he incurred during vocational rehabilitation efforts. During the summer of 1986 claimant was again being considered for a vocational rehabilitation program.

On June 16, 1986, Dr. Parvaresh reported that if claimant did not wish to be involved in vocational training, his psychiatric condition could be considered medically stationary and closed with an impairment rating of 5 to 10 percent as a result of the accidental injury of November 30, 1982. On the other hand, Dr. Parvaresh reported that if claimant showed good motivation to be involved in vocational rehabilitation efforts, then he should be provided with a period of three to six months of supportive psychiatric care in order to facilitate his vocational training. (Emphasis added). Without such services, Dr. Parvaresh feared that claimant would not persevere and vocational assistance would prove fruitless. Dr. Parvaresh explained his recommendation for supportive psychiatric care as follows:

> ". . . there are really two options. One is to engage this gentleman in ongoing psychiatric care and at the same time provide him with vocational training so that he will find suitable employment and

can get on with his life. (Emphasis added). This can take anywhere from three to six months providing he is actively participating in his vocational training at the same time. The prognosis can be good if enough motivation is employed and effort put into vocational training."

On July 30, 1986, a Determination Order awarded claimant temporary disability benefits through June 16, 1986 and awarded 30 percent unscheduled and 10 percent scheduled permanent disability.

On August 5, 1986, six days after claim closure, Dr. Cotton had his first contact with claimant. On September 30, 1986, Dr. Cotton opined that claimant was not psychiatrically stationary and in need of ongoing psychiatric treatment. However, since this opinion addressed claimant's condition subsequent to the date of closure it cannot be considered in determining whether claimant's psychiatric condition was stationary at the time of closure. Although Dr. Cotton discussed claimant's history of physical injuries which led to his heightened frustration, anger, depression and anxiety, Dr. Cotton's opinion regarding the medically stationary status of claimant's psychiatric condition did not speak to the time of closure, but rather six days after closure. We decline to infer more from it.

Claimant suffered from anxiety and depressive neuroses due in large part to his inability to find work within his physical restrictions. The proposed psychiatric treatment, although intended merely to maintain claimant's psychological condition through vocational rehabilitation, was also intended in the long run to materially improve claimant's psychiatric condition by enabling claimant to reenter the labor market in some capacity. Therefore, based upon the opinions and recommendations of Dr. Parvaresh, we agree with the Referee that further material improvement of claimant's psychiatric condition could reasonably be expected from psychiatric treatment, or the passage of time.

Since we find that claimant's psychiatric claim was prematurely closed by Determination Order, the issue of whether or not claimant subsequently suffered an aggravation of his psychiatric condition is rendered moot.

ORDER

The Referee's Order on Reconsideration dated June 29, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $850, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $222.

ALBERT W. FRASER, Claimant
Malagon & Moore, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-08059
March 10, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of that portion of Referee Michael Johnson's order which set aside its denial of claimant's medical services claim for further chiropractic treatment of his low back condition and remanded the claim to the employer for acceptance of up to one chiropractic treatment per month. Claimant cross-requests review of that portion of the order which affirmed a

Determination Order award of 20 percent (64 degrees) unscheduled permanent disability for his low back condition. The issues raised on review are medical services and extent of unscheduled permanent disability.

We modify on the medical services issue, and affirm and adopt on the extent of disability issue.

ISSUES

1. Propriety of the employer's prospective denial of further medical services relating to the accepted injury claim.

2. Reasonableness and necessity of further chiropractic treatment for the accepted injury.

FINDINGS OF FACT

Claimant compensably injured his low back on January 12, 1980. The initial diagnosis was a sprain. The claim was accepted for a disabling injury and closed by Determination Order on August 21, 1985, with an award of 20 percent unscheduled permanent disability. Claimant retired in 1983.

Claimant continues to experience low back pain radiating into the right leg. He has treated with Dr. Mang, his treating chiropractor since 1982. Treatment has been palliative, not curative, and has consisted of manipulative therapy approximately once per month. Claimant sees Mang on an "as needed" basis, usually after some type of overexertion. Treatment provides him relief from pain until he overexerts himself again. Relief has lasted up to two months. Treatment is intended to control myofascial pain syndrome in the low back, resulting from the compensable injury. Without treatment, claimant's condition will worsen.

On April 8, 1986, the employer issued the following denial of further treatment:

> "[I]t has been determined that further chiropractic treatment is not considered to be reasonable or necessary as it relates to your industrial injury of January 12, 1980. Therefore, [the employer] will not be responsible for any treatment rendered after April 8, 1986. The giving of these reasons does not preclude there being other reasons."

FINDINGS OF ULTIMATE FACT

Chiropractic treatment provided to claimant was reasonable and necessary to his recovery from the compensable injury.

CONCLUSIONS OF LAW AND OPINION

We agree with the Referee's decision to set aside the employer's denial of further chiropractic treatment. However, we do not agree that the employer's acceptance of medical services should be limited to one chiropractic treatment per month. We modify accordingly.

Prospective Denial

The denial here is prospective; it purports to deny all future treatment relating to the accepted claim for a low back injury. By issuing the denial, the employer is attempting to foreclose claimant prospectively from claiming that any treatment of his compensable low back condition is reasonable and necessary. We have previously held that a prospective denial of medical services relating to an accepted claim, which remains in accepted status, is invalid. Robert M. Bryant, 41 Van Natta 324 (February 23, 1989); Thomas A. Beasley, 37 Van Natta 1514, 1516 (1985). We adhere to that holding here. The denial is void.

We emphasize that a denial of medical services is applicable only to existing claims for those services. A claim for medical services is ordinarily made in the form of a medical bill or a request for authorization of treatment. Billy J. Eubanks, 35 Van Natta 131, 135 (1983). Where, as here, the medical services "denied" have not yet been rendered and no request for authorization of services has been submitted, the denial is meaningless for lack of an existing claim. Such denials do nothing more than dissuade injured workers and health care providers from seeking compensation for further treatment to which the workers are entitled under ORS 656.245(1). That is impermissible.

Reasonable and Necessary

In any event, we are persuaded that the chiropractic treatment provided to claimant is reasonable and necessary. It is undisputed that the treatment is palliative. Nevertheless, medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of an injury for which permanent partial disability has been awarded. ORS 656.245(1); Wetzel v. Goodwin Brothers, 50 Or App 101, 108 (1981). Chiropractic treatment that relieves claimant of pain and enables him to work is reasonable and necessary. West v. SAIF, 74 Or App 317, 320-21 (1985); Jose Ybarra, 40 Van Natta 5, 7 (1988).

Here, the medical evidence is divided. Dr. Mang explained that manipulative therapy is intended to control myofascial pain syndrome in the low back, which is exacerbated by physical activity. He stated that claimant is responding well to therapy and that, without therapy, claimant's condition will worsen, resulting in the need for more frequent treatment and possibly further disability. Claimant agrees that the chiropractic treatment is beneficial. He credibly testified that his pain is relieved after treatment and that relief has lasted up to two months. The pain ordinarily returns when he overexerts himself. He sees Mang approximately once per month, on an "as needed" basis.

Contrary opinions were offered by a panel at Independent Chiropractic Consultants (ICC) and by Dr. Howell, an osteopath. ICC and Howell conducted independent medical examinations in March and October, 1986, respectively. Both opined that further chiropractic treatment is not reasonable and necessary. However, we find Mang's opinion more persuasive. As treating physician, he had the best opportunity to evaluate claimant's condition and his response to treatment; therefore, his opinion is given greater weight. Weiland v. SAIF, 64 Or App 810, 814 (1983). Further, ICC and Howell apparently believed that claimant's symptoms were genuine and that Mang's treatment reduced his symptoms. There is no evidence of

functional overlay or that he is malingering. Claimant received treatment only when needed. We are unable to find that treatment has enabled claimant to work, because he retired in 1983. Nevertheless, we do find that chiropractic treatment has provided substantial, though temporary, relief from pain. We further rely on Mang's report in finding that claimant's condition will worsen without further chiropractic treatment. We find, therefore, that chiropractic treatment is reasonable and necessary to claimant's recovery from the compensable injury. See West v. SAIF, supra. Accordingly, treatment is compensable.

Finally, we note that one treatment per month is well within the guidelines issued by the Workers' Compensation Division, which identify two office visits per month as the usual frequency of medical services. OAR 436-10-040(2)(a).

ORDER

The Referee's order dated May 11, 1987, as reconsidered on June 25, 1987, is modified in part and affirmed in part. The self-insured employer's denial of medical services is set aside. The employer shall pay all medical bills received after the date of the denial unless specifically denied within the period required by law. Claimant's attorney is awarded a reasonable fee of $500 for services rendered on Board review concerning the medical services issue, to be paid by the employer. A client-paid fee, not to exceed $400, is approved.

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

WCB 86-02464
March 10, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Mulder's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 50 percent (160 degrees), as awarded by a Determination Order, to 70 percent (224 degrees). On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings, with the following additions.

Claimant was injured on February 25, 1985, when he slipped and fell from a trailer truck while employed as a diesel truck mechanic. As a result of the fall, claimant injured his low back, seeking medical treatment. Dr. Franks, a neurosurgeon, diagnosed a herniated lumbar disc. On April 18, 1985, claimant underwent a lumbar laminectomy with removal of a disc fragment at L4-5.

On November 20, 1985, claimant was declared medically stationary by Dr. Franks. Claimant, however, continued to have chronic low back pain, which was worsened by bending, lifting, stooping, twisting, and prolonged postures. He is specifically restricted from lifting over 35 pounds. Further, he has substantial difficulties with sitting, riding, and walking. Claimant is capable of working an eight hour day in a light duty position.

At the time of hearing claimant was 57 years old. His

formal education consists of a eleventh grade education. Claimant has had training in the mechanic trade, and possesses skills as a car and truck mechanic. He has performed this trade for 25 years.

Two Determination Orders have issued for claimant's injury. The first, on January 29, 1986, awarded claimant 30 percent (96 degrees) unscheduled permanent partial disability for his low back. The second, on December 12, 1986, awarded an additional 20 percent (64 degrees), for a total of 50 percent (160 degrees) for his low back.

Immediately prior to hearing, the employer at injury offered claimant a modified position as a light duty utility mechanic. Claimant did not accept the position. At the beginning of closing arguments at hearing, the offer was rescinded by the employer.

ULTIMATE FINDINGS OF FACT

Considering his physical impairments and nonmedical factors, claimant is capable of performing light duty work on a full-time basis. As a result of his compensable injury, claimant has suffered permanent impairment in the moderate range.

CONCLUSIONS OF LAW

The Referee concluded that claimant was not permanently totally disabled, as a result of his compensable 1985 low back injury. He specifically found claimant capable of full-time light duty work. Further, he concluded claimant had considerable skills and capabilities. Based on the medical record and vocational rehabilitation reports, he found that claimant was able to sell his services on a regular basis in a hypothetically normal labor market. The Referee also found persuasive, the fact that claimant was offered, and that he refused, a job offer for a specially created position from his employer at injury.

We agree with the Referee that claimant is not entitled to an award of permanent total disability. However, we disagree with that portion of his analysis that finds claimant's refusal of the employer's job offer to be evidence of lack of motivation.

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. Dr. Franks, claimant's long-time treating neurosurgeon, limited claimant to lifting 35 pounds on an occasional basis. Although he opined that claimant was unable to do the work of a heavy duty diesel journeyman truck mechanic, he also concluded that claimant was able to work eight hours a day in a light to sedentary position. He determined that claimant was moderately permanently impaired.

There are no contradicting medical opinions. Consulting neurosurgeon, Dr. Rosenbaum, assessed loss of function regarding the lumbar spine as mildly moderate due to the injury. He also recommended claimant avoid any occupation which would require heavy bending, lifting, or twisting; and which would allow for postural changes.

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. We are persuaded that he possesses sufficient physical capabilities, work experience, and vocational training to achieve a successful return to the work force.

Claimant is at the vocationally advanced age of 57 years old. Further, he has limited formal education. However, these negative social and vocational factors, are offset by claimant's extensive experience and knowledge of the mechanic trade.

Claimant's current vocational rehabilitation counselor, Mr. Alverson, testified that there were light duty positions available that claimant could do, provided claimant could sit or stand at will, and no stooping or bending would be required. Specifically, he felt claimant could do bench work, parking lot attendant, security work, and retail sales. Mr. Ross, another vocational rehabilitation counselor who has worked with claimant, agreed that claimant was employable. Mr. Ross identified several positions in the mechanic's trade which met claimant's physical limitation of working an eight hour day in a light duty job.

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, as the Referee did in this case, 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.

However, in so deciding, it should be noted that we do not rely on the fact that claimant did not accept the proffered position of light-duty utility mechanic. This job was a created position, in that the employer designed a specially built work bench to

Accordingly, claimant has failed to prove by a preponderance of the evidence, entitlement to permanent total disability resulting from the compensable 1985 low back injury.

ORDER

The Referee's order, dated August 4, 1987, is affirmed. A client-paid fee, is approved, not to exceed $160.

HARRY F. JAMES, Claimant
W.D. Bates, Jr., Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-07016
March 10, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Seifert's order that affirmed a Determination Order which had claimant 15 percent (48 degrees) unscheduled permanent disability for a back injury. On review, the sole issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the exception of the first full paragraph of Page 4 of the Opinion and Order, as well as the following paragraph. In addition, we make the following additional findings.

In May 1984, claimant was medically stationary with limitations of no heavy or repetitive lifting or carrying and no creeping, crawling, bending, stooping, or turning. These restrictions were based on subjective complaints, not objective findings.

Claimant has had intermittent difficulties with his back dating back to 1963. At the present time, he is able to do work at a medium level, has a preexisting mild degenerative disc disease in the lumbosacral area of the back, and is not a candidate for surgery.

Claimant's psychological condition predates his industrial injury, and is diagnosed as a histrionic personality disorder, with associated pseudologia fantastica, and psychogenic pain disorder.

FINDINGS OF ULTIMATE FACT

Claimant's psychological condition is not causally related to the industrial injury.

As a result of his compensable low back injury, claimant has incurred permanent impairment in the minimal range.

CONCLUSIONS OF LAW

Claimant argues that his psychological condition is a result of the industrial injury, and thus should be a factor considered in rating his permanent impairment. In support of this contention, he relies on the opinion of Dr. Toobert, his current treating psychologist, who causally relates the psychological condition to claimant's industrial injury. We find, however, Dr. Toobert's opinion to be based on an inaccurate and incomplete history. His opinion is based on a recitation of claimant's subjective complaints which are inconsistent with the medical history in the record. Accordingly, we find his opinion not persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Dr. Gardner and Dr. Holland both opine that claimant's psychological condition predates his industrial injury, and that the psychological condition has no causal relationship to the industrial injury. Unlike Dr. Toobert's opinion, these opinions were based on a complete and accurate medical history. We find the well-reasoned opinions of Drs. Gardner and Holland persuasive. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we find claimant's psychological condition not causally related to his industrial injury. Therefore, it is not a factor considered in rating claimant's unscheduled permanent disability.

In rating the extent of claimant's disability, we consider his permanent physical impairment, including that caused by his disabling pain, and all relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co, 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). We agree with the Referee that a 15 percent unscheduled permanent disability award adequately compensates claimant for his compensable back injury.

ORDER

The Referee's order dated September 28, 1987 is affirmed. A client-paid fee, not to exceed $864, is approved.

CHARLES D. KNOWLTON, Claimant
Jerry Gastineau, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 86-14360
March 10, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of that portion of Referee Brown's order which found that the claim was prematurely closed by the Determination Order dated March 12, 1987. We affirm.

ISSUE

The issue on review is premature closure.

FINDINGS

Claimant, 44 years of age at hearing, was employed as a gas station attendant. On April 11, 1986, he stepped off the gas pump island into a patch of oil. He fell onto his buttocks and left work shortly thereafter to see Dr. Frank, osteopath.

Frank diagnosed a lumbar strain, and released claimant for work on April 23, 1986. He found no permanent physical impairment.

He was released for work on May 9, 1986, although Frank did not feel he was yet medically stationary. On May 13, 1986, claimant returned to Frank because of pain and muscle spasm in his lower back. He diagnosed severe lumbar sacral strain with somatic dysfunction.

Claimant did not show up for an appointment with Frank on July 11, 1986, but came in on July 29, to report severe pain after exertion. Dr. Frank took him off work for two weeks or until he could be examined by Dr. Potter, an orthopedic surgeon. Potter examined him on August 25, 1986. He recommended physical therapy and home traction. He took claimant off work for two weeks.

When claimant again saw Dr. Potter on September 8, 1986, claimant could flex and touch his fingertips to the floor. Potter felt he was much improved and released him to light work. He ordered an EMG study on September 29. This was performed by Dr. Dickerman on October 2, 1986. Dickerman found no evidence of neurological impairment.

On October 13, 1986, Potter released claimant to light/medium work. Claimant then requested Dr. McIlvaine, chiropractor, as his treating physician. On November 21, 1986, McIlvaine reported that claimant had shown little or no improvement and that he could not predict a date when claimant would be medically stationary.

On December 30, 1986, McIlvaine reported that claimant's progress has been "on the unremarkable side." At this time, McIlvaine had treated claimant approximately three times per week through December, 1986.

Claimant was examined by Dr. Versteeg, orthopedic surgeon, on January 9, 1987. Versteeg noted that claimant "feels he has not significantly changed" compared to two or three months ago. Versteeg considered him medically stationary, although he recommended in his report a rehabilitation program. He considered further chiropractic care to be palliative.

On January 18, 1987, McIlvaine reported that claimant was reporting numbness in his right leg and had trouble sitting. He felt any light duty would have to afford the opportunity to change positions as required.

On January 27, 1987, Dr. McIlvaine told the insurer that he did not concur with Dr. Versteeg's report of January 9, 1987.

On February 23, 1987, claimant was examined by the Orthopaedic Consultants. They found claimant to be medically stationary and able to return to his job. They noted that claimant "has not benefited from his chiropractic treatment and has admitted this himself."

After receiving the report of the Orthopaedic consultants, the insurer asked Drs. Potter, Versteeg, and McIlvaine to review the report and indicate agreement or disagreement. Drs. Potter and Versteeg agreed with the report in letters dated February 25 and February 27, 1987. A Determination Order issued on March 12, 1987, awarding claimant temporary total disability for those periods he was off work and no permanent disability.

Dr. McIlvaine referred claimant to Dr. Kho, neurologist, who examined him on October 14, 1987, two days after the

Determination Order issued. Dr. Kho injected a trigger point in the right gluteus muscle. He felt there was marked improvement in the pain in claimant's right leg after this injection. He did not consider claimant medically stationary and recommended instructing claimant on back exercises.

On March 21, Dr. McIlvaine advised the insurer that he disagreed with Versteeg's opinion and submitted a copy of Dr. Kho's report. On March 24, 1987, Dr. Kho released claimant for work as a gas station attendant for 4 hour days.

At hearing, claimant's condition had not changed. He still suffered from low back pain and numbness in the right leg. His activities were significantly reduced. His treatment with Dr. McIlvaine relieved his symptoms for two or three days at a time.

ULTIMATE FINDINGS

Claimant was not medically stationary at the time of closure.

CONCLUSIONS

In determining whether this claim was prematurely closed, we must determine whether claimant's condition was medically stationary on the date of closure. ORS 656.005(17). In making this determination, we may consider evidence that was not available to the Evaluation Division at the time of closure. Schuening v. J.R. Simplot & Company, 84 Or App 622, rev den, 303 Or 590 (1987).

What was available to the Evaluation Division at the time of closure was medical evidence from Drs. Versteeg and the Orthopaedic Consultants that claimant was medically stationary. What was not available was the treating physicians's response to the insurer's request for agreement or disagreement with the Orthopaedic Consultant's report of February 23, 1987. The insurer mailed this to Dr. McIlvaine on March 3, 1987. The letter states in part:

> "[I]f you do not concur or if you would like to comment, please feel welcome to send a narrative report. Should we not hear from you within 14 days, we shall conclude you do not agree with this report." (emphasis added)

The Determination Order issued on March 12, 1987, before the 14 day waiting period expired. Within that 14 day period, Dr. McIlvaine had information from Dr. Kho which should have been considered before the Determination Order issued.

The question is now whether, in light of Dr. Kho's reports and claimant's testimony at hearing; i.e., evidence not available to the Evaluation Division at the time of closure, claimant was medically stationary on March 12, 1987? We find that he was not.

When the Evaluation Division closed this claim, it did not have Dr. McIlvaine's response to the insurer's letter. It did not have Dr. Kho's report, which includes his description of the injection he gave claimant, and which concludes that claimant was not medically stationary on March 14, 1987. There is no basis for the belief that claimant's condition changed between March 12, and March 14.

In determining that claimant was not medically stationary on March 12, 1987, we must weigh the opinions of Drs. McIlvaine and Kho against the opinions of Dr. Versteeg and the Orthopaedic Consultants. When the medical evidence is in conflict, we often give more weight to the opinion of the treating physician. Taylor v. SAIF, 74 Or App 783 (1985). We conclude, based on the opinions of Drs. Kho and McIlvaine, that claimant was not medically stationary on March 12, 1987; therefore the claim was prematurely closed.

ORDER

The Referee's order dated June 2, 1987, as reconsidered July 21, 1987, is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $400, to be paid by the insurer. A client-paid fee, not to exceed $374, is approved.

EVERETT L. McDONALD, Claimant
Roll, Westmoreland, et al., Claimant's Attorneys
Thomas Johnson (SAIF), Defense Attorney

WCB 86-05905
March 10, 1989
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of that portion of Referee Podnar's order that awarded claimant temporary total disability benefits. SAIF argues that claimant is not entitled to any temporary total or partial disability benefits inasmuch as he allegedly suffered no wage loss. Claimant cross-requests review of those portions of the Referee's order that: (1) determined his rate of temporary total disability benefits should be based on a monthly wage of $479.17; (2) authorized SAIF to offset up to $6,621.28 in allegedly overpaid temporary disability benefits; and (3) declined to assess a penalty and attorney fee for SAIF's allegedly unreasonable refusal to pay the correct rate of temporary total disability.

We modify the Referee's award of temporary total disability benefits and reverse his authorization of an offset.

ISSUES

1. Whether claimant is entitled to temporary disability benefits.

2. If claimant is entitled to temporary disability benefits, the correct rate of those benefits.

3. Whether SAIF is entitled to an offset for its allegedly overpaid temporary total disability benefits.

4. Whether the assessment of a penalty and attorney fee is appropriate.

FINDINGS OF FACT

Claimant and his wife entered into a contract with the employer in June 1985. The contract referred to claimant and his wife as the "CONTRACTOR." Under the terms of the contract, the "CONTRACTOR" agreed to perform certain janitorial services from July 1985 through June 1986 for $11,500. The $11,500 was to be paid monthly at $958.33. The contract specifically provided that the employer would provide workers' compensation coverage for the "CONTRACTOR."

Claimant performed approximately 80 percent of the janitorial services, although his wife, who was also otherwise employed, assisted. Claimant's actual hours of work varied from time to time. On August 2, 1985, claimant compensably injured his low back and was unable to continue working. Consequently, his wife, who had lost her regular job, began to perform such of the janitorial services as she was able. Claimant hired another individual to perform a portion of the services under the contract. The employer continued to pay the "CONTRACTOR" its full monthly wage. In addition, SAIF began paying claimant temporary total disability benefits from the date of his compensable injury. Benefits were calculated based on a preinjury monthly wage of $958.33.

After claimant was released to light-duty work on October 21, 1985, he began to help his wife a few hours a day. Accordingly, SAIF ceased paying temporary total disability benefits and began paying temporary partial disability, apparently based in some fashion on claimant's hours of work. That continued until February 20, 1986, when SAIF stopped paying temporary partial disability benefits.

On March 31, 1986, claimant and his wife informed the employer that they could no longer fulfill their contractual obligations. Consequently, on April 1, 1986, the employer ceased paying the "CONTRACTOR" under the terms of the contract and SAIF resumed the payment of temporary total disability benefits. That continued until November 3, 1986, when SAIF reduced claimant's temporary total disability benefits by one-half on the theory that he was entitled to only one-half the wages under the contract. Further, SAIF informed claimant that it had allegedly overpaid $6,261.28 in temporary disability benefits, adding:

> "when this file is submitted to the Workers' Compensation Department requesting issuance of a Determination Order, we will also request [that] any overpayment of temporary total disability or temporary partial disability be allowed as a deduction from any award of permanent partial disability."

CONCLUSIONS OF LAW

The Referee found that claimant was entitled to temporary total disability, less time worked, based upon a monthly wage of $479.17 from August 2, 1985 until proper termination. The Referee also authorized SAIF to offset up to "$6,621.28 [sic]" in allegedly overpaid temporary disability benefits. We modify and reverse.

Temporary Disability

An individual is totally disabled, for a temporary period, if a worker has lost, "including preexisting disability, the use or function of any scheduled or unscheduled portion of the body which incapacitates the worker from regularly performing work at a gainful and suitable occupation. Total disability describes the extent of disability that a worker may suffer." Cutright v. Weyerhaeuser, 299 Or 290, 295 (1985). There is no question that claimant, here, was totally disabled from the date of injury through October 21, 1987 when claimant was released to light-duty work.

The rate of payment of benefits is based on claimant's preinjury earnings and is reduced by any earnings he has during the temporary total disability period. Fazzolari v. United Beer Distributors, 91 Or App 592, aff'd on recon 93 Or App 102 rev den, 307 Or 236 (1988); Fink v. Metropolitan Public Defender, 67 Or App 79 (1984). ORS 656.210(1) provides that: "For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the director, by rule, may prescribe methods for establishing the worker's weekly wage." The director has prescribed no method applicable to the case at bar. Thus, we must determine the claimant's preinjury wage "to coincide with the objectives of the Workers' Compensation Law." Former OAR 436-60-020(4)(o).

In calculating claimant's preinjury wage, we must look to the wages he earned by his labor for the employer, not to his total income under the contract, for it was the capacity to generate that income that was lost by virtue of the injury. The unrebutted evidence established that claimant's labor satisfied 80 percent of the obligations he and his wife had assumed under the contract. Therefore, his preinjury earnings, upon which his benefit must be calculated, were 80 percent of the annual contract amount divided by 52.

The Referee erred in concluding that claimant was entitled to benefits based on 50 percent of the contract amount. The Referee's conclusion was based on the assumption that because claimant was jointly and severally liable under the contract with his wife, the income should be attributed equally to the two. This is error. This was a contract which did not prescribe the hours to be worked by either claimant or his wife; indeed, it did not require either of them to personally perform any service under the contract. Instead, it permitted the contractor to hire additional persons to perform the required services.

Under these circumstances, we must apportion preinjury income under the contract among the persons actually performing work under the contract. Had the claimant employed a third individual to do the manual work under the contract and injured himself in the course of inspecting or supervising the work, we would not credit him with preinjury earnings even approaching one-half of the contract amount. In this case, where claimant actually did 80 percent of the work under the contract, he should be credited with that share of the total contract amount.

We also reject SAIF's contention that claimant is entitled to no temporary disability benefits -- total or partial -- because he and his wife lost no earnings by virtue of his disability. Workers' compensation benefits are calculated in accordance with loss of earnings -- not loss of income. See Dale R. Heinecke, 40 Van Natta 1063 (1988). We do not deny temporary disability benefits to an individual because he or she receives income by gift or under an insurance program, public or private, during the period of temporary disability. Indeed, payments to disabled workers are in addition to, not an offset against, benefits. Former OAR 436-60-020(3). We cannot, therefore, deny claimant benefits even had it been established that claimant's wife was able to maintain the household income by increasing her labors under the contract. To do so, would require claimant's wife to subsidize the insurer by giving up either leisure or other remunerative work.

In any event, the facts in this case do not suggest that claimant's wife was able to maintain the household income. First, claimant and his wife had to hire an individual to work as needed to perform the tasks the wife was unable to perform; that individual worked for a period of hours on at least ten occasions. Second, a relative of claimant and his wife assisted them without compensation. Finally, the wife, who had been employed at Red Cross when the contract was executed, did not take new work when she lost that job. Therefore, even if we were to hold that a claimant is not entitled to temporary disability benefits if he does not experience a drop in household income, we could not make the predicate finding that would enable us to conclude that no benefits are do on this record.

Claimant is therefore entitled to temporary total disability benefits calculated as discussed above until October 21, 1985. From October 21, 1985 through the date claimant and his wife sought to "resign" under the contract, claimant is due temporary partial disability payments based on the preinjury wage calculated as discussed above reduced in accordance with ORS 656.212.

Claimant is also entitled to benefits beginning February 20, 1986 when SAIF unilaterally terminated benefits on the ground that it was paying claimant the full contract amount. An insurer must continue to pay temporary disability benefits unless a worker has become medically stationary, and has been released to return to work or has returned to regular work. ORS 656.268(1) and (2); Fazzolari v. United Beer Distributors, supra; see also Volk v. SAIF, 73 Or App 643, 646 (1985). Here, on February 20, 1986, claimant was neither medically stationary, released to return to regular work, nor had he returned to regular work. Therefore, SAIF was not at liberty to unilaterally terminate claimant's temporary partial disability benefits.

We turn to the period beginning April 1, 1986. On March 31, 1986, claimant and his wife attempted to rescind their contract with the employer, stating:

> "This is to inform the [employer] of our resignation as of this date. Because of the physical condition of [claimant], we are no longer able to continue in the position of school custodian."

As a result, on April 1, 1986, the employer ceased paying the "CONTRACTOR" its wages under the contract and SAIF resumed payment of claimant's temporary total disability benefits. We conclude that SAIF's payment of temporary disability benefits was proper, inasmuch as claimant ceased all work under the contract because his physician instructed him to discontinue that work. Again, however, the benefits should have been calculated based on preinjury earnings calculated as above.

Penalty and Attorney Fee

Given the unusual circumstances of this case, we do not find that SAIF acted unreasonably in calculating the rate of temporary disability payments. We do, however, conclude that there was no reasonable basis for SAIF's conduct in unilaterally terminating claimant's temporary partial disability benefits. Therefore, the assessment of a penalty and attorney fee is appropriate.

Offset

Lastly, we find that the Referee was incorrect in authorizing SAIF's request for a $6,621.28 offset of allegedly overpaid temporary disability benefits. Our decision, on the merits, requires recomputation of benefits and thus of the amount of any overpayment by the insurer. Under these circumstances, offset authorization at this time is premature.

Former ORS 656.268(4) provides, inter alia:

> "Any determination under this subsection may include necessary adjustments in compensation paid or payable prior to the determination, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards."

As can be seen, the statute envisions that an employer or insurer may obtain authorization for adjustments in compensation, i.e., the recovery of an overpayment, by way of the Evaluation Division's issuance of a Determination Order. In this particular case, it is preferable that an offset, if any, be authorized pursuant to closure. Until the Evaluation Division issues a Determination Order and determines the amount of claimant's temporary disability and permanent partial disability compensation, if any, SAIF's total obligation, and thus the amount of any offset, is not known.

Accordingly, although we recognize that there is authority to indicate that a Referee or the Board may authorize an offset, Forney, supra and Petshow v. Portland Bottling Company, 62 Or App 614, rev den 296 Or 350 (1984), we decline to do so, here, in order to allow the Evaluation Division to initially determine the matter.

For the above reasons, we do not authorize SAIF's request for a $6,621.28 offset in allegedly overpaid temporary disability compensation.

ORDER

The Referee's order dated December 19, 1986 is modified, reversed, and affirmed. In lieu of the Referee's award of temporary disability benefits, claimant is awarded: (1) temporary total disability benefits from August 2, 1985, through October 21, 1985; (2) temporary partial disability benefits from October 22, 1985, through March 31, 1986; and (3) temporary total disability benefits from April 1, 1986, until proper termination according to law. The Board reverses those portions of the Referee's order that: (1) authorized SAIF's $6,261.28 offset of temporary total disability; and (2) declined to assess a penalty and attorney fee for SAIF's impermissible unilateral termination of claimant's benefits. Accordingly, claimant is awarded a penalty equal to 25 percent of the amount of temporary disability compensation due, as described in this order, on February 20, 1986. All remaining portions of the Referee's order are affirmed.

Claimant's attorney is awarded: (1) an approved fee,

payable out of claimant's compensation, equal to 25 percent of the increased compensation resulting from this order, not to exceed $3,800; (2) a $300 penalty-related assessed fee, payable by SAIF; and (2) a $600 assessed fee, payable by SAIF, for services on Board review.

Board Member Ferris, dissenting:

I dissent and would reverse that portion of the Referee's order that awarded claimant temporary disability benefits.

Entitlement to Temporary Disability

In Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), the Oregon Supreme Court addressed the issue of whether a "retired" worker who suffers an aggravation is entitled to temporary disability benefits. In so doing, the Court stated:

> "A claim for temporary total disability benefits in the absence of wage loss seeks a remedy where there is no damage.
>
> "* * * * *.
>
> "Temporary disability benefits are maintenance benefits intended to provide support and help replace lost income during the healing or recovery process." (Emphasis added).

299 Or at 302.

Here, claimant lost no wages until April 1, 1986. That is, he and his wife, as the "CONTRACTOR," continued to receive their full wage under the terms of the contract through March 31, 1986. Accordingly, pursuant to Cutright, supra, I find that claimant was not entitled to temporary disability benefits until April 1, 1986; i.e., the date in which he began to experience wage loss.

Although the majority gives lip service to Cutright, it ignores the above quoted language from that case. Cutright unequivocally announced that temporary disability benefits were intended to provide a remedy for lost wages. Here, regardless of the majority's finding that claimant was "totally disabled from the date of his injury through October 21, 1987," he lost no wages until April 1, 1986. He, therefore, is not entitled to temporary disability benefits until that date.

Following the above reasoning, I further disagree with the majority's award of temporary partial disability benefits from February 20 through March 31, 1986. Regardless of whether SAIF unilaterally terminated claimant's benefits during that period, see Volk v. SAIF, 73 Or App 643 (1985); ORS 656.268(1) & (2), the fact remains that, pursuant to Cutright, claimant was not entitled to temporary disability benefits until after March 31, 1986. SAIF could not, therefore, have impermissibly unilaterally terminated claimant's temporary partial disability benefits, when it had no obligation in the first place to pay such benefits.

Rate of Temporary Disability

As to the correct rate of temporary total disability payable after April 1, 1986, SAIF apparently resumed paying claimant's benefits on the basis of the monthly wage of $958.33 under the contract. On this record, I agree with the Referee and find that inasmuch as claimant and his wife were jointly responsible for performing the janitorial services, the rate of claimant's temporary total disability benefits should be based on one-half the monthly wage under the contract; that is, $479.17 a month.

Despite claimant's estimate that his wife performed approximately 20 percent of the janitorial services, the fact remains that he and his wife jointly performed the janitorial services. Claimant understood that he was no more responsible for performing those services than was his wife. (Tr. 40).

Accordingly, on this record, I agree with the Referee's analysis concerning the correct rate of claimant's temporary total disability benefits.

Offset

The Referee did not err in authorizing SAIF's request for an offset. As the majority recognizes, such an offset is permissible under existing law. Forney v. Western States Plywood, 66 Or App 155, aff'd on other grounds, 297 or 628 (1984); Petshow v. Portland Bottling Company, 62 Or App 614, rev den 296 Or 350 (1984). In Forney, the court acknowledged that former ORS 656.268(4) did not provide the only circumstance in which offsets may be authorized. 66 Or App at 159. Moreover, in Petshow, the court affirmatively held that the Referee did not err in authorizing the offset, even though, as here, the Evaluation Division had not initially decided the matter. 62 Or App at 618.

Accordingly, I find no error in the Referee's authorization of SAIF's request for an offset.

SAMMY D. MURPHY, Claimant
Vick & Gutzler, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 85-14939
March 10, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Quillinan's order that: (1) awarded 10 percent (32 degrees) unscheduled permanent disability for a low back condition, in lieu of a Determination Order awarding no permanent disability; and (2) upheld the self-insured employer's denial of further chiropractic treatment in excess of the Medical Director's guidelines. The employer cross-requests review, contending that claimant has no permanent partial disability and is not entitled to further chiropractic treatment.

On review, the issues are:

(1) Extent of Permanent Partial Disability.

(2) Medical Services

(A) Whether any further chiropractic care is reasonable and necessary.

(B) Propriety of the Referee's ruling insofar as it addressed frequency of medical services.

(C) Whether claimant is entitled to chiropractic care in excess of the Medical Director's guidelines.

We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the finding that claimant "was laid off in about September 1986." We make the following additional findings.

At the time of his October 1984 injury, claimant was working as a fork lift driver. He returned to that job following his injury and continued to work as a fork lift operator until he was terminated in July 1986. Although claimant was able to perform this job, he experienced chronic low back pain at the end of the work day and acute symptomatic flare-ups associated with heavy activity.

At the time the employer issued its March 1986 denial, claimant was treating with Dr. Llewellyn on a regular, twice a month basis, with additional treatments for symptomatic flare-ups. Claimant continued that treatment schedule up to the time of hearing.

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury has predisposed him to future injury from strenuous and heavy activity, resulting in minimal permanent impairment.

The issue of "frequency of treatment" was not raised at hearing.

CONCLUSIONS OF LAW AND OPINION

Permanent Partial Disability

We adopt the Referee's opinion on this issue.

Medical Services

The Referee concluded that claimant was entitled to further palliative chiropractic care. However, she limited him to two treatments per month after October 2, 1985, the date he became medically stationary.

On review, the employer contends that no further chiropractic treatment is reasonable and necessary. Claimant contends that the Referee's ruling was procedurally improper insofar as it addressed issues not raised by the parties. In the alternative, claimant challanges the merits of the ruling on the ground that he is entitled to palliative chiropractic care in excess of the guidelines.

We affirm the Referee's conclusion that further chiropractic care after October 2, 1985, is reasonable and necessary.

Turning to the propriety of the Referee's frequency

limitation, claimant contends that the ruling improperly covers outstanding claims for post-October 1985 medical services that were submitted more than 60 days prior to the March 1986 denial. Claimant argues that his entitlement to those services was not, and could not have been raised at hearing because claims for those services were "impliedly" accepted by virtue of the employer's failure to deny them within 60 days of receipt. Claimant also argues that the Referee's ruling was improper because it addressed a "frequency of treatment" issue not raised at hearing.

We disagree with claimant's position that the Referee's ruling improperly covers medical services claims accepted by the employer. Acceptance of a claim cannot be inferred from a failure to process the claim in a timely manner. See Kemp v. Workers' Compensation Department, 65 Or App 659 (1983), rev den 296 Or 638, dec mod 67 Or App 270, rev den 297 Or 227 (1984); Velma C. Wilch, 40 Van Natta 997 (1988). To the contrary, the failure to do so creates a "de facto" denial, not an acceptance. See Syphers v. K-W Logging, Inc., 51 Or App 769 (1981). Where an insurer or self-insured employer fails to process a claim in a timely manner, the appropriate sanction is a penalty and attorney fee, not a forced acceptance of the claim.

However, we agree that the Referee erred in addressing the "frequency of treatment" issue. The employer's denial was for all further treatment, not treatment in excess of the guidelines. Furthermore, neither party raised the specific issue of frequency of treatment at hearing. Therefore, we conclude that the Referee's frequency limitation was procedurally improper. Accordingly, we conclude that the Referee should have set aside the employer's denial in its entirety.

Assessed Fee on Board Review

Claimant is entitled to an assessed fee on Board review for prevailing over the employer's cross-request to the extent that request required his attorney to respond to issues that otherwise would not have been before the Board. ORS 656.382(2); OAR 438-15-070; Alfred P. Adent, 40 Van Natta 1677, 1819 (1988). Accord Teel v. Weyerhaeuser Co., 294 Or 588, 590 (1983); Saiville v. EBI Companies, 81 Or App 469, 473 (1986); Travis v. Liberty Mutual Ins., 79 Or App 126 (1986).

Here, the extent issue raised in the employer's cross-request was otherwise before the Board as a result of claimant's request for an increase in his current permanent disability award. See Frances Gentry, 40 Van Natta 1697, 1701 (1988). However, the cross-request also raised the issue of entitlement to any further chiropractic care, which is separate from and broader than the frequency of treatment issue raised by claimant. Accordingly, claimant is entitled to an assessed fee for prevailing against the employer's cross-request on the medical services issue.

ORDER

The Referee's order dated February 27, 1987 is affirmed in part and reversed in part. The Referee's limitation of chiropractic treatment to two per month is reversed. The employer's denial of March 6, 1986 is set aside in its entirety. The remainder of the order is affirmed as supplemented. Claimant's attorney is awarded a $500 assessed fee for services on Board review regarding the medical services issue, including the employer's cross-request on that issue.

EUGENE W. MURR, Claimant
Velure & Yates, Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 87-00698
March 10, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of those portions of Referee Myers' order that: (1) set aside its partial denial of claimant's low back condition; and (2) found that claimant's right knee injury claim was prematurely closed. We affirm.

ISSUES

Whether claimant's low back condition is a compensable sequelae of his right knee injury. If so, whether claimant's claim was prematurely closed.

FINDINGS OF FACT

Claimant injured his low back in 1975 while at work. The condition was diagnosed as a lumbosacral strain and contusion with a transitional lumbosacral vertebra. The claim was closed by Determination Order with no award for permanent disability.

In 1984 claimant sustained a compensable left knee laceration which resulted in no permanent residual disability.

On January 23, 1985, claimant slipped on snow and ice at work and compensably injured his right knee. Dr. Jones, orthopedic surgeon, became the treating physician and diagnosed an acute tear of the anterior cruciate ligament.

Dr. Jones performed three right knee surgeries. On January 30, 1985, he performed: (1) an anterior cruciate reconstruction, intra-articular with the central third of the patella, and extra-articular, Ellison in type; (2) a total lateral meniscectomy; and (3) a lateral retinacular release. By February 1986, however, the pain and clicking in claimant's right knee had become a significant problem again. Therefore, on March 25, 1986, Dr. Jones performed: (1) a lysis of the intra-articular adhesions (transarthroscopic); and (2) a removal of the postarolateral screw. Subsequent to this second surgery, the pain and clicking in claimant's right knee continued. On August 21, 1986, Dr. Jones performed claimant's final right knee surgery, which included: (1) arthroscopy with excision of a regenerated posterior horn of the lateral meniscus; (2) a notchplasty; and (3) the removal of a staple.

In September 1986 claimant was very pleased with the results of the third surgery and had almost full flexion of the right knee.

Prior to claimant's third surgery, he was unable to fully extend his knee due to the pain and clicking sensation. As a result, he developed a significant limp.

Between claimant's second and third knee surgeries, his preexisting L4-5 spondylolisthesis condition became symptomatic.

On November 19, 1986, claimant was admitted to the hospital for treatment of severe low back pain.

On December 8, 1986, Dr. Jones diagnosed a narrowed disc space at L4-5 with osteoblastic changes on both endplates and anterior traction spurs with a very minimal Grade I spondylolisthesis. On December 15, 1986, the Orthopaedic Consultants diagnosed chronic L4-5 disc degeneration and rated the right knee impairment as mildly moderate. Dr. Schroeder, orthopedic surgeon, also diagnosed spondylolysis at L4 of longstanding duration.

On January 5, 1987, the insurer denied the compensability of and responsibility for claimant's low back condition.

By January 13, 1987, claimant's knee pain had significantly decreased. He no longer had any catching or locking. He continued, however to have significant quad atrophy. His range of motion was from -3 to 125 degrees. Because his rehabilitation was hindered by his low back pain, he continued to have significant right leg muscle atrophy.

On January 16, 1987, Dr. Jones stated that claimant would not be released to work until the back pain had resolved.

On May 13, 1987, Dr. Jones reported that claimant's knee was medically stationary. Although claimant's right knee was considerably weaker than the left, it was not possible to further strengthen the right knee given claimant's low back pain. His knee condition precluded heavy work as well as standing for long periods of walking on uneven ground.

On July 9, 1987, a Determination Order awarded claimant 20 percent scheduled permanent disability for loss of function of his right knee.

As a result of claimant's right knee injury, he developed an altered gait syndrome. That altered gait syndrome, in turn, aggravated claimant's preexisting spondylolisthesis at L4-5, to the extent that it became symptomatic and required medical services.

CONCLUSIONS OF LAW

The Referee believed that claimant's altered gait syndrome, which resulted from the compensable right knee injury, caused his preexisting spondylolysis at L4-5 to become symptomatic. Therefore, he concluded that claimant had sustained his burden of proof and found his low back condition compensable. We agree.

In exercising de novo review we generally defer to the Referee's determination of credibility, when it is based on the Referee's opportunity to observe the witnesses. Humphrey v. SAIF, 58 Or App 360, 363 (1982). Although the Referee noted that claimant was not a particularly good historian, he found claimant to be a credible witness based on his close and careful observation of his demeanor at hearing. After reviewing the record, we agree with the Referee's assessment of claimant's credibility.

Claimant's right knee disability is the result of an accident and not an occupational disease. Therefore, claimant need not prove that the injury caused a worsening of his preexisting spondylolysis condition in order to establish a compensable low back claim. See Jameson v. SAIF, 63 Or App 553, 555 (1983), citing Weller v. Union Carbide, 288 Or 27 (1979). In order to establish the compensability of the spondylolysis condition, claimant need only

show that the compensable right knee injury caused the spondylolysis to become symptomatic. Grace v. SAIF, 76 Or App 511, 517 (1985).

When the medical evidence is divided, we have tended to give greater weight to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In the present case, the medical evidence is divided.

Dr. Jones has been claimant's treating orthopedic surgeon for his right knee and back conditions since the date of injury in January 1985. He has witnessed the longterm effect of claimant's pain and lack of full knee extension on his gait. He performed all three knee surgeries and saw the improvement in claimant's knee condition following the third surgery in August 1986. Of all the physicians involved in this case, he is the most familiar with claimant's condition.

When claimant was admitted to the hospital in November 1986 with severe low back pain, Dr. Jones "assume[d] that his back pain was secondary to his longterm significant altered gait syndrome." On December 8, 1986, he clarified his opinion by stating that:

> "I believe [claimant] had a Grade I spondylolisthesis which was present prior to his knee injury; however, I feel his gait was so altered by his need to walk with a flexed knee that it flared his back and caused mechanical back pain."

On January 13, 1986, Dr. Jones reiterated his belief that claimant's limp was the cause of his low back symptoms, stating:

> "Again, . . . I feel his back pain is related to his knee injury in the respect that although he had preexisting degenerative disease in his spine, his walking with a severely flexed knee did aggravate the low back discomfort. Let me state here that I am not a fan of the altered gait syndrome. I find it very difficult in most instances to equate disabling discomfort to an altered gait. However, in this particular case, I believe it is reasonable to establish the correlation between the two because he was walking with such a severe flexed knee for an extended period of time and did have pre-existing back discomfort."

Claimant was also examined by the Orthopaedic Consultants and Drs. Schroeder and Langston, both orthopedic surgeons.

Dr. Schroeder believed that it was possible that claimant's altered gait was a contributing factor to his low back pain but had no firm opinion on causation, stating instead that its origin was "somewhat obscure." Therefore, we discount his opinion.

The Consultants opined that claimant had chronic disc degeneration at the L4-L5 level but felt that those degenerative changes were present at the time of his injury on January 23, 1985.

Since claimant's physical activity had been considerably reduced as a result of his knee injury, the Consultants also felt that his activity level had not materially affected the degenerative changes in his low back. Because the Consultants did not have the opportunity to observe claimant's altered gait over the long period of time prior to his third surgery in November 1986 and because they did not assess the effect that claimant's severe altered gait had on his low back condition, we find their opinion unpersuasive as well.

For reasons similar to the above, we do not accord Dr. Langston's opinion that claimant's low back problem was unrelated to his knee injury significant weight.

Based on the record as a whole, we conclude that claimant's low back condition is a compensable sequelae of his right knee injury. Therefore, we also agree with the Referee that the Determination Order prematurely closed the claim. The medical reports clearly indicate that the low back condition requires further treatment and that the knee condition is likely to improve if the back condition improves. Accordingly, the Determination Order is set aside as premature.

ORDER

The Referee's order dated November 10, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer.

WILLIAM D. REMIOR, Claimant
Malagon & Moore, Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 86-17790
March 10, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Gruber's order that: (1) found that claimant was not entitled to additional interim compensation benefits; and (2) declined to assess penalties and attorney fees for the SAIF Corporation's alleged unreasonable failure to pay these additional benefits. We reverse on the merits of the interim compensation issue and affirm with regard to penalties and attorney fees.

ISSUES

1. Interim Compensation.

2. Penalties and Attorney Fees.

FINDINGS OF FACT

Claimant compensably injured his back on November 17, 1986. He continued to work until November 20, 1986, when he left work to seek medical treatment. Due to the injury, he did not work on November 20 and November 21. The next two days, November 22 and 23, were his scheduled days off. He remained off work for the period November 24 through November 30, 1986.

On November 25, claimant was examined by Dr. Butdorf, who diagnosed a back strain and prescribed medication. A follow-up examination was scheduled for November 28. On November 28, Dr. Butdorf indicated that claimant could return to work on December 1, working half days for the first two days "to help build up stamina of muscles."

On December 1, 1986, claimant attempted to return to half-time work and found he was unable to do so. He sought additional medical treatment from Dr. Gorman, chiropractor. On December 16, 1986, Dr. Gorman notified SAIF that he was claimant's treating physician and that claimant was presently unable to return to work.

SAIF paid claimant interim compensation from November 23 through December 2, 1986. SAIF did not pay interim compensation for November 20 and 21 and for December 3 through December 15, 1986.

FINDINGS OF ULTIMATE FACT

Dr. Butdorf's November 28, 1986 release to work was not a full release to regular work but, instead, was a trial release.

Claimant was not medically stationary as of December 3, 1986.

CONCLUSIONS OF LAW AND OPINION

Interim Compensation

The Referee stated that an injured worker's eligibility for interim compensation terminates upon return to regular work, release by the treating physician for regular work, or issuance of a Determination Order declaring the worker to be medically stationary. He then found that Dr. Butdorf's November 28, 1986 report contained a release for full-time, regular work as of December 3, 1986. He, therefore, concluded that SAIF properly terminated interim compensation benefits as of December 3, 1986. We do not agree.

We find that the Referee incorrectly characterized Dr. Butdorf's report as a release to full-time, regular work. We addressed a similar release in Wayne A. Volk, 36 Van Natta 1083 (1984). In Volk, the claimant's physician released him to regular work stating that, after claimant the had worked for five or six weeks, he would expect him to be stationary. SAIF subsequently discontinued payment of temporary benefits. We treated the physician's release as a "trial release" rather than a full release. We concluded that the claimant was entitled to continued time loss benefits beyond the date of the trial release. We also held that penalties were not warranted as SAIF had not acted unreasonably. The Court of Appeals reversed on the penalty issue only. Volk v. SAIF, 73 Or App 643 (1985).

Here, Dr. Butdorf released claimant to half-day work for two days followed by full-time work. He explained that the short days were necessary to allow claimant to build up muscle stamina. The release to full duty was prospective. It was effectively conditional on claimant satisfactorily performing modified work. Claimant was subsequently unable to perform even the modified work. We conclude that the release was to a trial period of modified work, and that it did not become a full release with the passage of time. SAIF improperly terminated claimant's interim benefits.

We also note a second reason to reverse the Referee's order. Subsequent to issuance of that order, the Court of Appeals decided Fazzolari v. United Beer Distributors, 91 Or App 592, on recon 93 Or App 103, rev den 307 Or 236 (1988). In the process of interpreting ORS 656.268, the court stated that an insurer or

employer is not permitted to unilaterally terminate temporary disability benefits unless the injured worker is both medically stationary and released for work. Id. at 595.

Consequently, even assuming that Dr. Butdorf's release was to regular work, SAIF was nevertheless precluded from terminating claimant's temporary benefits until claimant became medically stationary. There is no evidence that claimant was medically stationary at any time between December 3 and December 16, 1986. Therefore, SAIF was not permitted to terminate claimant's interim benefits between those dates.

Moreover, our decision establishes that claimant was totally disabled between November 20 and December 16, 1986. Because this period of disability extends for 14 days or more, claimant is also entitled to disability benefits for the first three days of his disability. ORS 656.214(3). Our order will reflect this fact.

Penalties and Attorney Fees

In Fazzolari, supra, the court interpreted ORS 656.268 as permitting termination of temporary disability benefits only when claimant has returned to work or is both medically stationary and released to regular work. Prior to the court's decision in Fazzolari, we had held that an insurer or employer was permitted to terminate time loss benefits where claimant had returned to work, had been released by his attending physician to return to work, or had been declared medically stationary by Determination Order. See, e.g. Volk, supra. Because the court's decision is Fazzolari was issued after SAIF terminated claimant's benefits, we will not find SAIF's conduct unreasonable on that ground.

We also find that SAIF's interpretation of Dr. Butdorf's release as a release to regular work was not unreasonable. We note in this regard that Dr. Butdorf's release was not without ambiguity. At one point in his report he checks a box indicating that claimant may return to work without restrictions as of December 1, 1986. Later in the report he qualifies that by stating that claimant should work only half-days for the first two days. While we have interpreted that release as a trial release, SAIF's interpretation of the release as a full release commencing December 3, 1986 is not unreasonable. Cf. Volk v. SAIF, supra, 73 Or App at 646 (SAIF clearly misinterprets physician's medically stationary "prediction").

ORDER

The Referee's order dated July 1, 1987 is reversed in part and affirmed in part. Claimant is awarded interim compensation for the period from November 20, 1986 through December 15, 1986, less amounts previously paid. Claimant's attorney is awarded an approved fee of 25 percent of the increased interim benefits created by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

GRANT W. NAIRN, Claimant
Allen, Stortz, et al., Claimant's Attorneys
Daryll E. Klein, Defense Attorney

WCB 87-12276
March 13, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Myzak's order that upheld the insurer's denial of medical services relating to his low back. We reverse.

ISSUES

1. Whether the insurer may assert the last injurious exposure rule as a defense in this case.

2. Whether claimant has proven that his compensable 1979 injury is a material contributing cause of his current need for medical services.

FINDINGS OF FACT

Claimant originally injured his low back in August 1972 when he lifted a heavy object in the course of his employment with Skyline Mobile Homes (Skyline). He sought treatment from Dr. Hanson, a general practitioner, for complaints of low back and right leg pain. Dr. Hanson hospitalized claimant for about 10 days, but claimant's condition failed to improve significantly. Dr. Hanson suspected a herniated lumbar disc and referred claimant to Dr. Cohen, an orthopedist. Dr. Cohen prescribed further conservative treatment and claimant's condition improved. Claimant filed a claim for his injury which was accepted by Skyline's carrier. Claimant's claim was closed without an award for permanent disability at some time not specified in the record. Claimant returned to work at Skyline and continued in that capacity for about a year. During that period, he experienced periodic nondisabling bouts of low back pain.

Claimant began working for another employer, Sunshine Dairy (Sunshine), in approximately mid 1974. This job frequently involved repetitive and heavy lifting and claimant continued to experience periodic nondisabling bouts of low back pain. Then, on March 27, 1979, claimant experienced a severe exacerbation of low back pain after an incident at work in which the wheels of a heavily loaded handtruck he was pushing suddenly became lodged in a rut in the floor. He again sought treatment from Dr. Hanson. Dr. Hanson treated claimant conservatively and released him for regular work on April 14, 1979. Claimant returned to work at Sunshine and continued in that capacity until the business shut down in December 1979. Sunshine's carrier accepted claimant's claim for increased low back as a new injury and the claim was closed by Determination Order in July 1979 with no award for permanent disability.

