

VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 43

(Pages 2265-END)

This volume is a compilation of Orders of the Oregon Workers' Compensation Board and decisions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law.

Owing to space considerations, this volume omits Orders issued by the Workers' Compensation Board that are judged to be of no precedential value.

OCTOBER-DECEMBER 1991

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PRINTED ON RECYCLED PAPER

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CITE AS

43 Van Natta ____ (1991)

In the Matter of the Compensation of
RANDI E. MORRIS, Claimant
WCB Case No. C1-01811
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Howser & Munsell, Claimant Attorneys
SAIF Legal Department, Defense Attorney

Reviewed by Board Members Moller and Neidig.

On August 27, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

ORS 656.236(1) permits parties, by agreement, to make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 436-60-005(9) (Emphasis added). See also OAR 438-09-001(1).

Here, the accepted claims are "acute cervical/dorsal strain" (claim no. 4855111D), and "rotator cuff L shoulder" (claim no. 7036515D). In addition to releasing claimant's rights and the SAIF Corporation's obligations under the accepted claims, the agreement also purports to dispose of the following matters:

- (1) A denied cervical, lumbar, thoracic strain (claim no. 7089516A);
- (2) A denied thoracolumbar, trapezius, cervical strain (claim no. 7101360K);
- (3) A generalized overuse problem, diagnosed as myofascial syndrome, involving the neck, both shoulders, upper back, cervical, thoracic, and lumbar spine, right arm, right sacroiliac joint, and right trapezius.

The agreement further provides that the aforementioned claims, both accepted and denied, will be combined under one claim number, 4855111D. The accepted condition in claim no. 4855111D shall be amended to read "myofascial syndrome and strain involving the cervical/dorsal-thoracic/lumbar spine, and bilateral shoulders." The other claims (7036515D, 7089516A, and 7101360K) will be "administratively 'killed and combined' with the Claim No. 4855111D upon the approval of this Claims Disposition Agreement." Moreover, the agreement states that all outstanding medical billings will be processed for payment under claim number 4855111D. Consequently, claimant shall be held harmless for any medical billings arising out of the above claim numbers. See CDA p. 3, ll. 5-11 and 22-24; p. 4, l. 1.

The function of a claim disposition agreement is to dispose of an accepted claim, with the exception of medical services, as the claim exists at the time the Board received the CDA. See ORS 656.236(1). It is not the function of a claim disposition agreement to accomplish claim processing functions under ORS 656.262 or otherwise resolve compensability issues. There are other procedural avenues available to the parties to accomplish these objectives, such as stipulations and disputed claim settlements. See Frederick M. Peterson, 43 Van Natta 1067 (1991). Here, however, the agreement attempts to dispose of several denied claims. Although the parties do not represent that claimant's myofascial syndrome is in denied status, we assume that the compensability of this condition

is in dispute between the parties, and therefore, treat it as if it was in denied status.

The Director's rules state that a claim disposition agreement concerns an accepted claim. OAR 436-60-005(9). Claims that are in denied status cannot be considered "accepted." Inasmuch as the agreement attempts to dispose of denied claims, the claim disposition agreement impermissibly exceeds the bounds of OAR 438-09-020(1)(b). Therefore, we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). See Frederick M. Peterson, supra.

We note that the parties have attempted to convert and consolidate the denied claims into one accepted claim, apparently to bring them within the purview of the CDA process as well as to more efficiently administer claimant's claim. We decline to approve such an arrangement. We note that the parties have made the "acceptance" of these denied claims contingent on Board approval of the claim disposition agreement. See CDA p. 3, ll. 10-11. In the past we have declined to approve agreements that are subject to the occurrence of a future uncertain event. See James J. Trembl, 42 Van Natta 2594 (1990); Raymond E. Clonkey, 43 Van Natta 1778 (1991). Thus, because acceptance of these claims is contingent upon approval of the claim disposition agreement, we do not find there has been an acceptance of the denied claims.

Inasmuch as the disposition is predicated on SAIF's acceptance of the denied claims, and the offensive portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we conclude that we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, SAIF shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

October 1, 1991

Cite as 43 Van Natta 2266 (1991)

In the Matter of the Compensation of

DUANE H. BURIAN, Claimant

Own Motion No. 91-0138M

OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Malagon, et al., Claimant Attorneys

Claimant requests review of the self-insured employer's August 8, 1991, Notice of Closure which closed his claim with an award of temporary disability benefits for periods between February 14, 1991 and July 23, 1991. The self-insured employer declared claimant medically stationary as of July 24, 1991.

Claimant contends that his disability of February 14, 1991, should have been processed as a new injury or occupational disease claim and requests the Board to "take jurisdiction" over this Notice of Closure, but defer action until the self-insured employer accepts or denies the new claim. Claimant raised no issues regarding improper closure. Consequently, there is no action to defer.

Accordingly, we decline to "take jurisdiction" over the closure in order to defer action and dismiss claimant's request for review of the self-insured employer's Notice of Closure.

Despite our dismissal of claimant's request, we nevertheless note that our own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights, Miltenerger v. Howard's Plumbing, 93 Or App 475 (1988), which includes claimant's March 20, 1991 own motion reopening. Our authority over this own motion matter does not preclude claimant from contending at a hearing that his current disability is a new injury or occupational disease and, as such, should be processed as a new claim. Should claimant do so and prevail, we shall withdraw our March 20, 1991 Own Motion Order and the self-insured employer will be allowed credit for benefits paid pursuant to our own motion authority.

IT IS SO ORDERED.

October 1, 1991

Cite as 43 Van Natta 2267 (1991)

In the Matter of the Compensation of
CAROL L. CONAWAY, Claimant
Own Motion No. 91-0275M
OWN MOTION ORDER
Cash R. Perrine, Claimant Attorney

The insurer has submitted to the Board claimant's claim for an alleged worsening of her May 10, 1982, industrial injury. Claimant's aggravation rights expired June 25, 1987. The insurer accepts responsibility for claimant's condition, but opposes reopening of her claim for the payment of temporary disability compensation, contending that she is not in the work force.

We may authorize, on our own motion, the payment of temporary disability compensation when 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, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

We are persuaded that claimant's compensable injury has worsened requiring surgery. However, claimant must also be in the work force to qualify for temporary disability compensation. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). The insurer contends that claimant is not in the work force because she was laid off from her previous job. We disagree. Dr. Newby's chart notes indicate that claimant's condition worsened in February 1991. Claimant was laid off from work in March 1991. Dr. Newby's chart note dated April 8, 1991, indicates, and the insurer does not dispute, that claimant has been receiving unemployment benefits from the State of California. The receipt of unemployment benefits is prima facie evidence that claimant is willing to work and is making reasonable efforts to obtain employment. See John T. Seiber, 43 Van Natta 136 (1991). There is no rebuttal evidence. Therefore, we find claimant is in the work force. See Dawkins v. Pacific Motor Trucking, supra.

Accordingly, claimant's claim is reopened with temporary disability benefits beginning the date she is hospitalized for the proposed surgery. The insurer shall continue paying temporary total disability benefits until one of the following events occurs: (1) claimant is medically stationary and claim is closed; (2) claimant returns to regular or modified work; (3) the attending physician gives claimant a written release to return to regular employment; or

(4) the attending physician gives claimant a written release to return to modified work, such employment is offered in writing to claimant and claimant fails to begin such employment. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed \$150, as a reasonable attorney 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.

October 1, 1991

Cite as 43 Van Natta 2268 (1991)

In the Matter of the Compensation of
GARY D. LUCKY, Claimant
Own Motion No. 91-0473M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST ON RECONSIDERATION
Hollander, et al., Claimant Attorneys
SAIF Legal Department, Defense Attorney

Claimant requests reconsideration of our August 26, 1991 Order Postponing Action on Own Motion Request. Claimant contends that the statement in the order that there is a pending request for hearing on the compensability of his current condition is erroneous. Claimant is correct. The pending hearing request concerns issues of premature closure, temporary disability compensation and penalties and attorney fees (WCB Case No. 91-06726). There is no indication that the SAIF Corporation issued a written denial of compensability.

We nevertheless received an Own Motion Recommendation Form from SAIF, based on claimant's May 9, 1991 psychiatric hospitalization, in which it recommends against claim reopening. In order to clarify our decision to postpone action in this case, we review its posture before us. Claimant's claim was reopened for authorized training in February 1987. While the claim remained in open status, we authorized the payment of temporary disability compensation under our own motion authority. SAIF closed the claim by Notice of Closure on May 10, 1991; however, we set aside the closure, directing that closure be made by Evaluation under ORS 656.268, which was accomplished by a July 11, 1991 Determination Order. It is this Determination Order that is presently before the Hearings Division (WCB Case No. 91-06726). Meanwhile, on June 12, 1991, SAIF received notice of claimant's psychiatric hospitalization in May 1991. It is that notice that is the subject of this own motion request for reopening.

The Board generally postpones action on own motion claims when potentially related issues are pending at hearing. See OAR 438-12-050(2). Here, if claimant prevails at hearing on the premature closure issue, the own motion matter will be moot. Accordingly, we will continue to postpone action until the pending litigation in WCB Case No 91-06726 is resolved at hearing. Thereafter, the Referee in that case shall submit a copy of his order to the Board and the parties shall advise us of their respective positions regarding own motion relief and penalties and attorney fees.

Claimant also contends that the SAIF Corporation has failed to comply with its discovery obligations since June 1991, including its failure to provide claimant's attorney with a copy of SAIF's Own Motion Recommendation Form. Claimant requests that we issue an order requiring SAIF to comply with discovery requirements and impose sanctions for its failure to do so.

Discovery issues relating to claimant's Request for Hearing (WCB Case No. 91-06726) are not within our jurisdiction and therefore must be addressed at

hearing. As for the own motion proceeding, a copy of any document in such a proceeding, including correspondence, directed to the Board is required to be simultaneously mailed to all other parties, or the party's attorney, involved in the claim. OAR 438-12-016. We accordingly direct SAIF to provide a copy of its Own Motion Recommendation form and supporting documentation to claimant's attorney. The issue of penalties and attorney fees for failure to provide documents relating to the own motion proceeding shall be deferred until the merits of claimant's own motion request for reopening are reviewed.

Accordingly, our August 26, 1991, order is abated and withdrawn. As supplemented and amended herein, we adhere to and republish our August 26, 1991 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

October 2, 1991

Cite as 43 Van Natta 2269 (1991)

In the Matter of the Compensation of

MAY L. CHAUSSEE, Claimant

WCB Case No. 90-05212

ORDER ON REVIEW

Westmoreland & Shebley, Claimant Attorneys

Rod Peters (Saif), Defense Attorney

Reviewed by Board Members Crider and Tenenbaum.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's partial denial of her claim for a myocardial infarction. On review, the issue is compensability.

We affirm and adopt the Referee's order with the following supplementation.

FINDINGS OF FACT

The compensable injury was not the major contributing cause of the myocardial infarction (MI).

CONCLUSIONS OF LAW AND OPINION

The Referee correctly applied the Workers' Compensation Act as amended by Oregon Laws 1990 (Special Session). Claimant requested a hearing after May 1, 1990; therefore, the "litigation savings clause" contained in Oregon Laws 1990, Chapter 2, Section 54(2) does not apply. Furthermore, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See Oregon Laws 1990, Chapter 2, Section 54(3). Finally, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee, in applying the 1990 amendments, analyzed this case under ORS 656.005(7)(a)(B), which provides:

"If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

We disagree with the Referee's analysis. Although there is evidence that claimant had coronary artery disease which preexisted the compensable injury, inasmuch as the disease did not impact the injured body part, we are not persuaded that the injury combined with the disease within the meaning of ORS 656.005(7)(a)(B). Rather, we are persuaded that this case is best analyzed under ORS 656.005(7)(a)(A):

"No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

Claimant argues that SAIF's partial denial of the MI on the basis that the injury was not a "material contributing cause" of the MI precludes SAIF from now asserting the "major contributing cause" test as claimant's burden of proof. That argument lacks merit. SAIF's partial denial, though citing the incorrect test, sufficiently notified claimant that it was denying the compensability of the MI. Claimant must establish her claim by the standard of proof assigned by law. An insurer's misstatement of the standard of proof does not change the law, nor does it relieve claimant of the burden of establishing her claim according to law.

The compensability of the MI claim presents a complex medical question; therefore, although claimant's testimony is probative, resolution of this issue turns largely on expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). The relevant medical evidence was generated by Drs. Poulson, Ironside, Sachdev and Baron. Poulson, orthopedic surgeon, and Ironside, pulmonary specialist, found no causal relationship between the compensable injury and the MI (Exs. 36, 39, 40). Drs. Baron and Sachdev found a causal relationship. Baron, cardiologist, opined that stress, anxiety and depression resulting from the compensable injury were "probable causes of the exacerbation of her coronary artery disease and her myocardial infarction" (Ex 43), while Sachdev, cardiovascular specialist, opined that if claimant was under stress due to the injury, "there could have been a possible worsening of her cardiovascular status giving her the heart attack" (Ex 41).

Because none of the physicians addressed the issue of whether the compensable injury was the major contributing cause of the MI, and because claimant has other risk factors for coronary disease including chronic cigarette smoking and family history for premature coronary artery disease, we conclude that claimant has failed to sustain her burden of proof.

ORDER

The Referee's order dated October 3, 1990, is affirmed.

In the Matter of the Compensation of
AMERICA N. MILANI, Claimant
WCB Case No. 90-17328
ORDER ON REVIEW
Myrick, Seagraves, et al., Claimant Attorneys
Howser & Munsell, Defense Attorneys

Reviewed by Board Members Crider and Tenenbaum.

The insurer requests review of those portions of Referee Mongrain's order that: (1) set aside its denial of claimant's injury claim; and (2) assessed a \$2,000 insurer-paid attorney fee for claimant's counsel's efforts in overturning the denial. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, this matter is properly analyzed under the Workers' Compensation Act as amended, effective July 1, 1990.

Turning to the merits of the claim, the Referee found that claimant's June 4, 1989 work-related injury was a material contributing cause of her disability and need for treatment. Therefore, he concluded that claimant had established a compensable injury claim and set aside the insurer's denial. We agree.

On review, the insurer first contends that, in order to establish a compensable injury, claimant must show that the work incident was the "major" contributing cause of her current condition under ORS 656.005(7)(a)(A). We disagree. That provision requires a higher standard of proof for consequential conditions of a compensable injury. See Julie K. Gasperino, 43 Van Natta 1151 (1991). It does not affect the standard of compensability for an initial industrial injury claim, which remains "material" contributing cause. Mark N. Weidel, 43 Van Natta 855 (1991).

The insurer next contends that claimant's present condition is not causally related to the June 4, 1989 work injury. It relies on the opinion of Dr. Weinman, who reported that he did not believe that claimant's current chest pains were related to her 1989 injury. (Ex. 15). However, that opinion is directly at odds with his prior report that the cause of claimant's impairment was the June 4, 1989 work incident. (Ex. 7-6). Because Dr. Weinman changed his opinion, and did not provide a reasonable explanation for doing so, we do not find his opinion persuasive. Somers v. SAIF, 77 Or App 259 (1986).

We rely on the opinion of Dr. Versteeg, who, after an examination and review of medical records, diagnosed claimant's condition as post-traumatic osteochondritis. (Ex. 16). He noted that claimant "has tenderness in the lower lumbar and lumbosacral area" and that "palpation shows tenderness over the sternal area," and concluded that "claimant's symptoms are definitely related to

the incident in June of 1989." (Ex. 16). Based on that report, we conclude that claimant has established, by medical evidence supported by objective findings, that she sustained a compensable injury that was a material contributing cause of her disability and need for treatment.

Attorney Fees

The insurer contends that the Referee erred in awarding claimant a \$2,000 assessed attorney fee for her counsel's efforts in overturning the denial. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable fee for claimant's counsel's services at hearing concerning the issue of compensability is \$2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

Attorney Fee on Board Review

Because the insurer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). Based on the same factors and similar considerations listed above, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$700, to be paid by the insurer. We further note that claimant is not entitled to an attorney fee for defending on the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 15, 1991 is affirmed. For services on Board review concerning the compensability issue, claimant's counsel is awarded \$700, to be paid by the insurer.

October 2, 1991

Cite as 43 Van Natta 2272 (1991)

In the Matter of the Compensation of
DARREN C. RESCH, Claimant
WCB Case No. 90-13222
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Harri's order that: (1) awarded additional temporary disability compensation; and (2) assessed a penalty and attorney fees for an allegedly unreasonable failure to pay that compensation. On review, the issues are temporary disability compensation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT," with the following supplementation. The hearing was convened on November 1, 1990.

FINDINGS OF ULTIMATE FACT

Claimant returned to regular work on November 27, 1989.

The insurer's termination of temporary disability payments when claimant returned to work was not unreasonable.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

The hearing in this case convened November 1, 1990. The Referee applied the law in effect prior to the 1990 amendments to the workers' compensation law. Or Laws 1990 (Special Session), SB 1197. The Referee reasoned that, even though the hearing had not convened before July 1, 1990, the insurer's obligation under the old law had already accrued. We disagree.

The hearing in this case convened after July 1, 1990. Therefore, the "litigation savings clause" contained in SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. Or Laws 1990, Ch. 2, Sect. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Rocky L. Coble, 43 Van Natta 1907 (1991); Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The 1990 amendments to ORS 656.268 authorize the insurer to unilaterally terminate temporary total disability when a claimant returns to or is released to regular work -- even when the claimant is not medically stationary. ORS 656.268(3)(a) and (b). Here, claimant returned to regular work on November 27, 1989. Consequently, claimant has no procedural/lawful right to temporary total disability benefits after that date. Although claimant was subsequently laid off from that employment, the termination was unrelated to his compensable injury. Claimant's release to regular work continued in effect. Thus, the insurer had no duty to recommence payment of temporary total disability benefits after claimant was laid off. ORS 656.268(3)(b). Accordingly, we reverse the Referee's award of temporary disability benefits.

Penalty and Attorney Fees

We reverse the Referee's assessment of a penalty and attorney fee for the insurer's allegedly unreasonable termination of temporary total disability benefits. For the reasons discussed above, claimant is not procedurally/legally entitled to the temporary disability benefits at issue. Thus, there are no amounts due against which to assess a penalty, and claimant is not entitled to an assessed attorney fee for resistance to the payment of compensation. ORS 656.262(10) and 656.382(1); Ellis v. McCall Insulation, 308 Or 74 (1989).

ORDER

The Referee's order dated January 17, 1991 is reversed. The out-of-compensation and penalty-related fees awarded to claimant's attorney are reversed.

In the Matter of the Compensation of
MARY A. SALAZAR, Claimant
And, in the Matter of the Complying Status of
JOSE V.C. MARTINEZ, dba THE BULL RING RESTAURANT, Employer
WCB Case No. 89-06316

ORDER ON REVIEW

Vick, et al., Claimant Attorneys
Wittrock & O'Brian, Attorneys
Shelley McIntyre (Saif), Defense Attorney

Reviewed by Board Members Crider and Tenenbaum.

The alleged noncomplying employer, Jose V. C. Martinez, requests review of Referee Daughtry's republished order that dismissed his request for hearing concerning the SAIF Corporation's acceptance, on his behalf, of claimant's injury claim. On review, the issue is dismissal. We reinstate the hearing request, but decline to award relief on the merits.

FINDINGS OF FACT

Claimant was employed by the employer as a server in a restaurant. During the month of March, she suffered onset of back pain. The pain caused her to require treatment. She consulted Dr. Gill, D. C., who diagnosed a strain. The strain was caused by claimant's work activities.

Claimant filed a claim seeking compensation for a work-related injury that allegedly occurred in March 1988, at the employer's restaurant. On August 12, 1988, the Compliance Division of the Workers' Compensation Department issued an order declaring the employer to be a noncomplying employer and referred the claim to the SAIF Corporation for processing. On October 10, 1988, SAIF accepted the claim and sent the employer a letter that stated, in part:

"A copy of the claim acceptance notice mailed to this injured worker is enclosed for your review. If you believe this worker did not sustain a compensable injury while in your employ, you have the right to request a hearing. Your request must be in writing and be directed to the:

"Workers' Compensation Board
480 Church Street S. E.
Salem, OR 97310"

In reliance on SAIF's letter, Mr. Martinez, unrepresented by counsel, requesting a hearing. He did not mail a copy of the request to claimant; however, claimant and her attorney appeared at, and participated in, the hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee did not reach the merits of the question of compensability. The Referee determined only that, because the employer had not sent claimant a notice advising her of her statutory hearing rights, the employer had never properly denied the claim and could not now contest its compensability. Accordingly, the Referee dismissed employer's request for hearing.

In reaching his conclusion, the Referee relied on our decision in Lucy Linn, 40 Van Natta 1232 (1988). In that case, a noncomplying employer disputed the compensability of a worker's injury claim and requested a hearing. Although the employer sent a copy of the letter to the worker, it did not advise her of her statutory hearing rights on a denied claim. Therefore, because the employer

had never properly denied the claim pursuant to ORS 656.262, we held that the employer could not now contest its compensability.

Subsequent to the Referee's original order in this case, the court reversed our decision in Lucy Linn. See Clark v. Linn, 98 Or App 393 (1989). The court held that whether the noncomplying employer properly denied the claim pursuant to ORS 656.262 was irrelevant, because its right to challenge compensability of the claim does not originate from ORS 656.262, but from ORS 656.283(1). Accordingly, it concluded that we had erred in failing to address the question of compensability.

In light of the court's decision, we conclude that this employer likewise was entitled to request a hearing on the question of the compensability of the claim accepted by SAIF and could contest the issue even though it had not denied the claim. Finding the record sufficiently developed for review, we proceed with our determination on the merits of the question of compensability.

There is no dispute that claimant sustained a low back injury in the Spring of 1988. Dr. Gill, claimant's treating chiropractor, diagnosed claimant's condition as lumbar and lumbosacral subluxations. The employer does not challenge that diagnosis. The question in this case is whether the injury arose out of and in the course and scope of her employment.

The only expert opinion on medical causation comes from Dr. Gill. He concluded that claimant's low back condition was a direct result of her work activities, which include standing, lifting and carrying. Based on that evidence, and in the absence of any contrary medical reports, we conclude that the injury is compensable.

At hearing, the employer argued that claimant failed to give him timely notice of her injury. After our review of the record, we agree that the employer did not receive notice of claimant's injury within 30 days of its occurrence. See ORS 656.265(5). However, the defense of untimely notice is available to the employer only when the delay in notice has prejudiced the employer. ORS 656.265(4). The employer bears the burden of proving prejudice. Argonaut Ins. Co. v. Mock, 95 Or App 1 (1989). In this case, there is no evidence that claimant's failure to give timely notice prejudiced the employer in any way. Consequently, claimant is entitled to pursue the claim.

As a final matter, we note that the employer, in its reply brief, raises for the first time the issue of claimant's entitlement to an assessed attorney fee for her counsel's services rendered at hearing. The issue was raised evidently in response to claimant's respondent's brief, which, among other things, requested that the then-unchallenged attorney fee be affirmed. Although requesting that the fee be affirmed, claimant has not had an opportunity to respond to the employer's argument. Accordingly, we decline to entertain the issue raised in the first instance in the employer's reply brief.

Because the employer initiated review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an attorney fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 30, 1990 is reversed. The alleged non-complying employer's request for hearing is reinstated. The SAIF Corporation's acceptance of claimant's injury claim is upheld. For services rendered on Board review, claimant's attorney is awarded an assessed fee of \$500, to be paid by the SAIF Corporation, on behalf of the noncomplying employer.