After leaving Sunshine, claimant was unemployed except for brief periods when he dealt cards at a gambling establishment. He lived off of savings and his girlfriend's earnings. Beginning in 1981 or 1982, he experienced a gradual increase in low back and right leg pain. He sought treatment in January 1984 from Dr. Blake, an orthopedic surgeon. Dr. Blake diagnosed "chronic recurring lumbosacral spine pain secondary to disc disease at L5, S1" and prescribed conservative treatment. Claimant's pain continued to worsen and in April 1987 he sought treatment from

Dr. Poulson, an orthopedic surgeon. Dr. Poulson ordered a CT scan and myelogram which revealed a large disc rupture at L4-5. He recommended that claimant undergo surgery.

On July 27, 1987, Sunshine's insurer issued a denial in which it asserted that there was no causal relation between claimant's 1979 injury and his ruptured disc. Claimant requested a hearing on the denial on August 7, 1987 and raised a number of issues including medical services and aggravation. Claimant also requested own motion relief. The Board issued an order on November 12, 1987 postponing action on the own motion claim pending resolution of this proceeding. At the beginning of the hearing, claimant's attorney indicated that claimant's entitlement to medical services was the only substantive issue, thus waiving the issue of aggravation. Claimant filed no claim with his first employer, Skyline, or its carrier and neither was joined by Sunshine's carrier as a party to this proceeding.

FINDING OF ULTIMATE FACT

Claimant's 1979 industrial injury is a material contributing cause of his current need for medical services.

CONCLUSIONS OF LAW

Whether the Insurer May Assert Responsibility as a Defense

The Referee concluded that the last injurious exposure rule was inapplicable in this case because Skyline and its carrier had not been joined as parties. She nonetheless found that claimant had failed to prove that his 1979 injury was an "independent material contributing cause" of his current condition and upheld the carrier's denial on that basis. On Board review, claimant contends that despite the Referee's statement that the last injurious exposure rule was inapplicable, she actually employed the rule to defeat his claim in violation of Runft v. SAIF, 303 Or 493 (1987). In the alternative, he contends that the Referee improperly applied the last injurious exposure rule and should have placed the burden on the carrier to disprove an independent contribution to his current condition by the 1979 injury in accordance with Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984).

In fact, Sunshine's insurer has never asserted the last injurious exposure rule as a defense in this case. It merely argues that claimant has failed to prove a material causal relation between his current need for medical services and his 1979 industrial injury. We agree with claimant, however, that the Referee's statement that he had the burden of proving that his 1979 industrial injury was an "independent material contributing cause" of his current condition was a misstatement of his burden of proof.

Medical Services

Claimant may overcome the insurer's denial by establishing that his compensable 1979 injury is a material contributing cause of his current need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 257 (1983). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

The record contains three opinions regarding the causal relation between claimant's current need for medical services and his 1979 injury. Dr. Hanson, claimant's treating general practitioner, thought that claimant's ruptured L4-5 disc was caused primarily by his 1972 injury. He also indicated that the 1979 injury may have worsened the condition, but was unsure. Dr. Phipps, a consulting neurologist, agreed with Dr. Hanson that the primary cause of claimant's ruptured disc was the 1972 injury. He also opined, however, that the 1979 injury contributed to the subsequent worsening of claimant's condition. (Tr. 50). Dr. Schader, a consulting orthopedic surgeon, opined that the 1972 and 1979 injuries together "were the major contributing factors" to his current condition. (Ex. 11-2).

In light of these opinions, we conclude that claimant's 1979 injury is a material contributing cause of his current need for medical services. Although the 1972 injury was probably the most significant cause of claimant's current need for medical services, the evidence preponderates in favor of the conclusion that the 1979 injury also contributed significantly to his condition. Such a contribution is sufficient to satisfy the definition of a material contributing cause. We, therefore, conclude that the insurer's denial should be set aside.

ORDER

The Referee's order dated February 10, 1988 is reversed. The insurer's denial dated July 27, 1987 is set aside and the medical services claim is remanded to the insurer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded $2,000, to be paid by the insurer. A client-paid fee of up to $440 is approved.

DENNIS E. BERLINER, Claimant
Malagon, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-04496 & 88-17861
March 14, 1989
Order Denying Motion to Consolidate and For Immediate Remand

Claimant has moved the Board for an order consolidating WCB Case No. 88-17861 with WCB Case No. 86-04496, a case which is presently pending review, for purposes of review and "to remand [WCB Case No. 86-04496] for further clarification with reference to the question of Referee Johnson's Opinion & Order." The motion is denied.

WCB Case No. 88-17861 is claimant's appeal from Referee Howell's January 31, 1989 order that: (1) based upon the contents of Referee Johnson's September 16, 1988 order in WCB Case No. 86-04496, found that Referee Johnson's order did not require the employer to pay temporary total disability compensation; and (2) declined to assess penalties and attorney fees for the employer's refusal to pay the aforementioned compensation. A hearing transcript is presently being obtained. Thereafter, a briefing schedule will be implemented.

On the other hand, WCB Case No. 86-04496 is presently pending Board review pursuant to claimant's appeal from Referee Johnson's September 16, 1988 Opinion and Order. Among other findings, Referee Johnson upheld the self-insured employer's denial of claimant's aggravation claim for a right knee condition,

upheld the employer's denial of claimant's current lumbar problem insofar as it concerned coccygodynia, and set aside the employer's denial of claimant's psychological condition. At the time of review, the Board will also consider the employer's alternative motions to either remand to the Referee the question of the so-called "interim compensation" issue as it relates to claimant's psychological condition or to address the question on de novo review. The briefing schedule in WCB Case No. 86-04496 has been completed and the case is docketed for review.

An inter-relationship between some of the issues raised in the two cases is readily discernible. Yet, we do not consider such a situation to be unusual, particularly when the issue in the second case pertains to the enforcement of the order emanating from the first case. Moreover, a transcript has not even been obtained in WCB Case No. 88-17861, whereas WCB Case No. 86-04496 has already been fully briefed and docketed for review. Therefore, consolidation of the cases would result in a further extension of the review process. Under these circumstances and in the interests of substantial justice to all parties, we deny the motion for consolidation.

As an aside, we question the relevance of determining a Referee's "intent" in drafting an order when the merits of the case are now before us and subject to de novo review. Consequently, if claimant's motion to remand for "clarification" of the Referee's order is intended as an immediate request for action, it is likewise denied.

Accordingly, claimant's appeal and the motions to remand in WCB Case No. 86-04496 will be reviewed in the ordinary course of business. See OAR 438-11-015(2). Once a transcript is obtained and distributed to the parties, the briefing schedule in WCB Case No. 88-17861 will be implemented. Upon completion of the briefing schedule, claimant's appeal in WCB Case No. 88-17861 will be docketed for Board review.

IT IS SO ORDERED.

NOBLE J. CHASTEEN, Claimant
Samuel A. Hall, Claimant's Attorney
Jeff Gerner (SAIF), Defense Attorney

WCB 86-12596 & 86-12597
March 14, 1989
Corrected Order on Review

It has come to our attention that a clerical error appears in our Order on Review dated March 10, 1989. To correct this oversight, our prior order is withdrawn and replaced with the following corrected order.

The SAIF Corporation requests review of that portion of Referee Myers' order which set aside its denial of claimant's aggravation claim for a right shoulder (arm) injury. The issue on review is compensability of claimant's March, 1986, and October, 1986 aggravation claims. We reverse.

FINDINGS OF FACT

We adopt the findings of fact set forth in the Referee's Opinion and Order, with the following additional findings.

On March 7, 1985, Dr. Filarski noted continuing neuritis symptoms with repetitive activity. He restricted claimant from carpentry and lumber work because of claimant's physical

limitations which include discomfort, paresthesias, muscle cramping, and finger numbness. He recommended sedentary work and discussed the potential for ulnar nerve surgery if significant symptoms returned and were accompanied by a change in the nerve conduction study.

The above medical evidence was available to the parties at the time the May 6, 1985 stipulation was signed.

CONCLUSIONS AND OPINION

In order to establish an aggravation of his scheduled arm disability so as to warrant claim reopening, claimant must prove that his condition is worse. ORS 656.273. A worsened condition means a change which makes claimant more disabled than he was on May 6, 1985 the date the stipulation, the last arrangement of compensation, was approved. See Smith v. SAIF, 302 Or 396 (1986); International Paper Co. v. Turner, 84 Or App 248 (1987).

The Supreme Court, in Gwynn v. SAIF, 304 Or 345 (1987), has set out the requirements for establishing a worsening in cases in which claimant has already received a permanent disability award, and subsequently experiences a symptomatic flare-up. The first critical question in this case under those requirements is whether or not the award of 67.2 degrees was predicated on the anticipated recurrence of symptoms.

We find this case factually similar to International Paper Co. v. Turner, supra, which also involved a scheduled injury. In that case, a Referee's order granted 10 percent loss of use of the left leg. Evidence available at the time of that arrangement of compensation included the doctor's statement that, "when [claimant] is active on the knee, it swells up," and claimant's testimony that he would experience pain and swelling in the knee if he were to work on his feet for eight hours. Turner, 84 Or App at 251. On remand from the Supreme Court, the Court of Appeals noted that, although it was not clear whether or not the Referee had allocated a portion of the permanent award for anticipated recurrences of symptoms, it assumed that all relevant evidence concerning claimant's anticipated permanent disability which was before the Referee was considered in making the award of disability. The court concluded, therefore, that the award anticipated that claimant would have future periods of disability if he became active on his left knee. The court did not reach the question of whether or not the period of disability in that case exceeded the time anticipated in the order's award because the claimant's disability exceeded 14 days. Citing Gwynn, supra, the court determined that, because claimant was totally disabled for more than 14 days, he had established a worsening as a matter of law, and was entitled to time loss benefits.

In this case, we assume that the parties considered the evidence available at the time the stipulation was signed in fixing the award of 35 percent scheduled permanent disability. That evidence anticipated increased neuritis symptoms with activity. In addition, we infer from Dr. Filarski's restriction against returning to carpentry or lumber work and recommendation that he return to only sedentary work, that engaging in physical labor would cause a flare-up of symptoms which could result in periods of disability.

The second critical question is whether or not the periods of disability experienced by this claimant exceeded those anticipated in the prior permanent disability award. In Gwynn v. SAIF, supra, the Supreme Court held that, if the period of disability resulting from a flare-up of symptoms exceeds 14 days, or if claimant becomes an inpatient at a hospital for treatment of that condition, the claimant has sustained an aggravation as a matter of law. 304 Or at 353. See also Gwynn v. SAIF, 91 Or App 84 (1988).

In this case, secondary to overwork, claimant experienced a flare-up in March, 1986, for which Dr. Filarski authorized one week of time loss. Again in October, 1986, claimant's symptoms waxed as a result of physical work activities, and he missed two weeks of work.

Neither flare-up resulted in time loss exceeding 14 days, nor was claimant hospitalized for the increased symptoms. Since we find that this waxing of symptoms, which resulted in a short period of disability, was of the degree and duration anticipated in the last award or arrangement of compensation and because no period of disability exceeded 14 days, we conclude that claimant has not established a compensable aggravation as a matter of fact or law.

ORDER

The Referee's order dated December 31, 1986, as reconsidered February 27, 1987, is reversed in part. The SAIF Corporation's December 3, 1986 denial and the attorney fee for overcoming the denial is reversed. SAIF's denial is reinstateed and upheld.

RONALD C. EARL, Claimant
Peter O. Hansen, Claimant's Attorney
Kevin L. Mannix, Defense Attorney
Roberts, et al., Defense Attorneys

WCB 85-13161 & 85-01742
March 14, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Argonaut Insurance requests review of those portions of Referee Menashe's order that: (1) set aside its denial of claimant's medical services claim for his current psychiatric condition; and (2) upheld a denial of claimant's medical services claim for the same condition issued by EBI Companies. Claimant cross-requested review of the Referee's order, but subsequently filed a brief on review requesting that the Board affirm the order. We interpret claimant's brief as a withdrawal of his cross-request for review.

The issues on review are compensability of and responsibility for medical services.

We reverse on the responsibility issue.

FINDINGS OF FACT

Claimant has an underlying psychiatric disorder dating back to at least 1976. He experiences acute exacerbations of this chronic disorder in response to physical and emotional stress.

Claimant sustained a compensable left knee injury in

1978 for which he received an award of 20 percent permanent disability of the left leg. EBI is responsible for that injury.

In July 1981, claimant sustained a low back strain and herniated nucleus pulposus while working for Argonaut's insured. While he was recovering from this injury, he experienced an acute anxiety attack in the fall of 1981. At that time, he was experiencing various stresses attributable to the back injury, including disabling low back pain, concern over prospective back surgery and his inability to retain steady employment, and anxiety from the associated loss of income and self-esteem.

Claimant received psychiatric treatment for his anxiety attack, and his condition stabilized by April 1983. An Opinion and Order, dated July 6, 1983, determined that both the back injury and the acute anxiety attack were compensable and the responsibility of Argonaut. The order also closed the injury claim with no award of permanent psychiatric or low back disability. The order was affirmed on appeal and became final as a matter of law.

Claimant continued to suffer from low back pain following claim closure. In addition, he experienced an aggravation of his left knee condition in November 1983. His injury claim with EBI was reopened, claimant underwent left knee surgery in March 1984, and he requested reclosure of his claim the following September. Claimant made this request against the advice of Dr. Rusch, the treating knee surgeon, who opined that claimant was not yet medically stationary. The claim was reclosed by Own Motion Determination, issued December 20, 1984, with no additional award of permanent disability. Claimant did not appeal that determination.

In February 1985, claimant experienced an acute attack of depression and received emergency psychological counseling on one occasion. He filed a claim for this emergency treatment with EBI, and it issued a denial of compensability and responsibility on July 18, 1985. Claimant's psychiatric condition had stabilized by August 1985, but the following month he experienced another episode of increased anxiety and depression and sought further psychiatric treatment. He filed a claim for this treatment with Argonaut, and it issued a denial of compensability and responsibility on October 11, 1985.

In August 1986, Dr. Ball, psychiatrist, evaluated claimant and recommended psychiatric treatment. At that time, claimant was experiencing an acute episode of depression.

At the time of his acute psychiatric exacerbations in 1985 and 1986, claimant was experiencing numerous physical and emotional stresses, including: disabling low back pain; residual left knee pain and loss of range of motion; failure to locate employment within his physical limitations; and financial problems related to loss of employment and closure of his left knee injury claim. In addition, claimant was involved in bankruptcy proceedings and was experiencing significant personal problems with his teenage daughter.

Claimant requested a hearing on Argonaut and EBI's denials of his acute psychiatric exacerbations in 1985 and 1986. He and his supervisor testified in a credible and reliable manner.

FINDINGS OF ULTIMATE FACT

Claimant's acute psychiatric exacerbations in 1985 and 1986 are separate and distinct from the compensable 1981 psychiatric exacerbation addressed in the July 1983 Opinion and Order. Claimant's current acute psychiatric symptoms are attributable to a worsening of his underlying psychiatric disorder. The residuals of his successive industrial injuries and aggravations materially contributed to his current psychiatric exacerbation and associated need for medical treatment. Claimant's 1983 aggravation of his left knee injury with EBI's insured independently contributed to his current acute psychiatric condition.

CONCLUSIONS AND OPINION

Compensability of Medical Services

Argonaut and EBI both contend that the Referee erred in finding that claimant is entitled to medical treatment for his current psychiatric condition. We disagree.

As discussed above, a prior Opinion and Order, issued July 6, 1983, determined that claimant's acute anxiety attack in 1981 was compensable and the responsibility of Argonaut. That order was affirmed on appeal and became final as a matter of law. Therefore, claimant's current psychiatric exacerbations are compensable if they represent a continuation of his acute condition in 1981. If not, claimant must demonstrate: (1) that he has sustained a worsening of his preexisting psychiatric disorder requiring medical services or resulting in disability; and (2) that his industrial injuries have materially contributed to this worsening. See Jeld-Wen v. Page, 73 Or App 136, 139 (1985); Bracke v. Baza'r, Inc., 293 Or 239, 244-250 (1982) (dicta).

We conclude that claimant's current condition is not a continuation of his 1981 exacerbation. The medical record indicates that the latter acute condition had totally resolved by April 1983. This finding is consistent with the fact that claimant's 1981 injury claim was closed with no award for permanent psychiatric disability. Claimant must therefore, demonstrate both a worsening of his preexisting psychiatric condition and a causal link between that worsening and his industrial injuries. Id.

In regard to the worsening requirement, the record clearly demonstrates that claimant has experienced an acute symptomatic exacerbation of his underlying mental disorder requiring treatment. Furthermore, the medical evidence makes no persuasive distinction between claimant's mental condition and his symptoms. We, therefore, conclude that his current symptomatic increase is sufficient to demonstrate the requisite worsening of his underlying mental disorder. See SAIF v. Varner, 89 Or App 421 (1988).

Turning to the requisite causal relationship, Argonaut and EBI contend that claimant's current acute condition is totally attributable to his underlying personality disorder and off work stress. We disagree.

This is a complex medical question requiring expert

medical analysis. The Referee deferred to the opinion of Dr. Ball, psychiatrist, who evaluated claimant on two occasions in June 1986. Dr. Ball opined that claimant's recent psychiatric exacerbation is the result of his inability to adjust to the loss in physical capacity and self-esteem he experienced as a result of his successive industrial injuries. The insurers rely on the contrary opinion of Dr. Klein, psychiatrist, who conducted an independent psychiatric examination in August 1985. Dr. Klein attributed claimant's current psychiatric exacerbation to his underlying psychiatric disorder. A third psychiatrist, Dr. Beavers, evaluated claimant but was unable to render a definitive opinion on the relationship between his mental condition and prior industrial injuries.

We find Dr. Ball's opinion to be well-reasoned and consistent with the record as a whole. He explained that claimant's underlying disorder predisposed him to psychiatric flare-ups in response to injury related stresses. In addition, he noted that there was no record of serious interpersonal problems with fellow coworkers during periods when claimant was gainfully employed. Furthermore, we note that claimant does, in fact, have a past history of psychiatric exacerbations in response to physical pain, lost earning capacity and loss of financial security stemming from his industrial injuries. Moreover, he continues to experience many of the same injury related stresses that contributed to his prior exacerbations.

By comparison, the contrary opinion from Dr. Klein is neither as well-reasoned nor as consistent with the record. In particular, we note that Dr. Klein evaluated claimant at a time when his acute symptoms had stabilized. As a result, it is not surprising that she attributed his condition to his underlying disorder. Furthermore, Dr. Klein makes no attempt to explain why the injury related stresses that contributed to claimant's 1981 exacerbation are no longer a contributing factor of his current need for treatment.

Moreover, Dr. Klein's opinion conflicts with the law of this case. As discussed above, a prior Opinion and Order finally determined that claimant's 1981 back injury materially contributed to his psychiatric exacerbation in the fall of 1981. Nevertheless, Dr. Klein continues to attribute claimant's history of acute psychological exacerbations to his underlying personality disorder and off work personal problems. Although Dr. Klein is entitled to voice that opinion, it is inconsistent with the prior Opinion and Order and must be discounted. See Kuhn v. SAIF, 73 Or App 768 (1985).

For the reasons stated above, we defer to Dr. Ball's opinion and find that claimant's compensable industrial injuries remain a material contributing factor to his current need for psychiatric treatment. Accordingly, we affirm the Referee's finding that he is entitled to the requested psychiatric treatment.

Responsibility

As discussed above, claimant's current psychiatric flare-up is a separate and distinct condition from the anxiety attack he experienced in 1981. On review, Argonaut contends that the Referee erred in assigning it responsibility for claimant's current need for psychiatric treatment. Responsibility for this treatment rests with EBI if: (1) claimant's left knee aggravation

in November 1983 independently contributed to his current psychiatric flare-up; and (2) claimant's current condition is a worsening of his chronic psychiatric condition, as opposed to a mere symptomatic exacerbation. See EBI Companies v. Grover, 90 Or App 524 (1988). The Referee concluded that the psychiatric evidence did not establish that claimant's left knee aggravation in November 1983 independently contributed to his current acute psychiatric exacerbation. We disagree.

Claimant credibly testified that the bankruptcy proceedings initiated in 1984 were partially attributable to his left knee problems. He continued to experience left knee pain and lost range of motion following closure of his left knee claim in December 1984. Claimant's treating knee surgeon, Dr. Rusch, noted in January 1985 that claimant appeared at his office "extremely distressed" over financial problems related to the reclosure of that claim. The claim was closed at claimant's request and against the advice of Dr. Rusch, who opined that claimant's left knee condition was not medically stationary in December 1984. Claimant's supervisor credibly testified that claimant became increasingly depressed and frustrated after he was turned down for a job in December 1984. The record indicates that his left knee condition was partially responsible for his being turned down for that job.

Moreover, Dr. Ball attributed claimant's current psychiatric flare-up to his inability to adjust to the loss in physical capacity and self-esteem he experienced as a result of his successive industrial injuries. Dr. Ball included claimant's 1983 left knee aggravation in his earlier discussion of claimant's industrial injuries. We, therefore, conclude that the left knee aggravation was one of the "successive industrial injuries" to which Dr. Ball attributed claimant's current psychiatric flare-up.

We defer to Dr. Ball's opinion because it is both well-reasoned and consistent with the record. We recognize that Dr. Ball did not expressly state that the left knee condition resulted in a worsening of claimant's chronic psychiatric condition, as opposed to a mere increase in symptoms. However, claimant's underlying psychiatric condition was not disabling immediately prior to his current, acute exacerbation. Furthermore, Dr. Ball made no distinction between claimant's mental condition and its symptoms, and the medical evidence does not otherwise support such a distinction. In light of these factors, we conclude that claimant has experienced a worsening of his underlying psychiatric condition.

In reaching this decision, we rely on the rule enunciated in SAIF v. Varner, 89 Or App 421 (1988). The Varner court concluded that, in the absence of medical evidence of a persuasive distinction between a mental condition and its symptoms, a symptomatic increase was sufficient to demonstrate a worsening of the condition in a compensability context. We are aware that the Board has previously declined to recognize an increase of symptoms as a worsening of a condition in a responsibility context. See William C. Dilworth, 38 Van Natta 1036, 1037 (1986). We also recognize that the Court of Appeals has recently affirmed the Board's order in Dilworth. See Dilworth v. Weyerhaeuser Company, 95 Or App 85 (January 25, 1989). However, for the reasons discussed below we are not persuaded that those decisions prevent our application of the Varner rule in this case.

We first note that the court formulated the Varner rule because of its dissatisfaction with the legal distinction between "symptoms" and "conditions" in a mental illness context. See SAIF v. Varner, supra. We are persuaded that this rationale is equally applicable in a responsibility context.

Furthermore, the Dilworth Board did not address the Varner rule but, instead, declined to apply a prior rule enunciated in Adsitt v. Clairmont Water District, 79 Or App 1 (1986). In Adsitt, the court held that a showing of increased symptoms was always sufficient to demonstrate a worsening of a mental disorder in a compensability context. The Dilworth Board declined to apply the Adsitt rule in a responsibility context because that would always shift responsibility to the second employer. After the Board's decision in Dilworth, the court issued its decision in SAIF v. Varner, supra, in which it modified the Adsitt rule. As discussed above, the Varner rule recognizes a distinction between a psychiatric condition and its symptoms where the medical record contains persuasive evidence of such a distinction. As a result, application of the Varner rule in a responsibility context will not always shift responsibility to the second employer. Accordingly, the Dilworth Board's rationale is not pertinent to our application of the Varner rule in this and other responsibility cases.

Moreover, in affirming the Board's order in Dilworth, the court did not clearly adopt the portion of the order which addressed the Adsitt rule. The Board's discussion of the responsibility issue in Dilworth was two-pronged. The Board first adopted the Referee's conclusion that the claimant's work activity with the second employer was not a causative factor of his current psychological flare-up. In the alternative, the Board concluded that the claimant's symptomatic worsening was not sufficient to demonstrate a worsening of his condition, notwithstanding the Adsitt rule. It is not clear whether the court affirmed both bases for the Board's order. This is particularly significant in light of the fact that the alternative ruling on the "worsening" question was not essential to the Board's decision.

We, therefore, rely on the Varner rule in concluding that claimant has demonstrated a worsening of his chronic psychiatric condition. Accordingly, we conclude that EBI is responsible for claimant's current psychiatric exacerbation and related treatment, and we reverse the Referee on this issue.

Entitlement to Assessed Fee on Board Review

Finally, claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review regarding his entitlement to treatment for his current psychiatric condition. 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 April 7, 1987 is affirmed in part and reversed in part. EBI Companies' denial of claimant's

medical services claim is set aside, and the claim is remanded to EBI for processing according to law. The denial of claimant's medical services claim for the same condition issued by Argonaut Insurance is reinstated and upheld. All remaining portions of the Referee's order are affirmed. The Board approves a client-paid fee for Argonaut's counsel, not to exceed $300.

JESUS GARCIA, Claimant
Richard P. Noble, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB TP-88030
March 14, 1989
Third Party Distribution Order

The paying agency has petitioned the Board to resolve a dispute concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to the paying agency's entitlement to a lien for anticipated future expenditures. We find that the paying agency is entitled to recover a portion of the remaining balance of the settlement proceeds as partial reimbursement for its actual and projected claim costs.

FINDINGS OF FACT

In April 1986, while performing his employment duties as a fruit packer, claimant sustained a back injury. Surgery was eventually recommended. In November 1986, while being anesthetized for surgery, he suffered cardiac arrest and subsequently fell into a coma. Since that time, he has remained in a semi-comatose state. Inasmuch as claimant does not require active medical care, his parents are caring for him at their home. They receive $1,500 a month from the paying agency for their services.

When claimant's condition became stationary, he began receiving permanent total disability benefits. He receives $777.26 per month. Support benefits have also been provided to claimant's ex-wife and three minor children. By the time the children reach 21 years of age, the paying agency will have paid $10,748 for these support benefits. In addition, considering claimant's permanent total disability status, he will be entitled to burial benefits, not to exceed $3,000.

A third party action was initiated on behalf of claimant against the anesthesiologist for medical malpractice. In October 1987, with the paying agency's approval, a $1,000,000 settlement was reached, which equaled the third party's insurance policy limits.

After deducting claimant's one-third attorney's fee, litigation costs, and his one-third statutory share, a balance of $445,648.71 remains.

As of December 31, 1987, the paying agency has expended $147,536.46 in actual claim costs. The agency projects additional claim costs totalling $927,741.

Claimant is 35 years of age. The normal life expectancy for a 35-year-old male is 39.989 years. Considering claimant's vegetative state, the agency has discounted his life expectancy to 20.820 years. However, essentially no individuals in a "persistent vegative state" survive beyond 10 years.

FINDINGS OF ULTIMATE FACT

The paying agency has proven actual claim costs of $147,536.46. Claimant's reasonable life expectancy from the date of his November 1986 surgery is five years.

CONCLUSIONS OF LAW

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

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

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). 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).

In support of its lien for actual 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 19878 compilation. Claimant's counsel does not accept the paying agency's claim, contending that the computer printouts which have been submitted "do not match earlier submissions by the carrier and are different from what I believe the actual bills to be." The paying agency has not replied to claimant's rebuttal.

Inasmuch as the claims examiner's August 1988 letter merely provides an "estimate" of the paying agency's claim costs since the December 1987 compilation, we decline to rely on it for purposes of determining the agency's actual claim costs. Furthermore, because the paying agency has failed to respond by means of additional documentation or affidavit to claimant's objections to the computer ledger account, we find that submission unpersuasive.

Yet, claimant raises no specific objection to the December 31, 1987 compilation prepared by the paying agency's claims supervisor. Moreover, we find the compilation persuasive insofar as it concerns the agency's actual claim costs incurred after the ill-fated surgery. We consider this approach particularly reasonable since coincidentally the base-line for the paying agency's projected future claim expenditures is also

December 31, 1987. Accordingly, we conclude that the paying agency has established its entitlement to a lien for actual claim costs totalling $147,536.46.

We turn to the issue of future claim costs. 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).

Here, it is undisputed that the agency can reasonably anticipate expending $3,000 for burial expenses and $10,748 for beneficiary support compensation. It is similarly not disputed that the agency will be providing monthly compensation of $777.26 in permanent total disability benefits and $1,500 for home-care services. Instead, the dispute concerns the length of time these payments will continue. In other words, the conflict pertains to claimant's life expectancy.

The normal life expectancy for a 35-year-old male is 39.989 years. Relying on "actuarial experts," the paying agency has "discounted" this figure to 20.820. In response, claimant has provided an opinion letter from Dr. Sam Moore, of the Medical Underwriting, Structured Settlement Department for Reliance Life Companies of Philadelphia, Pennsylvania. Following his evaluation of the case, Dr. Moore concluded that an individual in claimant's "persistent vegative state" would not survive beyond ten years and, in most cases, would expire within three to five years. Dr. Moore cites a medical treatise, A. H. Roberts' Severe Accidental Head Injury, 1979, in support of his opinions.

Inasmuch as Dr. Moore provides an explanation, albeit cursory, for his opinion and also cites authority in support of his conclusions, we find him more persuasive than the "actuarial experts" mentioned in the paying agency's submission. Consequently, we conclude that it is reasonable to expect claimant to survive five years from the date of the November 1986 surgery, i.e., November 1991. Thus, as its lien for reasonably anticipated future expenditures for permanent total disability benefits and for home-care services, the paying agency is entitled to the present value of these expenses computed as of December 31, 1987, the date of its compilation for actual and future claim costs.

Accordingly, from the remaining balance of proceeds from the third party settlement, claimant's attorney is directed to promptly distribute to the paying agency, as reimbursement for its actual claim costs, the sum of $147,536.46. In addition, claimant's attorney shall distribute to the agency $13,748 for its reasonably anticipated future burial and child support benefits.

Finally, from the remaining balance of settlement proceeds, claimant's attorney shall distribute to the paying agency funds sufficient to meet the present value of claimant's permanent total disability benefits and home-care services, based on a life expectancy of five years from the November 1986 surgery, and computed as of December 31, 1987. If the aforementioned sum exceeds the remaining balance of settlement proceeds, the paying agency shall receive the entire balance. However, should a balance exist following this distribution, the remaining proceeds shall be disbursed to claimant.

IT IS SO ORDERED.

ALICE C. LADELLE, Claimant
Coons & Cole, Claimant's Attorneys
David C. Force, Attorney
Charles Lisle (SAIF), Defense Attorney

WCB 86-00676
March 14, 1989
Order on Reconsideration

Claimant requests reconsideration of our Order on Review, dated February 23, 1989, that modified claimant's attorney fee, finding that an assessed fee would be due, to be paid by the SAIF Corporation, for setting aside its aggravation denial, had the attorney filed a statement of services documenting his efforts in setting aside the denial at hearing. This assessed fee would be payable in addition to the Referee's award of an attorney fee of 25 percent of additional compensation made payable by his order.

Claimant has not submitted a statement of services concerning efforts expended at hearing. Rather, she contends that we erred in declining to award a fee in the absence of a statement of services. Claimant also contends that we erred in declining to award an assessed fee for services on Board review. We disagree with both contentions.

OAR 438-15-003(2) states that the administrative rules pertaining to attorney fees are effective as of January 1, 1988. OAR 438-05-010 states that the rules shall apply to all cases pending before the Board on and after that date. OAR 438-15-010(5) states that we cannot award an assessed fee unless claimant's counsel files a statement of services. Because no statement of services has been received to date, an assessed fee shall not be awarded.

Claimant's contention that she is entitled to an attorney fee on Board review as a result of her attorney's efforts in increasing her attorney fee award at hearing is equally without merit. See Dotson v. Bohemia, Inc., 80 Or App 233, 235 (1986).

Accordingly, the Board's order dated February 23, 1989 is withdrawn. On reconsidertion, as supplemented herein, we adhere to and republish our prior order, effective this date.

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

WCB 87-01109
March 14, 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 November 30, 1988 Order on Review. The request is denied.

FINDINGS

On December 14, 1987, the last brief on Board review was filed in this matter.

On February 11, 1988, the administrator for the Board notified all practitioners with cases currently pending review that executed retainer agreements and statements of services would be required in all cases that involved 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 February 11, 1988 letter, the statement of services was due within 15 days of the date of the letter.

On November 30, 1988, the Board issued its Order on Review. The Board's order affirmed the Referee's order that upheld the employer's medical services denial, upheld a "de facto" denial of claimant's claim for attendant care expenses, and declined to assess a penalty and attorney fee for allegedly unreasonable claims processing. 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 February 28, 1989, the employer's counsel filed a statement of services and attorney referral letter seeking authorization of a client-paid fee for services rendered on Board review.

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 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); 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003; Stanley, supra.

As previously mentioned, on February 11, 1988, the administrator for the Board notified all practitioners with cases currently pending review that the Board would be applying its rules concerning the authorization of assessed, client-paid, and extraordinary attorney fees to all cases pending Board review. Practitioners were advised that, under OAR 438-15-010(1) and 438-15-027(1)(d), an executed retainer agreement and statement of services were due within 15 days after the filing of the last brief in a case. For those cases where the last brief had been filed more than 15 days from the date of the administrator's February 11, 1988 letter, the administrator further stated that the statement of services would be due within 15 days of the date of the letter.

Here, the last brief was filed more than 15 days before the date of the admininstrator's letter. Therefore, the employer's counsel was required to submit its statement of services and retainer agreement within 15 days of February 11, 1988. Instead, the submission was made approximately one year later. Based on the aforementioned authority, such a submission is untimely.

Accordingly, because the request for a client-paid fee is untimely and since our order on the merits has become final by operation of law, we decline to authorize the employer's counsel's request. In so doing, 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.

CARMEN ANDAVERDE, Claimant
Max Rae, Claimant's Attorney

Own Motion 88-0770M
March 15, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her January 12, 1982 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim as claimant's treatment has been conservative in nature and no surgery has been recommended.

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 approximately five days in September 1988 for traction, physical therapy and testing. We are persuaded that claimant's compensable injury has worsened sufficiently to justify claim reopening pursuant to ORS 656.278. Accordingly, claimant's claim is reopened with temporary disability benefits to commence September 20, 1988 and to continue until claimant returns to her regular work at her 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 $350 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.

JAMES G. HEIDEN, Claimant
Garry L. Kahn, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-01669
March 15, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Heiden v. Don Pollock Investment, 93 Or App 425 (1988). In our Order on Review, dated July 16, 1987, we reduced the Referee's award of unscheduled permanent disability for claimant's right shoulder condition, from 75 percent (240 degrees)

to 50 percent (160 degrees). The court has instructed the Board to reconsider this case in the light of Armstrong v. Asten-Hill, 90 Or App 200 (1988). We proceed to do so.

ISSUE

The extent of claimant's unscheduled permanent disability for his right shoulder condition.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional finding.

Claimant suffers from moderately severe permanent physical impairment due to his compensable injury of May, 1985.

CONCLUSIONS OF LAW

In rating the extent of unscheduled permanent disability for claimant's shoulder, we consider his physical impairment as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in 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 (1984).

The Referee increased claimant's total award to 75 percent unscheduled permanent disability. In our prior order of July 16, 1987, we modified the Referee's order by reducing the claimant's total award to 50 percent. On remand from the Court of Appeals, we affirm the Referee's order and reinstate claimant's total award of 75 percent unscheduled permanent disabiliity.

Here, claimant is 62 years of age. His age limits both his physical rehabilitation from his compensable rotator cuff tear, as well as his ability to successfully return to the work force. He has no formal education beyond high school. His minimal educational background will also hinder his return to work. This is especially true, when, as here, claimant cannot return to his at-injury type of occupation (i.e., maintenance repair work) because it exceeds his present physical restrictions. Dr. Puzzis, claimant's treating surgeon, has limited claimant to sedentary and light work. Moreover, for the last 20 years claimant has worked solely as a maintenance repair person. His employment experience, therefore, provides few transferable skills to lighter occupations.

Furthermore, at the time of the hearing, claimant remained unemployed despite over 200 employer contacts by himself or on his behalf. The vocational evidence is divided. Claimant's vocational counselor testified that he felt claimant could perform work as a maintenance supervisor, real property manager, and apartment manager. On the other hand, Mr. Maye, a vocational expert, testified such jobs exceeded either claimant's skills or his present physical restrictions. Given Dr. Puzzis' restriction of no lifting beyond 20 pounds, claimant's age, his minimal formal education, and limited work experience, we are persuaded by Maye's testimony.

Lastly, claimant credibly testified that he is in constant pain and takes tranquilizers and pain medication. He

further testified that merely lifting a bag of groceries caused right arm pain.

Under such circumstances, we conclude that given claimant's moderately severe permanent physical impairment, his advanced age, his minimal education, his limited transferable skills to lighter occupations, and his disabling pain, that a total award of 75 percent unscheduled permanent disability appropriately compensates him for his loss of earning capacity due to his compensable injury.

ORDER

The Referee's order, dated November 4, 1986, is affirmed.

LYNDA D. MINNICK, Claimant
Cash Perrine, Claimant's Attorney
Ronald Smitke, Defense Attorney

WCB TP-88037
March 15, 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. Claimant contends that the paying agency orally agreed to accept a one-third share of the settlement amount as a "just and proper" distribution. See ORS 656.593(3). Claimant requests that the settlement proceeds be distributed in accordance with the alleged oral agreement. For its part, the paying agency denies any such agreement. We find that the paying agency did not agree to accept a one-third share of the settlement proceeds as a "just and proper" distribution.

In addition, claimant contends that a portion of the paying agency's lien was payable under an earlier claim so that the paying agency's lien on this claim is less than asserted. We find that the amounts under contention were properly paid pursuant to this claim. Therefore, such amounts are properly included within the paying agency's third party lien and the paying agency is entitled to distribution to it of the amount in dispute.

FINDINGS OF FACT

On July 1, 1986, while performing her employment duties as a shoe store manager, claimant was involved in a motor vehicle accident. As a result of this accident, claimant sustained injuries involving her neck and back.

Claimant's injury claim was denied by the paying agency. Claimant requested a hearing on the denial. The denial was set aside by a Referee's order dated July 1, 1987. The paying agency requested Board review of the Referee's order.

Claimant subsequently elected to pursue a third party action against the owner and the operator of the other vehicle. The third party defendants had a single policy limit of $100,000. Two other personal injury cases that arose out of the same accident had already been settled under the policy limit.

On October 1, 1987, claimant's counsel advised the paying agency by letter of claimant's election, advised the paying agency of the remaining amount available under the third party defendants' insurance policy, and proposed settlement of the third party action for the remaining amount of the policy limits.

Claimant's counsel further proposed that the proceeds of any settlement be divided one-third to attorney fees, one-third to claimant, and one-third to the paying agency in satisfaction of its third party lien.

Thereafter, by letters dated October 2, 1987 and October 27, 1987, claimant's counsel requested a copy of the paying agency's claim summary showing dates and amounts paid.

On October 29, 1987, claimant's counsel and senior claims examiner Petsu for the paying agency discussed, by telephone, settlement of the third party action and distribution of the proceeds. Petsu followed up the conversation with a letter to claimant's counsel dated November 2, 1987, writing that he wished to further discuss the "settlement split." He proposed that the paying agency waive its lien with the exception of $9,220.18 previously paid out in indemnity benefits. In return, claimant would agree to a disputed claims settlement affirming the paying agency's denial. Petsu concluded the letter by requesting the thoughts of claimant's counsel with regard to the proposal.

There was no further written correspondence between the parties until April 20, 1988, at which time Karen Smallman, a subrogation specialist with the paying agency, notified claimant's counsel by letter that she had assumed responsibility for claimant's file. Smallman indicated that the paying agency would not be able to consider the proposal from claimant's counsel until compensability of claimant's condition was decided by the Board on review.

Claimant also has another accepted claim with the paying agency for an ankle injury resulting from a December 10, 1984 work accident. A May 4, 1988 Determination Order awarded claimant temporary disability benefits from May 22, 1987 through March 25, 1988. However, claimant was already receiving temporary disability benefits pursuant to her 1986 neck injury claim. The paying agency continued to make payments under the neck claim. Claimant has requested a hearing challenging the May 4, 1988 Determination Order as premature.

By letter dated June 27, 1988, claimant's counsel indicated to Smallman his belief that he and Petsu had "basically agreed" to distribute the proposed settlement one-third to attorney fees, one-third to claimant, and one-third to the paying agency to be held in trust pending a Board decision on review. Claimant's attorney further indicated a willingness to immediately distribute the paying agency's one-third share if the paying agency dismissed its appeal.

Smallman responded by letter dated July 6, 1988, wherein she indicated that Petsu did not recall agreeing to the proposed settlement division advanced by claimant's counsel.

On July 15, 1988, the paying agency consented to settlement of the third party action for $89,974.

On July 27, 1988, the Board affirmed the Referee's order setting aside the paying agency's denial.

On September 23, 1988, the paying agency consented to a distribution of the settlement proceeds as follows:

Gross Settlement		$89,974.71
Litigation Costs		- 171.00
Claimant's Attorney's Share (1/3)	$29,934.57	
Paying Agency's Share (1/3)	$29,934.57	
To Claimant	$19,956.38	
Held in trust pending WCB Order of Distribution	$ 9,978.19	
TOTALS:	$89,803.71	$89,803.71

Therefore, the sum in dispute is $9,978.19.

The claim remains in open status. As of December 23, 1988, the paying agency had paid $45,514.72 in temporary disability compensation and medical expenses.

FINDINGS OF ULTIMATE FACT

The paying agency did not agree to accept a one-third share of the settlement proceeds as a "just and proper" distribution.

The paying agency is entitled to the remaining balance of the proceeds held in trust as a "just and proper" share of the third party settlement.

CONCLUSIONS OF LAW

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).

Claimant contends that the paying agency orally agreed to accept a one-third share of the settlement proceeds as its "just and proper" share of the third party settlement. Claimant argues that the paying agency should be required to abide by its agreement. Claimant relies, in this regard, upon the court's decision in Estate of Troy Vance v. Williams, 84 Or App 616 (1987).

Claimant in Williams, during the process of negotiating a third party settlement, requested a statement of the paying agency's lien. The agency provided claimant with a statement which did not include its anticipated future claim costs. Relying upon this statement, claimant negotiated and settled his third party action. The paying agency subsequently asserted entitlement

to a lien in excess of that represented in its prior statement to claimant. The additional amount represented the present value of its anticipated future costs. The court determined that the paying agency's "just and proper" share of the third party settlement would be limited to the amount of the originally asserted lien. The court reasoned:

> "[W]hen either a worker or an agency, in the course of negotiating a third-party settlement, makes a representation to the other which could affect the other's position on the amount of the settlement, the other is entitled to rely on that representation." Id. at 620.

Therefore, we examine the record in order to determine whether the paying agency made a representation to claimant upon which she relied.

In this regard, claimant submits the affidavit of her counsel wherein he states that, within several weeks of his October 1, 1987 letter to the paying agency, he had a telephone conversation with claims examiner Petsu, and that they "basically agreed" to distribute the proceeds of the proposed settlement on a one-third basis.

In response, the paying agency submits the affidavit of Petsu wherein he states that the one-third proposal "may have been one settlement option ...discussed," but at no time did Petsu accept such a proposal.

Inasmuch as each party presents a different account of their oral understanding, if any, we turn to the contemporaneous written record to reach a resolution of this matter.

In his affidavit, claimant's counsel refers to a telephone conversation "several weeks" after his October 1, 1987 letter. It was allegedly during this conversation that he and Petsu "basically agreed" to distribute the settlement proceeds on a one-third basis. Petsu, in his November 2, 1987 letter to claimant's counsel, refers to an October 27, 1987 telephone conversation wherein he and claimant's counsel discussed "the subrogation aspects" of claimant's claim. We conclude that the telephone conversation referred to in the affidavit from claimant's counsel is the October 27, 1987 conversation referred to in Petsu's letter.

Petsu's letter makes no mention of a settlement. To the contrary, the letter contains what is, in essence, a counter offer. Moreover, this counter offer was not accepted by claimant. In addition, on the same day as the telephone conversation, claimant's counsel sent a letter to the paying agency requesting a copy of the paying agency's claim summary. No mention is made in this letter of any distribution agreement.

We are persuaded that, while the parties were negotiating an agreement for distribution of the proposed settlement proceeds, no agreement had yet been reached. Further, we find that the paying agency did not represent to claimant that it would accept a distribution of one-third of the settlement proceeds as a "just and proper" distribution. Consequently, the

paying agency is not precluded from claiming entitlement to the amount currently held in trust as part of a "just and proper" distribution.

We must next determine whether the paying agency is, in fact, entitled to the disputed amount as a "just and proper distribution" of the settlement proceeds. In this regard, 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).

The paying agency asserts a current lien of $45,514.72. Claimant argues that the lien should be reduced because part of the time loss benefit component of that amount was payable under her 1984 ankle injury claim rather than her 1986 neck injury claim. We do not agree. The paying agency properly paid time loss to her on the neck claim which had been ordered accepted by the Referee. Such sums are properly included within the paying agency's third party lien.

The settlement here was in the amount of $89,974.71. After deducting litigation costs and one-third of the settlement as attorney fees for claimant's counsel, the sum remaining is $59,869.14. Claimant is entitled to one-third of this sum, or $19,956.38. Claimant has already received this amount. This leaves the sum of $39,912.76. The paying agency's current lien is well in excess of this amount. Therefore, the paying agency's lien exceeds the balance of the settlement, without even considering the agency's expected future expenditures. Accordingly, we hold that, pursuant to a "just and proper" distribution, the paying agency is entitled to the remaining balance of proceeds from the third party settlement. Consequently, claimant's attorney is directed to distribute the remaining balance to the paying agency as a "just and proper" distribution. See ORS 656.593(3); 656.593(1)(d).

IT IS SO ORDERED.

RAYMOND E. PARDEE, Claimant
Malagon & Moore, Claimant's Attorneys
Beers, et al., Defense Attorneys
Brian Pocock, Defense Attorney

WCB 86-16620 & 86-11295
March 15, 1989
Order on Review (Remanding)

Reviewed by Board Members Crider and Johnson.

Claimant and EBI Companies request review of that portion of Referee Emerson's order that awarded claimant additional temporary total disability benefits, in the form of interim compensation. EBI also requests review of that portion of the order that assessed a penalty and attorney fee for its failure to pay interim compensation. Finally, claimant requests review of that portion of the order that rated the extent of his unscheduled permanent partial disability. On review, the issues are entitlement to temporary total disability, related penalties and attorney fees, and the propriety of the Referee's extent rating. We reverse the Referee's extent rating.

FINDINGS OF FACT

Claimant sustained a compensable low back strain in July 1985 while working for Weyerhaeuser. The claim was closed in December 1985 without temporary or permanent disability, and claimant requested a hearing.

In May 1986, claimant experienced a compensable aggravation of his back injury, and Weyerhaeuser reopened his injury claim. His back condition improved with time loss and conservative treatment, but he continued to experience low back symptoms.

In July 1986, claimant began working for EBI's insured as a logger. On August 12, 1986, he had an episode of immediate, intense low back pain while bucking logs. Claimant was taken off work by his treating physician. Claimant filed an aggravation claim with Weyerhaeuser and a new injury claim with EBI's insured. At that time, his claim with Weyerhaeuser remained in open status, and Weyerhaeuser recommenced payment of temporary disability benefits. Claimant remained on time loss until October 30, 1986, when he returned to a light duty position with Weyerhaeuser.

EBI's insured received notice of claimant's new injury claim no later than August 15, 1986. It has paid no compensation on the claim. On or around September 16, 1986, EBI forwarded claimant a copy of his Form 801, signed by its representative. The "denied" box at the bottom of the form was checked. On November 14, 1986, EBI issued a formal denial of responsibility for claimant's August 1986 flare-up. Weyerhaeuser subsequently issued a formal denial of responsibility in February 1987.

Claimant requested a hearing on the denials. That request was consolidated with his earlier hearing request on the December 1985 Determination Order.

FINDINGS OF ULTIMATE FACT

The Form "801" EBI forwarded to claimant on or around September 16, 1986 did not state the factual and legal basis for the denial or inform claimant of his right to a hearing.

Claimant has not demonstrated that he received less than his wage at injury when he returned to light-duty work on October 30, 1986.

At the time of hearing, claimant's back injury claim with Weyerhaeuser remained in open status, and claimant had not become medically stationary.

CONCLUSIONS OF LAW AND OPINION

Entitlement to Interim Compensation/ Penalties and Attorney Fees for Failure to Pay Interim Compensation

We adopt the Referee's opinion on these issues with the following comment.

Claimant's filed a new injury claim with EBI on August 15, 1986. EBI paid no compensation on the claim and did not issue a written denial until November 14, 1986. The Referee, therefore, awarded temporary total disability, in the form of interim compensation, from the date of injury through October 30, 1986, the date claimant returned to light-duty work. On review, claimant contends that he is entitled to benefits through November 14, 1986, the date of EBI's denial.

An insurer may suspend payment of temporary disability benefits when a claimant accepts and commences wage-earning employment paying a wage equal to or greater than the wage at injury. See OAR 436-60-030(3). In awarding interim compensation through October 30, 1986, the Referee apparently found that claimant had not demonstrated that he received less than his wage at injury when he returned to work on that date.

We agree with the Referee's finding. The only indication in the record that claimant received less than his wage at injury is his testimony that Weyerhaeuser continued to pay him temporary partial disability benefits after he returned to work in October 1986. This, alone, is not sufficient to establish that he received less than his regular wage when he returned to work. Accordingly, we conclude that the Referee correctly awarded interim compensation through October 30, 1986.

Propriety of the Referee's Extent Ruling

The Referee found Weyerhaeuser responsible for claimant's current condition. The Referee then proceeded to rate the extent of claimant's permanent disability based on his condition immediately prior to the May 1986 aggravation. Claimant contends that the Referee should not have rated his disability because he was not medically stationary at the time of hearing. We agree.

A Referee should not rate permanent disability if the claimant is not medically stationary at the time of hearing or the claim is in open status. ORS 656.268(1); Kociemba v. SAIF, 63 Or App 557 (1983); Harmon v. SAIF, 54 Or App 121 (1981). The Board has followed this rule where the claimant was medically stationary when the claim was initially closed but, at the time of hearing, the claim was in open status or the claimant was not medically stationary because of a subsequent aggravation. See Theresa Skoyen, 39 Van Natta 462 (1987); Andrew Simer, 37 Van Natta 154 (1985); Gary A. Freier, 34 Van Natta 543 (1982). Furthermore, disability ratings should be based on a claimant's condition at the time of hearing. Gettman v. SAIF, 289 Or 609, 614-615 (1980). It is error to exclude information bearing on a claimant's condition at the time of hearing and rate disability as of a prior date. See Norton v. SAIF, 86 Or App 447, n. 2 (1987).

Here, claimant's treating physicians, Dr. Walborn, chiropractor, and Dr. Kuller, orthopedist, had not found claimant medically stationary following his August 1986 aggravation. The only contrary medical opinion is from Dr. Howell, D.O., who conducted an independent medical examination on January 20, 1987 and found claimant medically stationary as of that date. We defer to the opinions of Drs. Kuller and Walborn because they have had greater opportunity to observe claimant.

Accordingly, we conclude that claimant was not medically stationary when the Referee made his disability rating. Furthermore, claimant's injury claim remained in open status at the time of hearing. Finally, the Referee did not base his extent rating on claimant's condition as of the date of hearing. Instead, the disability rating was, therefore, improper and should be reversed. The extent issue is preserved until claimant becomes medically stationary and his claim is reclosed.

ORDER

The Referee's order dated June 29, 1987, as reconsidered July 21, 1987, is affirmed in part and reversed in part. That portion of the order that rated claimant's permanent disability is reversed. The extent of permanent disability issue is remanded to the Hearings Division to be preserved for litigation until claimant's condition becomes medically stationary. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $400, to be paid by EBI Companies, for services on review regarding the Referee's extent rating.

JERRY WINKLE, Claimant
James Francesconi, Claimant's Attorney

Own Motion 89-0030M
March 15, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his November 1, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the proposed 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. Surgery has been recommended and SAIF has agreed to accept responsibility for the procedure. However, the record before the Board indicates that claimant has not been gainfully employed for several years. Although he dealt with vocational counselors during some of 1988, it is clear that he was less than cooperative with efforts on his behalf. There is no indication that claimant has actively attempted to return to the work force recently. We are precluded from granting temporary disability benefits to claimants who are not in the work force prior to or at the time of a worsening of their compensable condition. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985). We conclude the request for own motion relief must be denied.

IT IS SO ORDERED.

THOMAS A. BENNETT, Claimant
Coons & Cole, Claimant's Attorneys
Phillip Nyburg, Defense Attorney

WCB 87-06607
March 16, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Garaventa's order that: (1) affirmed an award by Determination Order of 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm; and (2) declined to assess an attorney fee for the insurer's alleged unreasonable delay in providing discovery. On review, the issues are extent of scheduled permanent disability and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant's April 27, 1987 hearing request contained a continuing request for discovery of medical and vocational rehabilitation reports related to his appeal of the Determination Order. By September 8, 1987, claimant had not received any discovery. On September 28, 1987, claimant's attorney filed a supplemental hearing request and reiterated the discovery request. The supplemental hearing request raised the issues of penalties and attorney fees for failing to provide updated vocational rehabilitation and medical reports on an ongoing basis. On October 1, 1987, the insurer submitted discovery documents to claimant consisting of two physical capacity forms completed by claimant's treating physician on June 11 and June 29, 1987.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The Board adopts the Referee's Conclusions and Opinion with regard to the issue of extent of permanent partial disability.

Attorney Fees

Former OAR 438-07-015(2) provides that discovery shall be provided within 15 days of mailing of the demand for discovery, and provides that failure to comply "may be considered unreasonable delay or refusal under ORS 656.262(10)." In turn, ORS 656.262(10) provides:

> "(10) 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."

Therefore, at the time of the hearing, failure of a carrier to disclose documents pertaining to a claim within 15 days of a demand by the claimant may be considered unreasonable delay or

refusal under ORS 656.262(10). See Morgan v. Stimson Lumber, 288 Or 595, mod. 289 Or 93 (1980).

Here, there were no "amounts [of compensation] then due" at the time of the alleged discovery violation. Therefore, no penalty can be awarded even if the insurer violated the rule and its conduct was unreasonable. However, attorney fees may still be assessable. Spivey v. SAIF, 79 Or App 568 (1986); Mischel v. Portland General Electric Co, 89 Or App 140 (1987).

Attorney fees are assessable only if the insurer violated the rule by failing to provide documents in its possession within 15 days of demand. The evidence here is that the insurer did not provide claimant with copies of the treating physician's June 11 and June 29, 1987 reports until October 1, 1987. The insurer was subject to a continuing disclosure request throughout this period. If the insurer had the reports in its possession during this time, then it violated the rule. However, the record contains no evidence when the reports came into the possession of the insurer. In the absence of such evidence, we are unable to find a violation of the rule. Claimant has failed to sustain his burden of proof on this issue.

ORDER

The Referee's order dated November 2, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $432.

GEORGE D. BROWN, Claimant
SAIF Corp, Insurance Carrier

Own Motion 88-0663M
March 16, 1989
Own Motion Order

Reviewed by Board Members en banc.

SAIF Corporation has submitted to the Board claimant's claim for continuing medical benefits for his June 6, 1949 industrial injury. Claimant's aggravation rights have expired. SAIF opposes the relief claimant seeks.

Claimant sustained a compensable injury on June 6, 1949. Claimant is specifically requesting reimbursement for his medication costs.

The Board must decline the relief claimant seeks as there is no medical report in our record which would relate claimant's current need for medication to his 1949 injury. Without medical justification, we will not grant continuing medical services in pre-1966 claims. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

Board Member Crider, dissenting.

Claimant, who was compensably injured prior to January 1, 1966, has requested reopening of his claim for payment of medical benefits. In the request, which was properly directed to the insurer (OAR 438-12-025), the claimant offered to produce a medical report from Dr. Chamberlain of Medford, Oregon, concerning his current condition.