October 4, 1991

Cite as 43 Van Natta 2276 (1991)

In the Matter of the Compensation of
JAMES A. McCANNA, Claimant
WCB Case No. C1-01952
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Barnett, et al., Claimant Attorneys
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

On September 17, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Although the proposed disposition provides that claimant retains his right to medical services for the compensable injury, the agreement also states that "both parties stipulate and agree claimant's accepted conditions are currently medically stationary. Claimant's accepted SAIF claim shall be considered closed effective on the date this Claim Disposition Agreement is entered as a final order in this claim." (CDA, pg. 2, ll. 15-18). If claimant has been determined to be medically stationary by his treating physician or as established in accordance with OAR 436-60-035, claimant is limited to palliative care as governed by ORS 656.245(1)(b) and OAR 436-10-041.

Here, however, we do not know that to be the case. Claimant may or may not be medically stationary. Because claimant's medically stationary status is not susceptible to ready determination, we are unwilling to approve an agreement that recites that claimant's compensable conditions are in fact medically stationary. Because the above language could reasonably be interpreted as a partial release of claimant's statutory right to lifetime medical services, the agreement exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1), and is unreasonable as a matter of law. See ORS 656.236(2). See Keely K. Wilson, 43 Van Natta 1365 (1991); Sharon Watkins-Aubert, 42 Van Natta 2093 (1990).

We also note the agreement provided does not include the parties' original signatures. See OAR 438-09-025(1).

Accordingly, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, the SAIF Corporation shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

October 4, 1991

Cite as 43 Van Natta 2277 (1991)

In the Matter of the Compensation of
SUSAN E. VANDUSEN, Claimant
WCB Case No. 90-13331
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Miller, et al., Defense Attorneys

Claimant requests reconsideration of our September 6, 1991 Order on Review that modified a Referee's order by increasing claimant's total award of unscheduled permanent disability for a low back condition from 17 percent (54.4 degrees) to 36 percent (115.2 degrees). Specifically, claimant contends that her modified work falls within the medium to light category and further, that a value for a chronic condition limiting repetitive use should have been awarded. The self-insured employer also seeks reconsideration of that portion of our order which awarded claimant an impairment value for loss of range of motion in the hips.

Upon reconsideration, we continue to conclude that claimant's modified work falls within the category of medium. Claimant contends that there is no evidence of occasional lifting up to 50 pounds, and therefore, her modified work cannot fall within the category of medium. We do not agree that such a finding is necessary. Because claimant has returned to modified work, her adaptability value falls within the provisions of former OAR 436-35-310(3). However, former OAR 436-35-310(4) defines the categories and provides that, "(m)edium is defined as the ability to lift up to 50 pounds occasionally or up to 25 pounds frequently (emphasis added)." Former OAR 436-35-310(4)(b).

Here, claimant's modified work requires her to frequently lift from 20 to 25 pounds. Tr. 20, 92. Accordingly, claimant falls within the category of medium and it is not necessary to find that she is capable of lifting up to 50 pounds occasionally.

Claimant also contends that she is entitled to an impairment value for her chronic condition limiting repetitive use of her low back. Former OAR 436-35-320(4). The employer argues that claimant has not established entitlement to such an award, as she has merely cited to a medical report and has not cited specific support for a finding of a chronic condition. The employer also contends that claimant is not entitled to a value for her chronic condition because she has received an award in excess of 5 percent.

We agree that claimant is entitled to a value for her chronic condition. We note that the standards in effect at the time of the May 8, 1990 Determination Order do not preclude an award for a chronic condition even if claimant has unscheduled impairment equal to or in excess of 5 percent. See former OAR 436-35-320(4); Larry L. McDougal, 42 Van Natta 1544 (1990). Moreover, we conclude that the record establishes that claimant has a chronic condition which limits repetitive use of her low back.

Claimant testified that she was unable to perform her previous job of breaking down totes and lifting the totes and pallets. The Consultants also recommended that, among other things, claimant should restrict repetitive bend-

ing. The Consultants concluded that claimant's "current job description adequately provides those restrictions." Under the circumstances, we agree with the Referee that claimant is entitled to an award for her chronic condition limiting repetitive use of her low back.

We further agree with the Referee's conclusion that claimant has established a chronic condition independent of her non-compensable preexisting condition. Moreover, the parties do not dispute the Referee's conclusion that the 5 percent award should not be reduced by the 19 percent the Consultants attribute to claimant's preexisting condition. Therefore, we combine claimant's impairment value for loss of range of motion in the spine and hips (29) with the value for a chronic condition limiting repetitive use (5), for a total impairment value of 33 percent.

Finally, the employer contends that claimant has not established that her accepted injury resulted in impairment to her hips. We disagree. On June 28, 1988, claimant was seen by Dr. Nelson for complaints of back pain with radiation into the hips and thigh. In November 1988, claimant returned for a follow up on right hip and leg pain and was referred to Dr. Stanford for further assessment of her back pain.

In January 1989, Dr. Chester, M.D., reported claimant's symptoms were primarily those of a constant backache with occasional radiation into the buttocks. Claimant reported back and hip pain to her physical therapist in January 1989. In February 1990, the Consultants examined claimant and reported that hip rotation could not be performed. The Consultants diagnosed chronic low back pain and attributed 19 percent of her limitation of motion to her work.

We conclude that the record, as a whole, establishes that claimant has loss of range of motion in the hips which is due to the compensable injury. See Don O. Adams, 43 Van Natta 972 (1991). We, therefore, continue to conclude that claimant is entitled to an impairment value of 19 percent (the amount attributable to work, rather than to claimant's preexisting condition) of the total 24 percent impairment value for loss of range of motion in the hips.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to her education value, 6, the sum is 7. When that value is multiplied by claimant's adaptability value, 1, the product is 7. When that value is added to claimant's impairment value of 33, the result is 40 percent unscheduled permanent disability. Claimant's permanent disability under the "standards" is, therefore, 40 percent.

As a result of this order, claimant's permanent disability compensation has been increased from 36 percent to 40 percent. Claimant's attorney is awarded 25 percent of this increased compensation, payable directly to claimant's attorney by the self-insured employer. However, the total attorney fee awarded by the Referee and Board orders shall not exceed \$3,800.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, subject to the foregoing supplementation, we adhere to and republish our September 6, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of

DAVID G. GAINES, Claimant

WCB Case No. 91-06355

ORDER OF DISMISSAL

Westmoreland & Shebley, Claimant Attorneys

Daryl Nelson, Defense Attorney

The insurer requested review of Referee Thye's order which directed it to pay claimant's scheduled permanent disability award at the rate of \$305 per degree. The parties have submitted a proposed "Stipulation and Order," which is designed to resolve all issues raised or raisable in this matter. Specifically, the insurer agrees to pay claimant's scheduled permanent disability at a rate of \$305 rather than \$145 should "it be determined on final appeal that the applicable rate is \$305 per degree." Inasmuch as the parties refer to the Board's decision in Alan G. Herron, 43 Van Natta 1097 (1991) in a prior section of their agreement, it is our understanding that the insurer will pay claimant's scheduled permanent disability award at a rate of \$305 should a court holding to that effect in Herron become final.

Subject to the aforementioned understanding, we have approved the parties' agreement, thereby fully and finally resolving this matter. Accordingly, the request for review is dismissed with prejudice.

IT IS SO ORDERED.

October 7, 1991

Cite as 43 Van Natta 2279 (1991)

In the Matter of the Compensation of

WHYAT S. OCUMPAUGH, Claimant

Own Motion No. 91-0558M

OWN MOTION ORDER

Ackerman, et al., Claimant Attorneys

The self-insured employer has submitted to the Board claimant's claim for an alleged worsening of his June 17, 1981 industrial injury. Claimant's aggravation rights expired November 18, 1987. The self-insured employer has accepted responsibility for the proposed surgery and recommends that claimant's claim be reopened for the payment of temporary disability benefits.

We may authorize, on our own motion, the payment of temporary disability benefits when 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, we may authorize the payment of benefits from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

Medical evidence indicates that claimant's compensable injury to his right knee has worsened to the point that it requires arthroscopic surgery. Accordingly, we reopen claimant's claim for the provision of temporary disability compensation beginning the date he is hospitalized for the proposed surgery. The self-insured employer shall continue paying temporary total disability compensation until one of the following events occurs: (1) claimant is medically stationary and the claim is closed; (2) claimant returns to regular or modified work; (3) the attending physician gives claimant a written release to return to regular employment; or (4) the attending physician gives claimant a written release to return to modified work, such employment is offered in writing to claimant and claimant fails to begin such employment. 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.

We also note that claimant has another claim with the self-insured employer for a November 16, 1983 injury to his left knee, which is in open status (WCB Claim No. 83-01574). Claimant is not entitled to receive more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Therefore, when concurrent temporary disability is due the worker as a result of two or more claims, involving the same worker, the same employer and the same insurer, the insurer may make a pro rata distribution of compensation due under ORS 656.210 without an order by Compliance. The worker shall receive compensation at the highest temporary disability rate of the claims involved. ORS 436-60-020(8). Only if the higher rate is in the 1981 injury claim shall the insurer receive reimbursement from the Reopened Claims Reserve.

IT IS SO ORDERED.

October 7, 1991

Cite as 43 Van Natta 2280 (1991)

In the Matter of the Compensation of

TIMOTHY S. WAGGONER, Claimant

WCB Case No. 90-00014

ORDER DENYING RECONSIDERATION

Ainsworth, et al., Claimant Attorneys

Tom Dzieman (Saif), Defense Attorney

Claimant's former counsel has submitted a letter in response to that portion of our September 6, 1991 Order on Review which declined to resolve a question regarding the distribution of claimant's attorney fee between his former and current counsels. If the letter is intended as a motion for reconsideration it will not be considered as such because the letter fails to acknowledge that copies have been provided to the other parties to the proceeding. See OAR 438-05-046(2)(b). In any event, had we considered the letter as a motion for reconsideration, it would have been denied for the reasons previously stated in our prior order.

IT IS SO ORDERED.

October 8, 1991

Cite as 43 Van Natta 2280 (1991)

In the Matter of the Compensation of

JEAN M. BATES, Claimant

WCB Case No. 89-13041

ORDER ON REVIEW

Claudette L. Yost, Claimant Attorney

Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband, Crider and Neidig.

Claimant requests review of Referee Daron's order that: (1) upheld the insurer's denial of her occupational disease claim for mental stress; (2) declined to admit polygraph evidence; (3) declined to assess penalties and related attorney fees for an allegedly unreasonable failure to timely pay interim compensation; and (4) declined to assess penalties and related attorney fees for an

allegedly unreasonable denial. On review, the issues are compensability, evidence and penalties and related attorney fees. We affirm in part, and reverse in part.

FINDINGS OF FACT

Since 1986, claimant has been employed as a waitress. On August 23, 1988, she was promoted to head waitress, although the announcement of her appointment to the staff was not made until September 5, 1988. Because of her new position, claimant was required to work some Sundays with her male employer, whereas other employees were not required to be on the work premises.

In the late summer of 1988, claimant and her male employer had a brief, sexual affair, which involved a few sexual encounters occurring on the work premises after hours and on Sundays. Initially, claimant was a willing participant. However, by November 1988, she came to feel that she could no longer continue the relationship for reasons including the fact that she worked for and daily with the wife of her secret sexual partner. Therefore, on or around Thanksgiving, she informed her male employer that the relationship was at an end. However, he wanted to continue the relationship and often expressed that desire to her. He gave her gifts of an intimate nature and cards. She responded to his advances with letters in which she accused him of attempting to manipulate and dominate her, and in which she requested a relationship characterized by mutual respect. Her working relationship with both employers became increasingly strained.

Despite the increasingly strained working relationships, claimant was able to perform her duties until she began receiving harassing phone calls at home in the early morning between 1:00 a.m. and 5:00 a.m., around four times a week. On these occasions the caller would not speak, but after a brief period of time, would hang up the phone. Not knowing who was making the calls, and fearful, claimant reported the phone calls to the police who commenced an investigation in February 1989. In late February, the police placed a tap on claimant's phone, and thereby traced three calls to the employers' private home. These calls were made on March 2 at 3:06 a.m.; March 8 at 3:14 a.m.; and March 9 at 2:18 a.m. On March 20, 1989, both claimant and the employers were made aware of the calls' origin. Subsequent to the police investigation, claimant's relationship with both her employers deteriorated. Specifically, claimant's employers avoided her, and refused to direct her work effort or provide her with needed instructions to do her job as head waitress.