The insurer, rather than simply requesting that the

proferred reports be supplied, issued a lengthy communication to claimant advising him, among other things, that ORS 656.278 only allows award of medical benefits when curative treatment is being provided. The insurer stated that,

> "To enable us to consider your request, you must furnish complete, current medical reports which support the fact that the condition caused by the original injury of June 6, 1949 has worsened or become aggravated since the date of last closure."

Apparently the claimant did not respond. The insurer then recommended denial of own motion relief on the ground that "there has been no hospitalization or surgery, or any curative treatment to date that we are aware of."

ORS 656.278, as amended in 1987, allows the Board, in its discretion, to reopen a claim purely for the purpose of awarding medical benefits in a pre-1966 claim. Nothing in the statute makes a worsening a prerequisite to grant of such relief. And nothing in the statute requires that such medical benefits be curative rather than palliative. ORS 656.278(1)(b). See e.g., Ohman E. Christopher, 41 Van Natta ___ (February 22, 1989).

The insurer has responsibility for initial processing of the claim. OAR 438-12-020. That responsibility includes the responsibility for investigation of the reopening request so that a useful recommendation can be made. Where, as here, the insurer couples its request with a discourse on the law that is not only gratuitous but also inaccurate, the insurer chills the exercise of the right to request own motion relief. This chilling affect necessarily renders it less likely that the claimant will produce medical records and other information necessary for processing. In short, it interferes with proper investigation and processing of the claim.

Rather than denying relief for failure to produce relevant medical evidence, the Board should have directed the insurer to obtain the medical records and, simultaneously, advised the claimant of our need for such records. When the record is adequately developed, the Board should rule on the request.

DENNIS L. HIGGINS, Claimant
Malagon & Moore, Claimant's Attorneys
Kate Waldo (SAIF), Defense Attorney

WCB 87-01639
March 16, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Baker's order that: (1) found that his left leg claim was not prematurely closed; (2) upheld the SAIF Corporation's partial denial of his low back condition; and (3) declined to assess a penalty and associated attorney fee for alleged unreasonable claims processing. At hearing, SAIF requested authorization for an offset of overpaid temporary disability benefits. The Referee did not address this issue in his order. On review, SAIF repeats its request for authorization of an offset. We affirm on the premature closure and compensability issues; we award an attorney fee, but no penalty; and we grant the request for authority to offset.

ISSUES

1. Whether claimant's low back condition is compensably related to his June 6, 1986 injury.

2. Whether claimant's claim was prematurely closed.

3. Whether claimant is entitled to a penalty and/or associated attorney fee for SAIF's alleged unreasonable claims processing.

4. Whether SAIF is entitled to an offset of overpaid temporary disability benefits.

FINDINGS OF FACT

Claimant, a 37-year-old reforestation worker, compensably injured his left leg on June 6, 1986 when he slipped and caught his leg under a log. He came under the care of Dr. Roy, who diagnosed a hamstring strain. Dr. Roy treated claimant from June 28, 1986 until December 2, 1986. His treatment included immobilization of the knee and referral for physical therapy.

Dr. Roy released claimant to return to full work on August 3, 1986. Claimant was unable to return to his regular work because of his knee immobilization. He attempted to perform other work with the employer. However, due to his continuing complaints of left leg pain, Dr. Roy subsequently restricted him to light work.

Dr. Roy conducted a follow-up examination on December 2, 1986. Claimant was not working at the time. Dr. Roy's chart note from that examination stated:

> "After discussing the matter with [claimant] in some detail, it is decided to declare him medically stationary. It is felt that his case should be closed. He appears to have a mild to moderate degree of impairment..."

On December 30, 1986, SAIF requested departmental closure of the claim. However, SAIF apparently did not forward Dr. Roy's December 2nd chart note to the Evaluation Division.

On December 31, 1986, claimant moved to California. Shortly thereafter, he began working for his father who had just opened a business. His work activities involved light to moderate physical exertion. He worked for his father for three weeks. He then returned to Oregon.

Meanwhile, on January 16, 1987, the Evaluation Division responded to SAIF's request for closure stating that the information in its file indicated claimant was still receiving curative treatment and, therefore, was not medically stationary. In response to the Evaluation Division's January 16th letter, SAIF sent Dr. Roy's chart note to the Division.

On January 30, 1987, claimant began treating with Dr. Gorman, chiropractor. His primary complaint continued to be his left leg, but he now also reported low back complaints. Dr. Gorman completed a Change of Attending Physician form which was received by SAIF on February 3, 1987. The form contained multiple diagnoses

including lumbar myofascitis, lumbosacral radicular syndrome and chronic hamstring strain. Dr. Gorman indicated on this form that claimant was not medically stationary.

SAIF did not forward this form to the Evaluation Division. Instead, SAIF wrote to Dr. Gorman on February 9, 1987 requesting a narrative report explaining the relationship between claimant's low back complaints and his June 6, 1986 injury. SAIF indicated that the claim had been submitted for closure and, therefore, requested that Dr. Gorman respond within 14 days.

A Determination Order subsequently issued on March 9, 1987, awarding temporary benefits through December 2, 1986. Claimant was also awarded 10 percent scheduled permanent disability for loss of use of the left leg. This award was increased to 30 percent by the Referee. The issue of extent of permanent disability is not before us.

On March 17, 1987, one week after issuance of the Determination Order and five weeks after SAIF's inquiry, Dr. Gorman responded. He reported that claimant's injured hamstring had resulted in an altered gait which had, in turn, caused claimant's low back pain. He opined that claimant was not medically stationary.

Claimant discontinued treatments with Dr. Gorman on March 23, 1987.

On March 27, 1987, Dr. Roy opined that it was unlikely that claimant's back pain was related to his June 6, 1986 injury.

On April 8, 1987, SAIF issued its partial denial letter.

Claimant revisited Dr. Gorman on July 22, 1987 after a three-mile walk precipitated increased symptoms. Dr. Gorman reported that, in his opinion, claimant was medically stationary as of July 28, 1987. Dr. Gorman subsequently testified in a post-hearing deposition that he could not state whether claimant was stationary prior to then because he did not treat claimant between March 23, 1987 and July 22, 1987.

Claimant has walked with an altered gait since his injury.

Claimant was examined by Dr. MacRitchie, M.D., on referral from Dr. Roy, on October 17, 1986. Dr. MacRitchie noted an absence of any back complaints. Claimant did not report any back complaints until January 30, 1987, when he began treating with Dr. Gorman.

Claimant's low back condition and symptoms are not causally related to his June 6, 1986 injury.

Claimant is not a reliable witness.

CONCLUSIONS OF LAW AND OPINION

Denial of Low Back

The Referee found that claimant had failed to sustain his burden of proving a causal connection between the June 6, 1986 injury and his low back complaints. In reaching this conclusion, the Referee relied upon the extended delay in medical documentation of any back complaints as well as the intervening work in California.

Claimant argues on review that it is medically reasonable that his back would not begin to bother him until he became physically active in January 1987 while employed in California by his father. He also argues that his California work activities resulted in the appearance of his low back symptoms but did not independently contribute to a worsening of his underlying condition. He relies upon Dr. Gorman's opinions to establish both of these contentions.

Dr. Gorman's opinion that claimant did not suffer a worsening of his underlying condition is dependent upon claimant's explanation of his work activities while in California during January 1987, including his disavowal of any specific incident having occurred. The Referee made no express finding regarding claimant's credibility or reliability as a witness.

Claimant insisted a number of times at hearing that he told the physical therapist he was seeing under Dr. Roy's supervision that he was experiencing low back pain. However, there is no confirmation of this in the contemporaneous medical reports. In fact, Dr. MacRitchie's medical report dated October 17, 1986 expressly noted that claimant had no back pain. Furthermore, at another point in his testimony, claimant stated that he first noticed back pain while in California during January 1987. This is clearly inconsistent with his testimony that he repeatedly informed Dr. Roy's therapist of his back complaints.

Claimant also testified that Dr. Gorman and his therapist were able to do more for him than were Dr. Roy and his physical therapist. However, during the period he was actually treating with Dr. Gorman, claimant reported to his vocational counselor that his back pain was worse after treatment by Dr. Gorman's therapist than if there had been nothing done at all. While not entirely irreconcilable, these statements are clearly suggestive of an unreliable historian. We conclude, based upon the content of his testimony, that claimant is not a reliable witness.

Considering the extended delay in medical documentation of any back complaints, the intervening work in California, and the fact that Dr. Gorman's testimony is based upon claimant's unreliable history, we are not persuaded that claimant's back condition is causally related to his compensable injury.

Premature Closure

Claims are not to be closed until the worker's condition has become medically stationary. ORS 656.268(1). The March 9, 1987 Determination Order established December 2, 1986 as the medically stationary date. Dr. Roy, claimant's then treating physician, reported that claimant was medically stationary as of December 2, 1987. Dr. Gorman subsequently opined that claimant was not medically stationary as of March 17, 1987. We must, therefore, decide whose opinion is the more persuasive.

Dr. Roy began treating claimant shortly following his injury. He continued to treat claimant for the next five months. Thus, he had the opportunity to track claimant's progress over an extended period of time. Moreover, although Dr. Gorman reported that claimant was not medically stationary as of March 17, 1987, Dr. Gorman's billing statements disclose that he was treating claimant for back symptoms, which we have found are unrelated to the compensable injury. We conclude that Dr. Roy's opinion is more persuasive than that of Dr. Gorman, and that the claim was not prematurely closed.

Penalties and Attorney Fees

Claimant also argues that SAIF's processing of his claim was unreasonable in that SAIF failed to forward Dr. Gorman's January 30, 1987 Change of Attending Physician form to the Evaluation Division. SAIF's request for claim closure was pending at this time. Claimant contends that this form alerted SAIF that claimant was receiving treatment again for his leg complaints along with additional complaints allegedly related to the compensable injury. The inference is that claimant was not medically stationary as of January 30, 1987.

SAIF, on the other hand, asserts that it acted reasonably when it requested additional information from Dr. Gorman. SAIF argues that it would have been premature to submit the form to the Evaluation Division. SAIF notes that the form contained three different diagnoses, only one of which was clearly attributable to the compensable injury. Therefore, SAIF argues, the more reasonable course was to request clarification from Dr. Gorman in order to learn whether, in Dr. Gorman's opinion, claimant's nonstationary status was the result of the compensable injury or, instead, the result of an unrelated condition.

Former ORS 268(2) provides that "all medical reports *** shall be furnished to the Evaluation Division" when claim closure is requested. Similarly, former OAR 436-30-030 states that "all medical reports *** accumulated during the life of a claim are considered necessary for claim determination and shall be submitted ***", subject to two exceptions not relevant here. Neither the statute nor the rule provides for the withholding of ambiguous documents. Instead, the statute and rule require the submission of all medical reports. We conclude that SAIF's failure to submit Dr. Gorman's January 30, 1987 report was unreasonable.

Despite our finding that SAIF's conduct was unreasonable, a penalty can be assessed only if there are "amounts [of compensation] then due." ORS 656.262(10); Mischel v. Portland General Electric, 89 Or App 140, 142 (1987). On this record, there is no compensation then due for purposes of a penalty. Accordingly, no penalty can be awarded.

However, attorney fees may be assessed pursuant to ORS 656.262(10) and ORS 656.382(1), even though no compensation is "then due." Mischel v. Portland General Electric, 89 Or 140, 142-43 (1987). ORS 656.382 provides, in part:

> "(1) If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee ***." (Emphasis added).

SAIF, in seeking closure of the claim, withheld a medical report to the effect that claimant was not medically stationary. SAIF's conduct interfered with the Evaluation Division's ability to properly process the claim to closure. We conclude that SAIF's conduct amounts to an unreasonable resistance to the payment of compensation. Under the facts of this case, and in light of the factors enumerated in OAR 438-15-010(6), we conclude that a reasonable fee is $300.

Offset

The remaining issue is that of offset. It is apparent that the Referee merely overlooked SAIF's request for authorization to offset overpaid temporary disability against any increased award of permanent disability. We find that an offset is appropriate.

ORDER

The Referee's order dated December 21, 1987 is affirmed in part, reversed in part, and modified in part. That portion of the order that refused to award an insurer-paid attorney fee for services at the hearing for unreasonable resistance to the payment of compensation is reversed. Claimant's attorney is awarded $300 as a reasonable attorney fee, to be paid by the SAIF Corporation. In addition, SAIF is authorized to offset the amount of overpaid temporary disability compensation against future payments of permanent disability. The remainder of the Referee's order is affirmed.

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

WCB 87-09537
March 16, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of those portions of Referee Schultz's order which: (1) increased claimant's unscheduled permanent disability award for a neck and left shoulder injury from 15 percent (48 degrees), as awarded by Determination Orders, to 35 percent (112 degrees); and (2) assessed a penalty-related attorney fee for the insurer's alleged unreasonable failure to disclose claims information in a timely manner. We affirm.

ISSUES

(1) Extent of unscheduled disability.

(2) Penalty-related attorney fees.

FINDINGS OF FACT

Claimant, a line mechanic, compensably injured his neck and left shoulder on April 18, 1985 when he slipped and fell. The diagnosis was severe cervical radiculitis radiating along the left brachial plexus. Claimant was taken off work and treated conservatively by Dr. Bolera, a chiropractor. He was released for regular work on May 6, 1985.

Dr. Bolera declared claimant medically stationary as of July 17, 1985 with no permanent impairment. The claim was closed by Determination Order on August 13, 1985 with no permanent disability award.

Claimant subsequently began treating with Dr. Novick, a chiropractor, in May 1986. Novick diagnosed chronic costovertebral sprain with intercostal neuralgia, thoracic brachial radiculitis and paravertebral myofascitis. Novick reported that claimant's

condition had worsened and was not medically stationary. Novick recommended a change of vocation in August 1986, warning that the current job would lead to continued exacerbation and further degeneration of his condition. Claimant was taken off work on September 8, 1986. The aggravation claim was accepted.

Claimant was released for modified work in February 1987, and became medically stationary on March 16, 1987. He had limitations on crawling, climbing, repetitive lifting, pushing, pulling, grasping, fine manipulating, use of the arms above shoulder level, and lifting or carrying more than 20 pounds. The claim was closed by Determination Order on April 10, 1987 with 20 percent unscheduled permanent disability. Two weeks later, the insurer paid claimant the full award.

In April 1987, claimant was evaluated by a panel at the Orthopaedic Consultants. They opined that claimant needed no further treatment, and rated his shoulder impairment as minimal. Upon receipt of the Consultants' report, the insurer submitted the report with a completed Form 1503 (Insurer's Determination Request) to the Evaluation Division on April 24, 1987, requesting a reduction in the Determination Order award. That same day, the insurer mailed a copy of the Form 1503 to claimant, but for reasons unknown to the parties, it was never received. The insurer did not mail a copy of the Form 1503 to claimant's counsel until July 23, 1987. Claimant's counsel had submitted a written demand to the insurer for all claim-related documents in December 1986.

By Determination Order dated May 12, 1987, claimant's unscheduled disability award was reduced from 20 percent to 15 percent. Claimant filed a request for hearing on the Determination Order on June 22, 1987.

Claimant, who was 35 years old at the time of hearing, has a GED and a two-year degree in law enforcement. His prior work experience has been primarily limited to skilled auto mechanics. At the time of hearing, he was employed as a licensed insurance agent, earning less than he did as a mechanic.

We find that claimant's shoulder impairment due to this compensable injury is mild. At the time of hearing, claimant continued to experience pain radiating from the front of the left shoulder to the left shoulder blade, depending on his physical activity. He also had limitations on pushing, pulling, elevating his arm, and lifting more than 10 or 15 pounds.

CONCLUSIONS AND OPINION

The Referee increased claimant's unscheduled award from 15 percent to 35 percent, based on findings that claimant has a mild impairment and is precluded from heavy/medium work and light work requiring repetitive use of the upper extremities. The Referee also assessed a penalty-related attorney fee of $250 for the insurer's delay in providing claimant's counsel a copy of the Form 1503 requesting a reduction in the Determination Order award.

Unscheduled Disability

We adopt the Referee's Conclusions and Opinion with regard to the extent of unscheduled permanent disability issue.

Attorney Fee

In assessing a penalty-related attorney fee, the Referee relied on former OAR 438-07-015, which required full disclosure of claims information in contested cases. Subsection (2) of that rule required that the insurer furnish claimant, and claimant's counsel, copies of all documents pertaining to the claim within 15 days after claimant mailed a copy of the hearing request, or a written demand, to the insurer. That subsection further provided that "[f]ailure to comply with this section may be considered unreasonable delay or refusal under ORS 656.262(10)," thereby permitting the assessment of a penalty and attorney fee. These statutory sanctions were also available if documents acquired after the initial disclosure were not provided to claimant, and claimant's counsel, within 10 days after the insurer's receipt of the documents. See former OAR 438-07-015(4).

Former OAR 438-05-005 through 438-12-015 were adopted under the Board's statutory authority to provide rules of practice and procedure for hearing and review proceeding and for exercising its own motion authority. Former 438-05-005. In particular, former OAR 438-07-015 was intended to promote proper and expeditious disposition of claims in hearing proceedings through prompt disclosure of claims information between parties.

Here, claimant mailed a copy of his hearing request and demand for claim documents not later than June 22, 1987. The insurer provided claimant's counsel with a copy of the Form 1503 on July 23, 1987. This date is more than 15 days after the discovery demand. We conclude that the insurer violated former OAR 438-07-015 by failing to provide a copy of Form 1503 within the 15-day time limitation.

Although not raised by the parties or the Referee, we also note that the insurer violated the statutory prohibition in ORS 656.331(1)(b) against unilateral contact between the insurer and claimant without notice to claimant's attorney, where the contact affects the reduction of claimant's benefits. See also OAR 436-60-015(1)(c) (Director's rule to effectuate statutory prohibition). The insurer violated this statute and rule by mailing a copy of the Form 1503 to claimant without providing the same to claimant's attorney.

The insurer does not contend that it did not violate former OAR 438-07-015. Instead, the insurer argues that an attorney fee can be awarded only where such violation results in either the late payment of compensation or a refusal to pay compensation. In this regard, the insurer cites ORS 656.382(1) for the proposition that a carrier-paid attorney fee is allowed where the carrier unreasonably refuses to pay compensation.

We conclude, however, that the insurer's reading of ORS 656.382(1) is too narrow. That section 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 claimant a reasonable attorney fee ***." (Emphasis supplied).

We have previously held that an insurer "resists the payment of compensation" within the meaning of ORS 656.382(1) where the insurer violates a statutory requirement that timely action be taken even if claimant is not ultimately found to be entitled to compensation. Thus, in Wilma K. Anglin, 39 Van Natta 73 (1987), we awarded a penalty-related attorney fee for an untimely response to a request for authorization of surgery despite the fact that medical services are not compensation upon which a penalty may be assessed.

Similarly, we award a penalty-related fee for violations of our own rules and those of the Department requiring prompt claims processing even where claimant is not ultimately found to be entitled to any compensation and, thus, no compensation has been delayed. For example, in Clay B. Sheppard, 39 Van Natta 125 (1987), we awarded a penalty-related fee for a disclosure violation although no compensation was due.

Here, the insurer did not furnish claimant's counsel with a copy of the Form 1503, requesting a reduction in the Determination Order award, until three months after its submission to the Evaluation Division and claimant, and two months after the Evaluation Division reduced claimant's compensation in response to the Form 1503. The insurer's conduct violated both ORS 656.331(1)(b) and OAR 438-07-015. Moreover, although no compensation was due because claimant's permanent disability award had already been paid to him, the reduction in the award by Determination Order could have resulted in authorization for an offset. We conclude that the insurer unreasonably resisted the payment of compensation within the meaning of ORS 656.382(1). Therefore, a reasonable attorney fee will be awarded.

ORDER

The Referee's order dated December 28, 1987 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 $1,100.

RONALD J. JAMES, Claimant
Ernest W. Kissling, Claimant's Attorneys
Horne & Meserow, Defense Attorneys

WCB 86-04335
March 16, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Leahy's order that: (1) affirmed a Determination Order that awarded temporary total disability from June 8, 1983 to January 7, 1986; and (2) declined to rate claimant for extent of permanent disability. The issues on review are extent of permanent disability and temporary total disability. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant was 38 years of age at hearing. He has an extensive history of compensable injuries. In 1970, he suffered a broken pelvis and a low back injury in an industrial accident. He was awarded 5 percent unscheduled permanent disability by a 1971 Determination Order. He returned to work and was again compensably injured in 1974, resulting in a low back injury. This injury led to a lumbar fusion and insertion of Harrington rods in 1975. Claimant was awarded 20 percent unscheduled permanent disability by

a 1979 Determination Order, subsequently increased to 35 percent by a prior Referee's order.

Claimant was provided with vocational services and treatment in a pain center in Arizona. He attended two colleges in Arizona and received a GED and training as an emergency medical technician. He worked for a roofing company in Arizona bidding jobs. He also worked in sales.

In 1980, he returned to heavier work in Oregon, including welding and construction supervision. He experienced ongoing pain in the low back, occasionally requiring treatment. On June 8, 1983, while moving welding equipment he compensably injured his low back and cervical back. The insurer was subsequently found responsible for these injuries.

In February, 1985, Dr. Kelley, claimant's former treating physician, opined that claimant would be restricted to light or sedentary employment as a result of the 1983 compensable injuries. He recommended vocational rehabilitation. Claimant was involved in physical therapy during much of 1985, with fair results. He began to experience frequent rectal bleeding in late 1985.

He was reviewed by The Diagnostic Panel on January 7, 1986. They opined that there had been no change in his permanent preexisting disability. They found no permanent impairment from his 1983 compensable injury. A Determination Order issued on March 18, 1986, awarding claimant temporary total disability from July 6, 1983 to January 7, 1986, but no permanent disability.

Dr. Buhl, claimant's current treating physician, reviewed the report of The Diagnostic Panel. Although he agreed that claimant was medically stationary, Dr. Buhl disagreed with their other conclusions.

Dr. Kelley also reviewed The Diagnostic Panel's report and found it defective because the panel only looked at claimant's low back and not at his cervical injury.

Various tests were performed by Dr. Buhl in an attempt to diagnose the cause of claimant's rectal bleeding. On April 18, 1986, claimant was referred to Dr. Walta, who diagnosed hemorrhoids.

Jerry Gillis was assigned by the insurer to provide vocational rehabilitation services to claimant on April 10, 1986. He contacted claimant and an initial conference was held in Gillis' office on April 29, 1986. Claimant told him that, at that time, he felt he could not do any type of work, even light or sedentary work. Claimant contacted him on May 6, 1986, and told him he did not want further vocational rehabilitation services.

On June 8, 1986, claimant twisted his back at home and was admitted to the hospital. Dr. Wilcox diagnosed acute sciatic nerve compression secondary to his compensable injury. On June 10, 1986, Dr. Stover diagnosed acute flareup of chronic lumbar pain. He recommended conservative treatment.

In September, 1986, Dr. Buhl opined that claimant was totally disabled except for part-time sedentary work.

In October, 1986, Dr. Kelley opined that prior to the 1983 compensable injury, claimant had been able to do moderate/light work. He felt claimant could now do no more than part-time sedentary work.

Claimant was admitted to the Northwest Pain Center on October 22, 1986. An admission summary noted significant physical limitations, significant depression, and fair motivation to return to work.

On discharge, claimant was limited to lifting and carrying a maximum of 15 pounds; sitting for not longer than 45 minutes; standing a maximum of 10 minutes; and walking one-quarter mile on level ground. He was approved for sedentary to light work, within his physical limitations.

The psychological summary noted that claimant had started with a negative attitude and had made some improvement. Mr. Gillis participated in a conference at the pain center with claimant. He described claimant as non-committal about vocational testing and goals. Claimant informed Gillis that he would participate in vocational testing as soon as he was discharged from the pain center.

On December 29, 1986, claimant, claimant's attorney, and Mr. Gillis met. Claimant asked Gillis to defer beginning vocational rehabilitation until after the hearing scheduled for January 12, 1987.

ULTIMATE FINDINGS OF FACT

As of January 7, 1986, no further material improvement could reasonably be expected in claimant's condition from medical treatment, or the passage of time.

Claimant did not refuse to participate in vocational rehabilitation.

As a result of his 1983 compensable injury, claimant has suffered permanent impairment in the minimal-mild range and has suffered a permanent loss of earning capacity of 30 percent.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant "adamantly refused" to cooperate with vocational rehabilitation efforts. Consequently, the Referee held that claimant could not be rated for extent of permanent disability "[u]ntil he cooperates fully with the ... rules and statutes concerning vocational rehabilitation."

We disagree that claimant refused to cooperate with vocational rehabilitation efforts. Furthermore, even if he had done so, the Referee is obligated to rate claimant for the extent of permanent disability at hearing. ORS 656.283(7); Leedy v. Knox, 34 Or App 911 (1978); Craft v. Industrial Indemnity, 78 Or App 68 (1986).

When claimant was first contacted by Jerry Gillis in April, 1986, he may have been medically stationary from his compensable injuries, but he was suffering from an unrelated illness. Claimant's statement that he could not then work even an eight-hour day is understandable. Admittedly, claimant refused to further consider vocational rehabilitation in May, 1986. Yet, that was not a final refusal; claimant thereafter entered the Northwest Pain Clinic and also agreed to participate in vocational testing with Gillis.

The Referee reasoned that without input from vocational rehabilitation, he was unable to rate claimant without indulging in speculation. We disagree.

We note that the Director's "Greenbook" rules for rating unscheduled permanent disability, former 436-30-380 et seq, includes OAR 436-30-450. That section provides for input from rehabilitation counselors, and others, on a claimant's adjustment to his condition. Part of this consideration is "unwilling to adjust." This category calls for negative numbers, if applicable, and thereby reduce permanent disability to some extent. However, as previously discussed, we are not persuaded that claimant was unwilling to participate in vocational rehabilitation efforts.

Claimant's brief requests remand to the Referee for rating the extent of permanent disability. On de novo review, we are authorized to make any disposition of the case as is deemed appropriate, including determining the extent of permanent disability without remanding to the Referee, when sufficient evidence in the record exists to determine the issue. Brian W. Johnston, 40 Van Natta 58, aff'd mem Johnston v. Fred Meyer, Inc., 94 Or App 343 (1988);David L. Fleming, 38 Van Natta 1321 (1986), aff'd mem Fleming v. Daeuble Logging, 89 Or App 87 (1987).

We find the the record has not been "improperly, incompletely or otherwise insufficiently developed." See ORS 656.295(5). Therefore, this matter need not be remanded to the Referee for a determination of claimant's permanent disability resulting from his compensable injuries.

We rate claimant according to the Director's "Greenbook" rules for rating unscheduled permanent disability, former OAR 436-30-380 et seq. In so doing, we note that claimant has two "new injuries", one to his neck and one to his back. Because claimant has been previously awarded a total of 40 percent unscheduled permanent disability for his low back, we have considered these prior awards in rating him. Cascade Rolling Mills v. Madril, 57 Or App 398 (1982). While we give these prior awards for injuries to the same body area some weight, we do not strictly offset them against claimant's present loss of earning capacity. Norby v. SAIF, 303 Or 536 (1987); Cascade Rolling Mills, supra.

The testimony of Drs. Kelley and Buhl, who have treated claimant over a long period of time, indicates that claimant was significantly impaired prior to the 1983 compensable injury and that he has been further significantly impaired as a result of that injury. After review of the medical and lay evidence, and considering those factors listed in former OAR 436-30-380, as well as his prior awards for low back injuries, we conclude that, as a result of his 1983 compensable injury, claimant has suffered permanent impairment resulting in the loss of earning capacity of 20 percent. Therefore, claimant is awarded unscheduled permanent disability of 20 percent (64 degrees).

Concerning the temporary disability issue, we find that no material improvement in claimant's condition could be expected from further medical treatment, or the passage of time as of January 7, 1986. Therefore, we affirm that portion of the Determination Order which awarded temporary total disability until that date. ORS 656.005(17); 656.210(4); 656.268.

ORDER

The Referee's order dated March 27, 1987, is reversed in part and affirmed in part. That portion of the Referee's order that declined to rate the extent of claimant's permanent disability is reversed. Claimant is awarded 20 percent (64 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $3,800. The remainder of the Referee's order is affirmed.

KENNETH D. SALSBURY, Claimant
Steven C. Yates, Claimant's Attorney
Phillip L. Nyburg, Defense Attorney

WCB 86-12977
March 16, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) upheld the insurer's partial denial of claimant's claim for reimbursement of mileage expenses to and from his treating chiropractor; and (2) awarded his attorney a fee out of compensation, rather than a carrier-paid fee, for services at hearing in obtaining additional temporary disability benefits. In its brief, the insurer requests review of that portion of the order that awarded claimant additional temporary total disability benefits.

On review, the issues are entitlement to transportation costs, temporary total disability and attorney fees.

We reverse on the transportation costs issue.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant sustained a compensable neck and upper back strain in June 1986. At that time, he lived in Florence, Oregon, and he commenced treatment with Dr. Hebert, a chiropractor in Florence. Approximately five months later, claimant moved to Springfield. He continued to treat with Dr. Hebert and made approximately thirty round-trip visits of 200 miles from his home to Dr. Hebert's office before transferring treatment to a doctor in Springfield. Claimant submitted claims for his related transportation costs from Springfield to Florence, and the insurer refused to reimburse costs in excess of the distance from Springfield to the nearest urban area.

In October 1986, the employer presented claimant with an oral offer of modified employment. Dr. Hebert had opined that this work was within claimant's physical limitations. Claimant orally accepted the employer's offer but did not report to work at the specified time. His employment was subsequently terminated, and the insurer suspended payment of all temporary disability benefits on December 9, 1986.

Claimant requested a hearing on the suspension of his benefits and the partial denial of his transportation costs.

CONCLUSIONS OF LAW AND OPINION

Transportation Costs

On review, claimant contends that the Referee erred in upholding the insurer's denial of his transportation costs. We agree.

The transportation costs denied by the insurer were

incurred by claimant in receiving compensable medical treatment from his established provider after relocating to a new area. The Referee upheld the insurer's denial of these costs after finding that it had complied with the requirements of OAR 436-60-050(4). That rule provides as follows:

> "The worker may choose an attending physician within the state of Oregon. Reimbursement to the worker of transportation costs to visit the attending physician, however, may be limited to . . . the distance to the nearest city or metropolitan area, from where the worker resides and where a physician providing like services is available. A worker who relocates within the state of Oregon may continue treating with the attending physician and be reimbursed transportation costs accordingly. If an insurer chooses to limit reimbursement to the nearest available city, or metropolitan area, a written explanation shall be provided the worker along with a list of physicians who provide the like services within an acceptable distance of the worker. . ."

Claimant argues that, notwithstanding OAR 436-60-050(4), he is entitled to full reimbursement of his transportation costs under ORS 656.245. That provision authorizes reasonable and necessary medical treatment for compensable conditions, and it guarantees claimants the right to choose their own treating physicians within the state of Oregon.

We have not previously interpreted OAR 436-60-050(4) as part of our holding in a case involving transportation costs incurred by a relocated worker. However, the Board and the Court of Appeals have concluded in dicta that the transportation cost limitation authorized in the rule is not applicable to costs incurred by relocated workers in continuing treatment with an established provider. SAIF v. Holston, 63 Or App 348, 352, f.n. 2 (1983), affirming 34 Van Natta 952 (1982). We note that the Holston dicta is consistent with the language of the rule itself. Specifically, the third sentence of the rule provides that "[a] worker relocating within the state of Oregon may choose to continue treating with his attending physician and be reimbursed transportation costs accordingly." (emphasis added). Significantly, that sentence does not provide for reimbursement subject to the limitations established elsewhere in the rule.

Moreover, the position taken in Holston is consistent with the Court of Appeals' decision in Pyle v. SAIF, 55 Or App 965 (1982). As in the present case, the claimant in Pyle was a relocated worker who incurred transportation costs related to continued treatment with her established treating physician. The Pyle court held that the claimant was entitled to reimbursement of such costs by virtue of her right to choose her own treating physician under ORS 656.245. Id. at 968. See also Smith v. Chase Bag Company, 54 Or App 261 (1981).

Accordingly, we adopt the interpretation of OAR 436-60-050(4) set forth in Holston, and we conclude that the

limitation on transportation costs authorized by that rule is not applicable in the present case. We further conclude that claimant was entitled to full reimbursement of his transportation costs under ORS 656.245. See Pyle, supra; Smith, supra. Accordingly, we reverse the Referee on this issue.

Temporary Total Disability

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

Once an insurer accepts a claim and commences payment of temporary disability benefits, it must continue paying those benefits until claim closure except in the following limited situations. First, an insurer may terminate benefits prior to claim determination when a claimant returns or is both released to regular work and medically stationary. See Fazzolari v. United Beer Distributors, 91 Or App 592 (1988), recon 93 Or App 103, rev den 307 Or 236 (1988). Second, an insurer may suspend benefits when a claimant "accepts and commences" wage-earning employment paying a wage equal to or greater than the wage at injury. See OAR 436-60-030(3). Finally, an insurer may suspend benefits when a claimant refuses an offer of suitable modified employment paying a wage equal to or greater than the wage at injury, but only after the insurer provides a written offer of employment and complies with other procedural safeguards. See OAR 436-60-030(5).

Here, the insurer suspended claimant's temporary total disability benefits prior to claim determination after he failed to report to work after accepting an oral offer of modified employment paying a wage equal to his job at injury. The Referee analyzed the insurer's actions under OAR 436-60-030(5). He concluded that the suspension of benefits was improper because the insurer did not provide the written offer of employment required under that rule. The Referee did not address whether suspension was otherwise proper under OAR 436-60-030(3) or the criteria set forth in Fazzolari.

On review, the insurer contends that OAR 436-60-030(3) and (4), rather than OAR 436-60-030(5), are not applicable in this case arguing that claimant commenced work notwithstanding failure to report to work. It further contends that it was entitled to suspend payment of claimant's benefits under ORS 656.212 because the offer of employment establishes that claimant no longer suffered any lost earning power.

If claimant accepted and commenced work, the insurer would have been entitled to commence paying temporary partial disability and to continue to pay partial benefits notwithstanding a subsequent voluntary quit. OAR 436-60-030(3) and (4). However, claimant's failure to report to work was a "refusal" of employment within the meaning of OAR 436-60-030(5), not an acceptance and commencement of work followed by termination. The procedural safeguards set forth in subsection (5) ensure that temporary total disability benefits will be reduced only where a claimant knowingly refuses a specific offer of suitable modified employment. The rule also promotes the creation of a written record of the terms of proffered employment for purposes of future litigation. The need for these safeguards is the same whether claimant refuses the proffered employment outright or initially accepts the offer but then changes his mind prior to commencing work.

The insurer's reliance on ORS 656.212 is also misplaced.

The Director's rules amplify that status. We decline to read this statute so as to nullify the rules.

We, therefore, conclude that the Referee correctly analyzed claimant's actions as a "refusal" of employment under OAR 436-60-030(5). Furthermore, we agree that the insurer did not properly suspend claimant's benefits under that rule because it failed to strictly comply with the requirement of a written offer of employment. See Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986). Finally, we note that suspension of benefits was not otherwise proper under the criteria set forth in Fazzolari or OAR 436-60-030(3). At the time of suspension, claimant had not become medically stationary, been released to work, or accepted and commenced wage-earning employment paying a wage equal to or greater than the wage at injury. Accordingly, we agree with the Referee's conclusion that the insurer improperly suspended claimant's temporary disability benefits.

Attorney Fees at Hearing Level

Claimant contends that the Referee erred in awarding his attorney a fee out of compensation, rather than a carrier-paid fee, for services at hearing in obtaining additional temporary disability benefits. While the opinion section of the Referee's order states that claimant's attorney is entitled to a fee out of compensation, the order language awards a carrier-paid fee. We give precedence to the order language and conclude that the Referee effectively awarded the carrier-paid fee sought by claimant. As the insurer has not challenged this award on Board review, we decline to address it at this time.

ORDER

The Referee's order dated April 1, 1987, as reconsidered April 27, 1987, is affirmed in part and reversed in part. The insurer's September 12, 1986 partial denial of claimant's medical services claim for transportation costs is set aside, and the insurer is directed to process the claim according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $1,400 for services at hearing and on Board review regarding the transportation costs issue, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $440.

TIMOTHY R. SCHROEDER, Claimant
Doblie & Associates, Claimant's Attorneys
Julia Philbrook (SAIF), Defense Attorney
Constance Wold, Defense Attorney

WCB 87-14973 & 87-14972
March 16, 1989
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of those portions of Referee Podnar's order which: (1) declined to award him an assessed fee for services rendered at hearing on the issue of responsibility; (2) declined to assess a penalty and related attorney fee for the Wausau Insurance Company's allegedly improper denial of responsibility for his aggravation claim for a middle and low back condition; and (3) declined to assess a penalty and related attorney fee for the SAIF Corporation's allegedly unreasonable denial of responsibility for his "new injury" claim for the same condition. We affirm.

ISSUES

1. Claimant's entitlement to assessed fee for services rendered at hearing on responsibility issue.

2. Penalty and attorney fee for Wausau's allegedly improper claims processing.

3. Penalty and attorney fee for SAIF's allegedly unreasonable denial.

FINDINGS OF FACT

Claimant sustained a compensable injury on June 2, 1986 when he tripped and fell on his back while working for Wausau's insured. The diagnosis was "[a]cute traumatic moderate cervical/lumbar strain/sprain with concomitant acute vertebral subluxation of C7, T6 and L5 with associated left brachial/neuralgia and associated suboccipital cephalgia." Wausau accepted the claim for a nondisabling injury. Claimant treated conservatively with Dr. Breitenstein, a chiropractor, and he continued to work until December 1986, when he was no longer able to work due to an exacerbation of symptoms. Breitenstein authorized time off work. However, we do not find that Wausau either reclassified the accepted injury as disabling or paid claimant temporary total disability for the period that he was off work. Furthermore, we do not find that claimant requested a determination by the Evaluation Division of whether his claim is disabling or nondisabling. Claimant returned to work in January 1987 and was fired during late February or early March 1987.

Claimant was not yet medically stationary when he began working for SAIF's insured in May 1987 at a slightly higher wage than he had earned with Wausau's insured. His middle and low back symptoms increased. After a lifting incident at work on June 30, 1987, claimant saw Dr. Breitenstein with severe pain and spasms in the lower thoracic and upper lumbar region. The pain was similar to that he experienced in December 1986; however, it was more generalized, more severe, and located in a slightly lower region of the back. Breitenstein opined that "this appears to be a new injury to the same areas involved in the June 2, 1986 injury." Breitenstein rated the back impairment resulting from the 1986 injury as 10 percent and felt it was unlikely that the 1987 injury would result in any further impairment. Breitenstein also attributed claimant's need for modified work and vocational rehabilitation to the 1986 injury. Claimant was taken off work and has not worked since June 30, 1987.

Dr. Breitenstein sent copies of his report to SAIF and Wausau. Viewing the report as a "new injury" claim, SAIF denied responsibility for the claim on August 21, 1987. Wausau viewed the report as an aggravation claim and denied responsibility for the claim on September 5, 1987. Both insurers conceded the compensability of the claim. On September 30, 1987, the Compliance Division issued an order pursuant to former ORS 656.307, designating Wausau as paying agent and referring the matter for hearing. The Board received the ".307" order on October 5, 1987. The hearing was held in January 1988.

Prior to hearing, claimant was served with a subpena to appear at hearing. Claimant appeared with his attorney and offered testimony. His attorney contended that: (1) he was entitled to an attorney fee for participation in the hearing; (2) SAIF was the responsible insurer; and (3) penalties and attorney fees should be assessed for SAIF's allegedly unreasonable denial and Wausau's allegedly improper denial. Claimant's attorney elicited testimony from claimant and successfully objected to attempts by SAIF's attorney to impeach Dr. Breitenstein through claimant's testimony.

CONCLUSIONS AND OPINION

The Referee found SAIF responsible and set aside its denial of the "new injury" claim; however, he did not award claimant's attorney an assessed fee on that issue. The Referee also declined to assess penalties and attorney fees against either insurer.

Assessed Fee at Hearing on Responsibility Issue

Claimant contends that he is entitled to an insurer-paid attorney fee for services rendered at hearing on the issue of responsibility. We disagree.

Whereas the ORS 656.307 order referring this matter for hearing issued in September 1987, the hearing was not held until January 1988. For that reason, we are faced with the preliminary task of determining whether this case is controlled by pre-1988 law or by current law.

Attorney fees in workers' compensation cases may be awarded only as authorized by statute. Forney v. Western States Plywood, 297 Or 628, 632 (1984). Under pre-1988 law, ORS 656.386(1) is the sole statutory authority for assessment of attorney fees in responsibility hearings held under former ORS 656.307. ORS 656.386(1) provides for assessment of attorney fees if claimant prevails finally in a hearing before a Referee in a "rejected case." A "rejected case" is a case in which 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); Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989). Therefore, if claimant's entitlement to receive compensation is not an issue at hearing, he is not entitled to an assessed fee for services rendered at hearing on the responsibility issue. See id.

ORS 656.307 currently provides for formal arbitration of responsibility cases. Unlike its former version, the current version of ORS 656.307 authorizes an insurer-paid attorney fee if claimant participates in the responsibility proceeding. Specifically, subsection (5) provides that, if claimant appears in any arbitration proceeding and "actively and meaningfully participates" in the proceeding through an attorney, the arbitrator may require that a reasonable attorney fee be paid by the insurer determined by the arbitrator to be the party responsible for paying compensation. This statutory language is essentially duplicated in OAR 438-15-090, effective January 1, 1988.

Although the hearing in this case occurred after the effective date of the current law, we conclude that the critical event for determining what law governs this case is our receipt of the .307 order. ORS 656.307(2) currently provides that the Director initiate the arbitration proceeding by referring the matter to the Board for appointment of an arbitrator. See also OAR 436-60-180(13). The referral is made by issuing a .307 order designating an insurer as paying agent. OAR 436-60-180(12). Our current rules, effective January 1, 1988, direct us to establish an arbitration file upon receipt of the .307 order. OAR 438-14-010(1). Hence, under the statutory and administrative scheme outlined above, arbitration in responsibility cases is initiated only if we receive the .307 order on or after the effective date of the amendments to ORS 656.307, i.e., January 1, 1988. On the other hand, if we received the ".307" order before January 1, 1988, the case is

governed by pre-1988 law and is assigned for hearing. See former OAR 436-60-180(13).

Here, we received the ".307" order on October 5, 1987. Hence, this case is governed by pre-1988 law. Claimant's attorney participated at hearing to establish that claimant had suffered a new injury for which SAIF was responsible. However, a ".307" order had already been issued and, at hearing, neither insurer challenged claimant's entitlement to receive compensation. Because claimant's compensation was never at risk, this case is not a "rejected case" in which claimant's attorney is entitled to an assessed fee. See ORS 656.386(1); Short v. SAIF, supra; Rhonda L. Bilodeau, supra.

Penalties and Attorney Fees

1. Wausau's Denial

Claimant challenges the propriety of Wausau's aggravation denial, contending that it was invalid for the reasons stated in Safstrom v. Riedel International, Inc., 65 Or App 728 (1983), rev den 297 Or 124 (1984), and its progeny. We disagree.

The cases cited by claimant generally provide that an insurer cannot circumvent statutory provisions for claim closure and determination of the extent of disability by issuing a preclosure, partial denial which disclaims further responsibility for a previously accepted condition. See id.; Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984); Maddocks v. Hyster Corporation, 68 Or App 372, rev den 297 Or 601 (1984). We find those cases inapplicable here.

Wausau initially accepted claimant's original claim for a nondisabling injury. Despite the subsequent medical authorization for time off work in December, 1986, there is no evidence that the claim was ever reclassified as disabling. Although claimant's attorney stated at hearing that Wausau accepted the claim as disabling and paid his client temporary total disability compensation, that statement was not testimony, see former OAR 438-07-007, nor was it substantiated by testimony. Hence, it is not evidence and may not be considered. Moreover, the statement is inconsistent with the documentary evidence. First, there is no document indicating that temporary disability benefits were paid. Second, Wausau specifically denied "reopening" of the claim "for further benefits."

Because the injury claim remained classified as nondisabling, Wausau was not required to close it, see former ORS 656.268; rather, it was claimant's burden to seek reclassification. When Wausau failed to reclassify the claim as disabling in December, 1986, claimant could have exercised his statutory right to object to that failure by requesting a determination of the proper classification by the Evaluation Division. See former ORS 656.262(6)(b), 656.268(8). That statutory right continued for the period of one year after the original, nondisabling injury. See ORS 656.262(12). However, claimant did not avail himself of that right during that period and, therefore, is now without remedy for Wausau's failure to reclassify. See Davison v. SAIF, 80 Or App 541, 544 (1986).

After the one-year period above, a claim that a nondisabling injury has become disabling must be made pursuant to ORS

656.273 as a claim for aggravation. ORS 656.262(12). That was the case here. The incident that triggered Wausau's denial occurred on June 30, 1987, more than one year after the original, nondisabling injury. At that time, claimant's physician authorized time off work. Because more than one year had passed since the original injury, Wausau properly regarded the claim as one for aggravation and denied responsibility for it. Wausau's conduct was proper and does not warrant assessment of a penalty or attorney fee.

2. SAIF's Denial

Claimant also seeks assessment of a penalty and attorney fee against SAIF, contending that its denial of his "new injury" claim constituted an unreasonable refusal to pay compensation under ORS 656.262(10). In resolving this issue, the dispositive question is whether the information available at the time of SAIF's August 21, 1987 denial raised a reasonable doubt as to its responsibility for the claim. See Devereaux v. North Pacific Ins. Co., 74 Or App 388, 393, rev den 300 Or 162 (1985).

At the time of SAIF's denial, all of the medical evidence concerning the June 1987 incident had been generated by Dr. Breitenstein, the treating physician. In his final report on July 2, 1987, Breitenstein wrote: "Based on the lifting incident involved at [claimant's] new job, this appears to be a new injury to the same areas involved in the June 2, 1986 injury." Although that report was sufficiently probative to shift responsibility to SAIF, we are not persuaded that SAIF lacked reasonable doubt of its responsibility for the claim.

The symptoms resulting from the 1987 incident involved the same area of claimant's body as the 1986 injury. Indeed, the 1986 injury had not yet fully resolved when claimant began working for SAIF's insured. Furthermore, Breitenstein noted that the pain resulting from the 1987 incident was similar to that experienced after the 1986 injury. Breitenstein added that, whereas claimant sustained 10 percent impairment to his back as a result of the 1986 injury, it was unlikely that the 1987 incident would result in any further impairment. In addition, Breitenstein attributed claimant's need for modified work and vocational rehabilitation to the 1986 injury. The record at the time of SAIF's denial raised sufficiently reasonable doubt as to whether the work exposure at SAIF's insured independently contributed to claimant's preexisting back condition. We conclude that the denial was reasonable and does not warrant assessment of a penalty or attorney fee.

ORDER

The Referee's order dated February 1, 1988 is affirmed.

Board Member Crider concurring in part and dissenting in part.

I join in those portions of the decision denying penalties and related fees and holding that the hearing in this case was not an "arbitration" and therefore that claimant's entitlement to an attorney fee for services at hearing is governed by ORS 656.386 (1) and not ORS 656.307(5). I dissent from that portion of the order holding that claimant is not entitled to an attorney fee under ORS 656.386(1). SAIF denied claimant's new injury claim; Wausau denied his aggravation claim. A ".307" order issued. Claimant participated in the hearing personally and through counsel. He took the position

that claimant suffered a new injury and SAIF was responsible. The Referee agreed and set aside SAIF's denial. The affect of the responsibility decision was to entitle claimant to a higher rate of temporary disability than that to which claimant would have been entitled had responsibility been assigned to Wausau. Therefore, claimant had a stake in the proceeding. He is entitled to a fee. SAIF v. Phipps, 85-Or App 436 (1987); Rhonda L. Bilodeau, 41 Van Natta 11 (January 4, 1989) Board Member Crider, dissenting).

JOY A. HANNA, Claimant
Vick & Gutzler, Claimant's Attorneys
Jeff Gerner (SAIF), Defense Attorney

WCB 88-17106
March 20, 1989
Order of Dismissal (Remanding)

The SAIF Corporation has requested Board review of Referee Michael Johnson's order dated February 16, 1989. We have reviewed the request to determine whether we have jurisdiction to consider it. We conclude that jurisdiction rests with the Hearings Division.

FINDINGS OF FACT

The Referee's Opinion and Order issued February 16, 1989. On March 3, 1989, SAIF asked the Referee to abate his order. SAIF's request for Board review was filed on March 14, 1989. That same day, the Referee abated his order to allow SAIF time to submit a motion for reconsideration.

CONCLUSIONS OF LAW

Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. James D. Whitney, 37 Van Natta 1463 (1985).

Inasmuch as the Referee abated his order simultaneously with SAIF's request for Board review, we shall give effect to the Order of Abatement. Accordingly, the request for review is dismissed as premature. This matter is remanded to Referee Johnson for further consideration.

IT IS SO ORDERED.

CHARLES M. KEPFORD, Claimant
Malagon & Moore, Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-02846
March 20, 1989
Order on Review

Reviewed by the Board en banc.

The self-insured employer requests review of Referee Baker's order which awarded claimant temporary total disability, assessed a penalty and awarded an attorney fee for an unreasonable failure to pay compensation. On review, the employer contends that it was not required to pay temporary total disability benefits because, by the time it was ordered to accept and process claimant's occupational disease claim, claimant had retired from the work force. We affirm.

FINDINGS OF FACT

Claimant, 63 years of age at hearing, worked many years for this employer in the woods and as a millworker. He suffered a compensable low back injury in 1971 and received a 5 percent permanent partial disability award. He suffered another compensable back injury in 1974. He was awarded temporary total disability by Determination Order in 1978, and no additional permanent disability.

Claimant was transferred from the woods to utility mill work. He was assigned to "cleanup and light pull" on the green chain. On February 20, 1981, he was assigned to "hard pull" on the green chain. These activities hurt his back and he went home. Thereafter, his condition continued to deteriorate.

On August 25, 1981, claimant was examined by Dr. Whitney and was determined to be disabled. The employer received a copy of Dr. Whitney's report, which diagnosed spinal stenosis with degenerative changes of the spine. On October 14, 1981, Whitney performed a decompressive laminectomy of the bottom half of L3 and all of L4 and L5. He also performed a L4-5 diskectomy. The post-operative diagnosis was "degenerative spinal disease with lateral stenosis."

On March 29, 1982, Dr. Whitney opined that claimant was not medically stationary and would probably never work again. Claimant has not worked since February 1981.

On April 29, 1982, the employer filed a Form 1502, bearing the 1974 claim number, with the Evaluation Division. The form stated that the employer had previously accepted the claim as a nondisabling claim and was now denying it as a disabling claim. The form indicates that the employer paid claimant temporary total disability from October 14, 1981 to April 16, 1982.

A hearing was scheduled for August 4, 1982 on the employer's denial of the aggravation claim. On July 14, 1982, claimant filed a new claim for his back condition. His attorney wrote to the Referee and to the employer stating that claimant was also claiming that his back condition was an occupational disease, but was not abandoning the original aggravation claim. The hearing was held, but the Referee declined to consider the occupational disease theory because the employer had not had 60 days to consider the new claim.

The Referee upheld the employer's denial of the aggravation claim. We affirmed. Charles Kepford, 35 Van Natta 564 (1983).

Claimant's hearing request concerning his occupational disease claim proceeded to hearing. After a series of letters between counsel for claimant and the employer, the employer stated on April 28, 1983, that if an occupational disease claim had ever been filed, it was denied. The hearing concerning the occupational disease claim was held on February 28, 1984. The Referee upheld the employer's denial. A penalty and attorney fee were assessed for a late denial. We affirmed without opinion on September 28, 1984.

On November 9, 1982, claimant had been awarded

disability benefits by the Social Security Administration. These benefits were payable retroactive to August 1981. On May 26, 1983, claimant filed a notification of retirement with the employer and was given retirement benefits retroactive to February 20, 1981. He received a lump sum check for those prior months on July 1, 1983, and a monthly check thereafter.

Finding that claimant's occupational disease was work related, the Court of Appeals reversed our September 24, 1984 Order on Review. Kepford v. Weyerhauser, 77 Or App 363, rev den 300 Or 722 (1986). On June 10, 1986, pursuant to the court's mandate, we remanded the claim to the employer "for acceptance, payment of compensation according to law and processing to closure under the provisions of ORS 656.268."

On May 14, 1986, the employer apparently filed Form 1502 with the Evaluation Division, indicating that it had reopened its 1974 claim. On May 27, 1986, the employer filed Form 1503 requesting claim closure. On this form it used a new claim number and pointed out to the Evaluation Division that it was doing so. However, in completing the form, the employer listed time loss paid on the 1974 claim. Its accompanying letter contended that claimant was not entitled to further temporary disability compensation.

The Evaluation Division requested medical information from the employer. On July 30, 1986, the employer sent the Division's request to Dr. Whitney. He responded on August 19, 1986, stating he did not understand what was being requested. On September 11, 1986, the employer asked Whitney to examine claimant. He did so on September 30, 1986 and this information was apparently sent to the Evaluation Division.

In the meantime, the employer had not commenced paying temporary disability benefits to claimant. On September 4, 1986, following a series of letters from claimant's attorney seeking an explanation for this conduct, the employer's counsel replied that, since claimant had not sought work since February 20, 1981, he was not entitled to temporary disability benefits.

On March 16, 1987, the Evaluation Division advised the employer that it could not process the matter because the remand order referred to "occupational disease" and the Form 1502, filed by the employer on May 14, 1986, referred to a 1974 injury. The Department said it would "await the resubmission as a separate claim or a clarification of the issue." On July 21, 1987, the employer sent in new Forms 1502 and 1503 bearing a new claim number and indicating that no temporary total disability had been paid.

On August 10, 1987, the Evaluation Division wrote the employer that the claim remained in "accepted non-disabling status." The Division informed the employer that unless claimant objected to this status or the employer filed a Form 1502 changing the status to disabling, the Division could not determine the claim.

This was the status of the case at hearing on September 3, 1987. The Referee found that claimant had neither been released to regular work by his attending physician, returned to his regular work, nor had claimant's temporary total disability benefits been terminated by the Evaluation Division as required by

ORS 656.268. Consequently, the Referee awarded claimant temporary total disability from February 20, 1981, until the "date of this order, and continuing until termination of such compensation is authorized under ORS 656.268 or until actual return to work." The employer was also assessed a 25 percent penalty and associated attorney fees for unreasonable claims processing.

ULTIMATE FINDINGS OF FACT

Claimant left work due to his compensable occupational disease on February 20, 1981. He became unable to perform any work due to his compensable back condition no later than August 25, 1981.

The employer unreasonably refused to pay temporary total disability for the period February 20, 1981 and continuing through the date of the hearing.

CONCLUSIONS OF LAW

The employer's obligation to pay temporary total disability was initially relieved by its denial of claimant's occupational disease claim and the prior Referee and Board decisions upholding the denial. However, upon the Court of Appeals' finding of compensability, the employer's obligation to process the occupational disease claim was triggered. See ORS 656.262; 656.268.

The employer started to process the claim on May 14, 1986. At that time, claimant had neither returned to work nor been released to return to work since February 20, 1981, when he left work as a result of his disabling back condition. Since claimant had neither actually returned to work nor had his attending physician approved his return to regular employment, the employer was obligated to make temporary total disability payments until the issuance of a Determination Order. Former ORS 656.268(2); Former OAR 436-30-030(7); Weyerhaeuser Company v. McCullough, 92 Or App 204 (1988); Vip's Restaurant v. Krause, 89 Or App 214, on recon 91 Or App 472 (1988).

The present situation bears a resemblance to Vip's Restaurant v. Krause, supra. In Krause, the employer had denied the claim. A Referee set aside the denial and remanded the claim to the employer for processing. At the time, the claimant was medically stationary, but not released for work. The employer only paid temporary total disability through the medically stationary date, not until the issuance of a Determination Order. On appeal, the employer argued its conduct was justified in that since it was not paying temporary disability at the time the claim was found compensable, it could not "continue" or "terminate" benefits in the words of ORS 656.268(2).

The Krause court focused on the employer's duty to process a claim according to law, no matter whether the claim has just been filed or is being returned to the employer by a Referee, this Board, or an appellate court. We quote the Court of Appeals:

> "Employer asserts that the application of the statute in these circumstances will result in the payment of benefits greater than those it would have paid had it accepted the claim initially, because the

pendency of the litigation on compensability delays the process of claim closure. That is a situation within the control of employer. When an employer denies the compensability of a claim, it takes the risk that that issue may be resolved against it, i.e., that the claim was in fact compensable from the outset." 89 Or App at 217

Here, the employer argues that the holding of the Supreme Court in Cutright v. Weyerhauser, 299 Or 90 (1985) excuses its nonpayment of temporary total disability benefits for the period February 20, 1981 to claim closure. Specifically, the employer stresses that retired persons are not eligible for temporary total disability. This proposition is based on the Cutright rationale that temporary total disability is to replace lost wages and, because retired persons are not in the workforce, they cannot be said to be losing wages.

Claimant contends that cases like Cutright and Karr v. SAIF, 79 Or App 250 (1986) apply only to the processing of aggravation claims. He further submits that these cases do not justify either the termination of temporary total disability before he becomes medically stationary or the refusal to pay such benefits pursuant to court order because, in retrospect, it appears that claimant did not seek work after he initially became disabled. We agree and conclude that Cutright does not relieve the employer's duty to pay the aforementioned benefits.

The employer's argument is predicated on the assumption that we will find that claimant permanently withdrew from the workforce or retired for purposes of Cutright on February 20, 1981. We do not so find. Claimant had not retired from the workforce when he left his employment on February 20, 1981. Rather, he left work as a result of his compensable disabling back condition. In other words, at the time of his departure from work, he was a "worker." ORS 656.005(27). The fact that years later he applied for and received Social Security and disability retirement benefits, retroactive to the date of his departure, does not alter the conclusion that, on February 20, 1981, he was a worker who left work as a result of a compensable disability.

Thus, regardless of subsequent events, once the claim was found compensable, the employer was required to begin paying temporary total disability benefits effective the date claimant became disabled. Once begun, those benefits must continue until he is released for work and found medically stationary. Former ORS 656.268(2); Weyerhaeuser Company v. Rencehausen, 91 Or App 719 (1988); Northrup King & Co. v. Fisher, 91 Or App 602 (1988); Fazzolari v. United Beer Distributors, 91 Or App 592, on recon 93 Or App 103 (1988), rev den 307 Or 236 (December 20, 1988). Since neither of these events has occurred, we agree with the Referee that the employer is obligated to provide temporary total disability benefits commencing February 20, 1981 and continuing until termination of such benefits is statutorily authorized.

The logic of the aforementioned process becomes apparent when considered within the entire claim evaluation scheme. If a worker is medically unable to work and not medically stationary, temporary total disability benefits are paid. ORS 656.268(1). When the worker's condition becomes medically stationary, the

claim is closed and the extent of permanent disability is determined. ORS 656.268(2). If the worker is permanently incapable of regularly performing work at a gainful and suitable occupation and has made reasonable efforts to seek such work, permanent total disability benefits are awarded. ORS 656.206(1)(a), (3). If the permanent disability suffered by the worker is not total, permanent partial disability benefits are awarded. ORS 656.214.

Once the claim is closed and the claimant withdraws from the workforce, for whatever reason, he is no longer considered a "worker." Cutright, supra; Karr, supra. Because he has lost no wages, it follows that he is not entitled to temporary total disability benefits should his condition worsen. Id. Yet, this analysis is inapplicable where, as here, the claim has not been previously closed. In such cases, the reason for the worker's total disability is the compensable injury and, if the withdrawal from the workforce proves to be permanent, could result in a permanent total disability award.

After considering the entire claim evaluation scheme, we find that there is a distinction between pre-closure and post-closure "retirement" issues when applying the Cutright/Karr rationale. Specifically, we conclude that the principle espoused by the Cutright and Karr decisions is inapplicable to claims, such as this one, where the claim has not been closed.

Accordingly, we hold that any pre-closure "retirement" has no legal significance. Rather, only post-closure withdrawals from the workforce, as were present in Cutright and Karr, would constitute a basis for denying entitlement to temporary total disability benefits.

ORDER

The Referee's order dated October 1, 1987 is affirmed. For services on review, claimant's attorney is awarded $700, to paid by the self-insured employer. A client-paid fee, not to exceed $357, is approved.

Board Member Ferris, dissenting:

I dissent.

It is undisputed that claimant chose to retire while his occupational disease claim was in denied status. Commensurate with this retirement, he began receiving Social Security disability benefits, as well as retirement pension benefits from the employer. The latter benefits retroactively commenced on February 20, 1981, the date claimant stopped working.

Several years after claimant's retirement and his receipt of the aforementioned benefits began, the employer's denial was set aside by the Court of Appeals. In accordance with the court's decision, the employer began processing the claim to closure, but, considering claimant's retirement and his receipt of Social Security and pension benefits, did not pay temporary total disability benefits for that same period. I submit that the employer's actions were proper.

The majority would limit the Cutright and Karr holdings to the processing of aggravation claims. I suggest that the

holdings are applicable to the processing of all claims in which the claimant has retired from the workforce.

In my opinion, the aforementioned cases stand for the following propositions: (1) temporary total disability benefits are intended to provide wage replacement for a worker; (2) when the claimant has withdrawn from the workforce, for whatever reason, he or she is no longer a worker; and (3) if the claimant is no longer a worker, he or she cannot lose wages and, consequently, is not entitled to temporary total disability benefits. The basic reasoning behind these propositions was succinctly articulated by the Supreme Court in Cutright:

> "There is not one word in the statute 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 [by former ORS 656.005(28), now ORS 656.005(27)]." Cutright, supra, 299 Or at page 297.

In Karr, the Court of Appeals stated:

> "Whatever the reason, claimant has withdrawn from the work force. Temporary total disability is awarded for lost wages . . . and a person who has withdrawn from the work force has no lost wages." (Citing Cutright).

In Dawkins v. Pacific Motor Trucking, 91 Or App 562 (1988), the court stated:

> "Claimant contends that his withdrawal from the labor market should not preclude an award of temporary total disability, because it was involuntary and was the result of his work-related disability. As we held in Karr v. SAIF, ... a claimant who withdraws from the work force is not entitled to those benefits, which are awarded for lost wages. ORS 656.210(1); Sykes v. Weyerhauser Co. 90 Or App 41 ....(1988). A person who has withdrawn from the labor market, whether as a result of his injury or for other reasons, has no lost wages."

I would adhere to the basic precept advanced by Cutright and the other cases cited. That is, a claimant who has withdrawn from the work force is no longer a worker and cannot lose earnings. Therefore, although entitled to medical benefits resulting from the compensable condition, the "retired" claimant is not entitled to temporary total disability benefits.

In conclusion, the majority has affirmed a Referee's decision that, in effect, directed the employer to pay more than six years of temporary total disability benefits. Yet, most of these benefits are payable for a time period that is subsequent to claimant's retirement from the work force. Moreover, the temporary total disability benefits are payable for the identical period for which claimant has previously received the employer's retirement pension benefits and Social Security payments.

I submit that the majority's decision results in a double recovery for claimant, has an unduly onerous impact upon the employer, and, as previously discussed, is contrary to prevailing law. Furthermore, assuming only for the sake of argument that the employer was obligated to pay the temporary total disability benefits, I would not consider its failure to provide those benefits to have been unreasonable, yet the majority has so held. Considering the Cutright, Karr and Dawkins holdings, I would find the employer's conduct both understandable and justified. Common sense, at least occasionally, should prevail in this litigation-inflamed workers compensation system and common sense dictates that an employer should not be compelled to pay temporary total disability and retirement benefits for the same period to a worker who has retired.

JUDITH A. LANGE, Claimant
Ralph M. Yenne, Claimant's Attorney
Meyers & Associates, Defense Attorneys

WCB 87-02519
March 20, 1989
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of Referee Black's order which: (1) set aside its denial of claimant's medical services claim for a hot tub; and (2) assessed a 10 percent penalty and related attorney fee for an alleged unreasonable delay in issuing a denial. On review, the issues are compensability and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in June 1982. By the summer of 1986, claimant was experiencing increasing symptoms in her low back and had incidents where her back "locked up." Claimant had declined surgical options earlier, but chose to proceed with a discectomy in October 1986.

In September 1986, prior to the October 1986 surgery, Dr. Sirounian, claimant's treating surgeon, prescribed hot tub use as a means of dealing with pain discomfort. Also in September 1986, Dr. Segur, claimant's treating chiropractor, issued a similar prescription. Claimant's husband purchased a hot tub/Jacuzzi unit for approximately $2,800, which was installed on or about September 20, 1986. The hot tub/Jacuzzi is a basic, unadorned unit and claimant's husband had determined that a separate unit of this type was simpler and cheaper to install than an in-house modification of the bathroom and tub area. The unit is large enough that claimant can do exercises in it which she cannot do in the bathtub.

Claimant's surgery did not successfully relieve her pain symptoms, and following the procedure, she began experiencing more back pain as well as new pain in her left leg. Prior to the surgery, claimant had used hot tub therapy, for which she had to drive 30 miles, and a variety of prescription and nonprescription pain medications.

Claimant has not been declared medically stationary. Prior to installation of the hot tub at her home, she had been going to a health spa for hot tub and exercise treatments twice a week. Claimant now uses the unit two to three times per day and obtains approximately two hours lasting relief. Three days after the hot tub was installed, she was able to stop taking prescription medicine for pain. Claimant uses the unit for relief of pain and

as a forum for her exercises, which enable her to straighten her frame out, reduce stiffness, and enhance sleep.

The employer denied reimbursement for claimant's hot tub unit on February 5, 1987.

FINDINGS OF ULTIMATE FACT

Claimant requires a hot tub unit for relief of her chronic pain symptoms, chronic muscle spasms, and to perform prescribed exercises.

Claimant requires a hot tub unit due to her distance from other sources of hydrotherapy and her intolerance to standard, nonaddictive pain medications.

The employer's denial of the hot tub unit was issued more than 60 days after the unit was prescribed.

CONCLUSIONS OF LAW

At the outset, we find it necessary to clarify the interpretation of former OAR 436-10-040(7) and its application.

ORS 656.245 provides:

> "1) For every compensable injury, the insurer or self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such a period as the nature of the injury or the process of recovery requires..." (Emphasis supplied.)

Former OAR 436-10-040(7) (Amended February 1, 1988, and renumbered 436-10-040(8)) provides in relevant part:

> "... Articles such as beds, hot tubs, chairs, jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury and the process of recovery requires" that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments." (Emphasis supplied.)

As is evident from the emphasized portions of the statutory provision and the administrative rule, the rule seems to imply that the items enumerated are only compensable to the extent that they are curative. Conversely, the statute makes medical services compensable so long as they are reasonable and necessary as a result of the compensable injury. See e.g. McGarry v. SAIF, 24 Or App 883 (1976). The statute does not make the distinction between curative and palliative services, but rather bases compensability on the above-mentioned criterion.

We do not consider the use of the word "and" in the

administrative rule as an attempt to create a narrower standard for compensability of medical services or appliances, but rather intended to incorporate the language used in 656.245(1) as is evidenced by placing that portion of the rule in quotation marks. Accordingly, we reject an interpretation of former 436-10-040(7) that would make the items enumerated within the rule noncompensable if they are prescribed for palliative purposes.

Services provided pursuant to former OAR 436-10-040(7) are compensable, whether they be palliative or curative, so long as they are reasonable and necessary as a result of the compensable injury, and claimant has established with paticularity why she needs the service when the majority of workers with similar injuries do not. This interpretation is consistent with the clear language of the statute and the case law that medical services be rendered after the medically stationary date for palliative as well as curative purposes. See Wetzel v. Goodwin Brothers, 50 Or App 101, 108, (1981).

To the extent that prior Board decisions can be construed to require that services under former OAR 436-10-040(7) be curative, those decisions are disavowed. We further specifically disavow that portion of James Frank, 37 Van Natta 1557 (1985) which declares that the Director's rules are not binding upon us, but rather guidelines for us to follow. We are bound by the rules promulgated by the Director insofar as they are consistent with the Workers' Compensation Act, and the authority granted the Director by the Act. Cf. Miller v. Employment Division, 290 Or 285 (1980); McPherson v. Employment Division, 285 Or 541, 551 n. 8 (1979).

Turning to the merits of the present case and applying the foregoing discussion, claimant has established that she requires a hot tub unit as a result of her compensable injury.

Both Drs. Sirounian and Aversano agree that claimant's hot tub use provides symptomatic relief. Further, Dr. Segur reported that a hot tub unit is essential for control of the late effects of the post-surgical spinal impairment. These reports establish that a hot tub unit is reasonable and neccessary palliative care resulting from claimant's compensable low back injury.

In regard to why claimant needs a hot tub unit, when the majority of workers with similar impairments do not, we are persuaded by Dr. Segur's opinion. Dr. Segur reported that claimant specifically required a hot tub unit due to her distance from other sources of hydrotherapy and due to her intolerance to standard, nonaddictive pain medications. We further note that a home hot tub unit allows claimant to perform rehabilitive exercises recommended by Dr. Segur. In reaching this conclusion, we are aware that Dr. Sirounian indicated that claimant was no different than other patients who he had treated for herniated discs. However, we are not persuaded by his conclusory statement, given its lack of medical analysis. Moe v. Ceiling Systems, Inc., 44 Or App 429 (1984).

Following our de novo review, we conclude that claimant has established the requirements set forth in former OAR 438-10-040(7). Accordingly, the hot tub unit is compensable.

In regard to penalties and related attorney fee issue, we

adopt the conclusions and reasoning as set forth in Sections B. and C. of the "Opinion" portion the Referee's order.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review concerning the medical services 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). 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 October 13, 1987 is affirmed.

WILLIAM E. MILLER, Claimant
Hollis Ransom, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-15799
March 20, 1989
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Fink's order which upheld the self-insured employer's partial denial of claimant's medical services claim for a "contour chair." On review, the sole issue is compensability of medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's "findings of fact" with the following supplementation.

The medical evidence does not establish with particularity how claimant's condition differs from that of other workers with similar impairments such that he requires a "contour chair", when they do not.

CONCLUSIONS OF LAW

Based on a totality of the evidence, the Referee concluded that claimant had not met the burden of proving that a "contour chair" was compensable under former OAR 436-10-040(7). We agree and add the following supplementation.

In Judith A. Lange, 41 Van Natta 580 (Issued this date), we held that medical services provided pursuant to former OAR 436-10-040(7)(Amended February 1, 1988, and renumbered 436-10-040(8)) are compensable even if the services provide solely palliative relief. We found that services rendered pursuant to that provision were compensable, whether they be palliative or curative, so long as they are reasonable and necessary as a result of the compensable injury, and claimant has established with particularity why she needs the services when the majority of workers with similar impairments do not. Id. Accordingly, claimant's claim for a "contour chair" cannot be denied on the basis that it provides only palliative relief.

Although compensability of claimant's claim for a "contour chair" cannot be denied on the basis that it provides only palliative relief, former OAR 436-10-040(7) requires claimant to also establish with particularity why he requires a "contour chair", an item not usually considered necessary in the great majority of workers with similar impairments.

Following our de novo review of the evidence, including lay testimony, we find that claimant has not established why he requires a "contour chair", an item not considered necessary for the majority of workers with similar impairments. Dr. McKillop, orthopedic surgeon, recommended the chair and noted that it would help reduce claimant's pain symptoms. Dr. Daack, orthopedist, and Mr. Ylvisaker, claimant's physical therapist, also recommend the chair to reduce pain and circulatory symptoms. No medical opinion in the record gives any reasoning as to why claimant needs a "contour chair" when such an item is not necessary for the majority of workers with similar impairments.

In light of the foregoing, we conclude that claimant has not carried his burden of proving that he needs a "contour chair" when the majority of workers with similar impairments do not. See Ruby J. Stevens, 39 Van Natta 637, 638 (1987). Accordingly we conclude that the "contour chair" is not compensable.

ORDER

The Referee's order of August 19, 1987 is affirmed. A client-paid fee, not to exceed $150, is approved.

SHARON S. RAGER, Claimant
Martin J. McKeown, Claimant's Attorney
Beers, et al., Defense Attorneys

WCB 85-11532
March 20, 1989
Order on Review

It has come to our attention that our Order on Review, issued this date, contains some clerical errors. To correct these oversights, our prior order is withdrawn and replaced with the following order.

The insurer requests review of Referee Quillinan's order that set aside its partial denial of a spa or whirlpool. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant's physical discomfort responds well to chiropractic treatment, including a regimen of specific spinal adjustments, myofascial trigger point therapy, pulsed ultrasound, positive galvanic stimulation, moist hydrotherapy and the use of prescribed exercises. This treatment is effective in relieving her chronic pain, allowing her to remain actively employed and function on a daily basis.

CONCLUSIONS OF LAW

The Referee concluded that claimant had established the compensability of the hot tub since Dr. Ray's reports adequately justified the purchase of furniture not usually considered necessary. We disagree.

ORS 656.245 states that:

"[f]or every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for

> conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires . . ."

OAR 436-10-040(7) (Amended February 1, 1988, and renumbered 436-10-040(8)) enumerates specific medical services which shall be provided for every compensable injury. It provides that:

> ". . . hot tubs [and] jacuzzis . . . are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury and the process of recovery requires" that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments."

Services provided pursuant to former OAR 436-10-040(7) are compensable, whether they be palliative or curative, so long as they are reasonable and necessary as a result of the compensable injury, and claimant has established with particularity why she needs the service when the majority of workers with similar injuries do not. Judith A. Lange, 41 Van Natta 580 (Issued this date).

In the present case, Dr. Ray, claimant's treating chiropractor, had treated claimant with specific chiropractic spinal adjustments, myofascial trigger point therapy, ultrasound, cryotherapy, orthopedic support and prescribed exercise. Although the treatments had been quite effective in reducing the intensity, duration, severity and frequency of claimant's chronic pain, it had not been eliminated. Therefore, Dr. Ray prescribed a full-size Jacuzzi whirlpool.

Dr. Ray believed that the $4,000 home hot tub unit was quite justified since: (1) whirlpool type applications of moist heat are far more effective than a simple tub bath or heating pad; (2) claimant lived almost 25 miles from the nearest city that would have public hot tub facilities; and (3) claimant's modesty created a reluctance to frequent such public bathing facilities. He believed that the therapy was necessary so that claimant's chronic muscular spasms and pain were reduced prior to her retiring for the evening, thereby allowing her to sleep more fully and with less pain.

Although claimant has shown that a hot tub would provide effective palliative treatment for her pain syndrome, she has not shown with particularity why she needs the service when the majority of workers with similar injuries do not. Dr. Ray repeatedly stated that his various chiropractic treatments were quite effective in controlling claimant's pain syndrome. In fact, it is undisputed that chiropractic treatments have provided claimant with effective, short-term relief. Therefore, claimant has not shown a special need for the hot tub due to any ineffectiveness of traditional palliative medical treatment. Neither do we believe that her modesty or 25 mile distance from public hot tub facilities prove claimant's entitlement to an item not usually considered necessary in the great majority of workers with similar impairments.

Following our de novo review, we conclude that claimant has not met the minimum requirements set forth in former OAR 438-10-040(7). Accordingly, the hot tub unit is not compensable.

ORDER

The Referee's order dated August 12, 1987, as reconsidered October 22, 1987, is reversed. The insurer's partial denial of a spa or whirlpool is reinstated and upheld.

MARK S. SCHUMACHER, Claimant
Francesconi & Cash, Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 86-11599
March 20, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Seymour's order that set aside its denial of claimant's medical services claim for reimbursement for the purchase and installation of a hot tub for claimant's left knee condition. The issue on review is compensability of medical services. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to his left knee in 1985. Dr. Paluska performed reconstructive surgery on the knee. Thereafter, claimant received physical therapy, including hydrotherapy and hot packs.

Claimant obtained a prescription from Dr. Paluska on January 8, 1986, for the hot tub. The prescription states "Hot Tub-for knee rehabilitation." Claimant's attorney requested from Dr. Paluska a report discussing how the recovery process and the particular injuries suffered by claimant require a hot tub. The request specifically asked Dr. Paluska how claimant's knee condition was different and more severe than the usual knee injury.

Claimant's attorney received this reply from Dr. Paluska:

> "Mr. Schumacher sustained a very serious injury to his knee requiring major, ligamentous, knee reconstruction.
>
> The required surgery requires considerable and long term physical rehabilitation.
>
> "I recommended a hot tub to aid in his rehabilitative process since it was going to be a long lasting one.
>
> "It is my impression that it would be reasonable that a portion of the cost could be medically deducted.
>
> "I am not so naive as to think that the entire cost of the hot tub plus installation would be totally written off as a medical expense."

Claimant telephoned the insurer's claims representative after obtaining the prescription and asked if the hot tub would be

provided. The claims representative indicated he would respond later, but never did so. Claimant bought the hot tub with his own funds.

Claimant spoke with the insurer's new claims representative thereafter and was told he would need to submit the prescription and all information in writing. On August 7, 1986, claimant sent the prescription to the insurer and requested reimbursement in the amount of $3,500. The claim was denied.

ULTIMATE FINDINGS OF FACT

Dr. Paluska's report did not clearly justify, with particularity, that the hot tub was required as a result of claimant's injury and process of his recovery.

The purchase of a hot tub for claimant's personal use is not reasonable and necessary medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that Dr. Paluska's report satisfied the requirements of OAR 436-10-040 (7). We disagree.

Former OAR 436-10-040(7) (Amended February 1, 1988, and renumbered 436-10-040(8) states, in part:

> "Furniture is not a medical service. Articles such as beds, hot tubs, chairs, jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the 'nature of the injury and the process of recovery requires' that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments."

We have construed the words "with particularity" in this rule rather strictly. See Ruby J. Stevens, 39 Van Natta 637 (1987)(reclining chair); James R. Frank, 37 Van Natta 1555 (1985)(waterbed); compare, Janet E. Long, 39 Van Natta 819 (1987) (jacuzzi and recliner chair). We find the prescription in this case to be far from that level of particularity we required in James R. Frank, supra, where the treating physician issued a report. Here, there is a prescription from Dr. Paluska containing the words "Hot Tub-for knee rehabilitation", and a brief report that indicates only that Dr. Paluska would somehow have claimant and the insurer share the cost of the hot tub. The other medical evidence in the record consists of reports from Drs. Becker and Fry. Those reports rebut claimant's contention that he requires the hot tub in order to rehabilitate his knee. We find there is a failure of proof as required by the cited rule.

ORDER

The Referee's order dated October 26, 1987, is reversed. The insurer's denial is reinstated and upheld. A client-paid fee, not to exceed $625, is approved.

KENNETH L. PERKINS, Claimant
SAIF Corp, Insurance Carrier

Own Motion 89-0115M
March 21, 1989
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his August 22, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the proposed surgery, but opposes reopening of this claim for the payment of temporary disability benefits as it contends that claimant has not been a member of the work force since 1986.

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. Surgery has been recommended for claimant's compensable condition and claimant may be entitled to temporary disability benefits during his recovery. Claimant does not dispute SAIF's contention that he has not been regularly employed since 1986. However, periodically claimant has been on disability status because of his physical and mental conditions. Claimant has indicated that he is currently signed up with the job counsel in Medford in an effort to find work. We conclude claimant has not permanently removed himself from the work force. Claimant is entitled to compensation for temporary disability benefits during his recovery period. Chapel of Memories v. Davis, 91 Or App 232 (1988).

Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date he is hospitalized for the recommended surgery 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.

WILLIAM WILDER, Claimant
Peter O. Hansen, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

Own Motion 89-0041M
March 21, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his March 31, 1975 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for claimant's recent low back surgery, but oppose 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. Claimant recently required surgery for his compensable condition. However, the evidence is clear that claimant has not been gainfully employed for many years and has not looked for work or cooperated fully with vocational efforts. He contends he is entitled to

temporary disability benefits because he has not voluntarily removed himself from the work force, implying that his compensable condition renders him disabled from work. Roland L. Dawkins v. Pacific Motor Trucking, 91 Or App 562 (1988), indicates that an involuntary removal from the work force due to the residuals of the compensable condition no less than voluntary removal means that the worker is not entitled to temporary disability benefits during his recovery period. See also Cutright v. Weyerhaeuser Company, 299 Or 290 (1985). We conclude claimant is not entitled to compensation for temporary disability benefits during his recovery from the recent surgery. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

CARL W. CRAIN, Claimant
Peter O. Hansen, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-05256
March 23, 1989
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of those portions of Referee Galton's order which: (1) granted claimant permanent total disability; (2) affirmed a Determination Order award of temporary disability; and (3) assessed a 25 percent penalty for an unreasonable late payment of temporary disability. In his brief, claimant objects to that portion of the Referee's order which allowed the insurer to offset claimant's permanent partial disability payments against the permanent total disability benefits granted. On review, the issues are permanent total disability, temporary total disability, penalties, and offset. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings, with the following additions.

On May 21, 1984, claimant strained his back while attempting overhead work as a mechanic. As a result, claimant filed a claim for an injured back.

On June 6, 1984, Dr. Ritchy diagnosed claimant's condition as: (1) lumbosacral strain; and (2) possible aortic aneurysm. The diagnosis of aortic aneurysm was based upon diagnostic x-rays taken for the low back injury. Because the aneurysm was considered life threatening, claimant underwent immediate surgery to repair it. Subsequent multiple surgeries and complications followed, which precluded medical treatment for his low back.

On August 20, 1984, the insurer reclassified claimant's accepted original injury from nondisabling to disabling. Temporary total disability was paid from May 25, 1984 through August 20, 1985.

By February 1985, claimant had completely recovered from his vascular problems. There remained no significant residual disability due to that condition.

On February 14, 1985, Dr. Kullberg made an additional diagnosis of chronic impingement syndrome of claimant's left shoulder. This condition did not result in any significant loss of earning capacity.

ULTIMATE FINDINGS OF FACT

The insurer did not accept claimant's aortic aneurysm, and resulting medical care.

Claimant's aortic aneurysm is not causally related to to the compensable low back injury of May 21, 1984.

Claimant's aortic aneurysm surgery was not performed as a required preliminary procedure, or an integral part of treatment for the compensable low back injury.

Claimant's left shoulder disability was a consequence of a preexisting condition, and unrelated to the compensable low back injury.

Claimant's cervical back condition was a result of an injury, which occurred while he was engaged in a vocational rehabilitation program.

At the time of hearing, claimant had no physical impairment resulting from the cervical back injury.

As a result his compensable low back injury, preexisting disabilities, and nonmedical factors, claimant is permanently and totally incapacitated from regularly performing gainful and suitable employment.

Considering the extent of his physical incapacity and his nonmedical factors, it was futile for claimant to seek regular gainful employment.

CONCLUSIONS OF LAW

Permanent Total Disability

The Referee found claimant permanently totally disabled on two separate grounds. The first, based upon medical factors alone; and the second, based upon a combination of medical and nonmedical factors, otherwise known as the "odd-lot" theory. In finding claimant permanently and totally disabled based on physical incapacity, the Referee took into account not only claimant's compensable low back injury, but also an aortic aneurysm condition which was discovered during treatment for the low back. The Referee premised this conclusion upon three theories: (1) the insurer had specifically accepted claimant's aortic aneurysm; (2) the medical evidence established that the May 21, 1984, injury caused claimant's aneurysm "to produce symptoms and loss of earning capacity where none existed before;" and (3) the medical treatment for claimant's aneurysm was required preliminary procedure necessitated by the compensable injury.

We agree with the Referee that claimant is permanently and totally disabled. But we base our conclusion solely on the combination of medical and nonmedical factors. In so holding, we reject the Referee's analysis which finds claimant permanently and totally disabled based upon medical factors alone. In this regard, we specifically disagree with the Referee's inclusion of claimant's aortic aneurysm in his assessment of permanent total disability.

Compensability of claimant's aortic aneurysm for purposes of rating permanent disability.

An insurer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). If an insurer specifically accepts in writing only one of several conditions or injuries encompassed by a single claim, the insurer has not "specifically" or "officially" accepted the other conditions allegedly related to the accepted part of the claim. The insurer's knowledge or notice of a condition is not a substitute for a specific written acceptance as defined by Bauman v. SAIF, 295 Or 788 (1983). An insurer's failure to respond to a claim or one aspect of a claim is neither acceptance nor denial. Silence is neutral. Johnson v. Spectra Physics, 303 Or 49, 55-58 (1987); See Georgia-Pacific v. Piwowar, 305 Or 494 (1988).

The Referee found claimant's aortic aneurysm compensable because he concluded there had been an implicit acceptance by the carrier, when the carrier redesignated claimant's low back injury claim from nondisabling to disabling. However, the act of redesignation, without more, can not convert the carrier's silence into an affirmative act of acceptance.

Even assuming significance should be attributed to the carrier's reclassification of the claim, it is by no means certain that the discovery of the aortic aneurysm was the catalyst. It is equally plausible that the insurer was motivated by other factors in classifying the claim. For example, as early as May 29, 1984, a week before the aneurysm was discovered and months before the claim was reclassified, the treating physician ordered time loss for the back condition. The time loss authorization made this a disabling claim. Viewed in this light, the insurer responded appropriately by reclassifying the claim. However, regardless of underlying intentions, acceptances must be determined form the face of the document, and not on speculation about intent.

On no occasion did the carrier specifically in writing accept the aortic aneurysm. The only evidence found in the record bearing on this issue is an insurer's report (Form 1502), dated August 20, 1984. However, this report is nothing more than a report to the Workers' Compensation Division concerning the current status of the claim. It is not a notification to the claimant that the claim is accepted or denied. The Court of Appeals has specifically held that the information contained on the Form 1502 is not an official notice of acceptance. EBI Insurance Company v. CNA Insurance, 95 Or App 448 (March 8, 1989). Therefore, we find that the insurer did not accept claimant's aortic aneurysm condition, and thus, is not bound by the dictates of Bauman. Johnson, supra, 303 Or at 55.

Because of our holding above, we proceed to examine whether, in fact, the aortic condition was causally related to the May 21, 1984, low back injury. We conclude that it was not. Dr. Ritchy's check-the-box response is inadequate to convincingly establish a causal relationship. No other physician suggests such a relationship. Therefore, if any conclusion can be reached based on the medical record, it is that there is no causal relationship.

In essence then, the Referee makes a finding of compensability based upon a chronological sequence of events. He as much as says that because the condition, its symptoms, and need

for treatment arose after the industrial injury, there must be a relationship. However, the establishment of causation based on a chronological approach is disfavored unless all other explanations have been eliminated. Bradshaw v. SAIF, 69 Or App 587, 587-589 (1984). We will not make an inference of causation based upon timing where the medical evidence fails to do so. Edwards v. SAIF, 30 Or App 21, 24 (1977).

For similar reasons, we also reject the Referee's reliance on the "required preliminary procedure" theory as applied in Williams v. Gates, McDonald & Co., 300 Or 278, 281-282 (1985). There is no medical evidence which indicates that claimant's aneurysm surgery was an integral part of the treatment plan for the low back condition. The surgery was performed due to the nature of the aneurysm, not because of any relationship to the back injury.

Finally, notwithstanding the above findings, we also find that at the time of hearing, claimant's aortic aneurysm condition had resolved without significant residual impairment. Accordingly, we find it was improper for the Referee to include any disabling effects of aortic aneurysm when rating claimant's permanent total disability.

Compensability of claimant's left shoulder condition for purposes of rating permanent disability

Similarly, we find that claimant's preexisting, nondisabling left shoulder condition did not contribute to his physical impairment at the time of hearing. Therefore, in terms of rating claimant's permanent disability, the compensability of his left shoulder condition was irrelevant. Barrett v. D. H. Drywall, 300 Or 327 (1985), on recon 300 Or 553 (1986).

Compensability of claimant's cervical condition for purposes of rating permanent disability

On January 22, 1986, the insurer referred claimant to a rehabilitation center for work evaluation and assessment. On February 21, 1986, while enroute to attend the scheduled work tolerance screening, claimant was rear-ended in a motor vehicle accident. As a result, he sustained a neck injury.

An injury incurred while engaged in a vocational rehabilitation program is a compensable consequence of an original injury. See Firkus v. Alder Cr. Lbr., 48 Or App 251 (1980), rev den 290 Or 302 (1981); Wood v. SAIF, 30 Or App 1103 (1977), rev den 282 Or 189 (1978). It has also been held that when a worker is injured in an accident which occurs during a trip to see a physician for treatment of a compensable injury, the new injury also is compensable. Fenton v. SAIF, 87 Or App 78, 83 (1987).

Therefore, although claimant's cervical condition did not contribute to any physical impairment at the time of hearing, we find that the Referee's inclusion of the cervical condition when rating claimant's permanent total disability, was not improper.

Compensability based upon a combination of medical and nonmedical factors.

Although we find claimant's physical impairment due to

his low back condition to be substantial, we do not find it, standing alone, to warrant an award of permanent total disability. However, we do conclude that, when these medical factors are combined with claimant's nonmedical factors, he is entitled to an award of permanent total disability.

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 condition 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's industrial injury was superimposed upon preexisting degenerative joint disease in the lumbar back. Claimant's treating orthopedist, Dr. Tilson, found the majority of claimant's severe impairment to be due to degenerative changes in the back. Claimant's treating family doctor, Dr. Kullberg, specifically opined that claimant's primary disability preventing his return to work was chronic back pain and stiffness.

Claimant is not capable of physically performing more than sedentary to light work. Claimant's treating orthopedist, Dr. Tilson, has limited claimant to a maximum lifting capacity of 25 pounds at any given time, and 10 pounds repetitively. Further, he has restricted claimant from repetitive squatting, kneeling, bending, twisting, stooping, pushing, and pulling. Dr. Tilson also indicated claimant was not able to sit or stand more than 10 minutes without change of position. Additionally, claimant must lie down for 15 minutes each two hour period. Dr. Tilson indicated these restrictions are permanent. Claimant's treating family physician, Dr. Kullberg, concurred with this assessment.

Claimant's social and vocational factors are negative factors and increase his disability. At hearing, he was 63 years old, with a seventh grade education. His work history consists of repairing, driving, and loading and off-loading various types of equipment. Specifically, he has been employed as a heavy-equipment operator and diesel mechanic. However, due to the injury, claimant is unable to utilize these previous skills. Claimant possesses no other formal education or specialized skills.

As a consequence of the compensable back injury, claimant has been unable to work at regular gainful employment. Although claimant was offered the light-duty job of fuel injector serviceman, Dr. Tilson concluded that he would be unable to perform this job due to the fact he must lie down frequently. The vocational rehabilitation counselor, Mr. McNaught, whom the Referee found credible, relied upon these restrictions in conjunction with claimant's other negative social and vocational factors when he concluded that claimant was permanently totally disabled.

Considering claimant's severe physical impairment, his vocationally advanced age, limited educational level, work history, and lack of transferable skills, we are persuaded that claimant is permanently totally disabled. Furthermore, we conclude that it would have been an exercise in futility for claimant to look for gainful work. Accordingly, we hold that claimant has established his entitlement to permanent total disability.

Offset of Permanent Partial Disability Against Permanent Total Disability

The Referee relied upon Pacific Motor Trucking v. Yeager, 64 Or App 28 (1983), in allowing the insurer to offset permanent partial disability benefits, paid pursuant to the Determination Order, against claimant's permanent total disability award, which was paid after the effective date of the permanent total disability award. We agree.

There is both a theoretical and a practical reason for the holding that an injured worker is not entitled to simultaneous payments of more than one disability award. The theoretical reason is that a claimant can be no more than totally disabled at any given time. The practical reason is that if a claimant is allowed to draw simultaneous benefits from a permanent total and a permanent partial award, it may be more profitable for claimant to be disabled than to be well. This is a situation which compensation law always studiously avoids in order to prevent inducement to malingering. Yeager, supra, 64 Or App at 32.

However, the insurer would not be entitled to an offset if the Board or court subsequently ordered compensation disallowed or that the amount awarded should be reduced. ORS 656.313(2); United Medical Laboratories v. Bohnke, 91 Or App 144 (1986); SAIF v. Casteel, 74 Or App 566, remanded on other grounds, 301 Or 151 (1986). In the present case, the Referee granted claimant permanent total disability. Accordingly, since claimant's award has been increased, and not decreased, ORS 656.313(2), and the analysis in Casteel is not applicable. Therefore, the insurer may offset permanent partial disability, paid pursuant to the Determination Order, against permanent total disability benefits awarded after August 21, 1985, the effective date of the permanent total disability award. Sullivan v. Banister Pipeline American, 91 Or App 493 (1988).

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 December 31, 1986, as reconsidered on February 13, 1987, is affirmed. A client-paid fee not to exceed $160 is approved.

DEBBIE K. GOEDERT, Claimant
Malagon & Moore, Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 85-06990
March 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Podnar's order which: (1) upheld the insurer's partial denial for a rash condition and depression; and (2) found that no aggravation claim had been perfected. Claimant did not file a brief on Board review. The issues on review are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings as our own.

CONCLUSIONS

Following our de novo review of the medical and lay evidence, we are unable to conclude that claimant's rash or depression was related to her compensable carpal tunnel and/or thoracic outlet syndrome. Furthermore, Dr. Koning, claimant's treating physican, could not relate her depression and skin disease to her thoracic outlet syndrome. Accordingly, we agree with the Referee that the record fails to establish that the rash and depression are compensable.

We disagree with the Referee's reasoning that the March 1985 chart note was not a claim for aggravation. Dr. Sulkosky stated that claimant's nerve conduction test did not reveal a need for further surgery. However, he noted the need to repeat lab work and thyroid studies to determine if there was another etiology for her claimant's symptomatology. Further, he stated that claimant was to see Dr. Koning for further evaluation regarding her thoracic outlet syndrome.

The chart note indicated that claimant required further treatment of her thoracic outlet syndrome. A worker is entitled to additional compensation for "worsened conditions resulting from the original injury," and a physician's report indicating a need for further medical services is a claim for aggravation. ORS 656.273(1), (3); Krajacic v Blazing Orchards, 84 Or App 127, remanded 304 Or 436 (1987), adhered to on recon 90 Or App 593 (1988); Stratton v SAIF, 80 Or App 637, 638 (1986); Clark v SAIF, 50 Or App 139 (1981).

However, SAIF was not put on notice that it had to determine whether a worsening had occurred because it did not receive Dr. Sulkosky's entire two page chart note. Instead it received only Page 2 of the note, which did not indicate the need for any further related treatment. Additionally, accompanying the note, were two medical bills indicating treatment for conditions unrelated to her compensable injuries. Accordingly, we agree with the Refereee's conclusion that claimant did not perfect a claim for aggravation.

ORDER

The Referee's order dated June 26, 1987 is affirmed.

STEVEN L. HEDGEPETH, Claimant
Bloom, et al., Claimant's Attorneys
Ronald Rhodes, Defense Attorney
Acker, et al., Defense Attorneys

WCB 87-08610 & 87-04867
March 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Neal's order that upheld North Pacific Insurance Company's denial of claimant's aggravation claim for the low back and Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim. We affirm.

ISSUES

1. The compensability of claimant's February 1987 claim.

2. If the claim is compensable, the issue is responsibility between the two insurers.

FINDINGS OF FACT

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

Claimant's April 1983 compensable injury was not a material contributing cause of his disability in February 1987.

The February 2, 1987 incident at work was not a material contributing cause of claimant's disability or need for medical treatment.

CONCLUSIONS OF LAW

We affirm and adopt the Referee's opinion, with the following comment. In determining the compensability of claimant's claims, the Referee held that claimant had failed to prove that his 1983 injury was a "major contributing cause" of his 1987 condition. The Referee applied the wrong standard. In order to prove the compensability of his 1987 condition, claimant had to establish one of three things: (1) that his February 2, 1987 incident at work was a worsening of the condition he suffered as a result of his 1983 injury, Smith v. SAIF, 302 Or 396 (1986); (2) that the February 2, 1987 incident itself was a material contributing cause of his 1987 disability, Summit v. Weyerhaeuser, 25 Or App 851 (1976); or (3) that the 1983 injury remained a material contributing cause of claimant's 1987 disability despite the intervention of an off-the-job injury on February 22, 1987. Grable v. Weyerhaeuser Co., 291 Or 287 (1982).

After reviewing this record, we agree with the Referee that claimant has failed to prove the compensability of either of his 1987 claims.

ORDER

The Referee's order dated November 17, 1987 is affirmed. A client-paid fee of $450, payable by Liberty Northwest Insurance Corporation to its counsel, is approved.

DELORES A. MARTIN, Claimant
Kenneth D. Peterson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-01972
March 23, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Amfac, Inc. v. Martin, 94 Or App 177 (1988). In our Order on Review, dated January 7, 1988, we affirmed the order of the Referee, which set aside the insurer's denial of claimant's bilateral wrist condition. The court has instructed the Board to reconsider this case in the light of Armstrong v. Asten-Hill, 90 Or App 200 (1988). We proceed to do so. We affirm.

ISSUES

1. Whether claimant's bilateral wrist condition is properly characterized as an occupational disease or injury.

2. Whether claimant's bilateral wrist condition is compensable.

FINDINGS OF FACT

Claimant, 43 at the hearing, began working for the employer, a potato processing plant, in June 1984. Before that time, she had worked for approximately 18 years as a data entry operator. Although the data entry job required the use of her fingers and hands as well as some flexion of the wrists, claimant experienced no carpal tunnel symptoms.

At the employer, claimant initially worked on the "trim line," where she picked up potatoes from a conveyor belt and trimmed off defects with a paring knife. The job was fairly fast paced, but caused claimant no problems with her hands or wrists.

In October or November, 1984, claimant began working full time as a hand casing trainee. This work required that she pick up frozen potato patties by hand and place them in a tray. It caused no carpal tunnel symptoms.

After a brief plant shutdown in November 1984, claimant took a position in the quality control lab, where she worked until October 1985. The lab work required the use of her hands and wrists, but was not as repetitious as her two prior positions. In July 1985, she noticed that her hands were "falling asleep," while performing her lab duties.

In October 1985, claimant took the hand casing position for which she had trained. Nine days later (i.e., on October 23, 1985), she reported to Dr. Carpenter, M.D., with complaints of bilateral hand numbness and tingling. Carpenter diagnosed: "[A]cute synovitis of the paratenon sheaths around the flexor tendons with associated compression at the median nerve." He recommended anti-inflammatory medication, wrist splinting, and no further repetitive grasping with the hands.

Claimant was examined by Dr. Peterson, a chiropractor, in December 1985. Peterson diagnosed her condition as bilateral carpal tunnel syndrome.

A few days later, claimant was examined by Dr. Nathan, a hand specialist. Nathan also diagnosed bilateral carpal tunnel syndrome and recommended surgical releases.

In January 1986, claimant sought treatment from Dr. Gehling, M.D. Gehling performed a right carpal tunnel release in February 1986, followed by a left carpal tunnel release in March 1986.

ULTIMATE FINDINGS OF FACT

Claimant did not have a preexisting right or left wrist condition prior to the onset of her symptoms in July 1985.

There is no persuasive evidence that claimant engaged in nonwork activities requiring repetitive use of her hands or wrists.

CONCLUSIONS OF LAW

Occupational Disease or Injury

On remand, the court has instructed the Board to find whether claimant's bilateral wrist condition is an occupational disease or injury. We find that her condition is best analyzed as an occupational disease.

In Valtinson v. SAIF, 56 Or App 184, 187 (1982), the court provided, inter alia:

> "'What set[s] occupational diseases apart from accidental injuries [is] both the fact that they can [not] honestly be said to be unexpected, since they [are] recognized as an inherent hazard of continued exposure to conditions of the particular employment, and the fact that they [are] gradual rather than sudden on onset.'" [quoting O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975)].

Here, claimant alleges that her employment exposure beginning in June 1984, caused her bilateral wrist condition. Since that date, she has worked at multiple positions requiring repetitive use of her hands and wrists. Given the nature of claimant's work exposure, we conclude that it was not unexpected that she would develop a bilateral wrist condition. We further conclude, that her condition arose gradually, rather than suddenly, inasmuch as there was no incident or trauma that caused her symptoms.

Accordingly, claimant's bilateral wrist condition is properly characterized as an occupational disease.

Compensability

To establish a claim for an occupational disease, claimant must prove that her work activities were the major contributing cause of her bilateral wrist condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). If claimant's condition preexisted her employment, she must also prove that her work activities caused a worsening of her underlying condition producing disability or the need for medical services. Wheeler v. Boise Cascade Corp., 298 Or 452 (1985); Weller v. Union Carbide, 288 Or 27 (1979).

As we assess the evidence, neither the parties nor the

medical experts dispute that claimant developed bilateral wrist symptoms as a result of her work activities, which eventually required corrective surgery. (See e.g., Ex. 3-4). We further find that there is no dispute over the fact that claimant did not experience any symptoms or difficulties with her hands or wrists, until July 1985.

The sole dispute, in our view, is whether claimant had a preexisting condition, coined by Dr. Nathan as "carpal tunnel disease," which did not become symptomatic until July 1985. If so, the insurer contends that there is no evidence that claimant's preexisting condition worsened, see Wheeler, supra, and, therefore, she has not proven compensability.

We find that claimant did not have a preexisting condition in her hands or wrists prior to beginning her employment with the employer in June 1984. See Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985). The only evidence to the contrary is Dr. Nathan's opinion that claimant had a dormant underlying disease, that did not manifest itself, i.e., become symptomatic, until July 1985. We are not persuaded by Nathan's conclusory opinion.

Dr. Nathan never observed claimant prior to the onset of her symptoms in July 1985. Thus, his opinion concerning whether or not she had a preexisting condition prior to that date, is entirely retrospective. Moreover, the factual history of claimant's condition is that she experienced no hand or wrist symptoms until over a year after she began her employment with the employer. She experienced no difficulties prior to that date.

Accordingly, given claimant's on-the-job repetitive use of her hands and wrists, the lack of similar off-the-job exposure, and our finding that she did not have a preexisting carpal tunnel disease prior to June, 1984, we conclude that her work exposure was the major contributing cause of her bilateral wrist condition.

Claimant's counsel is entitled to a reasonable assessed fee for services on Board review. See ORS 656.382(2). However, because no statement of services has been received to date, see OAR 438-15-010(5), an assessed fee cannot be awarded.

ORDER

The Referee's order, dated January 28, 1987, is affirmed.

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

WCB 85-10736
March 23, 1989
Order Denying Request

Claimant's counsel seeks an award of an assessed fee for services rendered in this matter which culminated in our February 3, 1989 Order on Remand. The request is denied.

FINDINGS

On December 19, 1986, a Referee's order issued which upheld the self-insured employer's denial of claimant's current chiropractic treatment. Claimant requested Board review. On November 4, 1987, the Board issued its Order on Review, affirming the Referee's order. Claimant requested judicial review. Citing Armstrong v. Asten-Hill, 90 Or App 200 (1988), the Court of Appeals remanded the case to the Board for reconsideration on

August 17, 1988. Orozco v. U & I Group, Inc., 92 Or App 585 (1988).

Pursuant to our February 3, 1989 Order on Remand, we reversed the Referee's order and set aside the employer's denial. The Board's order further stated that since no statement of services had been received from claimant's counsel, no assessed fee would be approved. The February 3, 1989 order has not been appealed, abated, stayed or republished.

On February 22, 1989, the Board received a statement of services from claimant's counsel. On February 27, 1989, the Board received the employer's objection to the statement of services submitted by claimant's counsel.

CONCLUSIONS

Pursuant to our February 3, 1989 Order on Remand, claimant has finally prevailed after remand from the Court of Appeals. Accordingly, claimant's counsel is entitled to the award of a reasonable attorney fee for services before every prior forum. ORS 656.388(1). However, we conclude that we lack jurisdiction to award such a fee.

Pursuant to ORS 656.295(8), our order became final unless, within 30 days thereof, one of the parties appealed to the Court of Appeals for judicial review. No appeal was taken to the order. As previously noted, the statement of services from claimant's counsel was received prior to expiration of the 30-day appeal period. As stated in Betty J. Eyler, 40 Van Natta 977 (1988), we make every effort to promptly process requests received under these circumstances. Unfortunately, in this instance, the 30-day period to further consider our Order on Remand passed before the statement of services reached the record.

Inasmuch as the February 3, 1989 Order on Remand has neither been appealed, abated, stayed nor republished, it has become final by operation of law. International Paper Co. v. Wright, 80 Or App 444, 447 (1986). Because the February 3, 1989 order addressed 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. See Jane E. Stanley, 40 Van Natta 831 (1988). Therefore, we do not address the employer's objections to the amount of the fee request.

IT IS SO ORDERED.

HERIBERTO PEREZ, Claimant
Bischoff & Strooband, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

Own Motion 88-0428M
March 23, 1989
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his April 17, 1981 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 condition has not materially worsened. Claimant asks that the Board assess a penalty and attorney fee against the insurer for its failure to respond to the request for own motion relief in a timely manner.

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 1987 claimant required brief hospital stays for treatment of pain. He could be entitled to own motion relief under the current law. However, claimant has not been gainfully employed since approximately 1984. The evidence indicates that claimant does not feel he is employable and has made no attempt to return to work. We conclude claimant is not entitled to compensation for temporary disability benefits pursuant to Cutright v. Weyerhaeuser Company, 299 Or 290 (1985). The request for own motion relief is denied.

Claimant's request for relief was mailed to the insurer on March 1, 1988. The insurer responded to this request by its letter to the Board on July 11, 1988. OAR 438-12-025 (2) requires that the insurer advise the Board of its position no later than the 60th day after receipt of the request for own motion relief. The insurer has offered no explanation for the delay. Although we cannot assess a penalty against the insurer as there are no amounts due claimant on which a penalty could be assessed, we conclude claimant's attorney is entitled to a fee of $250, payable by the insurer.

IT IS SO ORDERED.

HAROLD R. POOLE, JR., Claimant
Bischoff & Strooband, Claimant's Attorneys
Nancy Marque (SAIF), Defense Attorney

WCB 87-05377
March 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) upheld the SAIF Corporation's denial insofar as it denied claimant's claim for a broken Harrington rod and broken spinal fusion; and (2) declined to award interim compensation or assess penalties and related attorney fees. On review the issues are compensability, interim compensation, penalties and attorney fees. We reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of the finding that the employer first knew of the back injury March 31, 1987. We make the following additional findings:

The safety director for SAIF's insured had notice of claimant's injury claim on March 23, 1987. SAIF received notice of claimant's release from work as a result of his fall at work on March 30, 1987.

The first payment for interim compensation arrived on April 14, 1987, with benefits retroactively beginning March 31, 1987.

CONCLUSIONS OF LAW AND OPINION

We adopt that portion of the Referee's "Opinion" entitled "Correctness of Denial." We turn to the interim compensation issue.

ORS 656.262(4) requires that the first installment of interim compensation shall be paid no later than the 14th day after the employer has knowledge or notice of the claim. Here, SAIF's

insured received knowledge of claimant's injury claim on March 23, 1987, the date its safety director signed claimant's injury claim. In addition, SAIF received Dr. Carr's March 27, 1987 medical report, which released claimant from work as a result of his fall on March 30, 1987. Therefore, at a minimum, the first installment of compensation was due no later than April 13, 1987. Consequently, the April 14, 1987 first installment of interim compensation was untimely. Consequently, a penalty and attorney fee for this unreasonable claim processing are justified. ORS 656.262(10).

ORDER

The Referee's order dated September 18, 1987, is affirmed in part and reversed in part. The SAIF Corporation is assessed a penalty equal to 25 percent of interim compensation which was untimely paid on April 14, 1987. For services at hearing and on Board review concerning this penalty issue, claimant's attorney is awarded a reasonable attorney fee of $500. The remainder of the Referee's order is affirmed.

RICKY F. RICH, Claimant
Roger Wallingford, Claimant's Attorney
Ruth Cinniger (SAIF), Defense Attorney
Noreen K. Saltveit, Defense Attorney

WCB 87-07828 & 87-08694
March 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Kemper Insurance Company (Kemper) requests review of Referee Norr's order that set aside its denial of claimant's aggravation claim for a low back condition and upheld the SAIF Corporation's denial of a new injury and/or occupational disease claim for the same condition. On review, Kemper submits reports of further diagnostic testing and neurological examinations conducted after the hearing. Kemper requests that the Board consider these documents in its review or, in the alternative, remand the case to the Referee for inclusion of these reports in the hearing record. On review, the issues are evidence, remand, and responsibility.

We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact and ultimate fact, and we make the following additional findings.

Claimant was employed with Kemper's insured at the time of his compensable low back injury in May 1985. His injury-related condition was diagnosed as lumbar strain with radicular symptoms in the left leg, superimposed on spondylolysis at L5-S1 on the left and disc protrusions at L4-5 and L5-S1, more marked on the left. Claimant received conservative treatment. As a result of his May 1985 injury, claimant was restricted from lifting over 30 pounds, prolonged sitting and standing, and frequent bending and twisting.

Following claim closure, Dr. Holman continued to provide palliative care for claimant's residual low back pain. Claimant's symptoms gradually worsened after he went to work for SAIF's insured in December 1986. This job involved activity exceeding claimant's physical restrictions. Then, on April 30, 1987, he

experienced a marked increase in symptoms after he unloaded lumber for SAIF's insured. He has not returned to work since that time. At the time of hearing, his symptoms had markedly improved and were only slightly more intense then when he went to work for SAIF's insured in December 1986.

CONCLUSIONS OF LAW AND OPINION

Evidence/Remand

On review, Kemper requests that the Board consider evidence not in the hearing record or, in the alternative, remand the case to the Referee for consideration of this evidence.

The evidence in question was generated as a result of an alleged worsening in claimant's condition following the issuance of the Referee's order. Claimant's treating neurosurgeon, Dr. Berkeley, ordered a CT scan which demonstrated an "unequivocal centrally prolapsed intervertebral disc at L4-5 causing some canal stenosis [and] foraminal stenosis as L4-5 and L5-S1 with some osteophytic formation bilaterally." Dr. Berkeley subsequently recommended surgery "in view of the patient's clinical findings and worsening of his condition."

Proceedings on Board review are limited to the record developed by the Referee. ORS 656.295(3) & (5). Accordingly, we decline Kemper's request to consider this new evidence on review.

In regard to Kemper's alternative request for remand, the Board may remand a case for the receipt of additional evidence if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

Remand is, therefore, appropriate for consideration of post-hearing diagnostic studies and medical opinion which were not available with due diligence at the time of hearing. For example, remand for consideration of such evidence is appropriate where a claimant's condition is initially not properly diagnosed; she continues to seek evaluation from other doctors; and her diligence is finally rewarded with a post-hearing objective medical explanation of her problem. See Egge v. Nu-Steel, 57 Or App 327 (1982); Armstrong v. SAIF, 67 Or App 498 (1984); Ronald J. Gazely, 36 Van Natta 212 (1984).

The present case is distinguishable from this relatively rare situation. Here, claimant's condition was properly diagnosed at hearing, and the additional diagnostic test and medical opinion were the result of a follow-up examination by claimant's long-term treating neurosurgeon. Under these circumstances, we are not persuaded that the post-hearing evidence at issue was not previously available with due diligence.

Accordingly, we deny Kemper's request for remand.