In March and April of 1989, psychotherapist Rhoades noted claimant's emotional reaction to the pending police investigation.

Subsequent to the police investigation, on March 29, 1989, claimant began receiving oral reprimands from her female employer.

On May 11, 1989, claimant received a letter of reprimand for an incident involving relations with customers.

On May 12, 1989, claimant sought treatment from her family physician, Dr. Bates, for emotional upset due to the harassing calls and the problems at work. Dr. Bates released claimant from work for four weeks due to her condition. Also on the same day, claimant sought further counseling from Rhoades, who also reported claimant's reaction to the above events.

On May 18, 1989, claimant filed a claim for mental stress. The insurer denied the claim on May 25, 1989.

Claimant returned to work on June 12, 1989. On June 26, 1989 she received a second letter of reprimand for failure to comply with instructions given by her female employer. After working approximately a week, claimant went on vacation.

On June 27, 1989, claimant saw a psychiatrist, Dr. Gardner, for an independent medical examination. He diagnosed "Adjustment Disorder with Mixed Emotional Features."

Rhoades referred claimant to Dr. Dixon, a psychiatrist. Claimant was seen and evaluated by Dr. Dixon on July 18 and again on August 14, 1989. Dr. Dixon also diagnosed claimant as having a "Adjustment Disorder with Mixed Emotional Features." He also found that claimant was unable to work.

Claimant filed another claim for mental stress on July 11, 1989. This claim was denied on July 24, 1989.

On July 25, 1989, Dr. Dixon took claimant off work. claimant did not return to work after that date.

Rhoades and Dr. Dixon referred claimant to Dr. Coutant, a clinical psychologist. Dr. Coutant saw claimant on September 18, 1989.

As of the date of hearing, claimant had not returned to work.

When other employees were reprimanded, reprimands were not done formally in writing as in claimant's case.

ULTIMATE FINDINGS OF FACT

Claimant's psychological condition arose out of and in the course of her employment resulting in disability and the need for medical treatment.

Claimant's psychological condition is generally recognized in the psychological community.

Employment conditions, which existed in a real and objective sense, were the major contributing cause of claimant's psychological condition.

The conditions which resulted in claimant's disabling psychological condition were not conditions generally inherent in every working situation; these conditions were not reasonable disciplinary, corrective or job performance evaluation actions; and were not associated with the cessation of employment.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

At hearing, claimant sought to offer the oral testimony of a polygraph examiner. Counsel for the insurer objected, and the Referee sustained the objection. Claimant then made an "offer of proof." Without the presence of the Referee, the witness testified that claimant had undergone a polygraph examination. Moreover, he testified as to claimant's responses to specific questions, and gave his assessment regarding claimant's truthfulness in regard to those answers. The evidence was offered for the sole purpose of supporting claimant's credibility, and was not offered for the truth of the matter asserted.

We therefore proceed to consider the admissibility of claimant's "offer of proof" for the purpose of supporting claimant's credibility. In State v. Brown, 297 Or 404 (1984), the Supreme Court held that, upon proper objection, polygraph

evidence shall not be admissible in any trial or proceeding subject to the rules of evidence under the Oregon Evidence Code. In State v. Lyons, 304 Or 221 (1987), the Court held that polygraph evidence shall not be admissible in such trials or proceedings even if stipulated to by the parties.

However, in Snow v. OSP, 308 Or 259 (1989), the Court held that in a proceeding before the Department of Corrections polygraph evidence for the purpose of supporting credibility would be admissible. In so holding, the Court recognized that no consensus had been reached about the reliability of polygraph evidence. The Court further noted that the concerns articulated in Brown for imposing "extraordinary strictures" on polygraph evidence were not present. The concerns included: the potential for undue delay; the potential for time consuming and confusing battles over the accuracy of the polygraph tests given in a particular case and over the qualifications and opinions of opposing experts; and the potential for misuse and over evaluation of polygraph evidence by the jury. Snow v. OSP, supra at 264, 267. The Court also noted that petitioner had requested the polygraph examination and did not object when the polygraph results were received into evidence at hearing.

In the consideration of evidence before the Workers' Compensation Board, we are not bound by the Oregon Evidence Code. Rather, the Board may conduct the hearing in any manner that will achieve substantial justice. See ORS 656.283(7). The basic evidentiary standard for admissibility is that evidence, excluding irrelevant, immaterial or unduly repetitious evidence, is of a type commonly relied upon by reasonably prudent persons in conduct of their serious affairs. See ORS 183.450(1).

Although we are not necessarily barred from admitting polygraph evidence, we note that in deciding Snow the Court considered the previously articulated Brown factors in finding polygraph evidence admissible. We find, with the exception of the potential for misuse and over evaluation of polygraph evidence by the jury, the Brown factors are applicable to our proceedings. We presume that Referees are familiar with the controversy concerning polygraph evidence and are not as likely as a jury to be overwhelmed by the results. However, the remainder of these potential problems can arise in the context of a workers' compensation proceeding. We find that such evidence must be excluded because its probative value is far outweighed by the reasons for its exclusion. Therefore, we conclude that polygraph evidence in workers' compensation proceedings is not admissible. In addition, we further note that unlike in Snow, the insurer in the present case objected to the presentation of polygraph evidence. Accordingly, we find that the polygraph evidence offered by claimant is not admissible.

Compensability

The Referee concluded that claimant's mental stress claim was not compensable. We disagree.

This claim is for an occupational disease. Claimant's last exposure to potentially causal employment conditions occurred after January 1, 1988. We therefore apply former ORS 656.802 as amended effective January 1, 1988, and before its amendment on July 1, 1990. In order to establish a compensable mental stress condition, claimant must prove by clear and convincing evidence that work related stressors, not otherwise excluded under former ORS 656.802(2), are the major contributing cause of the mental disorder. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991); Katherine E. Thrash, 43 Van Natta 846 (1991).

Pursuant to former ORS 656.802(1)(b) and (2), to prove a mental disorder, claimant must establish that: (1) she has a mental or emotional disorder which is generally recognized in the medical or psychological community; (2) she

required medical services or was disabled; (3) the mental disorder was due to employment conditions which were real and objective; (4) such employment conditions are not generally inherent in every working environment or reasonable disciplinary, corrective or job performance evaluation actions or were associated with the cessation of employment; and (5) the evidence is clear and convincing that the mental disorder arose out of and in the course of employment.

The Referee held that it was claimant's burden to demonstrate that work related "sexual harassment" was a material contributing cause of claimant's mental disorder. We disagree with the Referee's emphasis. Claimant was required to establish by clear and convincing evidence that work related stress was the major contributing cause of her psychological condition. In order to meet this burden claimant had to prove the elements of former ORS 656.802, as opposed to the elements of an unlawful employment practice charge of sex harassment brought under ORS 659.030.¹

We also reject the insurer's contention that by withdrawing her request for hearing on the July 24, 1989 denial, and proceeding to hearing on the May 25, 1989 denial, claimant confined herself to proof of a "sex harassment" case. Both the May 1989 denial and the July 1989 denial were for an occupational disease claim for stress. The July 1989 denial was a duplicate of the May 1989 denial, and was therefore surplusage. In that regard, the July 1989 denial itself indicated that a denial had already issued for claimant's claim. Accordingly, by withdrawing the request for hearing on the July 1989 denial, claimant is not barred from pursuing her mental stress claim, nor is she confined to arguing only the merits of a stress claim based on "sexual harassment" under civil rights law.

We proceed to the merits. The Referee found claimant to be not credible because of inconsistencies and inaccuracies in her testimony and because he found that she had certain "personal character deficiencies." The Referee did not describe claimant's so-called "character deficiencies" or explain the basis of that finding. Although the Board will ordinarily defer to a Referee's assessment of witness credibility based on witness demeanor, we are not bound by a Referee's unexplained assessment of a witness's personal character. In exercising de novo review we may make a credibility assessment based upon our evaluation of the substance of a witness's testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Upon review of the record, we are not impressed by the credibility of claimant or either of her employers. We are persuaded nevertheless, in light of the record as a whole, especially the unexplained telephone calls, that the events recited in our "Findings of Fact" did occur. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984); Cost Arvantis, 38 Van Natta 224, 225 (1986).

Claimant's condition is recognized in the medical or psychological community. In July and August 1989, claimant was referred by claimant's psychotherapist, Rhoades, to psychiatrist, Dr. Dixon. Upon examination and review of claimant's records, Dr. Dixon diagnosed claimant's condition as "Adjustment

¹ The Referee at the hearing, and even the parties on Board review, approached this case as they would a court trial under ORS 659.030 for "sex harassment." However, this is not a civil rights action. As further discussed below, the personal relationship between claimant and her male employer is relevant here only as it affected objectively claimant's employment conditions, and to the extent work related stress was the major contributing cause of claimant's psychological condition. Whether or not claimant has a viable sex harassment claim under ORS 659.030 is not a question before this Board.

Disorder with Mixed Emotional Features" (DSM III 309.28). On the other hand, a clinical psychologist, Dr. Coutant, referred by both Rhoades and Dixon, diagnosed claimant's condition as "Dysthymia" and "Generalized Anxiety Disorder." However, we find Dr. Dixon's well-reasoned opinion more persuasive than that of Dr. Coutant. In addition, Dr. Gardner, a psychiatrist who acted as an independent medical examiner in this matter, also diagnosed claimant's condition as "Adjustment Disorder with Mixed Emotional Features." Therefore, we find that claimant's condition, diagnosed as an adjustment disorder, is recognized in the psychological community.

Claimant's condition required treatment and resulted in disability. Since November 1988, claimant had been receiving treatment from psychotherapist Rhoades as part of a diversion program resulting from a drunk driving conviction. These counseling sessions involved claimant's drinking problem. However, shortly after the results of the police investigation were known to claimant, Rhoades' chart notes focused on claimant's strong emotional response to the police investigation. On May 12, 1989, a tearful and emotionally distraught claimant saw Dr. Bates, her family physician. He opined that claimant would be unable to work for four weeks due to her emotional condition. As a result, claimant did not return to work until June 12, 1989. Moreover, Dr. Dixon also opined that claimant was unable to work due to her condition. Dr. Coutant concluded that claimant's condition would require long term psychotherapy.

Claimant's need for treatment and disability is due to work related stress. Rhoades' chart notes, beginning March 14, 1989, reflect claimant's reaction to the revelation that her employer was responsible for the harassing phone calls she received. In addition, the chart notes show that after the police investigation, claimant was ostracized at work by her employers. In his letter of September 15, 1989, Rhoades opined that work related stress was responsible for "significant regressions" of an already emotionally fragile personality. Dr. Bates' chart notes also reflect that claimant's condition was due to work related stress resulting from harassing calls and the subsequent investigation. Finding claimant to be truthful, Dr. Dixon attributed claimant's condition to work related stress. She reported that after March 1989, job harassment escalated. Finally, Dr. Coutant opined that the harassing calls and subsequent harassment at work caused claimant's stress condition.

Based on the above, we conclude that the cause of claimant's disorder was the realization by claimant that the harassing calls were originating from her employers' residence. Up to this point claimant had been able to function at work. However, once she realized that she had been, in a sense, "betrayed" by someone she had trusted and relied on, she experienced tearfulness, depression, headaches and sleeplessness. Secondly, her work environment changed. From this point forward claimant's relationship with her employers at work deteriorated. Claimant was shunned at work by her employers who dealt with her in writing rather than in person. This causal relationship between the stress and work is supported by the record and the reports authored by Bates, Rhoades, Dixon and Coutant. Although these opinions did not explicitly state that work was the major contributing cause, their opinions did not identify any off-work stressors.

Noting that psychotherapist Rhoades, M.S., was not a licensed psychologist or physician, the Referee concluded that Rhoades was not qualified to be an expert witness. Accordingly, he rejected the opinion of Rhoades regarding the causal connection. However, we have previously held that it is not necessary to be licensed in order to provide an expert opinion on causal matters. See Ronald D. Robinson, 43 Van Natta 1058 (1991).