Responsibility

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

In reaching his decision, the Referee relied on treating chiropractor Holman's opinion that claimant's symptomatic flare-up in April 1987 was "an aggravation of his original condition." However, the Referee failed to note that Dr. Holman subsequently opined that claimant's low back condition had worsened as a result of his work activities with SAIF's insured. Therefore, Dr. Holman's opinion did not support the decision reached by the Referee.

Nevertheless, we agree with the Referee's ultimate conclusion that Kemper is responsible for claimant's current condition. In reaching this decision, we defer to the opinion of Dr. Wilson and the Orthopaedic Consultants that claimant's work activities with SAIF did not worsen his condition. Their opinion is entitled to considerable weight because they have special expertise in treating and diagnosing disc injuries. Furthermore, although the Consultants had not read Dr. Holman's July 24, 1987 report when they rendered their initial opinion, Dr. Wilson, who authored the Consultants' report, did not change his opinion after being apprised of Dr. Holman's report.

Accordingly, we conclude that claimant's condition did not worsen as a result of his work activities with SAIF's insured, and we affirm the Referee's assignment of responsibility to Kemper.

ORDER

The Referee's order dated January 11, 1988 is affirmed.

PEDRO M. SALINAS, Claimant
Biel, et al., Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 88-17416
March 23, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

The insurer requests review of Referee Hoguet's order that: (1) dismissed claimant's request for hearing for lack of jurisdiction; and (2) construed claimant's request for hearing as a request for a Determination Order and remanded the claim to the Evaluation Division (now Evaluation Section) for a determination. The insurer contends that the Referee lacked jurisdiction to support his order. Claimant has filed no brief on review. We reverse on the remand issue.

FINDINGS OF FACT

Claimant compensably injured his right knee on August 14, 1986. The claim was accepted and processed. The claim was originally closed by Determination Order of April 15, 1987 with an award of 5 percent (7.5 degrees) scheduled permanent disability.

The claim was subsequently reopened for right knee surgery on July 20, 1987.

On October 12, 1987, the insurer issued a Notice of Closure awarding claimant additional temporary disability but no permanent disability. The Notice of Closure informed claimant of his right to seek a determination of his claim by the Evaluation Division by submitting a request to the Department within one year of the mailing date of the notice.

On October 7, 1988, claimant filed a request for hearing with the Hearings Division, which raised the issue of the extent of his scheduled permanent disability. The case was set for hearing on December 22, 1988. Prior to hearing, the insurer filed a Motion to Dismiss on the basis that the Hearings Division lacked jurisdiction due to claimant's failure to request a Determination Order from the Evaluation Division within one year of the date of the employer's notice of closure.

On December 20, 1988, following submission of written arguments, the Referee granted the insurer's motion. In addition to dismissing the hearing request, the Referee stated:

> "IT IS FURTHER ORDERED that claimant's Request for Hearing is hereby construed as a request for a Determination Order pursuant to former ORS 656.268(3) effective as of October 6, 1988. This matter is therefore remanded to the Evaluation Division for proceedings consistent with former ORS 656.268 and this Order."

The insurer timely requested Board review of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

The Referee first determined that he lacked jurisdiction to address the extent of claimant's permanent disability. We agree. The procedure to be followed is set forth in former ORS 656.268(3). That section provides, in part:

> "When the medical reports indicate to the insurer or self-insured employer that the worker's condition has become medically stationary and the self-insured employer or the employer's insurer decides that the claim is nondisabling or is disabling but without permanent disability, the claim may be closed, without issuance of a determination order by the Evaluation Division. The insurer or self-insured employer shall issue a notice of closure of such a claim to the worker and to the Worker's Compensation Department. The notice must inform the worker of the decision that no permanent disability results from the injury; of the amount and duration of temporary total disability compensation; of the right of the worker to request a determination order from the Evaluation Division within one year of the date of the notice of claim closure; of the aggravation rights; and of such other information as the director may require. Within one year of the date of the notice of such a claim closure, a determination order subsequently shall be issued on the claim at the request of the claimant or may be issued by the Evaluation Division upon review of the claim if the division finds that the claim was closed improperly...."

The statute provides claimant a method by which to dispute the reasonableness of an insurer closure. Initially, the Evaluation Division is vested with jurisdiction to review the propriety of the insurer closure. Prior to this review, the Hearings Division is without jurisdiction to consider the closure's reasonableness. See McDonald v. Safeway, 87 Or App 86 (1987); Barbara Gilbert, 36 Van Natt 1485 (1984). Because claimant did not first request review of the insurer's Notice of Closure by the Evaluation Division, the Referee properly concluded that he lacked jurisdiction to consider the merits of the insurer's disability determination. [We note parenthetically that effective with claims closed on or after January 1, 1988, a claimant can directly request a hearing from a Determination Order. See current ORS 656.268(3)(e) and 656.319(4)]

Having so concluded, the Referee remanded the matter to the Evaluation Division for proceedings consistent with former ORS 656.268(3). However, the Referee apparently realized that, unless claimant invoked the Evaluation Division's jurisdiction by requesting a Determination Order within one year of the insurer's closure, claimant's right to further review would be foreclosed. Because the Referee's order issued more than one year following the insurer's closure, claimant would be unable to timely request the Division's review. Therefore, the Referee "construed" claimant's request for hearing as a request for a Determination Order, which he declared to be retroactively effective as of October 6, 1988, the date of the request.

No authority exists to support the Referee's action. To the contrary, we expressly stated in Barbara A. Gilbert, supra, 36 Van Natta at 1487, that the filing of a hearing request does not satisfy the obligation to timely request a Determination Order from the Evaluation Division. We continue to hold that view. We, therefore, conclude that the Referee acted improperly when he remanded the claim to the Evaluation Division with a "construed" effective date of October 6, 1988.

ORDER

The Referee's order dated December 20, 1988 is affirmed in part and reversed in part. That portion of the Referee's order that remanded the claim to the Evaluation Division (now Section) is reversed. The remainder of the order is affirmed.

GEORGE W. WALLER, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-02822
March 23, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of Referee Leahy's order which granted an award for permanent total disability effective November 22, 1985. We reverse.

ISSUES

The primary issue is whether claimant has proven by a preponderance of the evidence that he is entitled to an award for permanent total disability.

The employer also contends that claimant is not entitled to temporary total disability from November 25, 1985 through May 5, 1986.

Finally, the employer seeks authorization to offset an overpayment of $1,086.42.

FINDINGS OF FACT

Claimant is a 60-year-old man who dropped out of school in the ninth grade. His work experience includes working in the shipyards in the 1940's, working as a propeller mechanic, operating vacuum cleaner and sewing machine repair businesses, doing production work for this employer, and doing production work for a subsequent employer, Dillingham Ship Yards.

Claimant compensably injured his right knee on September 14, 1979. Claimant has had at least three surgeries to repair the right knee, including a total right knee arthroplasty in May 1986. Dr. Kiest has been his treating physician for the right knee problem since 1983. Claimant has received scheduled disability awards for the right knee totalling 35 percent. He has a moderate to severe impairment of the right knee. As a result of his right knee problems, claimant developed low back problems. (Ex. 3A-9, 13, 14) He has been awarded 25 percent unscheduled disability for the low back.

Claimant injured his left knee on April 18, 1983 while working for Dillingham. He has received an award for 50 percent of the left knee under the Longshore and Harbor Workers' Act.

Claimant has participated in Authorized Training Programs. Although his attendance has been good, he has shown little initiative or motivation to actually learn the jobs. He has twice been terminated from ATP's for inadequate performence.

Considering claimant's right knee and low back problems only, claimant is capable of doing sedentary to light work.

CONCLUSIONS

In order to prove entitlement to an award for permanent total disability, a claimant must prove by a preponderance of the evidence that he is "permanently incapacitated from regularly performing work at a gainful and suitable occupation." ORS 656.206(1). This requirement may be satisfied either on the basis of claimant's physical condition alone, or on the basis of claimant's physical condition taken together with the relevant social and vocational factors. Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

The Referee seems to conclude that claimant is permanently and totally disabled based on his physical condition alone. We disagree. Although Dr. Kiest testified that claimant is permanently and totally disabled, he admittedly based that opinion partly on claimant's left knee condition and partly on his assessment of social and vocational factors. We may not consider the left knee condition in deciding whether claimant is permanently and totally disabled because it is unrelated to this injury and because it is not a preexisting disability. Furthermore, Dr. Kiest's expertise is medical rather than vocational. Accordingly, we give little weight to his opinion that claimant is permanently and totally disabled. He certainly does not say that claimant is a physical permanent total. He acknowledges that there are jobs which claimant is physically capable of doing. In fact, his testimony concerning claimant's

physical limitations places claimant in the sedentary to light range for physical capacity.

Because claimant has not proven that he is totally disabled based solely on his physical condition, he must prove by a preponderance of the evidence that because of a combination of his physical condition and the social and vocational factors, he is precluded from doing regular gainful employment. He has not sustained that burden of proof. There is no evidence other than Dr. Kiest's non-expert opinion which supports the conclusion that claimant cannot do regular gainful employment. Even Dr. Kiest aknowledges that there are some jobs which claimant is capable of doing.

We note that claimant's motivation is also suspect. Although claimant operated a relatively complex business before he worked for this employer, he showed a lack of initiative and common sense in his ATP with Fred's Travelrama. This caused the vocational counselor to suspect that claimant was just going through the motions.

Because claimant has a moderate to severe impairment of the right knee and a total right knee arthroplasty, we conclude that he has actually lost 80 percent of the use of the right knee.

Claimant was medically stationary on November 22, 1985. There is no indication in this record that claimant's condition worsened until May 5, 1986, when he was admitted into the hospital for the total arthroplasty. Accordingly, claimant is not entitled to temporary total disability benefits for that period.

ORDER

The Referee's order of December 21, 1987 is reversed. Claimant is awarded 80 percent scheduled disability to the right leg (knee) in lieu of all prior scheduled disability awards. The employer is authorized to offset an overpayment of $1,086.42 against this or any future awards for permanent disability. Claimant is not entitled to temporary total disability benefits for the period November 22, 1985 through May 4, 1986. A client-paid fee, payable from the employer to its counsel, not to exceed $1,100, is approved.

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

WCB 86-03204
March 27, 1989
Order of Abatement

Claimant has requested reconsideration of that portion of our February 24, 1989 Order on Review that awarded a $510 assessed fee for his counsel's efforts in prevailing against a Referee's order that had upheld the SAIF Corporation's denial of his aggravation claim. Claimant asserts that the statement of services upon which his attorney fee was based only concerned his counsel's efforts on Board review. Enclosing a statement of services for services at hearing, claimant seeks an additional attorney fee pursuant to ORS 656.386(1).

After review of the statements 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 $1,500 for services at the hearing level, to be paid to claimant's attorney by SAIF. This award is in addition to the assessed fee previously awarded for claimant's counsel's services on Board review.

Accordingly, our order dated February 24, 1989 is abated and withdrawn. As amended herein, we adhere to and republish our order of February 24, 1989, in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

TED W. PECKHAM, Claimant
Coons & Cole, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys
Malagon & Moore, Attorneys
Roberts, et al., Attorneys

WCB 86-00033
March 27, 1989
Order on Reconsideration

On November 6, 1987, the Board abated its October 8, 1987 Order on Review, which had affirmed a Referee's order, that among other things, found that claimant was not entitled to temporary total disability benefits for the period coinciding with his incarceration and authorized the offset of these previously paid "overpaid" benefits against claimant's unscheduled permanent disability award. After considering the parties' additional arguments, as well as Amicus briefs from the Oregon Workers' Compensation Attorneys and the Association of Workers' Compensation Defense Attorneys, we proceed with our reconsideration. On reconsideration, we reverse the aforementioned portions of the Referee's order.

FINDINGS OF FACT

Claimant suffered a compensable back injury on September 22, 1983, when, while working as a timber faller, he was struck by a falling tree. Shortly thereafter, he was taken off work. The insurer began paying temporary total disability benefits.

On October 3, 1984, claimant was incarcerated. At the time of his incarceration, and continuing throughout the period of his incarceration, claimant was not released to return to regular work nor was he declared to have been medically stationary by the Evaluation Division. The insurer continued to pay temporary total disability benefits during claimant's incarceration.

Claimant was released from jail on June 9, 1985. His claim was closed by a December 9, 1985 Determination Order, which found his condition to be medically stationary as of November 15, 1985. The Determination Order did not award temporary total disability for the period coinciding with claimant's incarceration nor was claimant awarded such benefits between September 5, 1985 and October 6, 1985.

The Determination Order also awarded 15 percent unscheduled permanent disability for claimant's low back injury and authorized the insurer to offset the "overpaid temporary disability" against the permanent disability award. Thus, claimant did not receive any of his permanent disability award and an "overpayment" of $8,437.19 remained unrecovered.

That portion of the recovered "overpaid temporary disability" pertaining to the September 5, 1985 - October 6, 1985 "non-incarceration" period is not in dispute. Claimant's total award of 30 percent unscheduled permanent disability, as granted by the Referee, is likewise not disputed.

ULTIMATE FINDINGS OF FACT

From the outset of his September 22, 1983 back injury, claimant had been engaged to furnish services for a remuneration, subject to the direction and control of his employer.

During the period of his incarceration, claimant had not been released to return to regular work nor was his compensable condition medically stationary.

CONCLUSIONS OF LAW

Citing Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), the Referee stated that a claim for temporary total disability benefits assumes availability for work and the loss of wages. Since claimant was unavailable for work during his incarceration, the Referee reasoned that he had sustained no loss of wages. Consequently, the Referee concluded that claimant was not entitled to temporary total disability benefits from October 3, 1984 through June 9, 1985. In addition, the Referee increased claimant's unscheduled permanent disability award from 15 percent to 30 percent. Finally, the Referee permitted the insurer to offset the unrecovered temporary total disability benefits paid during claimant's incarceration against claimant's present and future awards.

On review, the insurer argues that, as an incarcerated worker, claimant had involuntarily withdrawn from the work force. Under such circumstances, the insurer contends that he was not eligible for temporary total disability during the period of his incarceration because he was not a "worker" as defined by the Cutright holding. This proposition is based on the Cutright rationale that temporary total disability is to replace lost wages and a person who has withdrawn from the workforce has not lost wages. The insurer also relies upon the holding of the Court of Appeals in Karr v. SAIF, 79 Or App 250, 253 (1986), which states that a person who has withdrawn from the work force, for whatever reason, has no lost wages and is not entitled to temporary total disability benefits. We disagree with the insurer's analysis.

Both Cutright and Karr concerned the processing of aggravation claims. In each case, at the inception of their claims for aggravation, the claimants had permanently withdrawn from the workforce. That is, they no longer "engaged to furnish services for a remuneration, subject to the direction and control of an employer." See ORS 656.005(27). Since they were no longer "workers," they were not entitled to temporary total disability benefits, regardless of the reason for their prior withdrawal from the workforce.

Here, unlike Cutright and Karr, claimant had not withdrawn from the workforce at the inception of his injury claim. Rather, he left work as a direct result of the disabling effects of his compensable injury. Consequently, at the time of his departure from the workforce, he was a "worker." ORS 656.005(27). Once established, we conclude that this status should continue throughout the processing of the initial claim. See Charles P. Kepford, 41 Van Natta 573 (March 20, 1989).

Furthermore, claimant's subsequent incarceration does not alter the undisputed fact that he remained totally disabled

from performing his work activities as a result of a compensable injury. Without question, his incarceration would have restricted his availability to return to the workforce had his compensable condition stabilized. Yet, notwithstanding his confinement, he remains entitled to temporary total disability benefits so long as he is medically unable to work. Those benefits must continue until he was released for work and found to be medically stationary. Former ORS 656.268(2). Since neither of these events occurred during claimant's incarceration, we conclude that he is entitled to temporary total disability benefits during this period.

We interpret the holdings of Cutright and Karr to support the proposition that once a claim is closed and the claimant permanently withdraws from the workforce, for whatever reason, he/she is no longer considered a "worker." Because the claimant has lost no wages, it follows that there is no entitlement to temporary total disability benefits should his/her condition worsen. Yet, this analysis is inapplicable where, as here, the claim has not been previously closed. In such cases, the reason for the worker's total disability is the compensable injury and he/she remains entitled to such benefits for the period coinciding with that disability. ORS 656.210(1); former 656.268(2).

The insurer suggests that we should refuse to award claimant benefits during a period when his total disability coincides with his unavailability to work. As a practical matter, such a suggestion would introduce an "availability to work" requirement into the temporary total disability analysis not otherwise present in the statutory scheme. Moreover, we foresee an array of potential issues should such an analysis be imposed. As examples, we pose the following questions. Are disabled claimants, who leave their community to visit a sick relative, considered to be a "worker" during their sojourn? Are disabled claimants, who are taken hostage during a bank robbery, considered to be a "worker" during their captivity? Must a disabled claimant, whose condition remains medically unstationary and has not been released to work, look for work within his/her modified limitations in order to remain entitled to temporary total disability benefits?

In short, the insurer's contention is not only contrary to former ORS 656.268(2), but it conflicts with the general statutory policy of the workers' compensation system to provide adequate and reasonable income benefits to injured workers and to restore them physically and economically to a self-sufficient status in an expeditious manner to the greatest extent practicable. See ORS 656.012(2)(a), (c). Furthermore, the insurer's position would also inject a concept into the temporary total disability analysis that, if followed, would create some untenable dilemmas in the processing of workers' compensation claims.

Accordingly, we conclude that claimant is entitled to the temporary total disability benefits paid during the period coinciding with his incarceration. Thus, those previously paid benefits do not constitute an overpayment. Inasmuch as these benefits were not overpaid, the insurer is not entitled to offset them against claimant's total award of 30 percent unscheduled permanent disability.

ORDER

The Referee's order dated October 1, 1986 is reversed in part and affirmed in part. In addition to the temporary total disability benefits awarded by the December 9, 1985 Determination Order, claimant is entitled to temporary total disability benefits payable from October 3, 1984 through June 9, 1985. Inasmuch as these benefits have previously been paid and are not an "overpayment," claimant is also entitled to the 30 percent (96 degrees) unscheduled permanent disability awarded by the Determination Order and the Referee's order, except for the previously applied offset of the undisputed overpayment of temporary total disability benefits paid from September 5, 1985 to October 6, 1985. Claimant's attorney shall receive 25 percent of this increased compensation, not to exceed $3,000. However, the total of attorney fees approved by the Referee and the Board shall not exceed $3,800. The remainder of the Referee's order is affirmed.

Board Member Ferris, dissenting:

I dissent.

It is undisputed that claimant was incarcerated from October 3, 1984 until June 9, 1985. Because he was obviously unavailable for work during this period, I submit that he was not a "worker" as defined by ORS 656.005(27). As such, he did not experience a loss of wages and, consequently, is not entitled to temporary total disability benefits.

The majority would limit the Cutright and Karr holdings to the processing of aggravation claims. I suggest that the holdings are applicable to the processing of all claims in which the claimant has withdrawn, either voluntarily or involuntarily, from the workforce.

As I stated in my recent dissent in Charles P. Kepford, 41 Van Natta 573 (March 20, 1989), the aforementioned cases stand for the following propositions: (1) temporary total disability benefits are intended to provide wage replacement for a worker; (2) when the claimant has withdrawn from the workforce, for whatever reason, he or she is no longer a worker; and (3) if the claimant is no longer a worker, he or she cannot lose wages and, consequently, is not entitled to temporary total disability benefits. The basic reasoning behind these propositions was succinctly articulated by the Supreme Court in Cutright:

> "There is not one word in the statute 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 [by former ORS 656.005(28), now 656.005(27).]." Cutright, supra, 299 Or at page 297.

In Karr, the Court of Appeals followed the Cutright analysis, stating:

> "Whatever the reason, claimant has withdrawn from the work force. Temporary total disability is awarded for lost

> wages . . . and a person who has withdrawn from the work force has no lost wages." (Citing Cutright).

The court has continued to apply this analysis. For example, in Dawkins v. Pacific Motor Trucking, 91 Or App 562 (1988), the court stated:

> "Claimant contends that his withdrawal from the labor market should not preclude an award of temporary total disability, because it was involuntary and was the result of his work-related disability. As we held in Karr v. SAIF, (citation omitted) a claimant who withdraws from the work force is not entitled to those benefits, which are awarded for lost wages. ORS 656.210(1); Sykes v. Weyerhauser Co., 90 Or App 41 (1988). A person who has withdrawn from the labor market, whether as a result of his injury or for other reasons, has no lost wages."

I would adhere to the basic precept advanced by Cutright and the other aforementioned cases. That is, a claimant who has withdrawn from the work force is no longer a worker and cannot lose earnings. Therefore, although entitled to medical benefits resulting from the compensable condition, the "withdrawn" claimant is not entitled to temporary total disability benefits.

In conclusion, the majority has awarded temporary total disability compensation to a claimant during a time that he was incarcerated. I submit that the majority's decision is contrary to the principles advanced by the Cutright, Karr and Dawkins holdings. Furthermore, common sense, at least occasionally, should prevail in this litigation-inflamed workers' compensation system and common sense dictates that a carrier should not be compelled to pay temporary total disability for the period that a claimant was incarcerated and unavailable to work.

I would adhere to the Board's October 8, 1987 Order on Review that affirmed the Referee's order.

ISAAC BOLDS, Claimant
Ann B. Witte, Claimant's Attorney
Ann Kelley, Assistant Attorney General

WCB 86-16297 & 86-17049
March 28, 1989
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee T. Lavere Johnson's order which: (1) declined to award permanent disability, either scheduled or unscheduled, stemming from an injury claim accepted by the Inmate Injury Fund; (2) found that the claim had been properly closed; and (3) declined to assess penalties and attorney fees due to the Fund's misconduct in processing the claim. We affirm in part and reverse in part.

ISSUES

1. The extent of claimant's permanent disability, scheduled and unscheduled.

2. Claimant's entitlement to temporary disability from September 9, 1986 to October 31, 1986.

3. Penalties and attorney fees for alleged misconduct by the Department of Justice, adjusting agent for the Inmate Injury Fund.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On May 27, 1986, the adjusting agent for the Inmate Injury Fund (Fund) acknowledged claimant's entitlement to time loss benefits beginning February 28, 1986 and began making payments. Time loss payments were paid for a total of $77.40. On May 25, 1986, Dr. Reynolds' report indicated that claimant was medically stationary as of May 22, 1986. Thereafter, time loss payments ceased. On September 9, 1986, Referee Mulder denied claimant's request that the amount and rate of his temporary disability payments be increased because: (1) the (Fund) had no evidence that claimant could not work during the period in question; and (2) ORS 656.210(1) clearly established the rate of temporary disability benefits.

Claim closure did not occur until October 31, 1986. When the claim was finally closed, it was classified as nondisabling, ignoring the previously acknowledged time loss. Furthermore, the notice of closure did not contain notice of all rights to which claimant was entitled. Specifically, claimant was not notified of his appeal rights under ORS 656.283 to ORS 656.304, as contemplated by ORS 655.525.

CONCLUSIONS OF LAW

The Referee awarded no permanent disability, either scheduled or unscheduled, because: (1) he was not persuaded that claimant's pain complaints were disabling; and (2) Dr. Reynolds projected no permanent disability.

Also, the Referee concluded that no temporary disability was due from September 9, 1986 to October 31, 1986 because Dr. Reynolds declared claimant medically stationary as of May 22, 1986. The Referee inferred from Dr. Reynolds' report that claimant was released to his regular work not later than May 22, 1986. Claimant offered no evidence to contradict the medically stationary date.

Although the Referee found that claimant had proven misconduct which would normally warrant the imposition of a penalty and attorney fee, he declined to award them. The Referee reasoned that no penalty was assessable because no compensation was "due and owed" claimant. Furthermore, the Referee concluded that no attorney fee was assessable because the Department of Justice was an "adjusting agent" under the Inmate Injury Fund, rather than an insurer or self-insured employer as referred to in ORS 656.382 and 656.262(10).

We agree with the Referee that awards of either temporary or permanent disability are not warranted. We conclude that the record fails to support claimant's entitlement to these awards.

Permanent disability

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

In rating the extent of claimant's scheduled permanent disability, we must consider the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2).

Dr. Reynolds projected no permanent disability, either scheduled or unscheduled, due to the compensable injury. He attributed any continuing discomfort in claimant's right wrist to the prior 1984 injury. Claimant's perceived limitations were primarily focused on the right wrist discomfort, which existed long before the compensable injury. No loss of earning capacity was shown as a result of chest or shoulder symptoms. Therefore, we agree with the Referee and decline to grant claimant permanent disability, scheduled or unscheduled.

Temporary Disability

Unilateral Termination of TTD

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). If a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. See Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Ore 337 (1980).

On September 9, 1986, Referee Mulder concluded by Opinion and Order that the Fund's unilateral termination of temporary total disability for the period of May 22, 1986 to September 9, 1986 was not improper. That decision was not appealed by claimant. Since that claim was litigated to final judgment, it precludes a subsequent action between the same parties on the same claim or any part thereof.

The record does not contain any evidence that claimant became disabled from work after he was declared stationary and released for work in May 1986. Therefore, claimant is not entitled to any further temporary disability from September 9, 1986 to October 31, 1986.

Penalty and Attorney Fee

ORS 656.262(10) provides for a penalty against unreasonable conduct by an insurer or self-insured employer. If an insurer or self-insured employer unreasonably delays or 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. The latter statute provides that if an insurer or self-insured employer 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.

Subject to certain exceptions not relevant here, ORS 655.515 provides that an inmate who sustains an injury shall be paid benefits in the same manner as provided for injured workers under the workers' compensation laws of Oregon.

In Johnson v. SAIF, 267 Or 299 (1973), the court addressed the question of whether the Injured Inmates Act authorized an award of attorney's fees in proceedings before the State Accident Insurance Fund board and the circuit court in those cases where the claimant ultimately prevailed. The court held that it did. The opposite view was viewed as unnecessarily narrow and restrictive.

It was apparent to the court that the Legislature intended to incorporate into the statutes dealing with inmates all of the procedural and remedial rights extended to injured workmen, with certain reservations necessitated by the unique position of the inmate. Id. at 302.

Although ORS 655.525 provides that an inmate may obtain review of action taken on his claim as provided in ORS 656.283 to 656.304, this statutory limitation was not intended to exclude those provisions dealing with payment of attorney fees by the insurer or self-insured employer (ORS 656.386 and ORS 656.388). Johnson v. SAIF, supra, at 303; See State of Oregon v. Spear, 94 Or App 677 (1989). Therefore, the Injured Inmates Act authorizes an award of attorney's fees in those cases where claimant ultimately prevails. The fact that the legislative language does not specify "adjusting agent" as a source for payment of attorney fees to a claimant who ultimately prevails, should not defeat the statutory purpose.

In the case at bar, the adjusting agent was involved in repeated misconduct concerning the handling of claimant's claim. On May 27, 1986, the Department of Justice acknowledged claimant's entitlement to time loss benefits beginning February 28, 1986. Dr. Reynolds' report, which declared claimant medically stationary on May 22, 1986, was received by the Department of Justice on August 11, 1986, at the latest. Yet, claim closure did not occur until October 31, 1986. When the claim was finally closed, it was classified as nondisabling. Furthermore, claimant was not informed of his appeal rights. Based on this uncontroverted evidence, claim closure was unreasonably late; the Fund unreasonably classified the claim as nondisabling and unreasonably failed to inform claimant of his appeal rights.

A penalty will not be assessed unless there is "an amount due and owing." Spivey v. SAIF, 79 Or App 568 (1986). Claimant has failed to show that there were any amounts "due and owing." Therefore, no penalty is assessed.

Even though there were no amounts upon which to base the award of a penalty, claimant was still entitled to an attorney fee. Mischel v. Portland General Electric, 89 Or App 140 (1987). In determining a reasonable attorney fee, we consider the factors set out in OAR 438-15-010(6). See Barbara A. Wheeler, 37 Van Natta 122 (1985). Applying those factors to the facts in our

case, we conclude that $800 is a reasonable attorney fee for services rendered at hearing and on Board review. Therefore, claimant's attorney is awarded a reasonable fee of $800, to be paid by the Fund.

ORDER

The Referee's amended order on reconsideration, dated October 6, 1987, is affirmed in part and reversed in part. Claimant's attorney is awarded a reasonable fee of $800, to be paid by the Inmate Injury Fund.

RICHARD C. CENTENO, Claimant
William B. Wyllie, Claimant's Attorney
Cash Perrine, Defense Attorney
Gary Wallmark (SAIF), Defense Attorney

WCB 87-09592
January 31, 1989
Order on Review (Remanding)

Reviewed by Board Members Crider and Ferris.

The deceased, claimant's cohabitant, Cindy Nitsche, requests review of Referee Myzak's order that dismissed her request for hearing regarding the SAIF Corporation's denial of death benefits for herself and her son, Rey C. Nitsche. On review, the issue is whether Ms. Nitsche filed timely hearing requests regarding SAIF's April 1, 1987 and November 17, 1987 denials and, if not, whether she had good cause for her failure to do so.

We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the findings of fact set forth in the "Sequence of Events" section of the Referee's order except for the finding that the June 1987 letter from Ms. Nitsche's attorney to SAIF was received by the Board on June 17, 1987. Based on the acknowledgment letter in the record, we instead find that the letter from Ms. Nitsche's attorney was received by the Board on June 16, 1987.

We make the following additional finding. On December 17, 1987, Ms. Nitsche filed a supplemental hearing request challenging SAIF's November 17, 1987 denial of death benefits for Rey C. Nitsche.

FINDINGS OF ULTIMATE FACT

The June 1987 letter from Ms. Nitsche's attorney to SAIF was a valid written request for hearing on SAIF's April 1, 1987 denial. The letter was not received by the Board until June 16, 1987, whereas the 60-day period for requesting a hearing on the April 1, 1987 denial expired on June 2, 1987. Ms. Nitsche has not provided any explanation for her failure to file the request on or before June 2, 1987, other than her attorney's assertion that he did not receive a copy of the April 1, 1987 denial.

Ms. Nitsche filed a request for hearing on SAIF's November 17, 1987 denial of death benefits for Rey C. Nitsche within 60 days of the denial.

CONCLUSIONS OF LAW AND OPINION

Death Benefits for Cindy Nitsche

On review, Ms. Nitsche contends that the Referee erred in dismissing her hearing request regarding death benefits under ORS 656.226. The Referee apparently dismissed the hearing request in regard to benefits for both Ms. Nitsche and her son, Rey C. Nitsche.

Subject to the following comment, we adopt the Referee's opinion insofar as it dismissed the hearing request in regard to Ms. Nitsche's death benefits. The prior Referee's May 11, 1987 Opinion and Order provided " . . . that the issue relating to the eligibility of Cindy Nitsche . . . for death benefits under ORS 656.226 may be raised through subsequent requests for hearings." On review, Ms. Nitsche argues that this language relieved her of any further duty to file a hearing request. We disagree. The prior Referee's order merely informed the parties of Ms. Nitsche's right to raise this issue in a subsequent hearing request. It did not relieve her of the duty to file that request in a timely manner.

Death Benefits for Ray C. Nitsche

We reverse the Referee's dismissal of Ms. Nitsche's hearing request insofar as it pertained to Rey C. Nitsche's death benefits under ORS 656.226. SAIF issued its denial of those benefits on November 17, 1987. The record indicates that a supplemental hearing request on that denial was received by the Board on December 18, 1987. The record further indicates that a copy of that request was served on SAIF. We are, therefore, persuaded that Ms. Nitsche filed a timely request for hearing on the November 17, 1987 denial. Accordingly, the Referee erred in dismissing Ms. Nitsche's hearing request insofar as it raised the issue of Rey C. Nitsche's entitlement to death benefits.

ORDER

The Referee's order dated January 6, 1988 is reversed in part and affirmed in part. We reverse that part of the order that dismissed the hearing request insofar as it raised the issue of Rey C. Nitsche's entitlement to death benefits under ORS 656.226. That portion of the case is remanded to the Referee for a hearing on that issue. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $100 regarding the hearing request on the SAIF Corporation's November 17, 1987 denial, to be paid by SAIF.

RICHARD C. CENTENO (Deceased), Claimant
William B. Wyllie, Claimant's Attorney
Cash Perrine, Defense Attorney
Gary Wallmark (SAIF), Defense Attorney

WCB 87-09592
March 28, 1989
Order on Reconsideration

On behalf of all parties to this proceeding, the SAIF Corporation moved for reconsideration of our January 31, 1989 Order on Review (Remanding). In that order, we reversed that portion of Referee Myzak's dismissal order insofar as it pertained to the issue of survivor's benefits for the minor, Rey C. Nitsche, and we remanded for a hearing on that issue. On February , 1989, we abated our order to consider the motion.

On reconsideration, SAIF represents that the parties have agreed that the aforementioned issue was separately litigated and decided by a subsequent Referee in WCB Case No. 87-19246, a case which has been pending review. Our order affirming the Referee's order in WCB Case No. 87-19246 has also issued today. SAIF submits that there is, therefore, no reason to remand the present case for further litigation, and it requests that the Board affirm Referee Myzak's order in its entirety.

The noncomplying employer has joined in SAIF's motion, and no objection has been received from Rey C. Nitsche's representative. Based on the representations contained in SAIF's motion, we conclude that the Referee's dismissal order pertaining to the issue of survivor's benefits for Rey C. Nitsche was correct. On reconsideration, we affirm the Referee's dismissal order pertaining to this issue, in lieu of that portion of our initial order that reversed and remanded to the Referee.

Accordingly, we adhere to and republish our January 31, 1989 order as modified herein, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

RICHARD C. CENTENO (Deceased), Claimant
MARY FRANCIS WEST, Employer
William B. Wyllie, Claimant's Attorney
Cash Perrine, Defense Attorney
Joseph McNaught (SAIF), Defense Attorney
Mark Braverman, Assistant Attorney General

WCB 87-19246
March 28, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The noncomplying employer requests review of Referee McCullough's order that set aside its denial of a claim for survivor's benefits filed by the deceased claimant's cohabitant, Cindy Nitsche, on behalf of her son, Rey C. Nitsche. In her brief on review, Ms. Nitsche cross-requests review of that part of the Referee's order that awarded a $3,000 assessed fee for services at hearing. In addition, she requests that the Board assess a penalty and attorney fee regarding the employer's processing of Rey C. Nitsche's claim for survivor's benefits, and she further argues that the employer does not have standing to challenge that claim. On review, the issues are:

1. Whether the standing and penalty and attorney fee issues raised by Ms. Nitsche are properly within the Board's scope of review. If so:

   A. Whether the employer has standing to challenge Rey C. Nitsche's claim for survivor's benefits; and

   B. Whether the employer acted unreasonably in processing Rey C. Nitsche's claim.

2. Paternity of Rey C. Nitsche.

3. Assessed fee for services at hearing.

We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact, including the findings set forth in the "Opinion and Conclusions" section of the order.

We make the following additional finding.

The sole issue at hearing was whether Rey C. Nitsche was the son of the deceased claimant and, therefore, entitled to benefits under ORS 656.226.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion with the following comment.

In her brief on review, Ms. Nitsche raises a number of arguments for the first time. Specifically, she argues that the employer does not have standing to contest Rey C. Nitsche's paternity because it had previously been found to be a noncomplying employer. In addition, Ms. Nitsche requests penalties and attorney fees for the employer's alleged unreasonable processing of Rey C. Nitsche's claim for survivor's benefits.

The sole issue raised and litigated at hearing was the paternity of Rey C. Nitsche. As a result, no record has been developed on the standing and penalty and attorney fee issues Ms. Nitsche raises on review. Under these circumstances, it would not be appropriate for the Board to address these issues. See Mavis v. SAIF, 45 Or App 1059 (1980).

Finally, claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for prevailing on the paternity issue on Board review. 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 October 28, 1988 is affirmed.

GREGORY L. FORSYTH, Claimant
Grant, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-10813
March 28, 1989
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Mongrain's order that upheld the self-insured employer's denial of claimant's claim for a low back condition. We affirm.

ISSUE

The issue is compensability.

FINDINGS OF FACT

Claimant, 29 years old at the time of hearing, works for the employer as a core layer. His job requires him to perform activities of bending, twisting and turning at waist level while handling eight-foot sheets of veneer. He had a history of an upper back and cervical condition, for which he treated from 1977 through 1980.

Claimant worked the graveyard shift on April 20, 1986, his seventh consecutive day on, when he experienced a gradual tightening and stiffness in his low back. Claimant had been experiencing similar symptoms for the prior several weeks. It was not uncommon for him to work a six-day shift.

Following his shift, he went home to sleep. He awoke in considerable pain. He immediately sought treatment from Dr. Herscher, osteopath, who advised hot packs and rest. Claimant then returned to bed. When he woke up later that evening he was suffering acute pain. He was seen in the emergency room again by Dr. Herscher. Claimant was treated with Valium and released from work. His employer was informed that he was unable to work that night.

On April 22, 1986, Dr. Lemley, osteopath, began treating claimant. Claimant was treated conservatively and was released from work until April 25, 1986. Later that day, Dr. Lemley contacted claimant and told him that he could return to light duty immediately, as the employer had a position for him.

Claimant continued to treat with Dr. Lemley. On June 6, 1986, he returned to core laying.

Claimant's claim was denied on June 10, 1986. The denial indicated that claimant had treated for mid-back complaints for a number of years prior to the onset of his symptoms, and therefore his condition and need for treatment did not arise out of or in the course of employment.

On July 31, 1986, claimant began treating with Dr. Flowers, osteopath. Dr. Flowers had previously treated claimant's upper back and cervical condition. He referred claimant to Dr. Narus, neurosurgeon, for consultation. X-rays revealed a narrowing of the L5-S1 disc space and spondylolysis at L5. A bone scan was normal. He recommended low back conditioning and referred claimant to Dr. Versteeg, orthopedist, for evaluation and treatment. On September 9, 1986, Dr. Versteeg evaluated and treated claimant.

During the first two weeks in April 1986, claimant, along with his wife, several other family members, a neighbor, and a co-worker, began constructing a fence around claimant's property. The hole digging was contracted out. The remainder of the work was done after work and on two weekends. During this time, a contractor installed a hot tub, and claimant's brother-in-law began constructing a deck surrounding the tub and along claimant's house. Claimant participated in both the work on the fence and the work on the deck.

Claimant had suffered from a cervical and thoracic condition. For the five years he worked as a core layer, claimant experienced continual low back tightness and stiffness with

accompanying sore muscles. However, he never was off work due to his low back condition.

We are unable to find that claimant's work activities and exposures, when compared to his off-work activities and exposures, were the major contributing cause of his low back condition.

CONCLUSIONS OF LAW AND OPINION

We must first determine whether claimant's condition is properly characterized as an occupational disease or as an industrial injury. In this regard, "[o]ccupational diseases are distinguished from accidental injuries in that the former are not unexpected and are recognized as an inherent risk of continued exposure to conditions of the particular employment and are gradual rather than sudden in onset." Hall v. Home Insurance Co., 59 Or App 526, 529 (1982).

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 core laying. If claimant's low back condition was not an inherent hazard of his core laying, or otherwise expected from such activity or exposure, an industrial injury, rather than an occupational disease, is indicated. O'Neal v. Sisters of Providence, 22 Or App 9 (1975).

In order to determine 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 (1982). If the condition resulted from a sufficiently discrete period of work activity, an industrial injury, rather than an occupational disease, is indicated.

Here, claimant's condition cannot be viewed as unexpected in view of the requirements of his job duties as a corelayer. He is required to constantly perform twisting, throwing, bending, and turning manuevers throughout his shift. Furthermore, his low back condition is not associated with any specific incident of trauma; the onset of his symptoms did not "coincide precisely" with a discrete event. Instead, his symptoms gradually increased and worsened over a period of several weeks to the point where he was disabled from regular work and required medical treatment. Consequently, we conclude that claimant's claim should be analyzed as an occupational disease.

To prevail on his occupational disease claim, claimant must prove that his work activities were the major contributing cause of the onset or worsening of his low back condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298 (1983); Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. Clark v. Erdman Meat Packing, 88 Or App 1, 5 (1987).

The employer contends that claimant's low back pain was a result of his off work activities involving the building of a fence around his home and a deck for a hot tub, approximately two weeks before his condition became acute. For his part, claimant asserts that his off-work activities were far less demanding than claimed by the employer's witnesses.

In our view, resolution of the compensability of claimant's low back condition presents a sufficiently complex medical question to require competent medical evidence on the issue of causation. Uris v. Compensation Department, 247 Or 420 (1967). This is particularly true considering the necessity of weighing the relative contribution of claimant's work exposures and off-work exposures. See Clark v. Erdman Meat Packing, supra.

Claimant relies upon the opinions of Dr. Flowers and Dr. Versteeg to sustain his burden of proof. Both Dr. Flowers and Dr. Versteeg opined that claimant's work activity was the major contributing factor to his low back injury. However, medical evidence on causation is only as competent as the history upon which it is based. See Somers v SAIF, 77 Or App 259 (1986). The history provided by claimant to his doctors was incomplete. In particular, he did not advise either doctor of his off-work construction activities. Therefore, the opinions based upon this inadequate history are entitled to little probative weight.

Moreover, the history provided to Dr. Flowers was inaccurate. Dr. Flowers reported in this regard that claimant experienced a sudden increase in symptoms while pushing an extra heavy power roll of plywood. However, the remainder of the record establishes that claimant instead experienced a gradual increase in symptoms during the workshift in question, culminating in an acute onset of symptoms later that day.

Inasmuch as Drs. Flowers' and Versteeg's opinions compose the entirety of claimant's medical evidence concerning the issue of causation, we find that he has failed to meet his burden of proving that his work exposures were the major contributing cause of his condition. Accordingly, the Referee's order which upheld the employer's denial will be affirmed.

ORDER

The Referee's order dated May 12, 1987 is affirmed. A client-paid fee is approved, not to exceed $766.

DONALD E. PETERS, Claimant
Bennett, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-12267
March 28, 1989
Order on Review

Reviewed by the Board en banc.

The insurer requests review of those portions of Referee Neal's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) awarded claimant's attorney an attorney fee for its allegedly unreasonable claims processing. The issues are compensability and attorney fees.

The Board reverses that portion of the Referee's order that set aside the insurer's denial and found claimant's bilateral carpal tunnel syndrome compensable. All remaining portions of the Referee's order are affirmed.

FINDINGS OF FACT

Claimant has worked approximately 14 years for the employer, a metal manufacturing plant. His work involves strenuous physical labor including lifting up to 50 pounds,

loading and reloading furnaces, and some clean-up work. In January 1986, he noticed that his hands went to sleep while wearing gloves at work. He attempted to work without gloves, but his supervisor ordered him to wear them.

In March 1986, claimant was examined by Dr. Button, hand surgeon. Button reported a recent onset of pain and numbness in the right hand, with occasional very mild symptoms in the left hand. He diagnosed a cumulative trauma disorder and right carpal tunnel syndrome.

Thereafter, claimant continued to treat with Button. In June 1986, Button reported that claimant's symptoms had increased with off-the-job activities including driving, auto repair, and home remodeling. Button felt that claimant's heavy wear pattern in the palmar surfaces of his hands, indicated that these off-the-job activities "play[ed] a significant part in his symptomatology . . . ."

In July 1986, claimant underwent a right carpal tunnel release performed by Button. Shortly thereafter, the insurer wrote Button and requested his opinion on whether claimant's carpal tunnel syndrome was more probably related to work or nonwork activities. Later that month, Button responded that claimant's auto repair and home remodeling activities were the material contributing factor to his carpal tunnel syndromes. In reaching his opinion, Button was impressed with the heavy wear pattern in claimant's hands, which persisted after claimant was taken off work for surgery.

The insurer denied the claim for "Carpal Tunnel" in August 1986, on the basis that claimant's nonwork activities were the primary cause of his "wrist" pain.

In January 1987, Button reported that he was quite familiar with various jobs at the employer's plant and that he had treated a number of its employes. He stated that job related carpal tunnel syndrome was a frequent condition at the employer's plant due to the required heavy physical work. However, in conclusion, Button stated that he felt claimant's nonwork activities were the major contributing cause of his carpal tunnel syndrome.

In April 1987, claimant was examined by Dr. Achterman, orthopedist, at the request of his attorney. In addition to claimant's right carpal tunnel syndrome, Achterman found a "mild" carpal tunnel on the left. Achterman opined that there had been significant industrial exposure. He "suspected" that claimant's work environment was "a major contributing factor" to the development of his carpal tunnel syndrome.

Button did not agree with Achterman. In May 1987, Button stated, inter alia:

> "[A]s I have stated in the past, I have been overly impressed with the significant amount of outside activities this individual has been engaged in and the very heavy wear pattern in both hands, even during the convalescent phase following his right carpal tunnel release. Certainly there is room for difference of opinion in

determining whether there is an occupational relationship in this type of situation[,] but my feeling has been it is his avocational activities that have been the major contributing factor relative to his carpal tunnel syndromes."

That same month Achterman responded, inter alia:

"This patient has a 14 year work history at [employer] and during that time he has done fairly heavy work on a continuous basis. In discussing his various activities with the patient, it is apparent that he also uses his hands in his off work status, however, I think that his work status should be regarded as at least a 50% contributor to the presence of the carpal tunnel syndrome."

Claimant credibly testified that his supervisor required him to wear cotton gloves beginning in January 1986. Thereafter, he wore the gloves for all work requiring the use of his hands. Inasmuch as grime soaked through the gloves, claimant regularly discarded them and began with a new pair each week.

Although claimant does not run an auto repair business, he has three old cars that he "play[s]" with. Accordingly, claimant testified, inter alia:

"We [claimant and his family] do the normal maintenance on them that has got to be done, your oil, lube, tires, brakes, any other little miscellaneous things that a normal shop would do, except I do it myself because I can't afford what they charge an hour."

In addition, claimant has a pick-up truck and a flat bed truck. His wife has a car. He regularly "work[s] on" these three vehicles. About two years prior to the hearing, he installed a generator in his flat bed truck. He uses this truck to haul scrap wood from the employer's plant. At the time of hearing, claimant had grime on his hands. The grime was the result of installing a power steering pump in one of his cars.

Approximately five years ago, claimant's house was remodeled. He helped with the sheetrock installation. After the remodeling was finished, his family painted the house. We find that claimant's work activities were not the major contributing case of his bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW

The Referee found that Button had an incorrect history concerning claimant's off-the-job activities. The Referee, therefore, concluded that claimant's bilateral carpal tunnel syndrome was a compensable occupational disease. We disagree.

To prove an occupational disease claim, the worker must show that his work activities were the major contributing cause of his disease. Dethlefs v. Hyster Co., 295 Or 298 (1983). He must also prove that he was not ordinarily subjected or exposed to the

disease off-the-job. ORS 656.802(1)(a). When we are confronted with conflicting medical opinions, we must choose which medical hypothesis is correct. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 416 (1986). Absent persuasive reasons to do otherwise, we generally accord greater weight to the treating physician's opinion. Id.; Weiland v. SAIF, 64 Or App 810 (1983).

Here, Button was claimant's treating surgeon. He first examined claimant in March 1986. Thereafter, he personally examined claimant on several occasions. Button understood that claimant was involved in nonwork activities including home remodeling, home auto repair, and wood cutting. Save for home remodeling, claimant's testimony largely supports Button's understanding. Claimant performs work on his old cars similar to that of a "normal shop." He also works on his two trucks and his wife's car. At the hearing, he admitted that his hands were grimy because he had recently installed a fuel pump in one of his cars. Although he has not cut wood in three years, he regularly hauls wood scraps in his flat bed truck. Under such circumstances, we do not find that Button had an incorrect history regarding claimant's off-the-job activities.

Moreover, Button's opinion is buttressed by the heavy wear pattern in claimant's hands. Claimant began wearing gloves at work in January 1986. He wore the gloves for all activities requiring the use of his hands. Claimant's position is that much of the grime and wear in his hands was due to leakage through his cotton work gloves. We do not accept claimant's argument. Claimant began with a new pair of gloves every week. Moreover, even after claimant was taken off work for his July 1987 surgery, his heavy wear pattern persisted.

Although Achterman disagreed with Button, we are unpersuaded by his contrary opinion. First, unlike Button, Achterman is not a hand specialist. Second, again unlike Button, Achterman only observed claimant on one occasion. See Weiland v. SAIF, supra. Third, Achterman agreed with Button insofar as he found that claimant "uses his hands in his off work status . . . ." Last, Achterman merely found that claimant's work activities were "at least a 50% [sic] contributor" to his bilateral carpal tunnel syndrome. However, claimant must prove that his work activities were the major contributing cause of his condition; not merely a contributor. Dethlefs, supra. Although we are aware that "magic words" are not a condition precedent to compensability, in this particular case the absence thereof weakens the persuasiveness of Achterman's opinion. See McClendon, supra, 77 Or App at 417.

Accordingly, we are more persuaded by Button's opinion. On this record, claimant has not proven that his work activities were the major contributing cause of his bilateral carpal tunnel syndrome.

ORDER

The Referee's order dated June 2, 1987 is reversed in part, and affirmed in part. That portion of the Referee's order that set aside the insurer's denial of claimant's bilateral carpal tunnel syndrome is reversed. The insurer's denial is reinstated and upheld. All remaining portions of the Referee's order are affirmed. A client-paid fee, not to exceed $2,130, is approved.

Board Member Crider, dissenting.

Claimant's carpal tunnel syndrome is compensable. I would affirm the order of the Referee.

Both Dr. Button and Dr. Achterman believed that claimant's carpal tunnel condition was work-related. The debate between them concerns whether claimant's at-work activities compared to his off-work activities were the major contributing cause of the condition.

In July 1986, following his performance of a carpal tunnel release, Dr. Button stated that he could not categorically answer the insurer's query concerning the major contributing cause for the syndrome. Later, after repeated inquiries from the insurer, Dr. Button opined that off-work activities were the major contributing cause. His opinion was explicitly based on his understanding of claimant's post-surgery activities off the job. He understood that claimant was doing remodelling and was running an auto repair shop post-surgery. Dr. Button then apparently assumed that because claimant's hands were calloused at the time of surgery, claimant was also involved in remodelling and auto repair when the syndrome developed.

The value of Dr. Button's opinion depends on the accuracy of his understanding of claimant's work activities and off-work activities. The Referee found claimant credible. Claimant's testimony undermines Dr. Button's assumptions about his off-work activities at the time the carpal tunnel condition was developing. Therefore, Dr. Button's opinion was not persuasive.

The Referee properly relied on Dr. Achterman's opinion and concluded that work exposure was the major contributing cause of claimant's bilateral wrist condition.

Therefore, I dissent.

WALTER R. SEARLES, Claimant
Welch, et al., Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorneys

WCB 86-13495
March 28, 1989
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of Referee Tenenbaum's order that granted claimant permanent total disability, whereas a Determination Order had awarded 30 percent (96 degrees) unscheduled permanent disability for a back injury. We reverse the Referee's order and modify the Determination Order.

ISSUE

Extent of unscheduled permanent disability, including permanent total disability.

FINDINGS OF FACT

Claimant worked 12 years for the employer, first as a truck driver and later as a cement mixer. He has had back problems intermittently for about 30 years. In January 1986, he filed a claim for worsening back pain. The diagnosis was degenerative osteoarthritis of the lower lumbar and lumbosacral spine. The

claim was accepted for a disabling "low back strain," and he was treated conservatively. He tried to return to work but was unsuccessful. The claim was closed by Determination Order on September 22, 1986, with 30 percent unscheduled permanent disability.

In 1983 claimant underwent partial excision of a cancerous colon and had a permanent colostomy. After surgery, he returned to work without any apparent difficulty and, by February 1986, there was not yet any recurrence of cancer. However, the colon cancer subsequently recurred and, in July 1986, he underwent further surgery for that condition. During surgery, it was discovered that cancer had spread to the pelvic region. Claimant has been receiving weekly chemotherapy since March 1987. Chemotherapy drains him of body energy and causes his food to taste bitter which, in turn, contributes to decreased energy and reduced physical energy.

Vocational assistance was begun, but later terminated when it was determined that claimant could not work due to both the back and cancer conditions and that he intended to retire.

Claimant is 61 years of age and has an eighth grade education. His prior work experience is limited to manual labor, including construction and truck driving. He was earning $10 per hour when he stopped working in January 1986.

Currently, claimant experiences low back pain, for which he takes medication. He has limitations on bending and prolonged sitting, standing and walking, though he can relieve pain by changing positions. His back impairment is minimal, and reduces his functional capacity to light work.

FINDINGS OF ULTIMATE FACT

Claimant's preexisting cancer condition was not disabling at the time of the accepted back claim. We do not find, when current disability attributable to cancer is excluded from consideration, that claimant is unable to perform any work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

The Referee granted claimant permanent total disability (PTD), apparently finding that he is unable to perform any gainful and suitable work. We disagree and, instead, reinstate the Determination Order award of 30 percent unscheduled permanent disability.

Permanent Total Disability

In determining whether claimant is permanently and totally disabled, we consider all of his medical impairment, including preexisting noncompensable disability. ORS 656.206(1)(a); Weyerhaeuser Company v. Rees, 85 Or App 325, 328 (1987). Here, we find that the noncompensable colon cancer preexisted the accepted back claim. Although the cancer was surgically removed prior to the claim, its subsequent "recurrence" evidenced a continuation of the original, preexisting condition.

We do not find, however, that there was any preexisting disability due to the cancer condition. Disability resulting from

a preexisting condition is considered as it existed at the time of the industrial injury. Donald L. Savage, 39 Van Natta 758, 760 (1987). After surgery in 1983, claimant returned to work for more than two years without further difficulty. There is no evidence that claimant had problems with cancer when he filed his back claim in January 1986. Because the preexisting cancer condition was nondisabling at the time of the accepted back claim, it will not be considered in rating permanent disability.

To prove his entitlement to permanent total disability, claimant must establish that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403, 408-09 (1977). Physically, claimant is totally incapacitated. However, his testimony establishes that much of the incapacitation results from current treatment for the noncompensable cancer condition. Therefore, we are not persuaded that he is totally incapacitated by the back condition alone. Consequently, he can prevail only by proving that he falls within the so-called "odd-lot" doctrine. Under that doctrine, a disabled person, capable of performing work of some kind, may still be permanently and totally disabled due to a combination of his 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).

In concluding that claimant was permanently and totally disabled under the "odd-lot" doctrine, the Referee dismissed a vocational report which listed several jobs considered to be within claimant's physical and vocational capabilities, assuming that he was not disabled by the cancer condition. These jobs include motor transportation dispatcher, shipping and receiving weigher, parking lot cashier, motel clerk, security guard and gate tender. The Referee noted that these jobs paid substantially lower wages compared to the $10 hourly wage claimant had been earning from the employer, and apparently concluded that these jobs were not "gainful." We disagree. First, it is not at all clear from the record what wages are paid at these jobs, much less whether these wages are substantially lower than claimant's previous wage. Second, we have previously observed that the purpose of awarding permanent total disability benefits is to maintain claimant, not restore him to pre-injury wage status (as is the purpose of vocational rehabilitation, for example). Steven E. Puttie, 40 Van Natta 1069, 1072 (1988); Walter R. LaChappelle, 36 Van Natta 1565, 1566 (1984). Given that purpose, it is not improper to deny claimant the maintenance benefits of permanent total disability when he is capable of earning a living, even at a rate below his original wage.

Given the specific job possibilities that are within claimant's physical and vocational capabilities, when the cancer condition is excluded from consideration, we are not persuaded that claimant is unable to perform any work at a gainful and suitable occupation. Absent that finding, we conclude that claimant has not proven his entitlement to permanent total disability benefits.

Permanent Partial Disability

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

impairment resulting from the compensable condition and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these formulas 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).