We do not find Dr. Gardner's opinion on causation persuasive. Although he did not find that claimant's relationship with her male employer was a source of

stress or work related disability, we find it significant that he did not discuss the clinical importance of the telephone calls, nor did he discuss the issue of harassment at work. Accordingly, we find that work related stressors were the major contributing cause of claimant's condition.

We also find that work related stressors existed in a real and objective sense. To the extent that the Referee held that claimant was required to prove real and objective stressors by clear and convincing evidence, we disagree. The clear and convincing standard of proof applies to the causal relationship issue. Claimant need only establish that her stressors existed in a real and objective sense by a preponderance of the evidence. See Katherine R. Johnson, 43 Van Natta 1369 (1991). Claimant has met this burden.

A primary stressor identified by the mental health professionals was the harassing telephone calls. Claimant testified she had received harassing telephone calls. The subsequent police investigation confirmed the truth of claimant's testimony by revealing the specific source of those calls. We do not find the explanation given by her employers for the calls credible. Although it may not be possible to identify which of her employers in fact made the calls, the evidence is sufficient to identify the calls as harassing and to establish that they were employer-generated.

Another stressor identified by the mental health professionals was the objective change in claimant's working conditions and environment after the police investigation. Claimant testified that her employers attempted to "freeze" her out. This testimony was corroborated by a co-worker, Shawnee Bowman. Claimant testified that as head waitress she had previously received daily briefings and instructions directly from her employers, and that she needed such information to perform her job. However, subsequent to the police investigation, claimant was required to get her job assignments from co-workers. In fact, corroboration was provided by the employers, who testified that after the police investigation, they distanced themselves from claimant, communicating with her only concerning business matters, only as the business absolutely required, and only in writing. We find that this evidence sufficiently establishes that this stressor existed in a real and objective sense.

We further find that the aforementioned stressful working conditions to which claimant was exposed are not generally inherent in every working situation. The Board has interpreted conditions which are "generally inherent in every working situation" to mean certain conditions which are usually present in all jobs and not merely the specific occupation involved. See Kathleen M. Payne, 42 Van Natta 1900, 1906, affirmed on recon 42 Van Natta 2059 (1990), rev'd on other grounds, City of Portland v. Payne, 108 Or App 771 (1991). Evidence concerning the generally inherent issue need not be direct, it may be circumstantial. Louis R. Orman, 43 Van Natta 226 (1991). Moreover, we have recently stated that the Board may use this agency's expertise to make findings that conditions to which claimant was subjected are not conditions usually present in all occupations. Leo G. Campbell, 43 Van Natta 1087 (1991).

We find harassing calls in the early morning hours by an employer are not generally inherent in every working situation. We are not aware of any occupation which would find acceptable the conduct described here. Moreover, after reviewing the testimony of claimant and other lay witnesses, we do not find that ostracizing or shunning an employee in a supervisory position, as here, is generally inherent in all occupations. In view of the Board's expertise in evaluating the evidence concerning claimant's employment conditions, we conclude that claimant's working conditions were other than conditions generally inherent in every working situation.

The medical reports of Drs. Dixon and Coutant, also place significance on the reprimands that claimant received in the spring of 1989. Claimant testified that after the police investigation she began receiving oral reprimands from her female employer. In addition, claimant received written reprimands on May 11, 1989, and June 26, 1989. These reprimands concerned specific incidents involving her work performance. From the record, it appears that there might have been some justification for the reprimands.

We do not consider the reprimands, however, to be reasonable disciplinary or corrective action. Claimant testified that prior to the police investigation she had not been disciplined for similar infractions. Secondly, we note that other employees, similarly situated, were not disciplined in this fashion. Thus, we conclude that the discipline imposed on claimant was not reasonable under the circumstances.

To establish compensability there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. To be clear and convincing, evidence must establish that the truth of the asserted fact is highly probable. Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). Claimant must prove by clear and convincing evidence that work related stressors, not otherwise excluded by statute, are the major contributing cause of the disorder. Based upon the totality of the evidence, we find it highly probable that the aforementioned stressors were the major contributing cause of claimant's psychological condition. Therefore, claimant's mental stress is compensable as an occupational disease.

Penalties and related attorney fees for an allegedly unreasonable failure to timely pay interim compensation

Claimant contends that she is entitled to penalties and related attorney fees for the insurer's allegedly unreasonable failure to timely pay interim compensation. The Referee did not address the issue at hearing. When an issue is not raised at hearing and the record is closed, that issue will not be subsequently considered. We have reasoned that to address an issue that was not raised at hearing would be fundamentally unfair. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Betty L. Robinson, 43 Van Natta 471 (1991).

Penalties and related attorney fees for an allegedly unreasonable denial

The Referee concluded that claimant was not entitled to a penalty and related attorney fee for an allegedly unreasonable denial. We agree. As long as the carrier has a legitimate doubt from a legal standpoint of its liability its conduct was not unreasonable. See Norgard v. Rawlings, 30 Or App 999, 1003 (1977). The medical evidence available to the insurer at the time of denial did not indicate that claimant's need for medical treatment was employment related. The insurer could have equally concluded that claimant's need for psychotherapy was related to other causal factors, *i.e.*, her substance abuse problem or a purely personal relationship gone sour. Thus, we find that the totality of the evidence in possession of the insurer at the time it issued the denial was sufficient to raise a legitimate doubt as to the compensability of the claim. Accordingly, we do not find that issuance of the insurer's denial was unreasonable.

Claimant has prevailed in a rejected case. Hence, she is entitled to an assessed fee. ORS 656.386(1). After considering claimant's statement of services, as well as the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$9,741.75, to be paid by the insurer. In reaching this conclusion, we have particularly

considered the time devoted to the case as represented by the lengthy hearing and the record as a whole, the significant complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 3, 1990 is affirmed in part and reversed in part. That portion of the order which upheld the insurer's denial is reversed. The denial is set aside and the claim is remanded to the insurer for processing in accordance with law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded an assessed fee of \$9,741.75, payable by the insurer.

Board Member Neidig dissenting:

I respectfully disagree with the majority's conclusion that claimant's stress condition is compensable. The harassing phone calls, which triggered claimant's condition, took place outside the work hours, and off the work premises; therefore I do not believe they are work related in a way that would give claimant a right to workers' compensation benefits.

It is not within the Worker's Compensation framework to award compensation for off-work sexual harassment merely because the perpetrator became acquainted with claimant at work. I believe claimant's remedies lie outside the Workers' Compensation system.

October 8, 1991

Cite as 43 Van Natta 2288 (1991)

In the Matter of the Compensation of
ROCKY L. COBLE, Claimant
WCB Case No. 90-10159
ORDER ON RECONSIDERATION
Vick & Gutzler, Claimant Attorneys
Allen Ludwick (Saif), Defense Attorney

Claimant requests reconsideration of our September 17, 1991 order that: (1) held that the SAIF Corporation was authorized to terminate claimant's temporary total disability benefits under amended ORS 656.268(3) on March 7, 1990; (2) found that claimant's claim had been prematurely closed; and (3) awarded claimant's attorney an out-of-compensation fee. Claimant contends that the former statute should apply to this case because application of the amended statute leads to an absurd result. In addition, claimant asserts entitlement to a carrier-paid attorney fee because SAIF requested review and the Board has effectively found that claimant's compensation should not be disallowed or reduced.

The SAIF Corporation also requests reconsideration, contending that: (1) the Board should not have addressed premature closure, because no party raised that issue; or (2) if premature closure was properly raised, no material improvement in claimant's condition was expected on the date of closure.

For the reasons set forth in our prior order, we continue to conclude that this case is subject to the 1990 amendments to the applicable statute. See also Bryan L. Dunn, 43 Van Natta 1673 (1991). (90 day period to issue a denial, as set forth in amended ORS 656.262(6), applied retroactively).

SAIF was the sole party to formally request review. Nonetheless, claimant argued in his appellate brief that he was not medically stationary when he was released to work and that there was further material improvement in his condi

tion. (Resp. Br. @ 2). Reasonably interpreted, that argument raised the premature claim closure issue. We can consider such informal requests for review, provided that a formal request for review has not been withdrawn. Eder v. Pilcher Construction, 89 Or App 425 (1988); Neely v. SAIF, 43 Or App 319, 323, rev den 288 Or 493 (1980); Jimmie Parkerson, 35 Van Natta 1247, 1250 (1983).

Because SAIF's formal request for review had not been withdrawn, we considered claimant's informal cross-request and concluded that the claim was prematurely closed. We note that claimant continued to improve with physical therapy, subsequent to his release to return to his regular work. (See Tr. 16-17). For this reason as well as the reasons stated in our prior order, we continue to conclude that claimant was not medically stationary when his claim was closed. Under these circumstances, we found claimant's attorney to be entitled to a fee payable from the increased compensation created by our order, not to exceed \$3,800. OAR 438-15-055(1).

However, we disagree with claimant's contention that he is entitled to a carrier-paid attorney fee for services on Board review. In this regard, we note that SAIF prevailed on that portion of its request for review which contended that the Referee erroneously awarded claimant temporary disability through April 7, 1991. We held that SAIF was authorized to terminate claimant's compensation on March 7, 1990. Inasmuch as the Referee had ordered SAIF to pay temporary disability compensation for April 6, 1990 and we reversed that portion of the Referee's order, claimant's compensation was reduced by our order. Because claimant's compensation was reduced by our order, claimant is not entitled to a carrier-paid attorney fee under ORS 656.382(2).

Accordingly, our September 17, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 17, 1991 order, including Member Crider's dissenting opinion, effective this date. The parties' rights of appeal shall begin from the date of this order.

IT IS SO ORDERED.

October 8, 1991

Cite as 43 Van Natta 2289 (1991)

In the Matter of the Compensation of
SUSIE A. FIMBRES, Claimant

WCB Case No. 90-16803

ORDER ON REVIEW

Black, Chapman & Webber, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Brown's order which set aside its partial denial of claimant's cervical spondylosis. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

In May 1987, claimant filed an 801 form making a claim for a stiff neck and left arm pain. In July 1987, the insurer accepted this claim as a nondisabling injury on the 801 form. Claimant's injury was initially diagnosed as a cervical/dorsal sprain/strain. Claimant continued to experience neck and left arm symptoms. In February 1989, claimant was seen by Dr. Corson for her continuing symptoms. At that time, Dr. Corson reported that claimant had cervical spondylosis which caused her ongoing symptoms.

On March 7, 1989, the insurer denied claimant's current cervical condition on the basis that it was unrelated to her compensable condition. In its denial letter, the insurer stated that it has recently received medical information indicating that claimant was suffering from cervical spondylosis. Claimant requested a hearing on the March 7, 1989 denial. On March 7, 1990, the insurer amended its March 7, 1989 denial to deny only responsibility for claimant's current cervical condition.

On June 20, 1990, the parties entered into a stipulation whereby the insurer rescinded its March 7, 1990 denial and reopened claimant's claim. On August 16, 1990, the insurer issued a denial that indicated that claimant's "current condition diagnosed as cervical spondylosis is unrelated to [claimant's] industrial injury of May 1, 1987."

On November 9, 1990, the insurer rescinded the August 16, 1990 denial and issued a new denial which stated in part:

"We have recently received information that you are seeking treatment and surgery for a degenerative neck condition, diagnosed as cervical spondylosis which you allege to be related to your injury of May 1, 1987. Medical evidence in your file indicates that your current degenerative condition, diagnosed as cervical spondylosis is unrelated to your industrial injury of May 1 1987 and, therefore, without waiving further questions of compensability, we submit this partial denial of your claim for benefits."

ULTIMATE FINDINGS OF FACT

We adopt the "Ultimate Findings of Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the insurer's denial was an improper "back-up" denial and therefore set it aside. We agree that the denial should be set aside; however, we do so on a different basis.

Under the res judicata doctrine of issue preclusion, 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. Drews v. EBI Companies, 310 Or 134, 139-40 (1990); North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Issues resolved by a stipulation and settlement are considered to be actually litigated and determined by a valid and final judgment within the meaning of the above rule. See International Paper Company v. Pearson, 106 Or 121 (1991).