The record is devoid of any express medical rating of claimant's permanent physical impairment due to the back condition alone. Claimant testified that he has low back pain for which he takes medication. He cannot bend and has limitations on standing, walking and sitting. After reviewing his testimony, we find that his back impairment is minimal. His earning capacity is further diminished by his advanced age, limited education, limited work experience and decreased functional capacity. Based on these factors, we conclude that an award of 35 percent unscheduled permanent disability adequately compensates claimant for his low back condition.

ORDER

The Referee's order dated June 12, 1987, as reconsidered on July 10, 1987 and amended on July 29, 1987, is reversed. In lieu of the Referee's award and in addition to the Determination Order award of 30 percent (96 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, giving him a total award to date of 35 percent (112 degrees) unscheduled permanent disability for his low back condition. Claimant's attorney fee shall be adjusted accordingly.

GENE A. HAWKINS, Claimant
Glen, et al., Claimant's Attorneys
Richard D. Barber (SAIF), Defense Attorney

WCB 84-07309
March 30, 1989
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of Referee Garaventa's order which: (1) upheld the SAIF Corporation's denials of his aggravation claims for a low back condition; and (2) declined to award additional temporary total disability (TTD) benefits for the six-week period that he wore a body cast.

ISSUES

1. Compensability of the 1984 and 1985 aggravation claims for a low back condition.

2. Compensability of the 1986 aggravation claim for TTD benefits for the six-week period that claimant wore a body cast.

   a) Claimant's entitlement to reopening of his claim for aggravation.

   b) Claimant's entitlement to TTD benefits.

We affirm and adopt that portion of the Referee's order that upheld the 1984 and 1985 aggravation denials, as supplemented by the findings of fact below. We reverse that portion of the order that declined to reopen the claim for aggravation during the period that claimant wore a body cast; however, we affirm the Referee's decision that he is not entitled to additional TTD benefits.

FINDINGS OF FACT

The last award of compensation was the October 31, 1983, Opinion and Order, in which the Referee affirmed the Determination Order awarding 50 percent unscheduled permanent disability for the low back injury and 50 percent scheduled permanent disability for the loss of use or function of the right leg. Prior to that award, on August 25, 1983, claimant had low back pain radiating into both legs. The pain increased with physical activity. His knees felt weak, as though they were going to "give way." He could not lift any weight and could sit for only 15 to 20 minutes before experiencing pain and numbness. He could not walk more than a few blocks. He also had difficulty with his urinary function.

The symptoms and limitations above remained the same through June, 1985. On June 3, 1986, Dr. Newby applied a body cast on claimant to relieve persistent low back pain resulting from the compensable injury. Claimant wore the cast for six weeks and was totally disabled during that period.

SAIF was advised of the application of the body cast, and responded by letter of September 22, 1986, that the claim remained closed for lack of evidence of any worsening in claimant's condition.

Claimant has neither worked nor sought work since the original injury in January, 1982, despite his release for light work in May, 1983.

FINDINGS OF ULTIMATE FACT

Claimant's low back condition had not worsened prior to the denials of June, 1984, and June, 1985. His condition worsened when he was placed in the body cast. That worsening resulted from treatment for the compensable injury. Claimant had removed himself from the labor market prior to the worsening.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that he was entitled to reopening of his claim with TTD benefits for the period that he wore the body cast. We agree that the claim should have been reopened, but we do not agree that he is entitled to TTD benefits.

Claimant may seek reopening of his original injury claim with additional TTD benefits by filing a claim for aggravation. See ORS 656.273(2). Here, SAIF received a medical report from Dr. Newby in June, 1986, indicating his intent to apply the body cast for six weeks. That report was an aggravation claim. See ORS 656.273(3). Although SAIF never formally denied that claim, it advised claimant that his claim remained closed for lack of evidence that his condition had worsened. Therefore, SAIF had, in fact, denied the aggravation claim.

In his hearing request and at hearing, claimant raised the issue of his entitlement to additional TTD benefits without explicitly challenging SAIF's de facto denial of his aggravation claim. We find, nevertheless, that the de facto denial was properly before the Referee. The Referee concluded that claimant was not entitled to TTD benefits, but she did not address the compensability of the underlying aggravation claim. We address that issue here.

To establish a compensable aggravation, claimant must prove that: (1) his condition has worsened since the last award of compensation, so that he is more disabled either temporarily or permanently; and (2) his compensable injury was a material contributing cause of the worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396, 399 (1986). In determining whether there is a worsened condition, we do not distinguish between a claimant who is physically unable to work and one who, because of necessary treatment, is unavailable to go to work; in both cases, claimant is disabled. See Weyerhaeuser Company v. Surprise, 89 Or App 296, 300 (1988).

Here, it is undisputed that application of the body cast was necessary treatment for the effects of the compensable injury and that claimant was totally disabled during its six-week application. Pursuant to Gwynn v. SAIF, 304 Or 345 (1987), total disability exceeding 14 days is a worsening as a matter of law. Consequently, claimant has established a worsening as a matter of law.

Claimant has also established a worsening as a matter of fact. To begin, we must determine whether the six-week period of total disability was anticipated by the prior award of compensation. See Smith v. SAIF, supra, 302 Or at 401. We do so by first determining whether the prior award anticipated that some period of total disability would result from the compensable injury. See Gwynn v. SAIF, 304 Or 345, 352-53 (1987). Here, there was medical evidence that claimant would experience flareups of severe pain which could eventually lead to the loss of use of both legs. That evidence was considered by a prior Referee in affirming the Determination Order award. We find that, although the award clearly did not anticipate the loss of use of both legs, it did anticipate future symptomatic flareups resulting in some periods of disability. However, we conclude that the prior award did not anticipate a six-week period of total disability. We conclude, therefore, that claimant has proven a worsened condition as a matter of fact. Consequently, whether as a matter of law or fact, claimant's aggravation claim is compensable.

However, claimant is not entitled to TTD benefits for the period that he wore the body cast, because he effectively withdrew himself from the labor market. TTD benefits are awarded for lost wages, see ORS 656.210(1), and a person who has withdrawn from the labor market has no lost wages. Cutright v. Weyerhaeuser Co., 299 Or 290, 302 (1985). It is immaterial that claimant's physical condition necessitated the withdrawal. Karr v. SAIF, 79 Or App 250, rev den 301 Or 765 (1986).

Finally, we emphasize that, although claimant is not entitled to TTD benefits, he is entitled to a determination of any additional permanent disability he may have sustained, upon eventual closure of the claim. See ORS 656.268.

ORDER

The Referee's order dated June 10, 1987 is affirmed in part and reversed in part. That portion of the order that upheld the SAIF Corporation's de facto denial of the aggravation claim of June, 1986, is reversed. That denial is set aside and the aggravation claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $750 for services at the hearing level and on Board review, to be paid by SAIF.

Board Member Ferris, dissenting:

I dissent. Claimant has not sustained his burden of proving that he suffered a compensable aggravation during the six-week period that he wore the body cast.

As a preliminary matter, I disagree with the majority's finding that Dr. Newby's letter of June 3, 1986, constitutes an aggravation claim. A medical report submitted as an aggravation claim must put the insurer on notice that treatment for a changed condition is indicated. ORS 656.273(1), (3); Avalos v. Bowyer, 89 Or App 546, 549 (1988); Krajacic v. Blazing Orchards, 84 Or App 127, 130, modified 85 Or App 477, remanded for reconsideration on other grounds 304 Or 436 (1987), on remand 90 Or App 593 (1988); Haret v. SAIF, 72 Or App 668, 672, rev den 299 Or 313 (1985). Newby's letter does not indicate that application of the body cast is treatment for a changed condition. Indeed, the letter does not report any change in claimant's condition since the last award of compensation in October, 1983. Rather, the letter indicates that application of the body cast is intended to relieve continuing low back pain, a symptom which has persisted since the last award of compensation. Hence, I do not find that the letter put SAIF on notice that treatment for a changed condition is indicated.

The majority apparently found otherwise, however, citing Weyerhaeuser Company v. Surprise, 89 Or App 296 (1988), for the proposition that treatment for the continuing effects of the compensable injury which are rendered after the last award of compensation may be sufficient alone to show a worsened condition if the treatment renders claimant temporarily more disabled than he was at the time of the last award. I disagree with that proposition and conclude that it is not supported by the court's holding in Surprise.

In Surprise the claimant compensably injured his low back. He was released for regular work and the claim was closed by Notice of Closure with an award of TTD. The Evaluation Division reviewed the notice and, in March, 1985, issued a Determination Order awarding additional TTD and PPD. Claimant was subsequently referred for pain center treatment for persistent low back pain. The employer denied responsibility for the treatment on the ground that it was not reasonable and necessary. Claimant nevertheless participated in the two-week treatment program, and his condition improved significantly. He sought a hearing on, inter alia, the denial of treatment and the propriety of the Evaluation Division's claim closure in March, 1985. The Referee set aside the denial, ordered the payment of TTD for the period of treatment, and set aside claim closure as premature. On Board review, we affirmed on the denial and TTD issues but upheld claim closure. On judicial review, the court set aside the denial, finding that pain treatment was reasonable and necessary for claimant's condition to improve. Based on that latter finding, the court also set aside the March, 1985, claim closure as premature. Additionally, the court upheld the award of TTD for the period of pain treatment, reasoning that a worker who, because of necessary treatment for a compensable injury, is unavailable for work has sustained a compensable loss of income for that period of treatment. Id. at 300.

The distinction between Surprise and this case is profound. The issue here is claimant's entitlement to reopening of his claim for TTD. That issue was not before the court in Surprise. Rather, the court addressed claimant's entitlement to TTD in the context of a prematurely closed claim. By setting aside claim closure as premature, the court essentially restored the claim to

open status, at least for the period of pain treatment. Consequently, claimant was relieved of the burden of proving his entitlement to TTD on an aggravation theory. He prevailed by proving that the treatment was a compensable consequence of his industrial injury and that he was unable to work during the course of that treatment. See id.

Here, the claim is closed. Hence, claimant's entitlement to TTD rests exclusively on an aggravation theory. It is not enough for claimant to prove that the recommended treatment is reasonable and necessary for the effects of the compensable injury and that he was unable to work during the course of that treatment. He must prove further that he has a worsened condition, i.e., a change in condition which makes him more disabled, either temporarily or permanently, than he was when the original claim was closed. See Smith v. SAIF, 302 Or 396, 399 (1986). A "change in condition" means a change in claimant's medical condition, i.e., symptoms or underlying condition, not merely the selection of a new method of treatment, albeit treatment that is temporarily disabling.

The result in this case is particularly troublesome. While the majority concludes that claimant is not entitled to TTD because he withdrew himself from the labor market, it nevertheless observes that claimant is entitled to a determination of any additional permanent disability he may have sustained, upon eventual closure of the aggravation claim. That determination would be an exercise in futility absent a showing that claimant's symptoms or underlying condition has changed since the last award of compensation. I conclude that such a showing must be made for claimant to prevail in this case.

The first medical report to indicate any change in claimant's condition is Dr. Lieuallen's March 17, 1987, report that claimant had a gradual increase in pain and discomfort in mid-1986 and that the body cast was subsequently applied. That was the first claim for aggravation. See ORS 656.273(3). SAIF neither accepted nor formally denied the claim; hence, its denial was de facto.

After reviewing the record, I conclude that claimant has not sustained his burden of proving a change in his condition since the last award of compensation in October, 1983. Lieuallen is the only physician to indicate any such change. His opinion is not persuasive, however, because he did not have an opportunity to observe claimant during mid-1986. Prior to March, 1987, Lieuallen last saw claimant in April, 1985. Second, Lieuallen's own report of claimant's symptoms does not reflect any change since 1983. I am most persuaded, instead, by the opinions of those physicians who saw claimant during the critical period in mid-1986. None of those physicians, including Dr. Newby, reported any change in claimant's condition. Absent proof of a changed condition, I conclude that claimant's aggravation claim is not compensable. See Smith v. SAIF, supra.

GARY J. JAMES, Claimant
Dale Jackins Lindamood, Claimant's Attorney
Coons & Cole, Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-04564
March 30, 1989
Order on Review

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Daron's order which: (1) upheld the insurer's denial of claimant's aggravation claim for his current cervical condition; (2) declined to assess penalties and attorney fees for alleged unreasonable claims processing; and (3) awarded claimant a carrier-paid attorney fee of $2,000. The insurer cross-requests review of that portion of the Referee's order which set aside its denial of claimant's aggravation claim for his current psychological condition. We affirm in part and reverse in part.

ISSUES

1. Whether claimant sustained an aggravation of his compensable psychological condition.

2. Whether claimant sustained an aggravation of his compensable cervical condition.

3. Whether claimant was entitled to penalties and attorney fees for the insurer's alleged unreasonable claims processing.

4. Whether claimant's award of attorney fees was reasonable.

FINDINGS OF FACT

Claimant was 24 and married with three children when he was drafted into the United States Army in 1968. He served in Vietnam until he was discharged in 1970 due to emotional problems. Prior to his military experience, claimant had not exhibited any psychological difficulties. While in the service, claimant's father died. Claimant's younger brother also served in Vietnam and committed suicide shortly thereafter. Following his return from Vietnam, claimant discovered that his wife had sold all of their belongings and left with their children. Claimant was unable to establish the whereabouts of his children until his wife put them up for adoption. Claimant was not able to obtain custody. In 1970, the stress of all these events caused claimant to suffer three "nervous breakdowns" in succession and a suicide attempt.

Between 1971 and 1976 claimant worked at a variety of odd jobs and received extensive treatment for psychological difficulties from several Veterans' Administration facilities. These difficulties were invariably diagnosed as anxiety reactions with fairly strong depressive elements, manifested by insomnia, depression, anxiety and mild reduction in psychomotor activity. Alcoholism was a secondary diagnosis.

Between March 1976 and November 1980, claimant continued to receive psychiatric treatment on an outpatient basis. On the whole, however, this period of time reflected relative psychological stability. The service-connected anxiety reaction

and alcoholism were under control with occasional episodes of backsliding. He worked full time as a sawyer off-bearer at a lumber mill and lived with another woman during this time. She left him, however, after his compensable accident in 1980.

On November 21, 1980, claimant sustained a compensable chest and neck injury. During 1981-82, Dr. Martinez, neurosurgeon, performed two anterior cervical diskectomies and fusions at the C5-6 level. He diagnosed pseudoarthrosis at the C5-6 level. In 1985, Dr. Smith, operated for a third time, performing an anterior cervical diskectomy and interbody fusion using allograft, cervical 4-5 and 6-7. He diagnosed spondylosis and spondylopathy, with cervical radiculitis and radiculopathy at the C4-5 and C6-7 levels.

In December 1983, claimant's relentless left trapezius and chronic cervical pain syndromes produced a major depressive disorder.

Due to claimant's increasingly severe psychological depression and the need for further cervical surgery, a July 13, 1983 Determination Order was set aside as premature by a July 12, 1985 Referee's order. Eventually, a December 4, 1985 Determination Order awarded claimant 65 percent (208 degrees) unscheduled permanent disability and 5 percent (9.6 degrees) scheduled permanent disability for loss of his left arm.

From August 15, 1983 until December 23, 1985, claimant worked part time. By December 23, 1985, however, he was no longer able to work. Dr. Middlekauff, claimant's treating psychiatrist, reported that claimant was more depressed and no longer medically stationary. He observed that there had been a significant deterioration in his emotional functioning and recommended reopening his psychological claim. On January 9, 1986, claimant was hospitalized at the Veterans' Administration Hospital Psychiatric Unit.

Claimant's mental deterioration was caused by his employer's attempt to increase his working hours, his fear of hurting someone at the mill due to the instability of his physical condition, his inability to work or be active the way he had been in the past, increasing neck and right arm pain, the realization that his physical condition was not improving, and increased feelings of failure.

On March 11, 1986, Dr. Middlekauff reported that claimant was still not physically capable of employment, and noted increased muscle spasms in the neck.

On March 23, 1986, the insurer denied that claimant's psychiatric condition had worsened and refused to reopen his claim. The insurer reasoned that while claimant may have continued to suffer from psychiatric disability, the industrial accident was no longer a material contributing factor to that psychiatric disability and need for treatment.

On June 17, 1986, claimant was admitted to St. Vincent Hospital for a repeat cervical myelogram study because of recurrent pain through the neck, shoulders and arms suggesting a possible acute, recurrent disk. The myelogram revealed some minimal changes at C3-4 above his previous C4-5 fusion and at

C7-T1. On June 18, 1986, claimant was discharged with a diagnosis of cervical spondylosis, C4-5, C7-T1, and cervical sprain. Dr. Middlekauf continued to maintain that claimant's physical condition had gradually worsened. Based upon the persuasive opinion of Dr. Middlekauf that claimant's underlying condition worsened and claimant's worsening symptoms, we find that claimant's cervical condition did worsen.

On July 8, 1986, the insurer issued a second aggravation denial. The basis of this denial was that claimant's cervical spine condition had not worsened.

Claimant's emotionally deprived developmental background combined with his Vietnam-related post-traumatic stress disorder to produce a personality disorder. This disorder was characterized as "mixed." It had primarily passive/dependent and schizoid features with mild histrionic traits. It manifested itself in the form of alcoholism and anxiety reactions. Claimant's compensable injury was not the cause of this personality disorder.

An anxiety reaction is a condition in which the anxiety level of an individual rises to a point where it interferes with that person's ability to function. It manifests itself by nervousness, difficulty coping with daily activities, ambivalence and an inability to make decisions.

Subsequent to claimant's compensable 1980 injury, he developed major depression. A number of factors contributed to the development of this condition. Claimant's three cervical diskectomies and fusions produced chronic cervical pain and permanent physical limitations which prevented him from returning to work. These were the primary contributing factors to his disabling psychiatric condition. Claimant's personality disorder was also involved, although much less so.

Anxiety reactions and major depressions are different conditions. A person suffering from an anxiety reaction is generally alert and their psychomotor activity is usually very good. An individual suffering from a major depression, however, generally exhibits retarded psychomotor activity, lethargy and weight loss. They usually feel helpless, hopeless and worthless.

CONCLUSIONS OF LAW

Cervical aggravation

The Referee upheld the insurer's denial of claimant's cervical aggravation. He found that Dr. Smith's diagnoses of cervical spondylosis and cervical spine strain were not causally linked to claimant's compensable 1980 injury. Although the Referee conceded that claimant's neck pain and associated physical problems were worse than at the last award of compensation, he refused to set aside the denial since claimant had failed to establish the relationship of spondylosis and cervical strain to the compensable injury. Since the compensability of claimant's cervical condition was never raised as an issue, we disagree.

The insurer's July 8, 1986 denial stated that:

"It is the position of the [employer] that your cervical spine condition has not

worsened since the Determination Order dated December 4, 1985."

"While we will continue to provide benefits under ORS 656.245, any additional time loss and permanent disability is respectfully denied."

The insurer denied only that claimant's cervical condition had worsened; it did not deny the compensability of his cervical condition. Since that specific issue was never raised by the insurer, we refuse to address it on review.

To establish a claim for aggravation, claimant must show "worsened conditions resulting from the original injury." ORS 656.273. Claimant may establish an aggravation claim by showing that his underlying compensable condition has worsened since the last award of compensation. However, it is also sufficient to show that the symptoms of the condition have worsened to the extent that claimant is more disabled, at least temporarily, than at the time of the last arrangement of compensation. Gwynn v. SAIF, 304 Or 345 (1987), on remand 91 Or App 84 (1988). The persuasive medical opinion of Dr. Middlekauff established that claimant had suffered a worsening of his underlying cervical condition. The medical and lay evidence together also established that claimant had suffered a symptomatic worsening and was hospitalized for treatment of that condition.

First, we discuss the evidence establishing an aggravation due to a worsening of claimant's underlying condition. On March 11, 1986, Dr. Middlekauff wrote in his chart notes that claimant was still physically not capable of employment.

On June 17, 1986, Dr. Middlekauff stated that claimant had neck surgery which at first decreased some of his cervical pain, but the pain had returned and he was having more problems with numbness as well. Overall, the doctor saw claimant's physical condition as gradually worsening.

On June 17, 1986, claimant was admitted to St. Vincent Hospital for a repeat myelogram study because of recurrent pain through the neck, shoulders and arms, suggesting a possible acute, recurrent disk. This study demonstrated no significant changes at the C3-4 or the C7-T1 spaces above and below his solid spinal fusion. Claimant was discharged home on June 18, 1986 with a diagnosis of cervical spondylosis, C3-4, C7-T1, and cervical sprain which Dr. Smith expected to soon resolve.

Dr. Middlekauff's June 17, 1986 letter made it clear, however, that claimant's physical condition had worsened. He stated that claimant's neck surgery decreased some of his pain, but the pain returned and he began to have problems with numbness. The pain caused by the compensable injury and three subsequent surgeries, however, never disappeared. Claimant's worsened condition was due to the increase in this pain. Since claimant established that his underlying cervical condition worsened, he has proven a compensable aggravation claim.

Second, we discuss proof of aggravation by symptomatic worsening. Claimant may establish a compensable aggravation based upon worsened symptoms alone. Gwynn v. SAIF, supra. If a prior award of permanent disability did not contemplate symptomatic flare-ups, the flare-up is at least a temporary worsening and is

thus an aggravation. 91 Or App at 88. If a prior award did contemplate symptomatic flare-ups, then an aggravation is established if the particular flare-up is greater than what the award contemplated or if the worker, as a result of a worsening of symptoms from the original injury, becomes totally disabled for more than 14 consecutive days or becomes an in-patient at a hospital for treatment of that condition, he/she has established an aggravation as a matter of law. Gwynn v. SAIF, 304 Or at 353.

On December 4, 1985, a Determination Order awarded claimant 65 percent unscheduled disability and 5 percent scheduled disability for loss of use of his left forearm. Based upon the prior medical evidence, we find that that award took into account anticipated future waxing and waning of claimant's cervical symptoms. See International Paper Co. v. Turner, 91 Or App 91, 93 (1988).

On June 17, 1986, claimant became an in-patient at St. Vincent Hospital for treatment of his compensable cervical condition and increasing symptoms which included a complete myelogram study. Claimant was not discharged until the following day.

Even though claimant's previous award of permanent disability contemplated that he would experience future waxing and waning of his cervical symptoms, it neither contemplated that he would begin experiencing new symptoms nor, as a matter of law, did it anticipate that he would be hospitalized for treatment of the cervical condition. Therefore, claimant also met his burden of proving an aggravation claim based on worsened symptoms or hospitalization for that condition. Claimant is entitled to compensation for temporary disability and to a reevaluation of the extent of permanent disability for his cervical condition when he becomes medically stationary.

Psychological Aggravation

The Referee set aside the insurer's denial of claimant's psychological aggravation claim. He based his decision primarily on Dr. Middlekauff's opinion that claimant's depression steadily worsened from mid-December 1985 until he was hospitalized in January 1986. The Referee was persuaded that claimant suffered from major depression at the time, not the effects of a preexisting personality disorder. We agree.

The insurer argues that it is not denying claimant's compensable psychological condition, but is merely denying responsibility for a chronic underlying condition. It may be possible for a claimant to have a chronic condition which is temporarily worsened by an on-the-job accident, but which eventually returns to the pre-accident condition. Aldrich v. SAIF, 71 Or App 168 (1984). The Aldrich court reasoned that any subsequent worsening might in fact be attributable only to the underlying condition, and a denial would then be proper. Id. at 172-3. This is not the case here.

Claimant's post-Vietnam anxiety reaction was controlled and nondisabling between 1976 and 1980. Subsequent to his compensable 1980 injury and three successive surgeries, however, claimant sunk into a major depression.

Dr. Middlekauff opined that the residual consequences of

claimant's industrial injury were, if not the sole cause, a material contributing cause of that major depression. The precipitating factors included claimant's chronic pain syndrome, financial hardship and social withdrawal associated with his physical limitations.

Based on claimant's credible testimony and Dr. Middlekauff's opinion as the treating psychiatrist, we conclude that claimant has established that he sustained a worsening of his compensably related psychological condition, requiring further medical treatment and rendering him incapable of employment. Therefore, we agree with the Referee, who directed the insurer to accept claimant's aggravation claim for continuing worsened psychological problems.

Penalties and Attorney Fees

The Referee refused to assess penalties and attorney fees for unreasonable claims processing concerning the denials. Since the Referee upheld the denial of the aggravation claim for his cervical condition, he refused to impose a penalty. Furthermore, given the contradictory medical evidence concerning the psychological aggravation claim, he concluded that that denial was neither unreasonable nor unreasonably delayed. We agree.

ORS 656.262(10) indicates that if an insurer:

> "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, 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."

Although Dr. Middlekauff indicated in December 1985 that claimant's depression had worsened, Dr. Turco opined in March 1986 that claimant's recurrent depression was not associated with his 1980 compensable injury. Therefore, we do not consider the insurer's denial of claimant's psychological aggravation claim to be unreasonable.

Dr. Middlekauff's December 23, 1985 chart notes indicated that claimant's condition was worsening. This is sufficient to constitute a claim for aggravation. However, there is no indication from the record as to when the insurer received this chart note. Consequently, there is a lack of evidence to establish that a 60-day period elapsed after the insurer received Dr. Middlekauff's chart note. Therefore, the denial was not unreasonably delayed.

Since there was sufficient doubt regarding the worsening of claimant's cervical condition, the insurer's denial thereof was also not unreasonable.

Adequacy of attorney fees

The Referee awarded $2,000 as a reasonable attorney fee for overturning the denial of claimant's aggravation claim for his current psychological condition.

ORS 656.386(1) states that in:

> "rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee."

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. OAR 438-15-010(6); Barbara A. Wheeler, 37 Van Natta 122 (1985).

We acknowledge the complexity and amount of time necessary to properly prepare this case, but agree with the Referee that $2,000 is a reasonable award for claimant's attorney's efforts at hearing in overturning the insurer's denial of claimant's psychological condition.

ORDER

The Referee's order dated March 25, 1987 is reversed in part and affirmed in part. That portion which upheld the insurer's denial of claimant's worsened cervical condition is reversed. The claim is remanded to the insurer for processing according to law. The remainder of the Referee's order is affirmed. Claimant's counsel is awarded: (1) an assessed fee of $300 for successfully defending against the insurer's request for review to reinstate its denial of claimant's psychological aggravation claim; (2) an assessed fee of $1,000 for his services at hearing and an additional $500 for services on Board review, in setting aside the insurer's denial of claimant's cervical aggravation claim. The Board also approves a client-paid fee not to exceed $1,039.

Board Member Ferris, dissenting in part:

I do not agree that claimant has established a compensable aggravation of his cervical conditon, and I would find, as did the Referee, that the claimant had failed to establish the relationship of spondylosis and cervical strain to the compensable injury.

In addition to not agreeing with the majority's analysis as a whole, I am particularly disturbed by a portion of that analysis. The majority cites Gwynn v. SAIF, 304 Or 345 (1987), in stating that an aggravation can be established as a matter of law if a worsening of claimant's condition requires in-patient hospitalization at a hospital for treatment of that condition. I agree with this statement. It goes on, however, to equate a myelogram study to in-patient hospitalization on the basis that claimant was admitted on June 17, 1986 and discharged the following day, thus constituting hospitalization for treatment of a worsened condition. Diagnostic procedures do not constitute in-patient hospitalization for the treatment of a compensable condition. See Leland Smith, Jr., 40 Van Natta 356 (1988). It follows therefore, that claimant's hospitalization, by itself, would not constitute in-patient hospitalization necessary to establish a compensable aggravation of his cervical condition. cf. Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581 (1984).

Accordingly, I do not agree with the order's statement that claimant's myelogram procedure constitutes "inpatient hospitalization" as that phrase is used in Gwynn v. SAIF, supra.

EDWARD O. MILLER, Claimant
Becker & Hunt, Claimant's Attorneys
Rankin, VavRosky, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Own Motion 82-0210M
March 30, 1989
Own Motion Order on Remand

This matter is before the Board on remand from the Court of Appeals. Miller v. Glen Falls Insurance, 94 Or App 264 (1988). Finding our prior order on remand, Edward O. Miller, 39 Van Natta 737 (1987), insufficient for judicial review under ORS 656.298(6), the court has reversed and remanded for reconsideration in light of Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). In accordance with the court's mandate, we proceed with our reconsideration.

FINDINGS OF FACT

In March 1970 claimant sustained a compensable head injury, while working for Brander Meat Company, Glen Falls' insured. He suffered a laceration and concussion, when he was struck in the head by a 25-pound beef shackle. In April 1970 his claim was closed by a Determination Order that awarded no permanent disability. Claimant's aggravation rights under this claim have expired.

In 1974 claimant suffered a compensable right hand injury, while working for Brander's successor, Coast Packing Company. This claim was accepted and closed by a July 1974 Determination Order, which awarded 10 percent scheduled permanent disability. The claim was subsequently reopened and reclosed in 1975 with an additional award of scheduled permanent disability. To date, claimant has received 35 percent scheduled permanent disability stemming from this injury.

In 1976 claimant sought treatment for psychological problems. Dr. Sloat, psychologist, and Dr. Duncan, psychiatrist, diagnosed paranoid psychosis. A major tranquilizer, Mellaril, was prescribed.

Claimant's paranoid psychosis preexisted both his 1970 and 1974 compensable injuries. His psychosis has resulted in a permanent loss of earning capacity. However, the 1970 compensable head injury did not cause his preexisting psychosis to become more syptomatic to the point of causing disability or a need for medical treatment. Consequently, claimant's paranoid psychosis is not related to his 1970 compensable head injury.

In May 1977 claimant and Coast Packing entered into a disputed claim settlement in which the compensability of claimant's emotional psychological and psychiatric problems were resolved insofar as each related to claimant's 1974 hand injury.

Claimant continued to seek treatment, complaining of upper arm, shoulder and neck pain. Dr. Coletti, orthopedist, diagnosed acromial bursitis due to the immobility of the right upper extremity. These complaints are not related to either compensable injury.

In April 1978 claimant began seeing Dr. Olmscheid, neurologist, reporting symptoms of recurrent headaches, dizzy

spells, intermittent bouts of shakiness in the extremities, light-headedness, nausea, a general sweaty sensation and dimming of the vision of both eyes. Claimant had begun experiencing these symptoms in the past 6 to 8 months. Dilantin was prescribed. A complex partial seizure disorder was subsequently diagnosed.

Claimant's complex partial seizure disorder is directly related to the compensable 1970 head injury. This disorder has manifested itself by temper outbursts, rage attacks and a personality change. The medication for claimant's psychosis most probably caused the disorder to surface because the medication lowered his seizure threshold. The seizure disorder has been managed by the administration of Dilantin.

Claimant is approximately 41 years of age. He has a tenth grade education and no GED. In addition to working at a slaughterhouse, claimant has worked as a service station attendant and miner. Vocational assistance efforts, primarily in the form of schooling in welding and engineering skills, were initiated in February 1976. These efforts were terminated in December 1977, due to claimant's noncompensable arm/hand problems and psychiatric problems.

The medical and lay evidence does not establish that claimant is permanently and totally incapacitated from regularly performing work at a gainful and suitable occupation as a result of his compensable head injury, complex partial seizure disorder, preexisting disabilities, age, education, and vocational adaptabilities. Furthermore, considering claimant's compensable conditions, the evidence does not establish that: (1) claimant is willing to seek regular gainful employment; (2) he has made reasonable efforts to obtain such employment; or (3) it would be futile for him to seek such employment.

As a result of his compensable head injury and complex partial seizure disorder, claimant has suffered permanent physical impairment in the mild range. When this impairment is combined with the aforementioned social/vocational factors, claimant has sustained a permanent loss of earning capacity of 20 percent.

CONCLUSIONS OF LAW

We previously found Brander responsible for claimant's paranoid psychosis and purported arm, neck, and shoulder syndrome, as well as the complex partial seizure disorder. Edward O. Miller, 37 Van Natta 174, 37 Van Natta 176 (1985). In so doing, we also awarded claimant 60 percent unscheduled permanent disability for his 1970 head injury. id. The Court of Appeals subsequently reversed our conclusions that Brander was responsible for claimant's psychosis or his arm, neck and shoulder complaints. Miller v. Coast Packing Company, 84 Or App 83, rev den 303 Or 534 (1987).

On remand from the court, we concluded that our prior award of permanent disability was based on the erroneous premise that claimant's underlying psychosis was causally related to his 1970 compensable head injury. Edward O. Miller, 39 Van Natta 737 (1987). After redetermining the extent of claimant's permanent disability, we held that the record did not establish that claimant had sustained a permanent loss of earning capacity as a result of his compensable 1970 head injury or his complex partial seizure disorder. Consequently, we declined to award permanent disability.

On reconsideration, we remain unpersuaded that claimant is permanently and totally incapacitated from regularly performing work at a gainful and suitable occupation. None of the medical evidence, including that supplied by claimant's treating neurologist, Dr. Olmscheid, or his treating psychiatrist, Dr. Duncan, support the contention that he is permanently and totally disabled from either a physical or mental standpoint. Moreover, the record neither establishes that, considering his compensable conditions, claimant has made reasonable efforts to seek work nor that it would be futile for him to do so.

Turning to a redetermination of the extent of permanent disability, we reiterate that claimant has a "class 2" aggravation of his paranoid psychosis. See Edward O. Miller, 37 Van Natta 176 (1985). Yet, because the court has held that this condition is not compensable, this impairment will not be considered in our evaluation. The record further establishes that claimant's 1970 head injury caused scar tissue in his brain. This damage eventually prompted his complex partial seizure disorder. Both treating physicians support this analysis. Furthermore, each physician is of the opinion that the administration of the Dilantin medication is managing these seizures and will continue to do so. Yet, despite the current management of this disorder, this medication regimen will permanently continue. Considering these circumstances, we conclude that claimant's compensable head injury and complex partial seizure disorder have resulted in permanent physical impairment in the mild range.

In rating the extent of claimant's permanent disability attributable to his 1970 head injury and complex partial seizure disorder, we consider his compensable physical impairment and all of the relevant social and vocational factors set forth in OAR 436 30-380 et seq. These rules are guidelines, not 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). After evaluating claimant's age, education, vocational adaptabilities, and permanent impairment, and considering the aforementioned guidelines, we determine that a 20 percent unscheduled permanent disability award provides adequate compensation for the permanent loss of earning capacity resulting from claimant's 1970 head injury and complex partial seizure disorder.

Accordingly, our prior award of 60 percent unscheduled permanent disability, as granted by our February 22, 1985 Own Motion Order, is modified. Claimant's total unscheduled permanent disability for his 1970 head injury and complex partial seizure disorder is reduced to 20 percent. Claimant's attorney's fee, as granted by our prior award, shall be likewise modified accordingly.

IT IS SO ORDERED.

SHEILA E. REEVES, Claimant
Roll, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-10670
March 31, 1989
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989). The court has concluded that a penalty for the self-insured employer's unreasonable delay in responding to claimant's request for documents in preparation for hearing may be

based on interim compensation due, but not on medical services. Consequently, the court has remanded with instructions to: (1) determine whether and when compensation was due claimant between August 19, 1986, which was 15 days after she demanded the claims documents in anticipation of hearing, and October 9, 1986, the date the employer complied with her demand; and (2) assess a penalty on any such compensation due during that time. We proceed with our determination.

FINDINGS OF FACT

Claimant filed an occupational disease claim for bilateral cataracts on July 7, 1986. At that time, the employer noted on the claim form that, on May 27, 1986, claimant had claimed exposure to radiation from x-ray machines had caused her cataracts. Claimant missed no time from work as a result of her cataracts until July 15, 1986, when she underwent out-patient cataract surgery. The employer denied the claim on July 17, 1986. It did not pay interim compensation.

On August 4, 1986, claimant requested a hearing and demanded that the employer forward all relevant claims documents to her attorney. The employer did not comply with claimant's discovery demand until October 9, 1986.

CONCLUSIONS OF LAW

The first installment of compensation shall be paid no later than the 14th day after the employer has notice or knowledge of the claim. ORS 656.262(4). "Claim" means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge. ORS 656.005(6). The procedure for processing occupational disease claims shall be the same as provided for accidental injuries. Former ORS 656.807(5) (now ORS 656.807(3)).

The employer issued its July 17, 1986 denial within 14 days of the date claimant filed her claim, July 7, 1986. However, the employer acknowledged on the claim form that it had notice of claimant's contention of employment radiation exposure by May 27, 1986. Such an acknowledgment leads us to conclude that, on May 27, 1986, the employer had sufficient knowledge of claimant's disease to lead a reasonable employer to conclude that workers' compensation liability was a possibility and that further investigation was appropriate. See Argonaut Insurance Company v. Mock, 95 Or App 1 (January 25, 1989).

Although the employer had notice or knowledge of the claim by May 27, 1986, claimant did not "leave work" until her July 15, 1986 cataract surgery. See Bono v. SAIF, 298 Or 405, 410 (1984). Thus, when the employer issued its July 17, 1987 denial, claimant had missed two days of work. Yet, pursuant to ORS 656.210(3), no disability payment is recoverable for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of the compensable injury unless the total disability continues for a period of 14 days or the worker is an in-patient in a hospital.

Here, claimant left work and underwent out-patient surgery on July 15, 1986. Therefore, at the time of the

employer's July 17, 1986 denial, claimant had missed less than three calendar days after she left work as a result of her cataracts and she was not an in-patient in a hospital. Consequently, no interim compensation was due. The denial was not withdrawn during the time the employer was in violation of the discovery rule. Thus, no compensation became due.

Accordingly, we conclude that no interim compensation was due claimant when the employer committed its discovery violation. Inasmuch as no compensation was due, there is nothing upon which to assess a penalty.

IT IS SO ORDERED.

KENNETH M. SIMONS, Claimant
Quintin B. Estell, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney
Cummins, et al., Defense Attorneys

WCB 87-02814 & 86-16762
March 31, 1989
Order on Reconsideration

Claimant has requested reconsideration of that portion of our March 2, 1989 Order on Review that declined to award an insurer-paid attorney fee for his counsel's efforts in prevailing against a Referee's order that had upheld Liberty Northwest Insurance Corporation's denial of claimant's medical services claim for diagnostic testing. 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 656.386(1).

After review of the statements 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 $750, to be paid to claimant's attorney by Liberty Northwest for services rendered concerning the medical services issue.

Finally, we note that, pursuant to our March 2, 1989 order, the Referee's responsibility finding concerning claimant's current back condition was reversed. Specifically, Liberty Northwest's denial of claimant's aggravation claim was upheld and the SAIF Corporation's denial of claimant's "new injury" claim was set aside. Inasmuch as SAIF's denial has now been set aside, it follows that SAIF, rather than Liberty Northwest, is responsible for the $1,200 attorney fee awarded by the Referee for services at hearing. Consequently, SAIF is directed to pay to claimant's counsel the $1,200 attorney fee awarded by the Referee.

Accordingly, our order dated March 2, 1989 is abated and withdrawn. As supplemented herein, we adhere to and republish our order of March 2, 1989, in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Reyes S. Garcia, Claimant.

GARCIA,
Petitioner,

v.

BOISE CASCADE CORPORATION,
Respondent.

(WCB 85-15946; CA A46569)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 27, 1988.

Quintin B. Estell, Salem, argued the cause and filed the brief for petitioner.

Paul Dakopolos, Salem, argued the cause for respondent. On the brief were Paul J. DeMuniz and Garrett, Seideman, Hemann, Robertson & DeMuniz, Salem.

Before Warden, Presiding Judge, and Graber, Judge, and Van Hoomissen, Judge pro tempore.

WARDEN, P. J.

Reversed and remanded for reconsideration.

WARDEN, P. J.

In this workers' compensation case, claimant seeks to establish the compensability of a disabling degenerative condition of his low back. At the hearing, he asserted that the degenerative condition was an occupational disease or, alternatively, that the herniated disc was caused by a compensable injury that he sustained on September 26, 1985, while working for employer. The referee upheld employer's denial of compensability. The Board affirmed the referee without comment. We review for substantial evidence and errors of law, ORS 656.298(6),[1] and reverse and remand for reconsideration.

To prevail on an occupational disease claim for a preexisting condition, the claimant must prove by a preponderance of the evidence that

> "(1) his work activity and conditions (2) caused a worsening of his underlying disease (3) resulting in an increase in his pain (4) to the extent that it produces disability or requires medical services." *Weller v. Union Carbide,* 288 Or 27, 35, 602 P2d 259 (1979).

See Wheeler v. Boise Cascade Corp., 298 Or 452, 457, 693 P2d 632 (1985); *AMFAC, Inc. v. Ingram,* 72 Or App 168, 171, 694 P2d 1005, *rev den* 299 Or 37 (1985). He must also establish that the work activity or conditions were the major contributing cause of the worsening of the underlying disease. *AMFAC, Inc. v. Ingram, supra,* 72 Or App at 171 n 2. To prevail on the

[1] Or Laws 1987, ch 884, § 12a. The opinion and order of the referee, which the Board affirmed without opinion, is adequate for judicial review under ORS 656.298. *George v. Richard's Food Center,* 90 Or App 639, 752 P2d 1309 (1988).

injury claim, claimant must prove by a preponderance of the evidence that the September 26, 1985, injury was a material contributing factor in producing the disability. *Hutcheson v. Weyerhaeuser*, 288 Or 51, 55, 602 P2d 268 (1979); *Destael v. Nicolai Co.*, 80 Or App 596, 600, 723 P2d 348 (1986).

The medical evidence comes only from Drs. Munson and Collada, both of whom treated claimant. Collada's deposition testimony is so ambiguous that both claimant and employer can and do rely on it to support their opposing positions. Munson believes that claimant's "heavy lifting" during his work with employer is "a major if not the major contributing factor aggravating his [degenerative low back

condition]." The referee discounted Munson's opinion, because "the record indicates that claimant's work did not involve heavy lifting" and "because [Munson] was unaware of the claimant's actual work history." Those findings are not supported by substantial evidence in the record. It is undisputed that claimant worked several years, including the years 1983 to 1985, "pulling greenchain" for employer, a job that the record reveals requires substantial lifting as well as pulling, bending and twisting. The record also indicates that Munson had treated claimant since 1973, so that he could not have been "unaware of claimant's work history." Because Munson's opinion supports claimant's position, and because the referee erred in discounting Munson's opinion for the reasons that he did, we reverse and remand for reconsideration.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lester W. Gatens, Claimant.

GEORGIA-PACIFIC CORPORATION,
Petitioner,

v.

GATENS,
Respondent.

(WCB 84-04437; CA A45204)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 4, 1988.

Jerry K. Brown, McMinnville, argued the cause for petitioner. With him on the brief was Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

Darren L. Otto, Salem, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed. -649-

PER CURIAM

The parties submitted their briefs in this judicial review on the assumption that our review is *de novo*. We review for substantial evidence and errors of law. ORS 656.298(6); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). Substantial evidence supports the Board's order.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Franklin L. Beebe, Claimant.

BEEBE,
Petitioner - Cross-Respondent,
v.
PHIBBS LOGGING & CUTTING et al,
Respondents - Cross-Petitioners.

(WCB 85-03872; CA A45186)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 4, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. With him on the briefs were Karen M. Werner, and Malagon & Moore, Eugene.

John E. Snarskis, Portland, argued the cause and filed the brief for respondents - cross-petitioners.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed on petition; reversed on cross-petition and remanded for reconsideration of award of attorney fees for Board review.

DEITS, J.

Claimant seeks review of a Workers' Compensation Board order reducing the amount of attorney fees awarded by the referee. Employer cross-petitions, seeking review of the Board's order awarding claimant attorney fees for obtaining payment of temporary disability benefits that had been suspended pursuant to an order from the Workers' Compensation Department. We affirm on the petition, reverse on the cross-petition and remand for reconsideration.

Claimant suffered a job-related injury and was awarded temporary disability benefits. Employer neither denied the claim nor contested the award. Subsequently, the Workers' Compensation Department (Department) suspended claimant's benefits because of his failure to keep a

confirmed appointment with a certified rehabilitation facility. He requested a hearing. The referee set aside the suspension and ordered claimant's benefits reinstated. He also awarded claimant $1,800 in attorney fees, to be paid by employer. Employer sought Board review on the merits of the reinstatement and on the award of attorney fees. The Board affirmed the reinstatement, but reduced the attorney fees to $1,200. It also awarded an additional $600 in attorney fees for services on Board review.

Claimant challenges the Board's jurisdiction to review the amount of attorney fees awarded by a referee pursuant to ORS 656.386(1). He argues that, under that statute, review of attorney fees rests exclusively in the circuit court. We disagree. The Board has jurisdiction to review the amount that a referee awards a claimant for attorney fees, so long as the employer has sought Board review on the merits of the claim. *Greenslitt v. City of Lake Oswego,* 305 Or 530, 537, 754 P2d 570 (1988). In this case, employer did seek Board review on the merits of the claim. Accordingly, the Board was correct in concluding that it had jurisdiction to review and reduce the amount awarded.

Employer cross-petitions, arguing that the award by the referee of insurer-paid attorney fees was not authorized by ORS 656.386(1), because employer never denied the original claim or acted unreasonably in following the Department's order to suspend payment of benefits. We agree. ORS 656.386(1) provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. * * * Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

In *Vip's Restaurant v. Krause,* 89 Or App 214, 748 P2d 164, *adhered to* 91 Or App 472, 756 P2d 47, *rev den* 306 Or 414 (1988), we held that, if an employer terminates temporary total disability payments on the date ordered by the Department, a claimant who successfully appeals the Department's order cannot recover attorney fees from the employer under ORS 656.386(1). We reasoned that such an award would be inappropriate, because the employer's conduct is not a "denial of compensability" under ORS 656.386(1). *See Short v. SAIF,* 305 Or 541, 545-47, 754 P2d 575 (1988). We see no relevant distinction between an employer's compliance with a Department-ordered termination date and compliance with its suspension order. Accordingly, we hold that it was error for the Board to affirm the referee's award of attorney fees under ORS 656.386(1).[1]

The Board awarded an additional $600 in attorney fees for services on Board review. To the extent that the award reflects services rendered in defense of the referee's decision to

[1] Claimant argues only that ORS 656.386(1) supports an award of attorney fees under the circumstances of this case. Because neither party argues that ORS 656.382(2) applies in these circumstances, we do not consider whether that statute might support an award.

reinstate temporary disability benefits, it was proper because the employer initiated the review. ORS 656.382(2). However, on remand the Board should determine what amount, if any, it awarded for defending the referee's grant of employer-paid attorney fees and should reduce the award by that amount.

Affirmed on the petition; reversed on the cross-petition; and remanded for reconsideration of the award of attorney fees for Board review.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Emil Kordon, Claimant.

KORDON,
Petitioner,

v.

MERCER INDUSTRIES et al,
Respondents.

(WCB 86-01089; CA A45185)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 4, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Remanded for reconsideration of claimant's claim for attorney fees; otherwise affirmed.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order which affirmed the referee's denial of permanent total disability. Claimant contends that he is permanently and totally disabled and that he was entitled to attorney fees incurred in prevailing on SAIF's request for a reduction in his permanent partial disability award. We affirm the denial of permanent total disability but reverse the denial of attorney fees.

At a hearing initiated by claimant, the referee upheld SAIF's denial of his claim for permanent total disability but awarded him 320 degrees for unscheduled permanent partial disability. ORS 656.214. Claimant requested review on the issue of permanent total disability. SAIF, in its responding brief to the Board, requested that the award of permanent partial disability be reduced. The Board affirmed the referee's

order and denied claimant's subsequent motion for attorney fees under ORS 656.382(2).

Claimant first contends that the Board erred in denying his claim for permanent total disability. We affirm the Board's denial, because there is substantial evidence supporting its order. ORS 656.298(6); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988).

Claimant next contends that he was entitled to attorney fees under ORS 656.382(2):

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

He argues that SAIF initiated a request for review when it asked the Board to reduce his award for permanent partial disability. A "cross-request" for review by the Board is the equivalent of an initiation of a request for review. *Travis v. Liberty Mutual Ins.*, 79 Or App 126, 128, 717 P2d 1269, *rev den* 301 Or 445 (1986); *see also Bohrer v. Weyerhaeuser Company*,

93 Or App 751, 763 P2d 1207 (1988). The Board specifically treated SAIF's request for reduction as a cross-request for review, and claimant successfully defended against it. Consequently, under the terms of the statute, claimant is entitled to reasonable attorney fees.

The Board, however, denied his request for attorney fees on the basis of OAR 438-47-075.[1] We recently noted that that rule is inconsistent with the statute and is no longer applicable. *Littleton v. Weyerhaeuser Co.*, 93 Or App 659, 763 P2d 742 (1988). Accordingly, the Board erred in denying the claim for attorney fees.

Remanded for reconsideration of claimant's claim for attorney fees; otherwise affirmed.

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[1] OAR 438-47-075 provides:

> "In the event of a cross appeal by either party, 47-000 to 47-095 shall be applied as if no cross appeal was taken, unless the party initiating the appeal withdraws his appeal and the cross appellant proceeds; in which case the cross appellant shall be considered the initiating party."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Marco Aguiar, Claimant.

AGUIAR,
Petitioner,

v.

J. R. SIMPLOT COMPANY,
Respondent.

(84-05596; CA A47942)

Judicial review from Workers' Compensation Board.

Argued and submitted November 16, 1988.

Kenneth D. Peterson, Jr., Hermiston, filed the brief for petitioner.

Kenneth L. Kleinsmith, Portland, argued the cause for respondent. With him on the brief was Meyers & Terrall, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

Claimant seeks review of an order of the Workers' Compensation Board on remand after our opinion in *Aguiar v. J. R. Simplot Co.*, 87 Or App 475, 742 P2d 709 (1987). We remanded the case to the Board to rescind the May 15, 1984, determination order as premature and for reinstatement of the referee's order, which had allowed certain medical services and had awarded attorney fees for services provided at the hearing.

The Board issued its order on remand, as directed. It reinstated the referee's award of attorney fees for services provided at the hearing, but declined to award additional attorney fees for services at subsequent levels of review. Claimant contends that, in its order on remand, the Board should have awarded reasonable attorney fees for each level of review through remand, pursuant to ORS 656.388(1), which provides, in part:

> "In cases in which a claimant *finally prevails after remand* from the Supreme Court, Court of Appeals or Board, then the referee, Board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum." (Emphasis supplied.)

Claimant contends that he has only now "finally prevailed after remand." In our previous opinion, *we* decided the merits of the substantive questions presented by claimant's petition. *We* determined that claimant was entitled to the additional medical services that he sought and that his claim had been

prematurely closed. There were no substantive matters concerning the compensability of the claim left undecided. Claimant finally prevailed on those issues when the case was here before. After our previous decision, claimant filed an untimely petition for attorney fees under ORS 656.386(1), which we denied. We remanded to the Board for the ministerial implementation of our decision.

There were no matters concerning compensability left to be decided by the Board and no matters on which claimant could finally prevail after remand. The Board properly held, therefore, that it had no authority to award attorney fees to claimant under ORS 656.388.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Giordano Zorich, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION et al,
Petitioners - Cross-respondents,

v.

ZORICH,
Respondent - Cross-petitioner,

and

ADVANCE INTERIORS et al,
Respondents - Cross-respondents.

(WCB 85-00696 & 85-01291; CA A42775)

Judicial review from Workers' Compensation Board.

Argued and submitted January 13, 1988.

Christine Chute, Assistant Attorney General, Salem, argued the cause for petitioners - cross-respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Robert Wollheim, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Welch, Bruun & Green, Portland.

Larry D. Schucht, Portland, argued the cause and filed the brief for respondents - cross-respondents.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded on petition; affirmed on cross-petition.

NEWMAN, J.

Claimant suffered a compensable back injury in 1978 while employed by Advance Interiors, whose insurer is Safeco, and received an award of 25 percent permanent partial dis-

ability (PPD). He suffered another compensable back injury in 1982 while employed by Western Partitions, whose insurer is SAIF. Each employer and its insurer disputed responsibility for the 1982 injury. Although no order was issued under ORS 656.307, Safeco paid temporary total disability to claimant for the 1982 injury until October 1, 1983.

In 1984, the Board ruled that the 1982 injury was a "new injury," that claimant was entitled to five percent PPD for that injury and that Western Partitions and SAIF were responsible. SAIF paid that PPD to claimant. SAIF was obliged to reimburse Safeco for the temporary total disability that it had paid claimant. It is not disputed that, instead of mailing the reimbursement check for $13,729.98 to Safeco, SAIF mistakenly mailed a check to claimant in that amount and drawn to his order. Claimant deposited the check in his account. SAIF demanded the return of the check. Claimant refused and stated that he had already spent the proceeds. He then requested a hearing on the extent of PPD and asked for an increase. In response, SAIF requested an order that claimant reimburse SAIF for the $13,729.98 payment that it had mistakenly made. Alternatively, SAIF asked that the referee order that the $13,729.98 payment be offset against benefits.

The referee increased claimant's PPD award from 25 percent to 40 percent for the 1978 injury, for which Advance Interiors is responsible. He did *not* increase the PPD award of five percent for the 1982 injury. He dismissed SAIF's requests, ruling that he had no jurisdiction to consider it, because neither the claim for reimbursement nor the offset was a "matter concerning a claim" within the meaning of *former* ORS 656.708(3).[1] He stated that it was "[SAIF's] mistake in send-

ing a check to an unentitled person. It was meant to be a payment from [SAIF] to [Safeco] for reimbursement of claim processing costs and had nothing to do with the right of claimant to receive compensation, or the amount thereof." Without comment, the Board affirmed. SAIF and Western Partitions petition for review, assigning as error that the Board in effect held that it had no jurisdiction to consider SAIF's claim for repayment or to order an offset. Claimant cross-petitions for review of the Board's ruling on extent of disability. On the petition, we reverse and remand; on the cross-petition, we affirm.

SAIF argues that the Board has jurisdiction of the requests, asserting that they are "matters concerning a claim." *See former* ORS 656.704(3). Claimant and SAIF apparently agree that SAIF's payment to claimant of $13,729.98 was an overpayment of compensation.[2] Claimant

[1] *Former* ORS 656.708(3) provided:

"The Hearings Division is continued within the board. The division has the responsibility for providing an impartial forum for deciding all cases, disputes and controversies arising under ORS 654.001 to 654.295, all cases, disputes and controversies regarding matters concerning a claim under ORS 656.001 to 656.794 and for conducting such other hearings and proceedings as may be prescribed by law."

[2] ORS 656.005(8) defines "compensation" as "all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer * * *."

also agrees that the Board has jurisdiction of SAIF's request for an offset but argues that *former* ORS 656.268(4)[3] is the exclusive remedy under the Workers' Compensation Law. Moreover, he asserts that no offset is available now, because SAIF had already paid PPD for the 1982 injury, and the Board did not hold SAIF's insured responsible for more PPD or other compensation against which the overpayment could be offset.

We hold that the referee and the Board had jurisdiction to consider SAIF's requests. The controversies here are "matters concerning a claim" within the meaning of *former* ORS 656.708(3), because they are "matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3). On remand, the Board

should consider what remedies it has authority to and should provide.[4]

In his cross-petition, claimant assigns as errors that the Board held that his loss of earning capacity from his 1978 injury did not exceed 40 percent and from his 1982 injury did not exceed five percent. On *de novo* review,[5] we agree with the Board.

Reversed and remanded on petition; affirmed on cross-petition.

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[3] *Former* ORS 656.268(4) provided, in part:

"Any determination under this subsection may include necessary adjustments in compensation paid or payable prior to the determination, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid."

[4] In *EBI Companies v. Kemper Group Insurance*, 92 Or App 319, 758 P2d 406, *rev den* 307 Or 145 (1988), Kemper was held responsible and ordered to reimburse EBI for its claim costs. EBI had been designated as paying agent under ORS 656.307. Kemper did not fully reimburse EBI, claiming that EBI had overpaid time loss to the claimant. EBI requested a hearing before the referee and asked for full reimbursement. The referee held that he lacked jurisdiction. The Board affirmed, and we affirmed the Board. We emphasized that the claimant had already received his compensation and was not a party to the dispute. We stated that the only issue was whether the responsible party in a dispute under ORS 656.307 must reimburse the designated paying agent. That question did not involve the worker's right to receive compensation or the amount thereof. *See also Howard v. Liberty Northwest Ins.*, 94 Or App 283, ___ P2d ___ (1988); *Schlecht v. SAIF*, 60 Or App 449, 653 P2d 1284 (1982).

[5] Petitioners filed the petition for judicial review on March 2, 1987. Claimant filed his cross-petition on March 9, 1987. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Karen J. Bates, Claimant.

STATE ACCIDENT
INSURANCE FUND CORPORATION et al,
Respondents - Cross-Respondents,

v.

BATES,
Petitioner - Cross-Respondent,

AETNA CASUALTY COMPANY et al,
Respondents - Cross-Petitioners.

(WCB 85-15422, 85-15423; CA A43316)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 19, 1988.

William E. McCann, Bend, argued the cause and filed the briefs for petitioner - cross-respondent.

Mark Ward, Eugene, argued the cause for respondents - cross-petitioners. On the brief was Brian L. Pocock, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents - cross-respondents. With him on the brief were Dave Fronhmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded on petition to determine claimant's insurer-paid attorney fees; affirmed on cross-petition.

NEWMAN, J.

Claimant petitions for review of the portion of a Workers' Compensation Board order that denied her attorney fees before the Board. Regina's Restaurant (Regina's) cross-petitions for review of the portion of the order that held that it is responsible for an aggravation of claimant's condition. On the petition, we reverse and remand; on the cross-petition, we affirm.

In February, 1985, claimant suffered a muscle tear in her neck and shoulder while she was employed at Regina's, insured by Aetna. In April, 1985, she began to work at Telecomm Systems (Telecomm) answering telephones. SAIF was its carrier. At Telecomm, claimant was required frequently to reach with both of her arms. There was no specific incident at Telecomm, but her pain increased. She quit on September 13, 1985.

Claimant filed an aggravation claim against Regina's, which denied responsibility, but not compensability, on the ground that claimant's activities at Telecomm were responsi-

ble for her condition. Claimant also filed a claim against Telecomm, which denied it on several grounds:

> "[W]e are unable to accept responsibility for any treatment and/or disability in connection with your current condition. Insufficient evidence exists to justify a contention that your condition is the result either of an injury or a disease precipitated by your occupational exposure at Telecomm Systems.
>
> "Further, you have indicated that your injury occurred on February 7, 1985, which is prior to your employment at Telecomm. Therefore, you were not a subject worker of Telecomm Systems at the time of your injury.
>
> "Furthermore, the law allows us to pay benefits only if the worker reports the injury to his employer within 30 days. You did not report your injury within the time limits provided by law nor have you given any good excuse for your failure to report your injury."

Because the claim was denied on both the grounds of compensability and responsibility, the Workers' Compensation Department denied Regina's request for an order under ORS 656.307.

The referee found that claimant's employment at

Telecomm aggravated the symptoms of her injury at Regina's but did not worsen her underlying condition. She held Regina's responsible and set aside its denial. She approved Telecomm's denial but assessed a 25 percent penalty, because she found that its assertion, in support of its denial, that claimant did not file the claim timely was unreasonable and delayed payment of compensation to claimant. She also ordered that Regina pay $1,200 to claimant's attorney for his services at the hearing. Regina requested Board review; Telecomm did not.

The Board affirmed the portions of the referee's order that found Regina's responsible, but modified the portion respecting attorney fees before the referee. It stated that Telecomm's denial prevented the issuance of an order under ORS 656.307 because, by asserting that the claim was not filed timely, it put compensability as well as responsibility in issue. It concluded that that denial justifiably prompted claimant's active participation at the hearing before the referee. Accordingly, the Board ruled that Telecomm, and not Regina's, was responsible for attorney fees awarded before the referee, but that $600, not $1,200, was reasonable. The Board, however, also ruled that, because "claimant's entitlement to compensation was not at issue on Board review, no attorney fee is awarded." *See Karen J. Bates,* 39 Van Natta 100 (1987).

Regina's again asserts that it is not responsible for claimant's compensation. With respect to attorney fees, it states:

> "We have never contended this claim was not compensable. Claimant was bound to prevail. The Board agreed with our contentions in that regard. It does not appear that claimant is contending that we are responsible for attorney fees."

Telecomm did not petition or cross-petition for review of any aspect of the Board's order,[1] and its brief says nothing about

[1] Telecomm initially filed a petition for review of the portion of the Board's order that required it to pay attorney fees for claimant's attorney before the referee. It then dismissed its petition.

attorney fees. It asserts here that it is not responsible and that Regina's is.

The Board erred when it denied claimant insurer-

paid attorney fees for services at the Board level. Telecomm argued to the Board:

> "Claimant filed a claim of injury specifying a date of injury of February 7, 1985. * * * The claim was made November 19, 1985. * * * The claim was denied for three reasons. First, because there was insufficient evidence to show any causal relationship between the injury or disease from claimant's occupation or exposure at Telecomm Systems. Second, that claimant was not a subject worker at the time of the claimed injury, and third that the claim was not timely filed. * * *
>
> "Thus, this is not simply a 'responsibility' case. Claimant must establish, as against Telecomm, that the major cause of her disability is her work exposure at Telecomm. There is absolutely no evidence which would carry that burden. Further, claimant did not file a claim stating an occupational disease, but rather specifying an injury which occurred before she was an employee of Telecomm. Claimant was not employed by Telecomm in February, and so the denial was proper. The claim was not filed within 30 days of the injury, and so the denial was proper. The claim for occupational disease is not sustained by the medical evidence, and the denial was proper. It is not SAIF Corporation's obligation to try and [sic] guess which ultimate theory claimant might ultimately prevail upon. Claimant made her claim, and SAIF Corporation responded to the claim as framed by claimant's own filing."

If Telecomm had successfully argued that the claim against it was not timely filed, and if claimant had suffered a "new injury" at Telecomm and not an aggravation of her injury at Regina's, claimant might not have been entitled to compensation from either employer. Claimant was justified in actively participating before the Board to protect her right to compensation. She is entitled to insurer-paid fees. ORS 656.382(2);[2] *see Stovall v. Sally Salmon Seafood,* 84 Or App 612, 735 P2d 18 (1987), *aff'd* 306 Or 25, 757 P2d 410 (1988);

Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 710 P2d 781 (1985), *rev den* 300 Or 722 (1986); *Nat. Farm. Ins. v. Scofield,* 56 Or App 130, 641 P2d 1131 (1982).[3]

[2] ORS 656.382(2) provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

[3] Indeed, after its decision in this proceeding, the Board stated:

> "We have previously held that when compensability is merely a potential issue on Board review, claimant is not entitled to an attorney fee. *See Wayne A. Hawke,* 39 Van Natta 31 (1987); *Karen J. Bates,* 39 Van Natta 100 (1987). Thus, to the extent the reasoning expressed in those cases is contrary to this holding, that reasoning is rejected." *Robert L. Montgomery,* 39 Van Natta 469 (1987).

Regina's is responsible for claimant's attorney fees before the Board. ORS 656.382(2). It initiated the request for Board review, and the Board did not disallow or reduce claimant's award. Review of the referee's order included her ruling upholding Telecomm's denial. Accordingly, Regina's request for review put compensability as well as responsibility in issue, placed claimant at risk and justified her active participation before the Board.

Reversed and remanded on the petition to determine claimant's insurer-paid attorney fees; affirmed on the cross-petition.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Charles I. Spear, Claimant.
STATE OF OREGON, DEPARTMENT OF JUSTICE,
INMATE INJURY FUND,
Petitioner,
v.
SPEAR,
Respondent.
(WCB No. 86-02003; CA A46205)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 4, 1988.

Christine Chute, Assistant Attorney General, Salem, argued the cause for petitioner. With her on the brief were Dave Frohnmayer, Attorney General, Virginia Linder, Solicitor General, and Ann Kelley, Assistant Attorney General, Salem.

No appearance for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Petitioner seeks review of an order of the Workers' Compensation Board that affirmed the referee's order that claimant's injury is compensable under ORS chapter 655 and ordered petitioner to pay attorney fees to claimant from the Inmate Injury Fund for services before the Board. Our review is for substantial evidence. ORS 655.525; ORS 656.298(6); ORS 183.482(7) and (8); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). We affirm.

The referee could have found from the evidence the facts that we state and that the parties do not dispute.[1] Claimant is an inmate at the Oregon State Penitentiary. He was

[1] Petitioner does not challenge the adequacy of the order under ORS 183.482(7) and (8).

employed during the daytime in authorized employment at the Penitentiary Farm Annex. *See* ORS 655.505(1). The state provided claimant with transportation to and from work. After he had finished work and while he was waiting at a warming hut on the work premises for transportation back to the penitentiary, another prisoner assaulted him. Claimant suffered injuries that required medical treatment.

Claimant filed a claim against the Inmate Injury Fund. The Department of Justice, as adjusting agent, *see* ORS 655.520, denied the claim on the ground that it was not "proximately caused by" or "received in the course of the authorized employment." The referee ruled that claimant was entitled to benefits and ordered the Department of Justice to accept the claim and pay compensation. Petitioner appealed, and the Board affirmed.

Petitioner assigns as error that the Board found the claim compensable. ORS 655.510(1)(a) provides in part that an inmate shall receive benefits for injuries

> "[w]here the injury is proximately caused by or received in the course of the authorized employment, with or without negligence of the inmate."

ORS 656.005(7)(a), a part of the Workers' Compensation Law, however, provides that a "compensable injury" is an accidental injury "arising out of and in the course of employment." Petitioner argues that that test of compensability

applies and that claimant's injury did not "[arise] out of and in the course of employment." *See Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980). Contrary to petitioner's argument, nothing in ORS chapters 655 or 656 makes the test for compensability under ORS 656.005(7)(a) applicable to inmate injuries covered by ORS chapter 655.[2]

Petitioner argues that, in any event, claimant is not entitled to benefits, because the injury did not occur "in the course of the authorized employment." Under ORS 655.510, however, an injury is compensable if it was "received in the course of the authorized employment" *or* "is proximately caused by * * * the authorized employment." The test is disjunctive. Although the referee did not specifically find that claimant's evidence satisfied either alternative of the test, he applied the test. Petitioner does not assign any error based on the form of the referee's finding.

We conclude that there is substantial evidence to support a finding that claimant's injury was "proximately caused by" the authorized employment. As an inmate, he was obliged to work at the farm annex. Because of that work, it was necessary for him to take transportation to and from the penitentiary and to wait for it at a particular place on the work premises, where he was assaulted and injured. The state provided the transportation. The person who assaulted him was another inmate who had also worked that day at the annex and was waiting for the same transportation. The Board did

[2] Although ORS 655.505(3) states that "[i]njury is defined as provided in ORS chapter 656," that chapter does not define "injury." It only defines "compensable injury." *See* ORS 656.005(7)(a).

not err in finding that the claim is compensable and that claimant is entitled to benefits for his injury.

Petitioner also assigns as error that the Board ordered it to pay attorney fees from the Inmate Injury Fund for services before the Board. It argues there is no statutory authorization and that, without it, the Board may not award attorney fees. We hold, however, that there is statutory authorization for the fees. In *Johnson v. SAIF*, 267 Or 299, 516 P2d 1289 (1973), the court allowed attorney fees for services before

the Board and on review where an inmate ultimately prevailed in a claim for an injury under ORS chapter 655.[3]

When the court decided *Johnson v. SAIF, supra*, ORS 655.525 did not refer to *former* ORS 656.382(2),[4] ORS 656.386, or ORS 656.388, which relate to attorney fees. The court stated, however:

> "Looking at the statutory scheme as a whole, it seems apparent that the legislature intended to incorporate into the statutes dealing with inmates and mentally retarded minor trainees all of the procedural and remedial rights extended to injured workmen, with certain reservations necessitated by the unique position of the inmate or trainee. An inmate claimant is entitled to the same measure of benefits as an injured workman. This is provided for in ORS 655.515, which reads:
>
> " 'If an inmate sustains * * * [a compensable injury][5] * * *

> benefits shall be paid in the same manner as provided for injured workmen under the workmen's compensation laws of this state * * *.'

[3] In particular, petitioner argues that in *Johnson v. SAIF, supra*, the court relied on ORS 655.525, which expressly incorporated the provisions of ORS 656.283 to ORS 656.304, including the provision for attorney fees in *former* ORS 656.301. ORS 655.525 provides:

> "An inmate or the beneficiary of the inmate may obtain review of action taken on the claim as provided in ORS 656.283 to 656.304."

Former ORS 656.301(2) provided that, on an appeal from the circuit court, a successful claimant was entitled to attorney fees. That provision has been repealed. Or Laws 1977, ch 804, § 55.

[4] ORS 656.382(2) now provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal of cross-appeal."

The provision is for all purposes like *former* ORS 656.382(2), which was applicable at all times pertinent to the decision in *Johnson v. SAIF, supra*.

Petitioner also argues that ORS 656.382(2) is inapplicable here, because the Department of Justice is not an employer or insurer. The argument is without merit. The state is claimant's "employer" for purposes of this case.

[5] When the court in *Johnson v. SAIF, supra*, quoted *former* ORS 655.515, it bracketed the words "a compensable injury." *Former* ORS 655.515, however, used the words "an injury," not "a compensable injury." *Former* ORS 655.515 provided:

> "If an inmate sustains an injury as described in subsection (1) of ORS 655.510, benefits shall be paid in the same manner as provided for injured workmen under the worker's compensation laws of this state * * *."

Present ORS 655.515 also refers to "an injury," not "a compensable injury." The court's addition of the adjective "compensable," however, had no effect on its decision.

"Similarly, the provision of the Workmen's Compensation Act for filing claims is made applicable to inmates by ORS 655.520(1):

" 'Claims for entitlement to benefits under ORS 655.505 to 655.550 [i.e. Inmate Injury Law] shall be filed by application with the State Accident Insurance Fund in the manner provided for workmen's claims in ORS 656.001 to 656.794 [i.e. the Workmen's Compensation Law], to the extent not inconsistent with ORS 655.405 to 655.550. * * *'

"Just as these two statutes were designed to incorporate all of the relevant provisions for benefits and for filing claims (to the extent not inconsistent with the inmates compensation statutes), we think that ORS 655.525 was intended to incorporate all of the relevant provisions of the Workmen's Compensation Act relating to judicial review of action taken on inmate claims. The purpose of the reference in ORS 655.525 to ORS 656.283 - ORS 656.304 was to identify the sections of the Workmen's Compensation Act setting out the hearing procedures and the scope of review *and was not intended to exclude other provisions in another part of the Workmen's Compensation Act under the heading of Legal Representation dealing with attorney's fees (ORS 656.386 and ORS 656.388) among other things.*" 267 Or at 302. (Emphasis supplied; brackets in original.)

Under *Johnson,* which binds us, ORS 656.382(2) is another provision dealing with attorney fees which ORS 655.525 does not exclude and which, when read in the light of the provisions of ORS chapter 655, provides the statutory authorization for the award of attorney fees.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sheila E. Reeves, Claimant.

EASTMORELAND HOSPITAL,
Petitioner,

v.

REEVES,
Respondent.

(WCB 86-10670; CA A46867)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 9, 1988.

Jerald P. Keene, Portland, argued the cause for petitioner. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Todd Westmoreland, Tillamook, argued the cause for respondent. On the brief were W. T. Westmoreland and Roll & Westmoreland, P.C., Tillamook.

Before Warden, Presiding Judge pro tempore, and Graber and Riggs, Judges.

GRABER, J.

Remanded for reconsideration of penalty; otherwise affirmed.

GRABER, J.

Employer seeks review in this workers' compensation case. The referee's order set aside employer's denial of the claim, awarded claimant attorney fees of $1,500 for prevailing, ORS 656.386(1), and awarded attorney fees of $300 plus 25 percent of claimant's medical bills as a penalty for employer's unreasonable delay in furnishing medical records to claimant's counsel. ORS 656.262(10); ORS 656.382(1); OAR 438-07-015(2). The Board affirmed and awarded an additional attorney fee for services on Board review concerning the compensability issue. Employer argues that the record does not contain substantial evidence of compensability and that the Board improperly imposed a penalty and related attorney fees. We review for substantial evidence and errors of law, ORS 656.298(6), affirm in part, and remand for reconsideration of the penalty.

Claimant has been an x-ray technician since 1968 and has worked for employer since 1979. She began to notice vision problems in late 1985. On June 23, 1986, Dr. Child, an opthamologist, diagnosed bilateral posterior subscapular cataracts, which were "compatible [with] radiation induced cataracts." Claimant filed a workers' compensation claim; employer denied it.

On July 15, 1986, claimant underwent cataract surgery. On August 4, she requested a hearing on the denial and demanded that employer forward all relevant documents to her attorneys. On September 15, her attorneys filed a supplemental hearing request, seeking penalties and fees for employer's failure to send the medical records. On October 3, claimant moved to compel production, and the referee granted the motion a few weeks later. The parties stipulated that employer mailed copies of the pertinent documents to claimant on October 9, 1986.

Employer contends, first, that there is not substantial evidence to support the finding that radiation exposure at work was the major contributing cause of claimant's occupational disease. *See McGarrah v. SAIF*, 296 Or 145, 166, 675 P2d 159 (1983). We disagree. Child, who was claimant's treating physician and a specialist in diseases of the eye, answered these questions from claimant's counsel:

> "1. Can exposure to radiation, such as encountered by an Xray technician[,] be a causative factor for the diagnosed extracapsulae cataracts?
>
> "_X_ Yes ___ No
>
> "2. Based upon a review of the medical and vocational history of [claimant], it is [sic] medically probable that [her] employment as an Xray technician at [employer] was the major contributing cause of the diagnosed bilateral extracapsulae cataracts for which [you] have surgically treated the patient?
>
> "_X_ Yes ___ No
>
> "It is my understanding that the above stated questions were to be answered in terms of medical probability, and that these opinions are based upon my review of the medical records,

knowledge of the medical literature, and the history provided to me by my patient."

In a separate letter, Child wrote that "radiation is a probable cause of the type of cataracts developed by [claimant]" and that "radiation exposure is the most likely cause of [her] cataract[s]." The record contains evidence from only one other doctor. Dr. Robinson, after reviewing unspecified documents but not examining claimant, concluded that it was not possible to find a causal relationship between claimant's work exposures to radiation and her cataracts.

Employer's attack on Child's opinion is two-fold. First, it argues that Child gave different answers to the question of causation at different times. It is not unusual for a treating physician's opinion to narrow or to become more certain as additional information comes to light. Neither is it unusual for a physician to use other than the "magic words" of statutes or decisions in describing a medical condition. That is what appears to have happened here, and it does not make Child's evidence of causation "insubstantial."

Employer's second assertion is that the absence of proof about the actual radiation levels that claimant experienced at work and about the precise levels that cause cataracts is fatal to Child's opinion. That contention affects the weight of the evidence but does not render it insufficient to support the Board's finding. Claimant admittedly was exposed to ionizing radiation on the job for many years. We hold that the

record contains substantial evidence to support the finding of causation.

The remaining issue is whether the Board properly assessed a penalty and attorney fees for unreasonable delay. Failure to provide documents pertaining to claims within 15 days of a written demand or request for hearing may be an unreasonable delay or refusal under ORS 656.262(10).[1] OAR 438-07-015(2).[2] Employer concedes that it failed to respond for more than two months to claimant's request for documents and offers no explanation for the delay. *See Morgan v. Stimson Lumber Company*, 288 Or 595, 607 P2d 150 (1980). Employer argues that the Board lacked authority to award a penalty or fees for the delay, because no amount of compensation was "then due," as required by ORS 656.262(10).

The Board based the penalty on claimant's medical expenses for the cataract surgery. "Pending acceptance or

[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."

[2] OAR 438-07-015(2) provides:

"Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing, or a written demand, to the insurer. Within fifteen (15) days of said mailing the insurer shall furnish the claimant, without cost, copies of all medical and vocational reports, records of compensation paid, and other documents pertaining to the claim(s) which are then or come to be in the possession of the insurer, except that evidence offered solely for impeachment need not be so disclosed. Failure to comply with this section may be considered unreasonable delay or refusal under ORS 656.262(1)."

denial of a claim, compensation payable to a claimant does not include the costs of medical benefits * * *." ORS 656.262(6). Therefore, the Board may assess a penalty under ORS 656.262(10) based on interim compensation due, but not on medical services. *Bono v. SAIF*, 298 Or 405, 410-11, 692 P2d 606 (1984).

On this record, we cannot determine whether any interim compensation was due, in addition to the medical services. We remand for a determination of whether and when compensation was due to claimant between August 19, 1986,

15 days after she demanded the documents, and October 9, 1986, when employer complied.

Attorney fees, however, do not depend on "amounts then due." Accordingly, claimant is entitled to her reasonable attorney fees for the delay, and we affirm that portion of the Board's order. *See Spivey v. SAIF*, 79 Or App 568, 572, 720 P2d 755 (1986).

Remanded for reconsideration of penalty; otherwise affirmed.

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.

Linda C. Love, Portland, argued the cause for petitioner. On the brief was Peter McSwain, Portland.

Patric J. Doherty, Portland, argued the cause for respondent. With him on the brief were Ronald W. Atwood, Curtis E. Heikkinen and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee and denying

increased compensation for an aggravation claim and his request for payment for chiropractic care. We review for substantial evidence and affirm.

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.

In order to establish an aggravation, claimant must show a worsening of his compensable condition that makes him less able to work. *Smith v. SAIF*, 302 Or 396, 399, 730 P2d 30 (1986). We conclude that the Board's finding that claimant's condition has not worsened is supported by substantial evidence. Furthermore, the Board's decision that further chiropractic treatments are not reasonable and necessary is supported by substantial evidence.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wallace W. Mock, Claimant.

ARGONAUT INSURANCE COMPANY et al,
Petitioners - Cross-Respondents,

v.

MOCK,
Respondent - Cross-Respondent,

and

FRED MEYER, INC.,
Respondent - Cross-Petitioner.

(WCB 84-04915, 84-06463; CA A41801)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 8, 1988.

Allen W. Lyons, Portland, argued the cause for petitioners - cross-respondents. With him on the brief was Davis, Bostwick, Scheminske & Lyons, Portland.

James L. Edmunson, Eugene, argued the cause for respondent - cross-respondent. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Bruce L. Byerly, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Moscato & Byerly, Portland.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

RICHARDSON, P. J.

Reversed on petition; affirmed on cross-petition.

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* Joseph, C. J., *vice* Newman, J.

RICHARDSON, P. J.

This is a workers' compensation case in which claimant seeks benefits for injuries that he sustained in an automobile accident in 1981 while he was employed by Progress Quarries (Progress). The claim for those injuries was not filed until 1984. Progress denied the claim on the ground that it was not timely and that, in any event, the injuries were not work related. Claimant also filed an aggravation claim with Fred Meyer, Inc., a previous employer, for the same injuries. The referee's decision, which was adopted by the Board, held that claimant sustained a compensable injury in 1981 and that the claim against Progress was timely.

Progress seeks review, contending that the claim is untimely and is not compensable. It also seeks dismissal of the claim because of alleged discovery violations. Fred Meyer cross-petitions for review, arguing that, in the event that we find that the claim is not compensable, the injuries sustained while it employed claimant did not materially contribute to his condition after the 1981 automobile accident and, therefore, it is not responsible for further medical treatment. Our review is *de novo*. We conclude that the claim was not timely filed against Progress. We affirm on Fred Meyer's cross-petition.

Claimant sustained compensable neck injuries in 1970 and again in 1971, while employed by Fred Meyer. In 1977, he began working for Progress as an oiler on a rock-crusher. In 1978, he experienced increased pain in his neck, arm and shoulder. He filed an aggravation claim against Fred Meyer, which was settled by a disputed claim settlement.

In January, 1981, claimant, who lived in Oregon, was working at Progress' Camas, Washington, plant and was commuting to work each day. On January 9, 1981, he was involved in an automobile accident in Vancouver, Washington, on his way to work. He was taken to the hospital and released that day after examination. He had complaints of neck and shoulder pain and knee abrasions. He did not file a workers' compensation claim but hired an attorney and filed an action against the other driver involved in the accident. That action was settled in December, 1981, for $50,000.

Claimant did not return to work at Progress after the

accident but worked in California and later in Oregon for another rock crushing company. In February, 1984, he filed an aggravation claim with Fred Meyer, which it denied in April on the ground that aggravation rights for the injuries at Fred Meyer had expired and that there had been an intervening automobile accident.

Claimant also filed a workers' compensation claim with Progress for injuries received in the motor vehicle accident. In the claim, he said that, on his way to work in Camas, he had stopped at Progress' Beaverton plant to pick up some parts for the rock crusher in Camas and that the accident occurred on his way to deliver the parts. Progress' comptroller questioned the claim on the ground that claimant did not

normally pick up and deliver parts. The claim was denied by Argonaut Insurance Company, Progress' insurance carrier, on the ground that it was untimely and not compensable.

ORS 656.265(1) requires that notice of an accident resulting in an injury be given to the employer within 30 days. ORS 656.265(4) provides:

> "Failure to give notice as required by this section bars a claim under [the workers' compensation act] unless:
>
> "(a) The employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice * * *."

The two requirements of subsection (a) to excuse late filing of a notice of accident are stated in the disjunctive—knowledge *or* lack of prejudice. One or the other must exist to avoid a claim being barred. If the employer had knowledge of the injury, the claim is not barred, even if the employer was prejudiced by the late filing of the claim. *Hayes-Godt v. Scott Wetzel Services*, 71 Or App 175, 691 P2d 919 (1984), *rev den* 299 Or 118 (1985). Claimant has the burden of proving that employer had knowledge of the injury, *Baldwin v. Thatcher Construction*, 49 Or App 421, 619 P2d 682 (1980), but employer has the burden of establishing that it was prejudiced by the delay. *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980). Only if we conclude that Progress did not have the requisite knowledge do we need to address the question of prejudice.

There is no question but that Progress knew that

claimant was injured in an automobile accident on his way to work. Injuries sustained while commuting to and from work are ordinarily not compensable. The issue is what knowledge will excuse an otherwise untimely notice. In *Colvin v. Industrial Indemnity*, 301 Or 743, 747, 725 P2d 356 (1986), the court said:

> "Timely notice, 'facilitates prompt investigation and diagnosis of the injury. It assures the opportunity to make an accurate record of the occurrence, and decreases the chance for confusion due to intervening or nonemployment-related causes.' *Vandre v. Weyerhaeuser Co.*, 42 Or App 705, 709, 601 P2d 1265 (1979)."

It follows that the "knowledge of the injury" must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury. If an employer is aware that a worker has an injury without having any knowledge of how it occurred in relation to the employment, there is no reason for the employer to investigate or to meet its responsibilities under the Workers' Compensation Act. Actual knowledge by the employer need not include detailed elements of the occurrence necessary to determine coverage under the act. However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate.

Hayes-Godt v. Scott Wetzel Services, supra, cited by claimant for his argument that knowledge of the *injury* alone is sufficient, illustrates that point. We said that the claimant

did not have to establish knowledge of the *claim* but only that the employer knew of the injury. We discussed the type of knowledge the employer, a chiropractor, had about the claimant's carpel tunnel syndrome and the possible work causes. We noted that the employer knew that the claimant had a preexisting injury to her wrist and that she was having problems doing the physical tasks required of her at work. We concluded that, because of his professional training, the doctor must have been aware that her work activities could have been a cause of the carpel tunnel syndrome.

In *Baldwin v. Thatcher Construction, supra,* which involved a question of the employer's knowledge, we noted that the employer knew that the claimant was injured while

trying to raise a wall on the job site. The employer had discouraged him from filing a claim, and he agreed that he would not. We said:

> "[ORS] 656.265(4)(a) does not require the employer's knowledge of a claim, but knowledge of an injury. It was sufficient that the employer knew the claimant had suffered an injury on the job." 49 Or App at 425.

See also Colvin v. Industrial Indemnity, supra; Golden West Homes v. Hammett, 82 Or App 63, 727 P2d 155 (1986); *Summit v. Weyerhaeuser Company,* 25 Or App 851, 551 P2d 490, *rev den* (1976).

The comptroller at Progress knew that claimant had been injured in an automobile accident by the day after it happened. He testified that he had no reason to conclude that it was work connected until claimant filed the claim in 1984. It was not claimant's ordinary function to pick up parts in Beaverton and transport them to the job site. Claimant did not recall telling anyone about the circumstances of the accident at the time or that he was delivering parts. Frank Clark, claimant's brother-in-law, who was Progress' general manager, was on vacation at the time of the accident and was fired on his return to work. Although he was told about the accident while on vacation, he did not recall when he became aware that claimant had been transporting machinery parts. He knew that claimant did, on occasion, pick up parts. The knowledge of a person in a supervisory capacity can be imputed to the employer. *Colvin v. Industrial Indemnity, supra.* However, in this instance, we conclude that, even if Clark was aware that claimant may have been transporting parts at the time of the accident, that knowledge was not available to employer. We conclude that claimant has not proved that Progress had sufficient knowledge of the relationship of his injuries to his employment to excuse the late filing of notice under ORS 656.265(1).

ORS 656.265(4)(a) would still excuse the untimely filing of the claim, despite Progress' lack of knowledge, if it or its insurer was not prejudiced by the lack of notice or knowledge. The employer or carrier must show actual prejudice and not merely the passage of time. *Grimes v. SAIF,* 87 Or App 597, 743 P2d 757 (1987). However, the passage of time may have an impact on the ability to make a timely investigation or

to seek current medical treatment and examinations. A primary issue in this case is whether claimant was in fact transporting parts for employer. A secondary issue is the extent of his injuries, the relationship of them to his previous injuries and whether his employment after the 1981 accident had any effect on his present condition. Progress was unable to conduct an investigation of whether claimant was in the course and scope of his employment or to have him examined by a physician of its choosing. It is clear from the hearing that the passage of three years had dimmed the memory of witnesses and had obscured the relationship of claimant's injuries while employed by Fred Meyer and the effect of his employment after the accident on his present condition. Additionally, as Progress points out, it was unable to participate under ORS 656.587 in the settlement that claimant obtained from the other driver involved in the accident.

We conclude that Progress has established that it was sufficiently prejudiced by the delay that claimant's late filing of the claim is not excused. Progress' denial based on the untimely filing of the claim is upheld.

Because we conclude that the claim against Progress was untimely, we do not address the claim of error relating to discovery. Also because we find that claimant suffered a new injury while employed at Progress, we conclude that Fred Meyer is not responsible for claimant's medical expenses.

Progress agrees that, if claimant was transporting spare parts, then the injuries from the ensuing accident were within the course and scope of his employment by Progress. It disputes that claimant had picked up parts on that day. The referee made specific findings regarding the credibility of witnesses for claimant and concluded that he was delivering the parts when the accident occurred. It is not necessary to detail the evidence. We have no basis for making a different credibility finding as to any witness. We conclude, as did the referee, that claimant was in the course and scope of his employment when he was involved in the automobile accident and that his present condition is the result of a new injury.

In summary, the claim against Progress is untimely, and the Board erred in reversing its denial. Claimant's present condition for which he sought compensation is the result of a new injury, for which Fred Meyer has no responsibility.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wallace W. Mock, Claimant.

ARGONAUT INSURANCE COMPANY et al, *Petitioners,*

v.

MOCK, *Respondent.*

(WCB 85-14684; CA A44665)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 8, 1988.

Allen W. Lyons, Portland, argued the cause for petitioners. With him on the brief was Davis, Bostwick, Scheminske & Lyons, Portland.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

RICHARDSON, P. J.

Affirmed.

* Joseph, C. J., *vice* Newman, J.

RICHARDSON, P. J.

In this workers' compensation case, employer and its insurer seek review of an award of penalties and attorney fees for failure to pay compensation ordered by a referee. *See Argonaut Ins. Co. v. Mock (A41801),* 95 Or App 1, ___ P2d ___ (1989). The petition for review was filed before July 20, 1987, and our review is *de novo. Armstrong v. Asten-Hill Co.,* 90 Or App 200, 752 P2d 312 (1988). We affirm.

On January 9, 1981, claimant sustained injuries in an automobile accident while driving to work. He did not file a workers' compensation claim but began an action against the driver of the other vehicle. That action was settled for $50,000. In April, 1984, he filed a claim against Progress, contending that he was delivering machine parts for it when the accident happened and, consequently, that the injuries sustained in the automobile accident were compensable. Argonaut denied the claim. Claimant sought a hearing, and the referee concluded that the injuries were compensable and ordered petitioners to pay temporary total disability. Petitioners did not pay the compensation but told claimant that it would credit 50 percent of the amount that he had received in settlement of the action against his compensation award.

Claimant challenged the refusal to pay the compensa-

tion and requested penalties and attorney fees. Employer contended before the referee and the Board and on review in this court that, because it did not have a chance to participate in the third-party action and settlement, it is entitled to a credit for amounts that it would have obtained from the settlement under ORS 656.593. The referee held that, even if employer was entitled to share in the settlement, it was not entitled to recover that share by unilaterally setting off the claim against claimant's benefits. The Board adopted the opinion of the referee.

Employer first contends that the referee did not have jurisdiction to consider the proposed setoff, because it concerned the distribution of the proceeds of a third-party action, which is within the jurisdiction of the Board only under ORS 656.593(3). The issue presented to the referee was whether employer could collect what it considered to be its share of the settlement by setting off compensation owed to claimant. That was a "matter concerning a claim," which was within the

referee's jurisdiction. *Former* ORS 656.108(3). The question whether employer was entitled to any portion of the settlement was not before the referee.

Alternatively, employer argues that penalties and attorney fees are not justified, because it is entitled to a portion of the third-party settlement. The "credit" was a reduction of claimant's compensation benefits and was not authorized. *See Forney v. Western States Plywood,* 66 Or App 155, 672 P2d 1376 (1983), *aff'd* 297 Or 628, 686 P2d 1027 (1984). Employer's unilateral act constituted an unreasonable refusal to pay compensation.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William C. Dilworth, Claimant.

DILWORTH,
Petitioner - Cross-Respondent,

v.

WEYERHAEUSER COMPANY,
Respondent - Cross-Petitioner,

and

EBI/ORION GROUP,
Respondent - Cross Respondent.

(WCB 85-05079; 85-11948;
CA A41591 (Control))

In the Matter of the Compensation of William C. Dilworth, Claimant.

WEYERHAEUSER COMPANY,
Petitioner,

v.

DILWORTH et al,
Respondents.

(WCB 85-0050M; CA A41737)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 9, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. On the brief were Karen M. Werner and Malagon & Moore, Eugene.

Allan M. Muir, Portland, argued the cause for respondent - cross-petitioner. With him on the brief were Roger A. Luedtke and Schwabe, Williamson & Wyatt, Portland.

Jerald P. Keene, Portland, argued the cause for respondent - cross-respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

In Case Nos. 85-05079 and 85-11948: on petition, reversed as to attorney fees and remanded for award of attorney fees to claimant for services before the Board; otherwise affirmed on petition and cross-petition. In Case No. 85-0050M, affirmed on petition.

NEWMAN, J.

Claimant seeks review of a Workers' Compensation Board order which affirmed the referee and held that Weyerhaeuser Company (Weyerhaeuser), and not EBI/Orion Group (EBI), is responsible for claimant's low back and disabling psychological condition and that claimant is not entitled to attorney fees for services before the Board. Weyerhaeuser cross-petitions, asserting, as does claimant, that the Board erred in holding it, not EBI, responsible for claimant's psychological condition after January 8, 1985.[1] We review *de novo*.

Claimant suffered a compensable low back injury in 1972, while working for Weyerhaeuser. After the injury, he had severe emotional difficulties. In May, 1984, a referee found that the 1972 injury materially contributed to claimant's psychological condition and held Weyerhaeuser responsible. Weyerhaeuser did not appeal the referee's finding and does not now assert that it is not responsible for claimant's psychological condition before the events of January 8, 1985, or his back condition.

In August, 1984, claimant began to work at EBI as a vocational consultant. He told his psychiatrist that he felt unqualified and apprehensive about the position. Because of the driving required by the position, he experienced increased back pain and lost some time from work. He also found the job extremely stressful. On January 8, 1985, he received a telephone call from a client in which the client either threatened to kill claimant or claimant reasonably perceived the caller to threaten that. During the call, he went blank. The next thing he remembers is that he was going down the back stairs of the building and was terribly frightened. He has not worked since.

Claimant sought payments for medical treatment and temporary disability benefits from both Weyerhaeuser and EBI. On February 1, 1985, Weyerhaeuser refused to reopen the 1972 claim on the ground that claimant's aggravation rights had expired. On April 5, 1985, EBI denied the claim "in its entirety" on the ground that claimant's employment

with EBI had not caused his back condition or psychiatric disabilities but that both conditions predated his employment with it. On June 3, 1985, Weyerhaeuser denied responsibility for claimant's "current psychiatric condition" on the ground that EBI was responsible for "a new injurious exposure." The denial recited that "[t]he giving of these reasons for the denial do[es] not preclude there being other reasons for denial." The Workers' Compensation Department denied claimant's request for an order under ORS 656.307, partly on the ground that it "read EBI's denial as one of compensability, not responsibility."

Claimant requested a hearing on Weyerhaeuser's June 3, 1985, denial and on EBI's April 5, 1985, denial. The referee found that claimant was unable to handle the stress

[1] Weyerhaeuser petitioned for judicial review of the Board's own motion order. We consolidated the reviews, and Weyerhaeuser makes no separate argument relating to the Board's own motion order. Accordingly, we do not separately address the petition for review of that order.

associated with his job at EBI because of his preexisting compensable condition, that the threatening phone call was the culminating event but was not a causative factor in claimant's worsening and inability to work and that claimant's employment at EBI did not contribute independently to his psychological condition or cause a permanent worsening of the underlying condition, but was merely the scene where the ongoing preexisting psychological condition manifested itself. He affirmed EBI's denial. Because claimant's aggravation rights had expired, he recommended that the Board exercise its own motion jurisdiction and order Weyerhaeuser to provide TTD and PPD benefits because of the exacerbation of the 1972 injury. *See* ORS 656.278. He also set aside Weyerhaeuser's denial of June 3, 1985.

Claimant requested, and Weyerhaeuser cross-requested, review of the referee's order. Weyerhaeuser's cross-request stated that the issues for Board determination were

> "1. Compensability of medical services for a low back and psychiatric condition;
>
> "2. Claimant's entitlement to attorney fees."

Claimant did *not* argue that his aggravation rights had not expired. Both claimant and Weyerhaeuser, in their briefs before the Board, urged that EBI's denial be set aside. Weyerhaeuser also urged that the Board reinstate its denial of June 3, 1985.

The Board adopted the referee's findings of fact and

affirmed the order of the referee. It also stated that the issue is responsibility. It ruled that claimant's worsening was an aggravation of the 1972 injury, for which Weyerhaeuser is responsible. The Board also ruled that claimant was not entitled to an employer paid attorney fee at the Board level. It stated, in part, that, although Weyerhaeuser cross-requested review, "its goal on review was exactly the same as claimant's—to have EBI's denial set aside." The Board noted that claimant had requested claim reopening by the Board under the provisions of ORS 656.278 if Weyerhaeuser were found to be responsible for claimant's condition. On its own motion, the Board ordered Weyerhaeuser to reopen the 1972 claim, effective January 8, 1985, and to pay claimant temporary total disability until closure.

In his petition, claimant assigns as error that the Board upheld EBI's denial of responsibility for the back and psychological conditions. In its cross-petition, Weyerhaeuser assigns as error that the Board held it responsible for claimant's psychological condition after January 8, 1985. Weyerhaeuser does not argue that his psychological condition is unrelated to the pre-existing psychiatric condition for which it is responsible or that claimant had not experienced a worsening of that condition that left him less able to work. It argues, however, that the employment at EBI independently contributed to that condition. Both claimant and Weyerhaeuser assert that the psychiatric condition, previously diagnosed as a moderate depression, had become a major depression as a result of his employment at EBI.

We agree with the Board, for the reasons that it gave, that the work at EBI did not independently contribute to claimant's back and psychological conditions and that Weyerhaeuser is responsible for those conditions, both before and after January 8, 1985. We affirm the Board's order.

Claimant asserts, relying on *Travis v. Liberty Mutual Ins.*, 79 Or App 126, 717 P2d 1269, *rev den* 301 Or 445 (1986), that, because Weyerhaeuser initiated a cross-request for review and the Board did not disallow or reduce claimant's award, he is entitled to insurer-paid attorney fees for services

at the Board level. ORS 656.382(2).[2] Weyerhaeuser first responds that OAR 438-47-075 precludes an award of attorney fees to claimant. We have held to the contrary. *Kordon v. Mercer Industries*, 94 Or App 582, ___ P2d ___ (1989); *Littleton v. Weyerhaeuser*, 93 Or App 659, 763 P2d 742 (1988). It also asserts that it did not "initiate" a request for review, *citing Saiville v. EBI Companies*, 81 Or App 469, 473, 726 P2d 394, *rev den* 302 Or 461 (1986), because its cross-request to the Board did not raise any issues that claimant did not raise before the Board. Weyerhaeuser, however, did file a cross-request and that constitutes initiation of a request for review under ORS 656.382(2). *Kordon v. Mercer Industries, supra.*

Weyerhaeuser also argues that claimant is not entitled to attorney fees before the Board, asserting that the only issue before the Board was responsibility. *See Petshow v. Farm Bureau Ins. Co.*, 76 Or App 563, 569, 710 P2d 781 (1985), *rev den* 300 Or 722, (1986). Claimant took the position that EBI was responsible on the ground that he had suffered a new injury, actively litigated that point and filed a brief before the Board. He had a stake in the outcome of that determination. If EBI was responsible, claimant's TTD would be increased. If EBI was not responsible, and if the Board did not exercise own motion jurisdiction and reopen the 1972 claim, claimant's claim for his psychological condition after January 8, 1985, other than for medical benefits under ORS 656.245, might not be compensated.

When claimant participated before the Board, he did not know whether it would exercise own motion jurisdiction. Moreover, when he filed his brief before the Board, claimant knew that, on June 3, 1985, Weyerhaeuser had denied his claim for medical benefits, had not limited its denial to the issue of responsibility and had stated in its cross-request for Board review that one of the issues was "compensability" of

medical services. Accordingly, his attorney justifiably and actively participated in the proceeding before the Board. *See SAIF v. Phipps*, 85 Or App 436, 737 P2d 131 (1987); *Petshow v. Farm Bureau Ins. Co., supra*, 76 Or App at 569.

[2] ORS 656.382(2) provides:

"If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

Weyerhaeuser is responsible for attorney fees. Contrary to the Board's interpretation, Weyerhaeuser's goal before the Board was not exactly the same as claimant's. Weyerhaeuser wanted the Board to reinstate its denial of June 3, 1985, a request which claimant did not make and which was contrary to his position throughout. Furthermore, review of the referee's order, which claimant and Weyerhaeuser both requested, included review of the referee's ruling upholding EBI's compensability denial. As noted, Weyerhaeuser's cross-request also stated that one of the issues was compensability for medical services. Accordingly, its cross-request, together with its request for reinstatement of its total denial of June 3, 1985, placed claimant at risk and justified his active participation before the Board. *See SAIF v. Bates*, 94 Or App 666, ___ P2d ___ (1989).[3]

In Case Nos. 85-05079 and 85-11948: on the petition, reversed as to attorney fees and remanded for award of attorney fees to claimant for services before the Board; otherwise affirmed on the petition and on the cross-petition. In Case No. 85-0050M, affirmed on the petition.

[3] Weyerhaeuser does not argue in its brief that its cross-request was not the cause of claimant's active participation before the Board.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William Albrecht, Claimant.

TRI-MET, INC.,
Petitioner,

v.

ALBRECHT,
Respondent.

(WCB 86-02160; CA A46942)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 9, 1988.

Kenneth L. Kleinsmith, Portland, argued the cause for petitioner. On the brief were Pamela A. Schultz and Meyers & Terrall, Portland.

Merrill Schneider, Portland, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed and remanded to referee.

WARREN, J.

In this workers' compensation case, claimant sought a hearing on a determination order, contending that he was entitled to a greater award of permanent partial disability.

Employer also sought a hearing, requesting a reduction in the permanent disability award. Before the hearing, employer requested two independent medical examinations. Claimant's attorney notified employer that she intended to be present at the examinations. After learning that, both doctors refused to conduct the examinations. They believed that the presence of a third party would impair their objectivity. Additionally, both were concerned that the presence of the attorney would influence claimant's behavior, especially in view of the fact that the attorney is a woman. One was concerned that he would be forced into the role of "advocate."

The Board, in affirming the referee, denied employer's motion to suspend the hearing until claimant agreed to attend the examinations without the presence of his attorney. It affirmed the determination order, neither increasing nor decreasing the award.

Employer seeks review, contending that, by insisting on the presence of his attorney, claimant "obstructed" the examinations, ORS 656.325(1), and, additionally, that the Board has deprived employer of the opportunity to develop a complete record. Employer seeks remand for that purpose.

In cases subject to the Oregon Rules of Civil Procedure, the rule appears to be that it is for the trial court to decide the conditions under which a physical medical examination is to take place. ORCP 44A. Presumably, that would include the power to determine who may be present at the examination. Our review, as of other issues related to the trial court's supervision over discovery, would be for abuse of discretion.

There are several reasons why, even in the context of civil discovery, the presence of an attorney at a medical examination is not favored. *See Pemberton v. Bennett,* 234 Or 285, 288, 381 P2d 705 (1963). It could tend to prolong the examination and create other than a neutral setting for what is supposed to be an objective evaluation. We agree with employer that those considerations apply with at least as great force in

the workers' compensation context, where one objective is to minimize expense and delay. *See Bigby v. Pelican Bay Lbr. Co.,* 173 Or 682, 692, 147 P2d 199 (1944). That goal would not be furthered by permitting the presence of an attorney at an independent medical examination, which would only serve to threaten the objective environment and which could lead to obstruction of the examination. Although there may be circumstances that would justify the presence of an attorney at the examination, the record must articulate what those circumstances are. Here, as the Board found, there is nothing to suggest a basis for permitting an attorney to be present. We conclude, therefore, that the Board had no basis for exercising its discretion to allow an attorney to be present. In doing so, it erred. Employer is entitled to an independent examination of claimant without the presence of his attorney.

Reversed and remanded to the referee.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Maria N. Flores, Claimant.

FLORES,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB Nos. 86-11534 and 85-05626; CA A46093)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 27, 1988.

Nelson R. Hall, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Physicians & Surgeons Hospital. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General.

Marianne Bottini, Portland, argued the cause for respondent Mission Insurance Company. With her on the brief was Bottini, Bottini & Lehner, Portland.

Before Warden, Presiding Judge pro tempore, and Joseph, Chief Judge, and Edmonds, Judge.*

JOSEPH, C. J.

Affirmed.

* Edmonds, J., *vice* Van Hoomissen, J.

JOSEPH, C. J.

Claimant seeks review of a Workers' Compensation Board order that reversed the referee and reinstated the denial of responsibility by Mission Insurance Company (Mission). We affirm.

Claimant first sustained a head injury in July, 1981, while working for employer, which was then insured by Mission. She sought treatment from Dr. Yand, her family physician, for headaches and visual abnormalities. He diagnosed a scalp hematoma, a mild cerebral concussion and a small skull fracture. Claimant returned to work in November, 1981, even though she was still experiencing mild nausea and headaches. A determination order awarded her temporary total disability.

In September, 1982, employer changed to coverage by SAIF. Claimant injured her head at work again in May, 1982, in August or October, 1983, and in March, 1984. She asserts that she filled out claim forms for each injury but that they were never processed. In June, 1984, she received another

head injury at work. She was seen by Yand, who diagnosed a hematoma and released her for regular work. Shortly thereafter, she was seen by Dr. Raaf, a neurosurgeon, who determined that her headaches were the result of an "anxiety tension state" and were not related to her 1981 injury. In September, 1984, Dr. Aversano agreed with Raaf that no further medical treatment, other than psychiatric, was necessary. SAIF issued a notice of closure in October, 1984, accepting claimant's injury as nondisabling and awarding no compensation. Claimant began seeing Dr. Rosenbaum in December, 1984.

In March, 1985, Mission denied responsibility for claimant's treatment by Rosenbaum on the basis that it was not related to her 1981 injury. Claimant appealed the denial and requested an order joining SAIF as a party and an order designating a paying agent. ORS 656.307. Although SAIF was joined, a .307 order never issued. In August, 1986, SAIF denied the aggravation claim for the June, 1984, injury on the ground that claimant's medical problems were consequences of the 1981 injury. The referee upheld SAIF's denial and set aside Mission's.

Judicial review is limited to errors of law and to whether there is substantial evidence in the record as a whole to support the Board's decision. ORS 656.298(6); *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988). A Board decision must contain findings sufficient to support its conclusions. *Johnston v. James River Corporation*, 91 Or App 721, 722, 756 P2d 696 (1988). The Board's findings are sufficient for review. There is substantial evidence to support the Board's finding that claimant's present need for medical treatment is not related to either her 1981 injury, covered by Mission, or to her 1984 compensable injury. There is also substantial evidence to support its finding that claimant had failed to establish an aggravation of the 1984 injury that SAIF had accepted.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Leora J. Whaite, Claimant, and
In the Matter of the Complying Status of
Castle Homes, Inc., Employer;
Richard J. Carney, individually, and
Dirk G. Stangier, individually.

CASTLE HOMES, INC., et al,
Petitioners - Cross-Respondents,

v.

WHAITE,
Respondent - Cross-Petitioner,

and

SAIF CORPORATION,
Respondent - Cross-Respondent.

(WCB No. 86-17464; CA A47482)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 16, 1988.

Michael J. Martinis, Salem, argued the cause for petitioners - cross-respondents. With him on the brief was Webb and Martinis, Salem.

William E. McCann, Bend, argued the cause and filed the brief for respondent - cross-petitioner.

No appearance for respondent - cross-respondent SAIF Corporation.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed on petition and on cross-petition.

WARREN, J.

In this proceeding to determine whether Castle Homes is a noncomplying employer under the Workers' Compensation Act, the question is whether claimant, a mobile home salesperson, was, at the time she was injured, an employe of Castle or an independent contractor. The referee determined that she was an employe and that Castle was a noncomplying employer. Castle seeks review of the determination that it is a noncomplying employer. Claimant cross-petitions, seeking attorney fees. We review pursuant to ORS 183.480 and ORS 183.482. We affirm on both the petition and the cross-petition and write only to address the question raised by the petition.

Claimant has sold mobile homes for many years. She first approached Kline, Castle's lot manager, in January, 1986, for the purpose of seeking to associate with the company in order to follow up on some sales leads. Claimant could not sell homes on her own, because she was not a licensed dealer. Kline told claimant that she could work at the dealership on Sundays so that he could take the day off. Gradually, claimant began coming in every day and the work became full time. Although Kline did not require her to do so, claimant usually opened the lot office at 9 a.m., as is the custom in the industry, and worked until closing. She was injured in February, 1986, when she fell over a telephone cord at a mobile home factory while negotiating a sale. For two weeks in April, 1986, Kline went on vacation, and claimant was the only salesperson on the lot. Claimant stopped working for Castle Homes in May, 1986, when she was "fired" by Kline. In September, 1986, she filed a claim for workers' compensation benefits allegedly due as a result of the February injury, which Castle denied on the ground that claimant was an independent contractor.

The test for determining who is a subject worker within the meaning of the Workers' Compensation Act is the employer's right to control the performance of the services. ORS 656.050(14) and (27). The test requires an application of the traditional "right to control" analysis and a consideration of the "nature of the work." *Woody v. Waibel,* 276 Or 189, 196, 554 P2d 492 (1976). Although in some cases there may be

questions of fact concerning the employment arrangement between the parties, where, as here, the facts are generally

undisputed, the question of the nature of the employment relationship is one of law. 276 Or at 192 n 3.

The principal factors in the traditional test of the right to control are: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. *Henn v. SAIF,* 60 Or App 587, 591, 654 P2d 1129 (1982), *rev den* 294 Or 536 (1983). The second and third factors are not particularly significant in this case. Claimant was paid strictly on commission, 10 percent of the gross profit on each sale. That method of payment is a neutral factor in determining the right to control. *Henn v. SAIF, supra,* 60 Or App at 592. The nature of the equipment furnished by Castle is not particularly significant and does not lead to an inference of a right to control the method of selling. *See* 1C Larson, *Workman's Compensation Law* § 44.34(g). The undisputed evidence concerning the remaining factors leads us to conclude that claimant was an employe.

The parties had no written employment contract. The evidence shows that claimant was independent in much of her work and that Kline in fact exercised little control over the details of her activities. Both claimant and Kline testified that claimant was not supervised. She was free to sell homes in any manner she chose. There were no company practices for claimant to follow and no company quotas or other requirements. She could follow her own sales leads. Claimant did not have to attend any sales meetings; there were none.

Although Kline did not, in fact, exercise control over many of the details of claimant's work, he did exercise control in certain significant respects. He implicitly required that she be present on the lot on all Sundays. He had to approve all financing, modifications in home design and sales for less than the listed price. Those aspects of the business are not mere "details." They are the most significant components of a sales transaction and indicate that Castle had the right to control claimant's work when it chose to do so.

Other factors lead us to conclude that Castle had a right to control claimant. Kline "fired" her; that is, he told her to leave, because she was no longer needed on the sales lot on Sundays and because her nervous behavior was driving customers away. That is evidence that Kline at least believed that

he had the right to terminate Castle's relationship with claimant at will, a situation that is not consistent with an independent contractual relationship, because it suggests a right to control. 1C Larson, *supra,* § 44.35; *see Collins v. Anderson,* 40 Or App 765, 596 P2d 1001 (1979); *Carlile v. Greeninger,* 35 Or App 51, 580 P2d 588 (1978).

Additionally, certain factors about the nature of claimant's work and Castle's business persuade us that claimant should be treated as an employe for purposes of workers' compensation. She was, according to her uncontradicted testimony, responsible for the sales lot much of the time, including

Sundays, many mornings and the two week period when Kline was on vacation. Although claimant was apparently free to associate with other dealerships, she did not. Claimant worked virtually full time for Castle and was permitted to hold herself out as an associate, as evidenced by the fact that the company provided her with business cards. The selling of mobile homes was not only an integral part of the business of Castle Homes, it was, as far as the record shows, the only business of the company. Claimant was an essential part of that business. *See* 1C Larson, *supra*, § 45.20. We conclude that she was an employe and, therefore, we affirm the Board's determination that Castle was a noncomplying employer.[1]

Affirmed on petition and on cross-petition.

[1] This case is distinguishable from *Henn v. SAIF*, *supra*, where we held that the claimant, a magazine sales representative, was an independent contractor. There, the evidence did not show that the claimant could be terminated for any reason other than a violation of her agreement with the putative employer. Additionally, in *Henn*, we did not consider the nature of the work. We do not comment on the correctness of our statement in *Henn* that it is not appropriate to consider the nature of the work unless it is impossible to determine the claimant's status under the traditional "right to control" test. In *Woody v. Waibel*, *supra*, however, the court seems to have mixed the two concepts by saying that the nature of the work is a factor in determining the right to control and an element of the right to control. *Woody v. Waibel*, *supra*, 276 Or at 197.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Russell V. Hunnicutt, Claimant; and
In the Matter of the Complying Status of
Willis D. Dollarhyde, Employer.

HUNNICUTT,
Petitioner,
v.
DOLLARHYDE et al,
Respondents.

(WCB Nos. 87-18715, 87-18716; CA A48528)

Judicial Review from Corrected Order of Workers' Compensation Board Referee.