In February 1989, Dr. Corson informed the insurer that claimant's symptoms were due to cervical spondylosis. Dr. Corson made no other diagnosis for claimant's cervical condition. On March 7, 1989, the insurer issued a denial of claimant's current cervical condition, which it indicated was cervical spondylosis, on the basis that it was unrelated to her compensable injury. Claimant requested a hearing on this denial. On March 7, 1990, the insurer amended its denial to deny only responsibility for claimant's cervical condition. On June 20, 1990, the parties entered into a stipulation and settlement in which the insurer agreed to rescind its denial and reopen claimant's claim in exchange for claimant agreeing to dismiss her hearing request.

The record establishes that claimant's current cervical spondylosis is the same condition the insurer accepted by the June 20, 1990 stipulation. Thus,

under the doctrine of issue preclusion, the June 1990 stipulation establishes as a matter of law that claimant's cervical spondylosis is compensably related to her 1987 industrial injury. Therefore, the insurer is precluded from subsequently denying claimant's cervical spondylosis on the basis that it is unrelated to the industrial injury. Inasmuch as the insurer's November 9, 1990 denial denies claimant's cervical spondylosis on that basis, it must be set aside under the res judicata doctrine of issue preclusion. See International Paper Company v. Pearson, supra; Dewey H. Gilkey, Sr., 43 Van Natta 1154, 1157 (1991).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 16, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$500, payable by the insurer.

October 8, 1991

Cite as 43 Van Natta 2291 (1991)

In the Matter of the Compensation of
PHILLIP E. HAGER, Claimant
Own Motion No. 91-0481M
OWN MOTION ORDER
Pozzi, et al., Claimant Attorneys

The insurer has submitted to the Board a request to reopen claimant's claim for the payment of temporary total disability compensation related to his March 17, 1982 industrial injury. Claimant's aggravation rights expired October 11, 1989. The insurer recommends against the payment of temporary total disability compensation on the ground that there was no worsening of claimant's compensable condition.

Once claimant's aggravation rights have expired, the Board may exercise its own motion authority to reopen a claim. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). This authority is limited to two situations: a) to provide temporary disability compensation; and b) to provide medical services related to injuries that occurred prior to 1966. ORS 656.278(1). We note that medical services related to injuries that occurred after 1966 are to be provided by the insurer or self-insured employer pursuant to ORS 656.245.

The Board may award additional temporary disability compensation only 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, we may authorize the payment of temporary disability compensation commencing at the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

For purposes of reopening under its own motion authority, the Board defines surgery as an invasive procedure which is undertaken for a curative purpose. See Fred E. Smith, 42 Van Natta 1538 (1990), and defines hospitalization as a nondiagnostic procedure that requires an overnight stay in a hospital or similar facility. See, e.g., Roger D. Jobe, 41 Van Natta 1506 (1989). On July

12, 1991, claimant was hospitalized for a cerebrofemoral arteriogram, a surgical procedure performed to evaluate the status of claimant's large cerebellar artery aneurism. This procedure revealed that the size of claimant's aneurism had not increased and no further surgery was recommended. Because the procedure and resulting hospitalization were for diagnostic, not curative, purposes, the Board declines to authorize the payment of temporary total disability compensation. Accordingly, we deny the request for own motion reopening.

Claimant's lifetime right to medical services under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

October 8, 1991

Cite as 43 Van Natta 2292 (1991)

In the Matter of the Compensation of

KAREN M. HOOPER, Claimant

WCB Case No. 90-20681

ORDER ON REVIEW

Dahn & Morrison, Claimant Attorneys

Schwabe et al., Defense Attorneys

Reviewed by Board Members Moller and Gunn.

The self-insured employer requests review of those portions of Referee Galton's order that: (1) set aside its back-up denial of claimant's claim for a low back injury; (2) assessed a penalty for an allegedly unreasonable denial; and (3) assessed a penalty-related attorney fee for an allegedly unreasonable denial. Claimant has requested that we remand this matter for admission of further evidence. On review, the issues are remand, compensability, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order.

FINDINGS OF ULTIMATE FACT

We adopt the "Findings of Ultimate Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant has moved for remand for the admission of evidence generated subsequent to the hearing. The evidence is a report and chartnotes from Dr. Fraback, rheumatologist, generated in May and June of 1991. We consider the proffered evidence solely for the purposes of deciding the motion to remand.

We may remand a case for further evidence if we determine that the case has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In addition, to merit remand for consideration of additional evidence, it must be clearly shown that the material evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Claimant contends that Dr. Fraback's report and chartnotes should be admitted because they refute Dr. Rosenbaum's suggestion that her symptoms were due

to rheumatoid arthritis. Dr. Rosenbaum's report was dated October 29, 1990, approximately two months prior to the hearing. Under these circumstances, we find that Dr. Fraback's report and chartnotes were obtainable, with due diligence, prior to the hearing. We also note that Dr. Fraback's report and chartnotes refer to claimant's condition in May 1991, whereas the issue here is whether claimant sustained a compensable injury in June 1990. Accordingly, claimant's request for remand is denied.

Compensability

We adopt the conclusions and reasoning concerning the employer's back-up denial as set forth in the "Compensability" section of the Referee's order with the following supplementation.

Dr. Rosenbaum, who saw claimant approximately 3-1/2 months after her injury, questioned whether her current symptoms were related to the injury. His opinion does not address the issue of whether claimant sustained a compensable injury in June 1990. Accordingly, we agree that his opinion is not persuasive.

Penalties

We adopt the conclusions and reasoning concerning the penalty issue as set forth in the "Unreasonableness" section of the Referee's order with the following supplementation.

Although claimant did not tell either Dr. Rosenbaum or Dr. Flemming of her previous low back symptoms, neither physician suggested that she had not sustained a compensable injury in June 1990. Rather, Dr. Rosenbaum, and to some extent Dr. Flemming, questioned whether her current symptoms were due to the compensable injury. Therefore, although the employer may have had a legitimate doubt as to its liability for claimant's current low back condition, it had no legitimate basis for doubting that claimant had sustained a compensable injury in June 1990. Accordingly, we agree with the Referee that the employer's denial was unreasonable.

Attorney Fees

The Referee found the employer's denial unreasonable and awarded claimant a penalty with one-half of the penalty payable to claimant's counsel under ORS 656.262(10). The Referee also awarded claimant's counsel a \$300 assessed attorney fee pursuant to ORS 656.382(1). The employer contends that claimant's counsel is not entitled to an assessed attorney fee pursuant to ORS 656.382(1). We agree.

Former ORS 656.262(10) authorized the assessment of an attorney fee under ORS 656.382(1) if a carrier unreasonably refuses to pay compensation. However, the legislature amended ORS 656.262(10) during its 1990 Special Session. See Or Laws 1990 (Special Session), Ch. 2, 15. In place of the language authorizing the assessment of an attorney fee under ORS 656.382(1), ORS 656.262(10)(a) provides that, if the worker is represented by an attorney, the attorney shall receive one-half the penalty "in lieu of an attorney fee."

Here, the factual basis asserted in support of the ORS 656.382(1) fee -- the employer's unreasonable denial -- is identical to the factual basis for which the Referee assessed a penalty under ORS 656.262(10)(a). Under such circumstances, the simultaneous assessment of an attorney fee under ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991). Accordingly, claimant is not entitled to a separate fee under ORS 656.382(1).

Attorney Fees/Board Review

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$750, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for defending the Referee's award of a penalty. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated February 15, 1991 is reversed in part and affirmed in part. That portion which awarded claimant's counsel a \$300 assessed attorney fee for the self-insured employer's unreasonable denial is reversed. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of \$750, payable by the self-insured employer.

October 8, 1991

Cite as 43 Van Natta 2294 (1991)

In the Matter of the Compensation of
RONALD F. THOMAS, Claimant
WCB Case No. 90-21178
ORDER ON REVIEW (REMANDING)
Saif Legal Department, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant, pro se, requests review of Referee Daron's order which dismissed his request for hearing. On review, the issue is dismissal. We remand.

FINDINGS OF FACT

On November 21, 1990, the Board received claimant's request for hearing. In his request for hearing, claimant indicated that he was not represented. On February 4, 1991, claimant's prior counsel wrote the Referee and advised that claimant was withdrawing his request for hearing. No executed retainer agreement between claimant and his prior counsel was submitted. On February 8, 1991, the Referee dismissed claimant's request for hearing on the basis that the request had been withdrawn.

On February 19, 1991, claimant requested review of the Referee's order.

FINDING OF ULTIMATE FACT

The record has been incompletely and insufficiently developed.

CONCLUSIONS OF LAW AND OPINION

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Here, the Referee evidently dismissed claimant's request for hearing on the basis of his prior counsel's letter. The record, however, does not contain a retainer agreement or other evidence indicating that claimant's prior counsel

was representing claimant in this matter. In fact, claimant's request for hearing indicated that he was not represented. Under such circumstances, we cannot determine whether claimant withdrew his hearing request. We, therefore, conclude that the record before us has been incompletely and insufficiently developed.

We, therefore, remand this matter to the Presiding Referee with instructions to assign this matter to a Referee to conduct further proceedings to determine whether claimant had withdrawn his request for hearing. If the Referee finds that claimant had withdrawn his request for hearing, a final order shall issue setting forth the Referee's reasoning. Should the Referee find that claimant's hearing request should not be dismissed, the matter shall proceed to hearing on the merits of the issues raised in claimant's hearing request and upon closure of the hearing record, the Referee's opinion and order shall issue.

ORDER

The Referee's order dated February 8, 1991 is vacated, and this matter is remanded to the Presiding Referee for further proceedings consistent with this order.

October 8, 1991

Cite as 43 Van Natta 2295 (1991)

In the Matter of the Compensation of
THOMAS T. TRAVER, Claimant
WCB Case No. TP-91017
THIRD PARTY DISTRIBUTION ORDER
Lindstedt, et al., Claimant Attorneys
J. David Thurber (Saif), Defense Attorney

Claimant has petitioned the Board for resolution of a dispute concerning the just and proper distribution of the proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute involves the distribution of the parties' respective shares of proceeds from a "structured settlement." We find that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

In July 1988, while performing his work activities as a highway inspector, claimant sustained a compensable injury when he was struck by a road grader at a construction project site. The SAIF Corporation, the workers' compensation insurer for claimant's employer, accepted the claim and has provided benefits. SAIF's lien for actual and projected claim costs total \$39,300.

Claimant engaged legal representation. He and his attorney entered into an "Attorney's Contingent Fee Agreement." The agreement provided that, in the event suit or action was filed, claimant's attorney would receive 33 1/3 percent of any amount collected.

Thereafter, claimant instituted a third party action against the general contractor who employed the operator of the road grader. In April 1991, prior to trial, claimant and the third party reached a settlement. The third party agreed to pay claimant \$136,800 by means of a \$30,000 lump sum payment, a \$20,000 payment on December 31, 1998, with the final installment (\$86,800) payable December 31, 2010. Claimant and the third party further proposed to distribute \$39,300 of this final installment to SAIF to satisfy its lien, with the remaining \$41,500 going to claimant. The cost of the bonded and guaranteed annuities to fund the installments was \$29,723.

On April 16, 1991, SAIF responded to the settlement. Noting that it was unwilling to wait 20 years to recover its lien, SAIF declined to accept the offer of settlement of claimant's third party action. As alternative methods of payment, SAIF suggested two options: (1) a statutory distribution of the cash payment and purchase price of the annuity; or (2) a distribution in which SAIF would receive 1/3 of the cash payment and 1/3 of 3 equal 5 year installments of the settlement.

On April 26, 1991, claimant's counsel sought reconsideration of SAIF's refusal. Reminding SAIF that there was "a good deal of dispute over both liability and damage," claimant's counsel explained that there was "a significant potential of resulting in a defense verdict." Relying upon the statutory distribution scheme concerning structured settlements, as interpreted by Breck D. Meyer, 42 Van Natta 659 (1990), Dick A. Cole, 40 Van Natta 1021 (1988), and Ralph W. Schemmel, 40 Van Natta 951 (1990), claimant's counsel contended that claimant's attorney fee and litigation costs would be paid first. Since those payments would eliminate all but approximately \$3,000 of the \$30,000 lump sum payment, claimant's counsel stated that the remainder of the lump sum payment as well as the 1998 \$20,000 installment would be provided to claimant as recovery for his statutory 1/3 share. Claimant's counsel concluded that full satisfaction of SAIF's \$39,300 lien would occur on December 31, 2018, when the final installment would be made. Claimant would recover the remaining \$47,500 of that final payment.

On May 15, 1991, in reply to claimant's counsel's letter, SAIF confirmed that it did not disagree with the \$136,800 settlement offer. However, contending that a 20-year delay in receiving reimbursement would create "an unjust and improper burden on the employer," SAIF objected to the proposed distribution scheme. Noting that the "present day dollar offer" equalled \$59,723 (\$30,000 lump sum payment + \$29,223 purchase price for annuities + \$500 bonding fee), SAIF suggested that this amount be distributed in accordance with the statutory distribution scheme. Alternatively, SAIF proposed that the \$30,000 be equally apportioned between claimant, his counsel, and SAIF, with the remaining portion of SAIF's lien payable in equal 5 year installments.

On May 20, 1991, claimant's counsel rejected SAIF's alternative distribution proposals. Asserting that SAIF's proposals conflicted with the distribution scheme as applied to structured settlements, claimant's counsel notified SAIF that it would petition the Board pursuant to ORS 656.593(3) to resolve the conflict over the "just and proper" distribution of settlement proceeds.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from the third person. The proceeds of any damages recovered from a third person by the worker or beneficiaries 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 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 scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd. Estate of Troy Vance v. Williams, supra. 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). However, the amount that the agency is "authorized to accept" from a third party settlement is less precise than the amount of its lien from damages recovered from a third party under ORS 656.593(1)(c): i.e., an amount which is "just and proper," as opposed to "its expenditures for compensation . . . and . . . the present value of its reasonably to be expected future expenditures for compensation." Estate of Troy Vance v. Williams, supra, 84 Or App at page 620.

The aforementioned statutes do not discuss the distribution of proceeds from a third party "structured" settlement. However, we have held that the "proceeds" of a third party settlement encompass not only immediate cash payments, but also annuity payments payable over a period of years. See Dick A. Cole, supra; Ralph W. Schemmel, supra. In reaching our conclusion, we reasoned that such annuity payments do not alter the fundamental principle that the payments are "proceeds" from a third party recovery and, as such, should be distributed in accordance with the schedule set forth in ORS 656.593(1).

Here, in accordance with the aforementioned reasoning, we hold that the "total proceeds" of the structured settlement are comprised of the initial lump sum payment plus the annuity payments. We further conclude that these proceeds should be distributed in accordance with the statutory schedule. Pursuant to that schedule, incurred litigation costs and attorney fees shall initially be paid, followed by the worker's statutory one-third share of the remaining balance. See ORS 656.593(1)(a), (b). The paying agency's lien applies only after the aforementioned shares have been disbursed. See ORS 656.593(3); 656.593(1)(c).

SAIF is mindful of the Board's prior holdings concerning a just and proper distribution of proceeds in third party structured settlements. However, SAIF objects to such a proposed distribution, contending that under such a schedule it would not be until December 31, 2010 when claimant would fully recoup his statutory 1/3 portion of the recovery and when SAIF's lien would be satisfied.

Considering such circumstances, SAIF urges the Board to adopt a distribution which allocates the settlement proceeds "in a more reasonable manner." Specifically, SAIF suggests that claimant, his attorney, and SAIF receive portions of each installment in a manner that will permit each party to eventually receive their full share of the third party recovery. In effect, SAIF is proposing that the initial cash payment for the third party settlement and the forthcoming installments be pro-rated. We rejected such an approach in Schemmel and Cole, reasoning that the statutory distribution scheme to apportion those "total proceeds" in accordance with ORS 656.593(1) is clear and precise.

We appreciate SAIF's concern that its inability to recover its share of the recovery will have a negative impact on the premium rates for its insured. We further acknowledge SAIF's argument that the legislature could not have expected a result in which claimant and the paying agency do not recover their respective shares of a settlement for a number of years. Yet, SAIF neither refers to any legislative history supporting its contention nor are we aware of any. Moreover, although two legislative sessions have been convened since the Schemmel/Cole holdings, the statutory distribution scheme has remained unaltered.

Given such circumstances, we are not prepared to disavow our previous holdings concerning the distribution of proceeds from structured settlements. As with all of our decisions regarding third party distribution disputes, these holdings are designed to provide a consistent and ascertainable basis for resolving questions concerning the allocation of proceeds from a third party recovery. Such an approach is traditionally taken to avoid making "equitable distributions on an ad hoc basis and to permit the parties to generally know where they stand as they seek to settle a third party action." See Marvin Thornton, 34 Van Natta 999, 1002 (1982). After considering this matter, we find no persuasive reason to depart from our longstanding approach.

Finally, SAIF also expresses the concern that the investment income from the annuity, rather than the cost of the annuity itself, is actually a portion of the "total proceeds" from the third party settlement. Moreover, it raises the specter that the entity providing the annuity could go bankrupt, thereby foreclosing claimant and SAIF from recovering all or any portion of their respective shares. To permit claimant's attorney to receive his share of the recovery based on funds which do not belong to claimant and may never be received by any of the parties, SAIF argues is "patently unfair."

We do not share SAIF's concerns regarding the eventual recovery of settlement proceeds and annuity payments. To begin, the annuity has been bonded and guaranteed. Thus, the likelihood of claimant (or his beneficiaries) and SAIF failing to fully recover their respective shares is extremely remote. Admittedly, Schemmel does suggest that the cost of the annuity is included in determining the total proceeds of a third party recovery. However, Schemmel involved monthly annuities over the life of the claimant, while here the annuity is funded to distribute two separate installments at 7 and 19 year intervals from the date of the settlement. Thus, the gross value of the present third party settlement is readily ascertainable, i.e., the initial lump sum and two subsequent installments.

Accordingly, claimant's attorney is directed to distribute the "total proceeds" of the third party settlement in accordance with ORS 656.593(1)(a), (b), and (c). The "total proceeds" shall be comprised of the \$30,000 initial lump sum, the \$20,000 second installment, and the \$86,800 third installment; i.e., a total of \$136,800.

The total proceeds shall be allocated to the following individuals and entities in the amounts described below:

Settlement (Total Proceeds)	\$136,800
Attorney Fee (1/3)	<u>45,600</u>
Subtotal	\$ 91,200
Claimant's Share (1/3)	<u>30,400</u>
Subtotal	\$ 60,800
SAIF's Lien	<u>39,300</u>
Remainder to Claimant	\$ 21,500

In accordance with the Schemmel/Cole rationale, the proceeds from this structured third party settlement shall be distributed in the following manner. Claimant's attorney shall receive the entire \$30,000 lump sum payment as partial payment of his \$45,600 attorney fee. Claimant's attorney shall also receive the first \$15,600 of the December 31, 1998 \$20,000 payment. Claimant shall receive the remaining \$4,400 of the \$20,000 payment as partial payment on his statutory 1/3 share (\$30,400). Claimant shall receive the first \$26,000 of the December 31, 2010 \$86,800 payment. Thereafter, SAIF shall receive the next \$39,300 of that payment as reimbursement for its lien. Finally, claimant shall receive the remaining \$21,500.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA A. WEST, Claimant
WCB Case No. 90-16599
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Bethlahmy's order which: (1) increased her award of unscheduled permanent disability for a low back injury from 24 percent (76.8 degrees), as awarded by Determination Order, to 28 percent (89.6 degrees); and (2) awarded her 6 percent (8.1 degrees) scheduled permanent disability for loss of use or function of the right foot, whereas a Determination Order had not awarded any scheduled permanent disability. On review, the issue is extent of scheduled and unscheduled permanent disability.

We affirm and adopt the order of the Referee with the following comment.

After the briefs were filed, the insurer submitted a supplemental memorandum of authorities. Claimant objects to this submission. Supplemental briefs are generally not allowed; however, parties may submit supplemental authorities advising of recent changes in the law that are relevant to the decision. See Betty L. Juneau, 38 Van Natta 553 (1986). Here, the insurer cites to a recent court decision relevant to the issues at hand. Accordingly, we allow the insurer's submission, but consider it only to the extent that it advises us of a recent development in the law.

ORDER

The Referee's order dated January 29, 1991 is affirmed.

In the Matter of the Compensation of
DONALD A. WILLIAMS, Claimant
WCB Case No. 89-17142
SECOND ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Claimant has requested abatement of our September 12, 1991 Second Order on Reconsideration, which adhered to and republished our July 30, 1991 Order on Reconsideration that had denied remand, and reinstated and upheld the insurer's August 28, 1989 denial of an occupational disease claim. Representing that the parties have now settled their dispute, claimant seeks abatement of our order to permit the parties an opportunity to prepare their settlement agreement and submit the agreement for Board consideration.

In light of this un rebutted representation, the Board withdraws its September 12, 1991 order to await the submission of the parties' written agreement. Upon receipt of the proposed settlement, the Board will proceed with its review of the agreement. In the meantime, the parties are requested to keep the Board apprised of any further developments in this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
GAVINO CHAVEZ, Claimant
WCB Case No. 89-15443
ORDER ON REVIEW
Quintin Estell, Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband and Crider.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) found the SAIF Corporation had correctly calculated claimant's rate of temporary total disability (TTD) benefits; and (2) declined to assess a penalty and penalty-related attorney fee for SAIF's allegedly incorrect calculation of claimant's TTD benefits. On review, the issues are rate of temporary disability benefits, and penalty and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own with the following supplementation. Claimant was hired at the end of the hops training season to train hops.

FINDINGS OF ULTIMATE FACT

Claimant was hired to work for three days. Claimant was hired to work eight hours a day, rain excepting.

CONCLUSIONS OF LAW AND OPINION

Rate of Temporary Total Disability Compensation

The Referee concluded that SAIF correctly calculated claimant's temporary disability compensation based on his status as a three-day a week, seven-hour a day worker.

We affirm and adopt that portion of the Referee's reasoning and conclusion that found no individual working for the insured had either apparent or actual authority to bind the insured to a contract of hire, and supplement with the following.

On review, claimant contends that he is entitled to a higher rate of temporary total disability for two reasons. First, he contends that he is entitled to temporary disability compensation based on a five to six-day workweek, rather than a three-day workweek. Second, he contends that he is entitled to temporary disability compensation based on an eight-hour workday, rather than a seven-hour workday. We agree with claimant's second contention only.

Five to Six-Day Workweek

ORS 656.210 provides that a regularly employed worker whose compensation is based solely on daily wages shall be entitled to temporary disability compensation based on the number of days in his or her workweek. For workers not regularly employed, the rate of compensation is computed by the wages determined in accordance with former OAR 436-60-020(7). We are not persuaded that claimant was "regularly" employed on a five to six-day a week basis.

Ms. Annen, a corporate officer for the insured, testified that claimant was hired to work for three days. Specifically, claimant was hired to complete the hops training in "Fuch's" field. A review of the record reveals that

claimant was hired at the end of the hops training season. Claimant, along with the rest of the hops training crew, worked eight hours on Monday; performed no work on Tuesday due to rain; worked eight hours on Wednesday; and worked only five hours on Thursday, again due to rain. The crew completed the remainder of Thursday's work in Fuch's field on Friday. Claimant did not work on Friday as he was compensably injured on Thursday.

Consequently, as the work claimant was hired to perform was completed within three working days of his date of hire, we find claimant was hired to work for three days, rather than five to six days a week.

Eight-Hour Workday

We are persuaded, however, that while claimant was only employed to work three days, he was employed to work eight hours a day. Mr. Annen, the hiring agent and a corporate officer for the insured, testified that laborers worked eight hours a day, unless rain shortened the workday. Claimant worked two eight-hour days and, due to rain, one half day prior to his compensable injury.