Argued and submitted December 12, 1988.

Robert G. Dolton, Portland, argued the cause and filed the brief for petitioner.

No appearance for respondent Willis D. Dollarhyde.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Joseph, Chief Judge, and Graber and Riggs, Judges.

PER CURIAM

Reversed; remanded to referee for further proceedings not inconsistent with this opinion.

PER CURIAM

The referee found that claimant is not a subject worker under ORS 656.027 and held that Dollarhyde is not, therefore, a noncomplying employer. ORS 656.023. Claimant has petitioned for judicial review of that order under ORS ch 183.

SAIF concedes that Dollarhyde is an employer under ORS 656.029(1).[1] Both Dollarhyde and the referee misread ORS 656.027(3)[2] to exclude as subject workers casual *employes*. That subsection refers to casual *employment*. That one's employment is casual does not deprive an employe of protection, if the employment is in the course of the trade, business or profession of the employer.

Reversed; remanded to the referee for further proceedings not inconsistent with this opinion.

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[1] ORS 656.029(1) provides:

"If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in [the Workers' Compensation Law] for the payment of benefits to the worker of a noncomplying employer."

[2] ORS 656.027 provides, in relevant part:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(3)(a) A worker whose employment is casual and either:

"(A) The employment is not in the course of the trade, business or profession of the employer; or

"(B) The employment is in the course of the trade, business or profession of a nonsubject employer.

"(b) For the purpose of this subsection, 'casual' refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ernest F. Erck, Claimant.

ERCK,
Petitioner,

v.

BROWN OLDSMOBILE et al,
Respondents.

(WCB 86-05134; CA A47689)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 12, 1988.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were Nelson R. Hall, Donald R. Wilson and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Randy G. Rice, Portland, argued the cause for respondents. With him on the brief was Beers, Zimmerman & Rice, Portland.

Before Joseph, Chief Judge, and Graber and Riggs, Judges.

PER CURIAM

Affirmed.

Riggs, J., dissenting.

PER CURIAM

In this workers' compensation case, we review for substantial evidence. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). The Board's order is sufficient for review, there is substantial evidence to support its findings, and its reasoning connects those findings to the conclusion. Therefore, we hold that the Board did not err in reversing the referee's award of permanent total disability.

Affirmed.

RIGGS, J., dissenting.

If the Workers' Compensation Board reverses a referee, on judicial review this court must be furnished specific findings in the Board's opinion that substantiate the conclusions that are contrary to the referee's findings and conclusions of law. *Johnston v. James River Corp.*, 91 Or App 721, 722, 756 P2d 696 (1988).

In this odd lot case, the 62 1/2 year old, ninth grade educated claimant sought review of a determination order that awarded 30 percent unscheduled disability. Earlier, a referee had found claimant's claim compensable, and Orion Group/EBI Companies referred the case to Orion Rehabilitation Services and then to Hetfield Associates, Inc., for return-to-work assistance.[1] Hetfield claimed non-cooperation and lack of motivation by claimant, resulting in the termination of assistance. Claimant argues that he cooperated with Orion and that Hetfield provided only superficial assistance. The referee, in detailed findings of fact and conclusions of law

[1] Claimant worked with an Orion rehabilitation counselor from February 25, 1985, until October 14, 1985, when Hetfield became the service provider. In February, 1986, the Hetfield rehabilitation counselor wrote to claimant indicating that she needed greater participation from him. Claimant's attorney wrote to the counselor on February 24, 1986, requesting clarification as to what conduct she was looking for and stating that claimant had worked well with Orion and was willing to work with the Hetfield counselor. The counselor sent a letter on March 26, 1986, outlining the rules for claimant to maintain his vocational assistance, and then on April 11, 1986, sent notice of the termination of his return-to-work assistance because of nonparticipation, effective immediately.

At the hearing, the Hetfield counselor admitted that she never looked into claimant's job search efforts with the Orion counselor, nor, in any of the three visits that she had with claimant, did she ever inquire about his own independent job search efforts.

found, among other things, that claimant was an honest, credible witness and concluded that the charge of lack of motivation was unfounded. The referee concluded that claimant was entitled to a permanent total disability award.

The Board's review was *de novo,* and it reversed the referee. After it recited some negative facts that pertained to the non-cooperation charge, it concluded that claimant had refused vocational assistance and therefore was not entitled to an award of permanent total disability. The Board did not address the referee's findings, which favored claimant, or his determination that claimant was credible. It is not evident whether the Board considered the Orion Rehabilitation Service records that were received in evidence after the hearing, which document claimant's ample efforts to find employment with and without the assistance of the rehabilitation service.

Our review requires that an order contain facts sufficient to justify a result contrary to the referee's. The Board's final order is not sufficient for that review. I would reverse and remand for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Hun J. Kim, Claimant.

KIM,
Petitioner,
v.
MT. HOOD COMMUNITY COLLEGE et al,
Respondents.

(WCB 86-09851; CA A47789)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 12, 1988.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun & Green, Portland.

Jas J. Adams, Portland, argued the cause for respondents. With him on the brief was Acker, Underwood & Smith, Portland.

Before Joseph, Chief Judge, and Graber and Riggs, Judges.

JOSEPH, C. J.

Reversed and remanded for reconsideration.

JOSEPH, C. J.

Claimant sustained injuries while contributing his labor to a charitable foundation. He seeks review of an order of the Workers' Compensation Board that affirmed a referee's order that denied his claim. Because the referee's order is inadequate for review, we reverse and remand.

Claimant works in employer's maintenance department. He and other workers from that department agreed to contribute a "package" of work to be sold at an auction for the benefit of the Mt. Hood Community College Foundation (foundation). The foundation is a non-profit corporation whose sole purpose is to raise money for the benefit of employer and its students. Claimant and the others who had agreed to contribute their labor met at employer's premises on a Saturday in May, 1986, and, using employer's equipment, went out to work for those who had bid successfully. None of them expected to be paid for the work. During the course of the day, claimant fell from a roof and was injured. Employer denied his claim, and claimant sought a hearing.

In his order, the referee recited the testimony of several witness and then stated that the issue was "whether claimant's injury occurred in the course and scope of his employment" with employer.[1] He decided that cases about injuries sustained during recreational or social activities were the most analogous and relied on the criteria for evaluating those injuries that we had earlier quoted from 1A Larson, *Workmen's Compensation Law*, § 22.200:

> " 'Recreational or social activities are within the course of employment when
>
> " '(1) They occur on the premises during a lunch or recreation period as a regular incident of the employment; or
>
> " '(2) The employer, by expressly or impliedly requiring participation, or by making the activity part of the services of an employee, brings the activity within the orbit of the employment; or
>
> " '(3) The employer derives substantial direct benefit from the activity beyond the intangible value of improvement

> in employee health and morale that is common to all kinds of recreation and social life.' " *Richmond v. SAIF*, 58 Or App 354, 357, 648 P2d 370, *rev den* 293 Or 634 (1982).

The referee concluded that only the third criterion might be relevant and that claimant's activity provided employer only an indirect benefit. He did not explain that conclusion. He affirmed the denial. Claimant appealed to the Board, which adopted the referee's order but did not refer to either the factual statements or the reasoning. Claimant then sought review in this court.

Our review is for substantial evidence. ORS 656.298(6); ORS 183.482(7), (8). *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988), requires that the Board provide "a reasoned opinion based on explicit findings of fact." 90 Or App at 205. The Board adopted the referee's opinion and order. We assume that it approved his findings and conclusions. *See George v. Richard's Food Center*, 90 Or App 639, 752 P2d 1309 (1988). However, those findings and conclusions are inadequate for review.

The referee did not make findings of fact that reflected an evaluation of the evidence but simply recited the

[1] Because the referee said that the question was whether claimant's injury occurred in the course of his employment, it is not clear why he also discussed whether claimant was an employe when he was injured.

evidence that several witnesses presented. That is not enough.[2] *See Armstong v. Asten-Hill Co., supra,* 90 Or App at 207. Furthermore, even assuming that the referee was correct in his legal conclusion that the factors listed in *Richmond v. SAIF, supra,* are relevant, he did not explain why he decided that employer received indirect rather than direct benefits from claimant's work. There is evidence that the institutional ties between employer and the foundation were very close and that the foundation spends all of the money that it raises in ways that benefit employer. If the referee believed the evidence, as it appears that he did, then logically he should have concluded that claimant's work provided direct benefits to employer. The referee's conclusion to the contrary presents an instance "when the credible evidence apparently weighs overwhelmingly in favor of one finding and the [referee has found] the other without giving a persuasive explanation" based on explicit findings of fact. *Armstrong v. Asten-Hill Co., supra,* 90 Or App at 206.

Reversed and remanded for reconsideration.

[2] Employer argues that the referee implicitly found the facts in accordance with the testimony that he recited. Even if we could treat his recitations in that way, the referee made no attempt to explain his resolution of any conflicts in the testimony or otherwise to explain his findings.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

COPE,
Appellant,
v.
WEST AMERICAN INSURANCE CO. OF THE OHIO CASUALTY GROUP et al,
Respondents.

WEST AMERICAN INSURANCE CO. OF THE OHIO CASUALTY GROUP,
Third-Party Plaintiff,
v.
HURLEY-HENDERSON, INC., dba Hurley-Henderson Insurance, Inc., fka Driscoll, Padgett & Hurley,
Third-Party Defendant.

(86-356 CV; CA A45475)

Appeal from Circuit Court, Klamath County.

Richard C. Beesley, Judge.

Argued and submitted May 18, 1988.

George W. Kelly, Eugene, argued the cause and filed the briefs for appellant.

Timothy C. Gerking, Medford, argued the cause for respondent West American Insurance Co. of the Ohio Casualty Group. With him on the brief was Brophy, Wilson & Duhaime, Medford.

Christopher Ledwidge, Medford, argued the cause for respondent Hurley-Henderson Insurance, Inc. With him on the brief was Frohnmayer, Deatherage, deSchweinitz, Pratt & Jamieson, Medford.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded.

DEITS, J.

Plaintiff appeals a summary judgment entered in favor of defendants, arguing that there were genuine issues of material fact and that summary judgment was therefore improper. We reverse and remand.

In September, 1985, plaintiff drove her automobile to work and parked in her employer's parking lot, which was across a public street from her employer's premises. After parking her car, she walked across the lot and had either entered or was about to enter the public sidewalk area when she was struck by an automobile driven by a co-employe, who was also on his way to work. Plaintiff filed a claim with the co-employe's insurance company and was paid $25,000, the liability limit on his policy. She then filed an underinsured motorist claim[1] with defendants, her own insurers, alleging additional damages in excess of $150,000. Defendants denied the claim, in part on the ground that her injury was not covered because she was within the scope of her employment at the time of the accident.[2] Plaintiff then filed the present action for a declaratory judgment that she is covered under the policy and a judgment for her damages.[3] After depositions had been taken, defendants moved for summary judgment pursuant to ORCP 47. The trial court granted the motion, and plaintiff appeals.

Summary judgment is proper when

> "the pleadings, depositions, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." ORCP 47C.

In reviewing a summary judgment, the record is viewed in the light most favorable to the party opposing the motion. *Seeborg*

v. General Motors Corporation, 284 Or 695, 699, 588 P2d 1100 (1978).

Plaintiff's underinsured motorist coverage provided

[1] *See* ORS 743.789(2).

[2] Defendants also denied liability on the basis that plaintiff's insurance policy had lapsed at the time of the accident. However, defendants concede that this basis for denying liability was not raised in the motion for summary judgment below. Therefore we do not address the issue.

[3] Plaintiff also filed a workers' compensation claim with her employer. Employer denied the claim on the basis that plaintiff's injuries did not arise out of and in the course and scope of her employment. Plaintiff apparently did not request a hearing on the claim, and neither party asserts that the employer's denial has any evidentiary or legal significance in this action.

that defendants would pay "damages which a covered person is legally entitled to recover from the owner or operator of an [underinsured] vehicle." Thus, if plaintiff was legally entitled to recover from the co-employe who hit her, then she was legally entitled to recover from defendants. Defendants argue that her recovery against them is barred by ORS 656.018(3), which exempts employes from liability for negligent acts committed against each other if the employer has complied with the Workers' Compensation Law and if the injured employe is acting within the course and scope of the employment at the time of injury. We agree that, if plaintiff was acting within the course and scope of her employment at the time of injury, ORS 656.018(3) entitles defendants to judgment as a matter of law. The question presented on appeal, therefore, is whether there was a genuine issue of fact as to whether plaintiff was within the course and scope of her employment at the time of injury.[4]

Oregon cases have uniformly held that employe injuries that occur in parking lots owned or maintained by the employer arise out of and in the course of employment. *Montgomery Ward v. Cutter*, 64 Or App 759, 762, 669 P2d 1181 (1983). Defendants argue that the evidence clearly establishes that plaintiff's injuries occurred in employer's parking lot and, therefore, arose out of and in the course of her employment. Defendants rely on plaintiff's statements in her deposition, in which she stated that the accident occurred in the parking lot. Specifically, she testified:

> "[Counsel for defendants]: Why don't you tell me how the accident happened; when it was; where you were going; how it happened—that kind of thing.
>
> "[Plaintiff]: Okay, * * * I had parked my automobile, gotten out of my car, walked diagonally across the parking lot *and was almost on the sidewalk when Mr. Tideman, the gentleman that hit me, turned into the driveway and struck my right leg.*

> "* * * * *
>
> "As he pulled into the driveway, he hit me in the right leg and I fell down. *I did not see him coming into the driveway, as I was facing sort of a diagonal, and like I said, I was almost on the sidewalk.* * * *.
>
> "* * * * *
>
> "[Counsel]: *Were you in the crosswalk at the time he hit you?*
>
> "[Plaintiff]: *No; I was still in the parking lot.*
>
> "* * * * *
>
> "[Counsel]: Were you in front of the entrance to the parking lot?
>
> "[Plaintiff]: The driveway into the parking lot, you mean? *I believe I had one foot on the sidewalk and one foot was still in the parking lot.*
>
> "*It did not happen exactly in the driveway. He swung wide when he pulled in and it happened. I'm honestly not certain—it happened very, very fast* * * *." (Emphasis added).

[4] Neither party separately addressed the issue of whether the co-employe was acting within the course and scope of his employment at the time he injured plaintiff. Because we conclude that there was evidence from which it could be found that plaintiff was not within the course and scope of employment and that, therefore, summary judgment was improper, we need not address that issue.

Plaintiff contends that there was a genuine issue of fact as to her exact location at the time of the accident. She relies on statements made in her affidavit submitted in opposition to defendant's motion for summary judgment:

> "That I stated in my deposition * * * that I was almost to the sidewalk when struck by Mr. Tideman. I also stated in the deposition * * * that I had one foot on the sidewalk and one foot on the parking lot.
>
> "That when giving the deposition I did not clearly describe the area for the reason that the sidewalk area is blacktop covered the same as the parking lot and the driveway from Klamath Avenue crosses the sidewalk area into the parking lot.
>
> "That at the time that I was struck by Mr. Tideman's automobile I was in the crosswalk area, although I had one foot in the driveway area that crossed the sidewalk area when I was struck by Mr. Tideman's automobile.
>
> "I cannot definitely say how far out into the sidewalk area I was at the time I was struck as I did not see the approaching vehicle of Mr. Tideman at the time I was struck."

Plaintiff also relies on exhibits attached to her response to the motion for summary judgment, which include

a written statement by Tideman, the co-worker who injured her, and Keen, another co-worker who arrived on the scene after plaintiff had been hit. Tideman stated that, when his vehicle struck plaintiff, "she was in the sidewalk portion of the parking lot and she came to rest near the middle of the sidewalk after she fell." Keen's affidavit stated that he found plaintiff "lying on the sidewalk area * * * in between the curb area and a parking lot sign located at the edge of the parking lot and the sidewalk area."

Defendants argue, relying on *Henderson-Rubio v. May Dept. Stores,* 53 Or App 575, 632 P2d 1289 (1981), that a material fact cannot be put in issue for purposes of opposing summary judgment by filing an affidavit that contradicts testimony given at a deposition. In *Henderson-Rubio,* the plaintiff was repeatedly asked during deposition to state the basis for his overtime wage claim. He specifically stated that it was based on his understanding of federal wage law, but that he was not aware of any company policy regarding the matter. After the employer filed a motion for summary judgment, the plaintiff filed an affidavit asserting that the employer had a policy regarding overtime wages. We held in that case that such an affidavit could not create a genuine issue of fact. However, we limited the case to its facts:

> "This is not a case where plaintiff's affidavit explains or adds to his deposition; neither does he claim that he was confused at the time of his deposition. Plaintiff's affidavit directly conflicts with his deposition testimony. He made no attempt to explain this inconsistency." 53 Or App at 585.

We explained further in a footnote:

> "Not all discrepancies contained in an affidavit justify a court's refusal to give credence to such evidence. *Our decision is limited to the facts of this and similar cases, where the two statements are clearly inconsistent and no attempt is made to explain the inconsistency.*" 53 Or App at 585 n 6. (Citations omitted; emphasis supplied.)

In this case, plaintiff did offer an explanation for the inconsistency between her deposition testimony and the assertions made in her affidavit. Further, she submitted statements by witnesses that arguably support her assertion that she was on the sidewalk at the time when she was injured. Viewing the record in the light most favorable to plaintiff, we

conclude that there is a genuine issue of fact as to her location at the time of the accident. Accordingly, summary judgment was improper.

Defendants argue in the alternative that, even if plaintiff was on the sidewalk at the time when she was injured, she was still within the scope of her employment and, therefore, cannot recover as a matter of law. Essentially, defendants argue that the "parking lot" rule of *Montgomery Ward v. Cutter, supra,* should be extended to cover not only injuries that occur on the employer's parking lot but also injuries that occur en route between the parking lot and the employer's premises.

However, regardless of what the rule may be in other states, control over the premises is the crucial ingredient to parking lot injury cases in Oregon. In *Adamson v. The Dalles Cherry Growers, Inc.*, 54 Or App 52, 633 P2d 1316 (1981), the employe had parked her automobile in front of the employer's premises and was injured while walking to the front door. We held that she was not entitled to worker's compensation because she was not within the course and scope of her employment at the time of injury:

> "In this case, the claimant was injured on a public street, not on the employer's premises. The street was located between the employer's facilities and was frequently used by its employes. The claimant was forced to park on the street on the day of the injury because the other parking areas were full or inaccessible. The street was the only way she could get to her place of work. *However, there is no evidence that the street had become a part of the employer's facilities or that the employer regularly exercised control over street traffic, use of the street or its maintenance.*" 54 Or App at 58-59. (Emphasis supplied.)

See also Montgomery Ward v. Malinen, 71 Or App 457, 460, 692 P2d 694 (1984).

In this case, there is no evidence that plaintiff's employer exercised any control over the sidewalk area that plaintiff allegedly was on at the time of the accident. Accordingly, defendants were not entitled to judgment as a matter of law, and summary judgment was inappropriate.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Richard B. Nehring, Claimant.
EBI INSURANCE COMPANY et al,
Petitioners,
v.
CNA INSURANCE et al,
Respondents.
(WCB 86-12728, 86-03222; CA A47014)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 17, 1988.

Susan D. Isaacs, Portland, argued the cause for petitioners. On the brief was Randy G. Rice, Portland.

Craig A. Staples, Portland, argued the cause for respondents CNA Insurance and Tandy Corporation. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Glen J. Lasken, Portland, waived appearance for respondent Richard B. Nehring.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Don Rasmussen BMW (Rasmussen) seeks review of an order of the Workers' Compensation Board that affirmed the referee's order overturning a denial of claimant's aggravation claim. It contends that Tandy Corporation (Tandy), a subsequent employer, is responsible because it accepted claimant's new injury claim, and its later denial is therefore barred by *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983). We affirm.

Claimant sustained a compensable back injury in 1983 while employed by Rasmussen. During his subsequent employment with Tandy, he began experiencing back pain and his treating chiropractor notified Rasmussen that he had suffered an aggravation. Rasmussen denied the claim, and claimant then filed a new injury claim with Tandy, which it denied by letter. Subsequently, Tandy filed two reports with the Workers' Compensation Division on a Form 1502. The first indicated that the claim against Tandy was denied, but the second stated "claim originally denied, now accepted." two days later, Tandy filed a third Form 1502 that explained that the notation on the second form was a clerical error and that the claim was in a denied status.

The referee found that claimant's current condition is an aggravation of the 1983 injury sustained while working at Rasmussen and ordered Rasmussen to accept the claim. The Board affirmed that part of the decision.

Rasmussen does not challenge the finding that claimant's condition is an aggravation of the original injury, but contends that Tandy is responsible, because it accepted the claim when it noted its acceptance on the Form 1502.

A witness explained that the Form 1502 is a report to the Workers' Compensation Division of the current status of a claim. It is not a notification to a claimant that the claim is accepted or denied. The form was not intended to be a notification to claimant of anything. In *Bauman v. SAIF, supra,* the court said:

> "If, as in this case, the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny the compensability of the claim * * *." 295 Or at 794.

Official notice of acceptance or denial is described by ORS 656.262(6) and must include certain information and advice to the claimant. We conclude that the information on the Form 1502 was not an official notice of acceptance.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of the Beneficiaries of Wilma F. Macaitis, (Dec'd), Claimant.

ESTATE OF WILMA F. MACAITIS,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 87-06841; CA A48503)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 4, 1989.

Quintin B. Estell, Salem, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded for further proceedings not inconsistent with this opinion.

RICHARDSON, P. J.

The deceased worker's estate seeks review of the Workers' Compensation Board order upholding the referee's dismissal of a request for a hearing. We reverse.

The worker had requested a hearing regarding the extent of benefits for an accepted claim. About three weeks before the scheduled hearing, she died from causes unrelated to the compensable injury. In a letter notifying the referee of the death, her attorney requested a postponement to determine whether she had left any survivors who would be entitled to pursue the claim. The request for postponement was denied. The hearing was convened as scheduled and, because neither the worker nor her counsel appeared, the request for hearing was dismissed. The attorney contended that he had no authority, at that time, to appear on behalf of the estate.

The personal representative of the estate then requested Board review of the dismissal, contending that a postponement should have been allowed to see if the estate wished to proceed. The Board did not address that issue but concluded that dismissal was proper, because the worker was not survived by anyone who could pursue the claim under ORS 656.218(3). The Board also refused the estate's request to remand the case to the referee for consideration of its right to collect burial expenses under ORS 656.204(1), because that issue had not been raised before the referee.

A Board rule allows postponement of a hearing because of "extraordinary circumstances beyond the control of the party or parties requesting postponement." OAR 438-06-081. The death of the worker and the fact that counsel needed time to determine if there was a basis for continuing the claim or asserting any other matter constituted extraordinary circumstances, as a matter of law. It is true, as the Board held, that the matter of a claim for burial expenses was not raised before the referee, but the reason was that the deceased's estate had not been given time to obtain a personal representative, hire counsel and address the need to appear in the proceedings and file a claim.[1]

Reversed and remanded for further proceedings not inconsistent with this opinion.

[1] In the light of ORS 656.218, which allows processing of a claim by a deceased claimant's survivors, it was a colossal waste of resources for the referee to deny a continuance and then to dismiss the request for hearing on SAIF's motion.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Patrick L. Buchanan, Claimant.

SAIF CORPORATION et al,
Petitioners,

v.

BUCHANAN,
Respondent.

(WCB 86-0278M; CA A47091)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 17, 1988.

John A. Reuling, Jr., 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.

Allen T. Murphy, Jr., Portland, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

PER CURIAM

Employer seeks review of a Workers' Compensation Board order on reconsideration awarding permanent total disability. Our review is as specified in ORS 656.298, because the petition for review was filed after July 20, 1987. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). The order appealed from adopts and republishes a November 18, 1987, Board order, which says, in pertinent part:

> "After thorough review of the evidence, the Board concludes [that] claimant is permanently and totally disabled and is entitled to such benefits commencing the date of this order."

The order is not sufficient for review under ORS 656.298. *Armstrong v. Asten-Hill Co., supra.* It lacks any explanation or reason of why the Board, on reconsideration, awarded permanent total disability after having originally granted only temporary total disability.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gloria G. Sweeden, Claimant.

SWEEDEN,
Petitioner,

v.

CITY OF EUGENE,
Respondent.

(WCB 86-02493, 86-13988; CA A48111)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 23, 1988.

Jerald P. Keene, Portland, argued the cause for petitioner. With him on the brief was Roberts, Reinisch & Klor, P.C., Eugene.

Brian L. Pocock, Eugene, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee's dismissal of her request for hearing as untimely. ORS 656.319(1)(a). We affirm.

The referee's order states, in part:

> "[T]he employer's July 25, 1986 denial is approved, as the claimant's Request for Hearing was not filed within 60 days after the employer issued the denial. The approval of the denial relates only to medical services received on or before the date of hearing."

In her brief, claimant summarizes her contention:

> "Claimant does not challenge the Referee's finding that * * * [the] Request for Hearing was untimely, and that no good cause had been established for the delay. The Referee, however, improperly applied that denial to medical services provided and claimed between the date of the denial and the date of hearing."

Because the request for hearing was untimely, the referee did not have jurisdiction to address any merits of the claim. The ruling of the referee was that the request was untimely and that the denial, therefore, would stand. Only the ruling about timeliness is appropriate for our review. Because claimant does not challenge that ruling, there is nothing for us to review.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James R. Cheney, Claimant.

CHAMPION INTERNATIONAL CORPORATION, *Petitioner,*

v.

CHENEY, *Respondent.*

(WCB 86-00195; CA A47501)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 17, 1988.

On petitioner's petition for reconsideration filed January 11, 1989. Former opinion filed November 9, 1988, 93 Or App 780, 764 P2d 238.

Bradley R. Scheminske, and Scheminske & Lyons, Portland for petition.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Reconsideration allowed; former opinion withdrawn; reversed and remanded for reconsideration.

PER CURIAM

Employer petitions for review of our decision, 93 Or App 780, 764 P2d 238 (1988), in which we affirmed the referee's and the Board's conclusion that claimant's knee condition is compensable. We treat the petition as a petition for reconsideration and allow it.

Employer contends that the referee's opinion and order, which was adopted by the Board, is not sufficient for judicial review. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). Particularly, employer complains that the order does not address whether claimant's condition is compensable in the light of *Wheeler v. Boise Cascade*, 298 Or 452, 693 P2d 632 (1985), and *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979). We agree that the order is deficient and does not meet the guidelines propounded in *Armstrong v. Asten-Hill Co., supra.*

Reconsideration allowed; former opinion withdrawn; reversed and remanded for reconsideration.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Tony Fazzolari, Claimant.

FAZZOLARI,
Respondent on Review,

v.

UNITED BEER DISTRIBUTORS et al,
Petitioners on Review.

(WCB 85-16090; CA A45497; SC S35329)

In Banc

On petition for review filed June 29, 1988.*

Randy G. Rice, Beers, Zimmerman & Rice, Portland, for petitioners on review.

Robert L. Burns, Gresham, for respondent on review.

Jerald P. Keene, Roberts, Reinisch & Klor, P.C., Portland, for amici curiae Associated Oregon Industries, Association of Workers' Compensation Defense Attorneys and Oregon Self-Insurer's Association.

MEMORANDUM OPINION

Petition for review denied.

Linde, J., dissented and filed an opinion in which Gillette, J., joined.

* Judicial review of order of Workers' Compensation Board. 91 Or App 592, 757 P2d 857 (1988).

LINDE, J., dissenting.

The Workers' Compensation Law provides that an injured worker's claim "shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary * * *." ORS 656.268(1). That section (in the form applicable here) continues:

> "(2) When the injured worker's condition resulting from a disabling injury has become medically stationary, * * * the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and the employer, if any, and request the claim be examined and further compensation be determined. * * * 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. * * *"

The Court of Appeals wrote in this case:

> "The statute does not permit unilateral termination of temporary total disability benefits, unless the claimant is *both* medically stationary and released for work. Here, employer continued to pay temporary total disability benefits after claimant was released for work on March 22, 1985, and after

> he was determined to be medically stationary on August 23, 1985. There is no question but that employer is entitled to offset the benefits which it paid after claimant was *both* released to work and medically stationary. The question is whether it may also offset what it paid after claimant had been released for work but before he became medically stationary." (Emphasis in original.)

Fazzolari v. United Beer Distributors, 91 Or App 592, 595, 757 P2d 857 (1988). The Workers' Compensation Board, however, allowed the employer and insurer an offset against future payments for sums that the insurer had paid for time loss after claimant's attending physician released him for unrestricted work, even though claimant's condition had not become medically stationary. The Court of Appeals, instead of applying its statement that the statute requires *both* that the claimant's condition be medically stationary and that he be released for work, remanded the case to the Board to determine whether the claimant had been "actually disabled." If there is an explanation why this "actually disabled" standard replaced the

statutory "medically stationary" standard that the quoted passage of the court's opinion states to be indispensable, I do not see it in the opinion.

I would allow the petition for review to examine the analysis of the Court of Appeals.

Gillette, J., joins in this dissenting opinion.

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of John L. Katzenbach, Claimant.

BOISE CASCADE CORPORATION,
Petitioner of Review,

v.

KATZENBACH,
Respondent on Review.

(WCB 85-14924; CA A46766; SC S35641)

On review from the Court of Appeals.*

Argued and submitted February 1, 1989.

H. Scott Plouse, Medford, argued the cause and filed the petition on behalf of the Petitioner on Review. With him on the petition was Cowling & Heysell, Medford.

Robert L. Chapman, Medford, argued the cause on behalf of the Respondent on Review.

Before Peterson, Chief Justice, and Linde, Carson, Jones, Gillette and Fadeley, Justices.

PER CURIAM

The decision of the Court of Appeals is reversed. The decision of the Workers' Compensation Board is reversed. The case is remanded to the Workers' Compensation Board for further proceedings consistent with this opinion.

---

* Appeal from the Workers' Compensation Board. 93 Or App 202, 761 P2d 554 (1988).

PER CURIAM

This is a Workers' Compensation case. Petitioner Boise Cascade Company (the employer) seeks review of a decision of the Court of Appeals affirming without opinion a decision of the Workers' Compensation Board (the Board), holding that employer's denial of a claim by claimant Katzenbach (the claimant) was premature. For the reasons hereafter stated, we reverse the decision of the Court of Appeals and remand the case to the Board.

The procedural history of the case is important. The claimant suffered a non-disabling on-the-job injury that was diagnosed as "right wrist tendonitis." The employer accepted the claim for that injury and paid benefits in the form of medical services. Later, after reporting swelling in his right forearm, the claimant was diagnosed as having an avascular necrosis on the lunate bone of his right wrist. The employer then denied further medical services on the ground that, while the claimant was seeking treatment for symptoms that were the same or similar to those associated with his compensable injury, his present symptoms were not related to the compensable injury.

The claimant sought a hearing. The referee denied that claim, but did so on the basis that he could not be sure that the original (accepted) injury had actually occurred. Because the claimant's theory of the etiology of the avascular necrosis was based on the assumption that his wrist had suffered the earlier trauma, his claim failed. As the referee summarized it,

> "The 'bottom line,' as far as I am concerned, is that since the weight of the evidence does not support a conclusion that the claimant experienced a specific injurious event in June, 1985, the weight of the medical evidence does not support a conclusion that the claimant sustained an injury at work that was a material contributing cause of his lunate bone necrosis. Accordingly, [the employer's] denial must be approved."

The claimant then sought review by the Board, arguing that to defeat his necrosis claim on the basis of disbelief in the existence of an earlier, accepted injury was the functional equivalent of a "back up denial" of the kind condemned by this Court in *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027

(1983). Rather than meet the merits of this contention, however, the Board took a left turn. It held, based on its earlier decision in *Ana M. Guerrero*, 39 Van Natta 1 (1987), that "[a]

partial denial of a previously accepted inseparable condition, issued while the claim is in open status, is not permissible." (Citations omitted.) Thus, it ruled, the employer's denial of responsibility for the avascular lunate necrosis would have to wait until the status of the claim changed. On that basis, it held that the claimant was entitled to benefits.

The employer then sought review in the Court of Appeals, which had in the meantime affirmed the Board's *Guerrero* doctrine, holding that "[a]n employer may not issue a partial denial of a previously accepted inseparable condition while the claim is still open." *Guerrero v. Stayton Canning Co.*, 92 Or App 209, 212, 757 P2d 873 (1988). As noted, the Court of Appeals affirmed the present case without opinion. *Boise Cascade Corp. v. Katzenbach*, 93 Or App 202, 761 P2d 554 (1988).

Both parties now argue to us — and we agree — that the *Guerrero* doctrine, whatever its merits,[1] has nothing to do with this case. No one authorized to do so has yet found that these two conditions are "inseparable." For all that appears in this record, the fight between the parties has always been over the etiology of the necrosis condition, with the referee taking the first unexpected turn when he chose to decide as a fact that the previously accepted injury had not occurred. The claimant appealed that determination to the Board and everything went downhill from there. The Board erred in deciding this case under the *Guerrero* doctrine instead of addressing the merits of the claimant's appeal under *Bauman v. SAIF, supra; Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987); and *Georgia Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988). The Court of Appeals erred in affirming the Board.

The decision of the Court of Appeals is reversed. The decision of the Workers' Compensation Board is reversed. The case is remanded to the Workers' Compensation Board for further proceedings consistent with this opinion.

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[1] Both parties are clear as to the merits of the *Guerrero* doctrine — they agree that it has none. It may be that, if the merits of the doctrine ever are before us, someone can offer a justification for it that thus far has escaped both counsel.

INDEX CONTENTS

OVERVIEW OF SUBJECT INDEX

JURISDICTION

LABOR LAW ISSUES

LUMP SUM
See PAYMENT

MEDICAL CAUSATION

MEDICAL OPINION

MEDICAL SERVICES

MEDICALLY STATIONARY

MEMORANDUM OPINIONS

NON-COMPLYING EMPLOYER
See COVERAGE QUESTIONS

NON-SUBJECT/SUBJECT WORKERS
See COVERAGE QUESTIONS

OCCUPATIONAL DISEASE CLAIMS (FILING)

OCCUPATIONAL DISEASE CLAIMS (PROCESSING)

OCCUPATIONAL DISEASE, CONDITION, OR INJURY

OFFSETS/OVERPAYMENTS

ORDER TO SHOW CAUSE
See REQUEST FOR HEARING (PRACTICE & PROCEDURE)

OVERPAYMENT
See OFFSETS

OWN MOTION RELIEF

PAYMENT

PENALTIES

PPD (GENERAL)

PPD (SCHEDULED)

PPD (UNSCHEDULED)

PERMANENT TOTAL DISABILITY

PREMATURE CLAIM CLOSURE
See DETERMINATION ORDER; MEDICALLY STATIONARY

PSYCHOLOGICAL CONDITIONS & CLAIMS

REMAND

REQUEST FOR HEARING (FILING)

REQUEST FOR HEARING (PRACTICE & PROCEDURE)

REQUEST FOR BOARD REVIEW (FILING)

REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE)

REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE, PROCEDURE)

RES JUDICATA

RESPONSIBILITY CASES
See SUCCESSIVE EMPLOYMENT EXPOSURES

SAFETY VIOLATIONS

SETTLEMENTS & STIPULATIONS

SUBJECT WORKERS
See COVERAGE QUESTIONS

SUCCESSIVE (OR MULTIPLE) EMPLOYMENT EXPOSURES

TEMPORARY TOTAL DISABILITY

THIRD PARTY CLAIMS

TIME LIMITATIONS
See AGGRAVATION CLAIM; CLAIMS, FILING; REQUEST FOR HEARING (FILING); REQUEST FOR BOARD REVIEW (FILING); REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE, PROCEDURE)

TORT ACTION

VOCATIONAL REHABILITATION

CITATIONS TO COURT CASES

CITATIONS TO COURT CASES

CITATIONS TO COURT CASES

CITATIONS TO COURT CASES

CITATIONS TO COURT CASES

CITATIONS TO COURT CASES

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REFERENCES TO CASES IN VAN NATTA'S

REFERENCES TO CASES IN VAN NATTA'S

REFERENCES TO CASES IN VAN NATTA'S

REFERENCES TO CASES IN VAN NATTA'S

CITATIONS TO OREGON REVISED STATUTES

ADMINISTRATIVE RULE CITATIONS

LARSON CITATIONS

OREGON RULES OF CIVIL PROCEDURE CITATIONS

OREGON EVIDENCE CODE CITATIONS

The following Memorandum Opinions are not published in this reporter. These decisions may be ordered from the Workers' Compensation Board using the numbers provided.

MEMORANDUM OPINIONS 1989

Name, WCB Number (Month/Year)

Abou-Jamous, Ahmed, 86-17937 (3/89)
Baker, Lonny J., 86-12029 (2/89)
Baker, Steven C., 87-05886 (3/89)
Bates, Stanley D., 86-17395 etc. (2/89)
Brickner, William T., 86-12777 (3/89)
Brown, Etta M., 86-08491 (3/89)
Brundidge, Clen A., 86-09372 (3,3/89)
Castro, Stewart, 87-11003 (3/89)
Chavez, Rudolfo, 86-10990 (3,3/89)
Cortez, Eric G., 87-03293 (3/89)
David, (n/a), 87-06862 (2/89)
Dobyns, Kathleen M., 87-03976 (3/89)
Doran, Ron A., 87-09785 (3/89)
Downey, John L., 86-17785 (3/89)
Dupree, Derland A., 85-10471 (3/89)
Garrison, Ken, 87-09021 (2/89)
Gill, William R., 86-10065 (3/89)
Graham, Lisa L., 87-07478 (1/89)
Grimes, Rebecca J., 87-12892 (1/89)
Hall, Patricia N., 87-09563 (1/89)
Hargand, Charles H., 87-00715 etc. (3/89)
Hill, Ronald, 87-07745 (3/89)
Johnson, Mark A., 87-02654 (2/89)
Johnson, William D., 87-08530 etc. (3/89)
Krussell, Robert L., 87-16931 (2,3/89)
Lacy, George L., 86-09432 (1/89)
Lombardi, Linda L., 86-11315 (2/89)
Mapes, Robert L., 87-04038 (1/89)
McMillion, Joan R., 85-01540 (2/89)
Mills, Rosemary, 87-01919 (2/89)
Nicholson, Randy L., 86-01438 etc. (1/89)
Pelto, Gene M., 87-04397 (3,3/89)
Phibbs, Ross S., 87-07311 (3/89)
Plemmons, Loreen H., 87-15554 (3/89)
Quindt, Charleene L., 88-07988 (1/89)
Robertson, Audrey A., 87-11417 (1/89)
Shuttlesworth, Larry D., 87-01710 (3/89)
Sorrels, Michael A., 87-15688 (1/89)
Stark, Susan K., 86-05043 (3/89)
Stevenson, Barbara J., 87-14606 etc.(3/89)
Sundstrom, Leland R., 86-14782 (3/89)
Surface, Leland S., 87-01765 (2/89)
Sutton, Donna J., 86-16464 (3/89)
Teague, Webster J., 85-06785 (3/89)
Thompson, Jerome S., 87-01681 (2/89)
Whitlow, David L., 86-14624 (2/89)
Wilder, William D., 84-11216 (3/89)
Wilding, Debbie A., 87-00184 (2/89)
Wilkerson, Barbara J., 86-07372 (1/89)
Wright, Gary D., 86-11840 (3/89)

The following orders under the Board's Own Motion Jurisdiction are not published in this reporter. They may be ordered from the Workers' Compensation Board using the numbers provided.

OWN MOTION JURISDICTION 1989

Name, WCB Number (Month/Year)

Adams, Wanda J., 88-0825M (3/89)
Aderton, Francis, 89-0110M (3/89)
Akers, Ronald, 89-0116M (3/89)
Allen, William, 88-0726M (1/89)
Armstrong, Ruth, 88-0803M (1/89)
Arnold, Charles, 89-0078M (3/89)
Ashworth, Flora L., 87-0297M (3/89)
Baker, Anthony, 89-0071M (2/89)
Barber, Vivian, 88-0209M (2/89)
Beebe, Fred, 88-0821M (1/89)
Bell, Allen, 89-0149M (3/89)
Bielenberg, Darline M., 89-0010M (1/89)
Boyd, Danny L., 87-0142M (3/89)
Braddock, Frank H., 89-0011M (2/89)
Briley, Carroll, 88-0799M (1/89)
Broadbent, Kenneth, 89-0044M (2/89)
Brown, Donie, 89-0134M (3/89)
Brown, Patrick B., 88-0016M (3/89)
Buchanan, Clark W., 86-0412M (3/89)
Burch, Dwane M., 86-0585M (3/89)
Burgess, Edward, 89-0017M (3/89)
Carmien, James, 88-0333M (3/89)
Catto, Dale, 89-0105M (3/89)
Chase, Sharon, 88-0777M (3/89)
Christiansen, Daniel, 89-0089M (2/89)
Christopher, Ohman E., 87-0746M (2/89)
Clancy, Patrick, 87-0348M (3/89)
Clayton, Linda, 89-0003M (3/89)
Cook, Maureen, 89-0096M (3/89)
Coonrod, Kenneth L., 89-0050M (2/89)
Cooper, David, 88-0684M (1/89)
Couch, Billie D., 87-0322M (3/89)
Crenshaw, Carl, 88-0816M (1/89)
Cruzan, Herbert D., 88-0658M (3/89)
Cutler, Gary L., 89-0039M (2/89)
Daley, Warren, 89-0135M (3/89)
Dalton, Robert W., 88-0085M (1/89)
David Hernandez, Isabel, 88-0071M (1/89)
Davidson, Richard, 85-0612M (1/89)
Dawson, Dennis L., 88-0812M (2/89)
Deal, Joann M., 87-0355M (3/89)
Dearmond, Gayford, 87-0475M (3/89)
Denny, Carol, 88-0766M (3/89)
Derby, Richard, 89-0051M (2/89)
Diebel, Daniel, 88-0544M (3/89)
Diemer, Anita, 89-0101M (3/89)
Dilley, Patrick, 89-0033M (2/89)
Dixon, Marlene, 88-0828M (1/89)
Eagleton, Beulah M., 89-0002M (1/89)
Ellis, Gary, 89-0025M (1/89)
Ellis-Phillips, Jodey, 88-0796M (1/89)
Emmert, Marvin E., 89-0128M (3/89)
English, James C., 88-0641M (2/89)
Erickson, Lillian, 87-0329M (3/89)
Eyman, Ronald L., 88-0114M (3/89)
Ferber, Gwynn, 86-0417M (1/89)
Fincher, Delores J., 89-0131M (3/89)
Flannery, Leonard K., 89-0155M (3/89)
Forrester, Harry, 88-0814M (3/89)
Fouts, Leonard C., 88-0775M (3/89)
Fowler, Leroy R., 89-0016M (1/89)
Fraser, Brian P., 89-0015M (1/89)
Freed, John P., 88-0463M (3/89)
Fuller, Virginia, 89-0111M (3/89)
Gandy, Kenneth, 89-0079M (3/89)
Getman, Gary A., 86-0681M (3/89)
Gibbs, Frank L., 86-0002M (3/89)
Glenn, Lester, 88-0561M (2/89)
Good, David, 88-0408M (1/89)
Graham, Robert, 88-0783M (3/89)
Gregg (Freeman), Laurie, 87-0180M (3/89)
Griffith, Vernon, 89-0139M (3/89)
Hamilton, Harold, 88-0806M (1/89)
Harper, Betty L., 87-0763M (2/89)
Hatfield, Wilma, 87-0573M (2/89)
Hawkins, Floyd, 83-0382M (3/89)
Hembree, Donald E., 89-0014M (1/89)
Henry, John, 88-0823M (2/89)
Hershey, Thomas E., Sr., 89-0062M (2/89)
Hicks, Mitchell, 88-0705M (1/89)
Higgins, James, 88-0752M (1/89)
Hinson, Gayle, 88-0730M (1/89)
Hodges, Charles V., Jr., 88-0785M (1/89)
Holst, Albert S., 87-0530M (1/89)
Hookland, Richard, 89-0073M (2/89)
Howard, Richard, 89-0074M (2/89)
Howell, Donald, 88-0357M (3/89)
Hunt, Clifford E., 89-0130M (3/89)
Huntsucker, Clifford, 89-0102M (3/89)
Hyde, James, 84-0419M (3/89)
Irwin, Robert, 89-0008M (2/89)
Jackson, Donald, 89-0036M (3/89)
Jacobson, Bert N., 85-0648M (3/89)
Johnson, Betty Lue, 88-0311M (3/89)
Johnson, Harry, 88-0822M (2/89)
Johnston, Sheila, 89-0072M (2/89)
Jones, Margaret, 89-0032M (1/89)
Joseph, Elaine, 87-0740M (1/89)
Judkins, David, 88-0395M (3/89)
Justen, Terry, 88-0207M (3/89)
Kartak, Michael, 88-0656M (3/89)
Kennedy, Richard, 89-0113M (3/89)
King, Janice M., 89-0136M (3/89)
King, Judith, 89-0068M (3/89)
King, Walter F., 89-0117M (3/89)
King, William R., 89-0012M (1/89)

OWN MOTION JURISDICTION 1989

Name, WCB Number (Month/Year)

Kingsland, Alfred, 89-0099M (3/89)
Kitchin, Ronald, 88-0810M (3/89)
Knapp, Gerald, 88-0672M (2/89)
Knodel, Carol, 89-0065M (2/89)
Kosel, Lucie Mae, 88-0532M (1/89)
Krening, Jack E., 89-0083M (3/89)
Lakey, Conrad, 89-0055M (2/89)
Larsen, Teri L., 88-0780M (2/89)
Larsen, Teri L., 88-0780M (3/89)
Lee, Robert E., 89-0094M (3/89)
Lemons, Kim, 89-0120M (3/89)
Leslie, Paul E., 87-0715M (2/89)
Liverman, Jack, 88-0490M (3/89)
Logan, Richard, 85-0591M (3/89)
Lotfi, Fred, 89-0023M (3/89)
Love, William, 89-0054M (2/89)
Magoulas, Jim F., 89-0027M (2/89)
Mangun-Wolverton, Beverly, 88-0147M (1/89)
Marchuk, James M., 88-0673M (1/89)
Marsh, Jackquline, 89-0022M (2/89)
Martin, David, 84-0207M (1/89)
Martin, Elson, 88-0152M (1/89)
Maugh, Floyd, 89-0137M (3/89)
Maupin, Eddy V., 87-0122M (1/89)
May, Ronald L., 88-0589M (1/89)
McFall, Dora, 88-0453M (1/89)
McMullen, John M., 88-0216M (1/89)
McPherson, John C., 89-0123M (3,3/89)
McRae, Billy, 88-0768M (3/89)
McSwain, Malcolm, 88-0614M (1/89)
Meadows, Betty, 89-0059M (2/89)
Meyers, Robert J., 89-0121M (3/89)
Michael, Vernon, 89-0075M (2/89)
Millsap, Lawrence E., 88-0606M (1/89)
Moore, Daniel P., 89-0013M (1/89)
Moore, Jack D., 86-0609M (3/89)
Morgan, Owen B., 88-0795M (1/89)
Morris, Arthur, 89-0063M (2/89)
Mueller, Barbara, 88-0596M (1/89)
Neal, James, 88-0137M (3/89)
Nemec, Phillip, 89-0092M (3/89)
Newman, Sarah L., 87-0584M (3/89)
Nicks, Edward, 89-0053M (2/89)
North, Michael, 88-0794M (1/89)
Norvald, Gene H., 88-0817M (1/89)
Ougheltree, Marie, 89-0097M (3/89)
Owens, Linda D., 88-0685M (2/89)
Pacheco, Williadeane, 88-0585M (1/89)
Padilla, Victor, 88-0725M (1/89)
Parks, Duke, 88-0181M (3/89)
Peacock, James, 87-0062M (2/89)
Pendergrass, David, 88-0827M (1/89)
Persinger, Christopher, 88-0793M (1/89)
Philippi, Wesley, 89-0056M (2/89)
Phillips, Brian C., 89-0006M (1/89)
Phillips, Roger, 89-0034M (2/89)
Poague, Robert, 88-0129M (1/89)
Pool, Naomi, 88-0762M (1/89)
Powers, Roland, 88-0247M (3/89)
Price, David, 86-0422M (3/89)
Price, Ricky J. (3/89)
Privatsky, Norman P., 89-0086M (3/89)
Punneo, Claude Dean, 89-0114M (3/89)
Puttie, Steven, 88-0791M (2/89)
Pyle, Henry, 89-0141M (3/89)
Ramirez, Ricardo, 89-0119M (3/89)
Rard, John P., 89-0100M (3/89)
Ray, Sally, 89-0142M (3/89)
Reinertsen, Judith, 89-0127M (3/89)
Richards, Stanley L., 88-0798M (1/89)
Rictor, Donald A., 86-0244M (2/89)
Riley, John B., Sr., 87-0751M (1/89)
Roberts, Bruce, 88-0815M (1/89)
Roberts, Donald, 88-0529M (1/89)
Robertson, Robert, 89-0019M (2/89)
Rodriguez, Guadalupe, 89-0118M (3/89)
Ross, Larry G., 89-0126M (3/89)
Rumpel, Billie, 88-0754M (2/89)
Runey, Stevan, 89-0057M (2/89)
Sabey, Jimmy, 88-0813M (1/89)
Sanchez, Enrique M., 84-0435M (3/89)
Schmidt, Marlene G., 89-0173M (3/89)
Self, Ira, 88-0577M (3/89)
Sevey, Gene, 89-0004M (1/89)
Sharman, Donald R., 88-0778M (3/89)
Sherman, Harvey L., 88-0566M (3/89)
Sherratt, Pamela L., 88-0526M (3/89)
Shiffer, John, 88-0782M (3/89)
Silvers, Orlan, 86-0608M (2/89)
Simmons, Roy D., 87-0696M (2/89)
Simnitt, Nancy S., 86-0052M (3/89)
Slayton, Ellen, 88-0519M (1/89)
Slinger, Edward, 89-0148M (3/89)
Smith, Christine, 89-0091M (3/89)
Smith, Evelyn, 89-0133M (3/89)
Smith, Willard, 87-0537M (1/89)
Smouse, Judy, 89-0087M (3/89)
Southworth, Everett, 88-0502M (3/89)
Spence, Paul E., 87-0373M (1/89)
Spencer, Robert R., 89-0104M (3/89)
Spivey, Harvey F., 85-0615M (3/89)
Stenzel, Ronald, 89-0098M (3/89)
Stephens, William, 88-0820M (1/89)
Sterba, Gary, 89-0067M (2/89)
Stibik, David, 88-0081M (2/89)
Stockebrand, Keith L., 88-0432M (3/89)
Strauss, Steven J., 89-0122M (3/89)
Swanberg, Betty J., 83-0281M (3/89)
Sweeney, Kathy A., 87-0571M (3/89)
Tarpley, Gary, 89-0132M (3/89)
Thissell, John, Sr., 88-0727M (3/89)
Thrasher, Ronald W., 86-0696M (3/89)

OWN MOTION JURISDICTION 1989

Name, WCB Number (Month/Year)

Thurston, Lewis, 87-0686M (3/89)
Tila, Raimo, 89-0018M (1/89)
Tilton-Kidd, Doris, 88-0166M (3/89)
Timpy, Charles, 84-0530M (3/89)
Trollope, Stephen W., 88-0146M (3/89)
Turchy, Frank, 88-0037M (3/89)
Tuttle, David, 88-0746M (1/89)
Ultsch, Bruce, 89-0093M (3/89)
VanBurger, Earl D., 87-0520M (3/89)
Vance, Robert E., 86-0260M (3/89)
Vanderpool, William, 88-0811M (1/89)
Vanzant, Timothy R., 88-0631M (3/89)
Vatland, Milnar, 87-0603M (3/89)
Waddell, Ralph, 89-0160M (3/89)
Wainwright, Charles, 88-0548M (1/89)
Wall, Robert N., 89-0124M (3/89)
Walsh, Marjorie R., 85-0680M (3/89)
Warf, Steven, 88-0231M (3/89)
Webb, Andy, 88-0144M (1/89)
Webber, Richard, 88-0571M (3/89)
Westfall, Marion, 88-0819M (1/89)
Whitaker, Gloria, 89-0125M (3/89)
Wigle, Joseph, 88-0588M (1/89)
Wigle, Joseph, 88-0588M (2/89)
Wilbanks, Danny, 88-0649M (3/89)
Williams, Arbra, 88-0743M (2/89)
Wilson, David, 89-0042M (2/89)
Windom, Walter, 89-0088M (3/89)
Wood, Joan M., 89-0061M (2/89)
Woolridge, Michael, 87-0577M (3/89)
Yakes, Audrey, 88-0765M (1/89)
Young, Gail, 89-0020M (1/89)

The following orders issued by the Workers' Compensation Board are not published in this volume. While they contain more information than Memorandum Opinions, they were judged to have no precedental value. Copies may be obtained from VAN NATTA'S for a small charge.

UNPUBLISHED ORDERS 1989

Claimant, WCB Number(s) (Date issued)

Baker, Kenneth C., 87-14577 & 87-00325 (3/7/89)
Buckle, Jerry V., 86-00040 (2/23/89)
Clark, Ronald L., 87-06342 (3/31/89)
Dilworth, Jerry D., 86-16967 (2/9/89)
Edens, Glen L., 84-07667, 82-09893, 82-09894 etc. (3/14/89)
Fisher, Delmar E., 86-03939 (3/28/89)
Francoeur, Idalee E., 86-09705 (3/8/89)
Hayhurst, Landy J., 86-10957 (3/8/89)
Jaeger, Jon D., 87-04158 & 87-02703 (2/23/89)
Johnson, Robert W., 87-13077 (2/3/89 & 2/22/89)
Kaeo, Cornel D., 87-06274 (2/16/89 & 3/20/89)
Kemhus, Evelyn E., 86-15806 (2/23/89)
Krueger, Harriett, 87-02876 (1/5/89)
Marshall, Arlene, 86-06142 (3/14/89)
McArthur, William L., 86-05236 & 86-06051 (3/2/89)
Meredith, Patricia A., 86-17614 (3/8/89)
Mills, Donald R., 87-02797 (2/23/89)
Munch-Kearl, Peggy S., 86-01897 (2/24/89 & 3/16/89)
Napier, Steven K., 86-13032 (2/23/89)
Partridge, Edward H., 86-16459 (2/13/89)
Purdy, Rhonda E., 86-00412 (3/16/89)
Rogers, Kenneth d., 87-08313 & 87-08964 (3/28/89)
Schwarz, Denise K., 86-16364 (2/24/89)
Sherman, William L., 87-11797 & 87-14074 (3/23/89)
Shields, William T., 87-03693 & 87-03692 (1/5/89)
Shuler, Susan E., 86-16034 (2/23/89)
Thompson, Ernest E., 85-07828 (3/8/89 & 3/16/89)
Trafton, Leonard F., 86-13723 (3/2/89)
Turner, Ronald J., 87-04630 (2/23/89 & 3/13/89)
Vick, Linda, 86-15972 (2/24/89)
Walsh, Marie C., 86-17420 (3/8/89 & 3/20/89)
Wells, Fred E., 87-02021 & 87-08754 (3/2/89 & 3/23/89)
Wilcox, Shirley A., 87-09028, 87-04362 & 87-13607 (3/8/89)
Williams, Mary E., 87-00078 (1/5/89)

CLAIMANT INDEX 1989

Claimant (WCB Number and/or Court Number)--------page(s)

Claimant (WCB Number and/or Court Number)--------page(s)

Claimant (WCB Number and/or Court Number)--------page(s)

Claimant (WCB Number and/or Court Number)--------page(s)

Claimant (WCB Number and/or Court Number)--------page(s)

CLAIMANT INDEX 1989

Claimant (WCB Number and/or Court Number)--------page(s)