Therefore, claimant's TTD rate should be computed based on his employment eight hours a day, three days a week. Accordingly, SAIF is directed to recalculate claimant's rate of TTD under the rule.

Penalties and Attorney Fees

Penalties and attorney fees may be assessed for an employer's unreasonable refusal to pay compensation. Former ORS 656.262(10); ORS 656.382(1). The Referee concluded that claimant was not entitled to penalties and attorney fees because he failed to establish his entitlement to temporary disability compensation in excess of that paid by SAIF. We disagree.

The employer's agent, Mr. Annen, testified that laborers worked eight hours a day unless the work day was shortened by rain. The employer was aware that, prior to his injury, claimant worked two eight-hour days. Because the employer's knowledge of claimant's work hours is imputed to the carrier, see Nix v. SAIF, 80 Or App 656 (1986); Keith L. Nutting, 43 Van Natta 183 (1991), we conclude that, in calculating claimant's temporary disability benefits on a seven-hour workday, SAIF acted unreasonably and resisted the payment of compensation. Therefore, claimant is entitled to a penalty and assessed attorney fee.

We assess a penalty of 25 percent of the increased compensation created by this order. In addition, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services regarding the penalty issue is \$500. In reaching this conclusion, we have particularly considered the value of the interest involved.

ORDER

The Referee's order dated May 16, 1990 is reversed. That portion of the Referee's order that found that the SAIF Corporation had correctly calculated claimant's rate of temporary disability benefits is reversed. The claim is remanded to SAIF to recalculate claimant's rate of temporary disability benefits in accordance with this order. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's counsel by SAIF. However, the total out-of-compensation fee paid under the Referee and Board orders shall not exceed \$3,800. That portion of the Referee's order that declined to award a penalty is also reversed. SAIF shall pay to claimant a penalty equal to 25 percent of the additional temporary disability

benefits due as a result of this order. For services regarding the penalty issue, claimant's counsel is awarded a fee of \$500, payable by SAIF.

Board Member Crider dissenting:

Claimant was hired to work six days per week, eight hours per day as long as the work lasted, rain permitting. Claimant was so advised by the employer's agent. I conclude that the intent at the time of hire was that claimant would work a six-day week. TTD should be calculated on that basis, not on the basis of the hindsight employed by the majority. Former OAR 436-60-020(7). For that reason, I dissent from that portion of the order that directs TTD to be calculated based on a three-day work week.

October 9, 1991

Cite as 43 Van Natta 2302 (1991)

In the Matter of the Compensation of
ALEXANDER J. DOMBROWSKI, Claimant
WCB Case No. 90-06056
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Crider and Tenenbaum.

Claimant requests review of that portion of Referee Holtan's order that upheld the SAIF Corporation's denial of his occupational disease claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT," with the following supplementation.

Claimant's employment was not the major contributing cause of his psychological condition.

CONCLUSIONS OF LAW AND OPINION

Because the hearing request was filed before May 1, 1990, and the hearing was convened before July 1, 1990, we analyze this case under the workers' compensation law in effect before the 1990 amendments. See Or Laws 1990 (Special Session), Ch. 2, 54(2). On review, claimant contends that he established a compensable mental disorder under former ORS 656.802. We disagree.

Relying on our opinion in Ellen L. Crawford, 41 Van Natta 1267 (1989), the Referee stated that, in order to prove a compensable mental disorder under former ORS 656.802, claimant must prove that his employment was a material cause of his psychological condition. However, the Court of Appeals has since held, in Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991), that the contributing causation standard under former ORS 656.802(1) is "major" rather than "material." Furthermore, claimant must satisfy that "major contributing cause" standard by clear and convincing evidence. See former ORS 656.802(2)(d).

Reviewing the record under the "major contributing cause" standard, we agree with the Referee's ultimate conclusion that claimant has not sustained his burden of proof. Dr. Cookson is the only expert who addresses the major causation standard; he opines that claimant's work-related stress was the major contributing cause of the onset of his disability and need for treatment (Ex 14). However, Cookson's opinion is based on incomplete history. He is unaware of

other non-work-related stressors which could have contributed to claimant's condition, including the loss of his rental home, uncertain living arrangements and financial difficulties. Cookson's opinion is discounted accordingly. See Somers v. SAIF, 77 Or App 259, 263 (1986); Ronald M. Lyday, 42 Van Natta 2692, 2694 (1990).

Mr. Fairman identifies claimant's uncertainty about his job as the "major issue" of his life (Ex 12). However, Fairman does not indicate whether job-related stress was the major cause of claimant's psychological problems, nor does he discuss the impact of other non-work-related stressors on claimant's condition.

We conclude that Dr. Turco's opinion is better reasoned (Ex 11). He opines that claimant does not have a diagnosable psychological disorder but is suffering from a preexisting personality trait disturbance. He also discusses many non-work-related stressors which could be contributing to claimant's condition. Based on our review of the medical record, we do not find that claimant has proven by clear and convincing evidence that his employment was the major contributing cause of his psychological condition. We conclude that claimant has not established a compensable mental disorder under former ORS 656.802.

ORDER

The Referee's order dated August 24, 1990, is affirmed.

October 9, 1991

Cite as 43 Van Natta 2303 (1991)

In the Matter of the Compensation of
GARRY C. DOYLE, Claimant
WCB Case No. 90-05017
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Crider and Tenenbaum.

Claimant requests review of Referee Thye's order that: (1) upheld the self-insured employer's denial of claimant's current low back condition; (2) upheld the employer's denial of claimant's medical services claim for weight loss treatment; and (3) affirmed a Determination Order award of no permanent partial disability for claimant's back injury. On review, the issues are compensability, medical services and extent of permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, a 34 year old laborer, compensably injured his low back on April 30, 1989, when he and three coworkers attempted to unload a heavy canvas tent from a truck. He sought treatment from Dr. Walker, N.D., who noted low back and hip pain and diagnosed acute lumbar strain. He released claimant to regular work on May 15, 1989. Claimant returned to work for employer sporadically.

Claimant treated with Dr. Walker again on July 21, 1989, and sought no further treatment until September 19, 1989, when he treated for a mild exacerbation of his back condition. The exacerbation resolved; on October 4, 1989, Dr. Walker declared claimant medically stationary without permanent impairment. Claimant's claim was closed by a November 17, 1989 Determination Order with an award of temporary disability through May 14, 1989, but no permanent disability.

Claimant sought no further treatment until February 9, 1990, at which time he consulted Dr. Lisook, D.O., for a sudden increase in low back pain and numbness radiating into both legs. The symptoms came on after he tightened straps on a truck he was operating while self-employed. He was referred to Dr. Baum, an orthopedist, who found that claimant had gained about 100 pounds since his compensable injury and prescribed a specific weight loss program.

On July 2, 1990, the employer issued a denial of claimant's current condition, asserting that it "did not arise out of and in the course and scope of your employment with Barrett Business Services nor is it related compensably to your April 10, 1989 injury." (Ex. 24). In the same document, the employer also denied claimant's request for a weight loss program, alleging that it was not compensably related to his accepted condition.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Compensability--Low Back Condition

It is unclear from the record whether claimant is simply asserting a medical services claim for his current condition or whether, in fact, he contends that he has sustained a compensable aggravation of his compensable low back condition. We need not resolve that question, however, given our conclusion that claimant had fully recovered prior to February 1990 and that the April 1989 compensable injury played no role in his current low back disability and need for treatment.

The primary medical evidence in this case comes from Dr. Lisook and Dr. Baum. Dr. Lisook, an osteopathic physician, concluded that claimant had sustained a new injury in February 1990. He based his opinion on the fact that claimant had not sought treatment for low back pain for approximately four months prior to the February incident and that the incident caused a sudden increase in pain. He also relied on the fact that the February incident caused an onset of bilateral radicular leg pain, a symptom that had not previously been present. (Ex. 22).

Dr. Baum, an orthopedic surgeon, initially attributed claimant's current condition to the April 30, 1989 compensable injury. That opinion, however, was based on an inaccurate history provided by claimant. Upon obtaining an accurate history, Dr. Baum retracted his earlier opinion and also concluded that claimant sustained a new injury. (Exs. 22A, 25).

Based on those opinions, and in the absence of any contrary medical evidence, we conclude that the evidence preponderates in favor of finding that claimant's strain resulting from the April 30, 1989 work-related incident had resolved and that claimant sustained a new injury in February 1990, which is the sole cause of his current low back condition and need for treatment. Accordingly, claimant has failed to establish a compensable claim resulting from his April 1989 injury.

Medical Services--Weight Loss Program

Claimant contends that, even if his current low back condition is not compensable, the employer is liable for the prescribed weight loss program because his weight gain was a result of his compensable back strain. We agree.

For his compensable injury, claimant is entitled to medical services for conditions resulting from the injury "for such period as the nature of the injury or the process of recovery requires." ORS 656.245(1). Because claimant is seeking compensation for an alleged consequence of a compensable injury, he bears the burden of proving that his compensable injury was the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); See also Julie K. Gasperino, 43 Van Natta 1151 (1991).

Since his April 1989 injury, claimant's weight increased from approximately 270 pounds to 373 pounds. Upon examination in February 1990, Dr. Baum prescribed a weight loss program and referred claimant to Dr. Nelson, a specialist in bariatrics, for professional care. Dr. Baum related claimant's weight gain directly to his compensable condition and believed that the weight loss program would be "most beneficial" to claimant. There is no contrary medical evidence.

After our review of the record, we conclude that claimant has established, by a preponderance of the evidence, that his April 1989 injury was the major contributing cause of his weight gain, and that the treatment for that condition is a compensable medical service. Accordingly, the employer's denial of such treatment must be set aside.

Permanent Disability

We adopt the conclusions and reasoning concerning the extent of claimant's permanent disability as set forth in the Referee's order.

Because claimant has prevailed, in part, against a denial of compensation, claimant's counsel is entitled to an assessed fee under ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on Board on review concerning the compensability of the weight loss program is \$1,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated January 9, 1991 is affirmed in part and reversed in part. The self-insured employer's denial is set aside to the extent that it denied payment for the weight loss program. For services associated with partially overturning that denial, claimant's counsel is awarded \$1,500, to be paid by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
LEONARD JENNSEN, Claimant
WCB Case No. 83-02943
ORDER DENYING RECONSIDERATION
Emmons et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Claimant's former attorney seeks reconsideration of that portion of our February 13, 1989 Order on Review that declined to award an insurer-paid attorney fee for services rendered at hearing and on Board review for prevailing against the SAIF Corporation's partial denial of claimant's polyneuropathies, thoracic outlet syndrome, and bilateral rib resection. We declined to award an attorney fee because we stated that we had received no statement of services. Contending that he had submitted a statement of services, claimant's former attorney requests an insurer-paid attorney fee award. The request is denied for lack of jurisdiction.

FINDINGS OF FACT

On March 10, 1988, claimant's former attorney submitted a "statement of services" concerning his efforts in this case, which was presently pending review. On September 8, 1988, the Board received a letter from claimant's new counsel announcing that he was seeking the status of claimant's case because her former attorney was "apparently no longer in practice."

On February 13, 1989, the Board issued an Order on Review. Copies of the order were mailed to all parties to the proceeding and their attorneys of record. A copy of the order was not mailed to claimant's former attorney.

Pursuant to the Board's order, the Referee's order, which had upheld SAIF's partial denial of claimant's neuropathies, thoracic outlet syndrome, and rib resection, was reversed. The Board order further stated that since no statement of services had been received to date from claimant's counsel, no assessed fee could be awarded. That order has not been appealed, stayed, or republished.

On July 30, 1991, the Board received a letter from claimant's former attorney seeking an assessed fee. Enclosed with the request was a copy of an undated statement of service from claimant's former attorney to the Board which also sought an attorney fee award. Review of the file reveals that the former attorney's statement of service was received by the Board on March 10, 1988.

CONCLUSIONS OF LAW

Pursuant to our February 13, 1989 order, claimant prevailed against a partial denial of his compensation. Under such circumstances, we reasoned that he was entitled to an insurer-paid attorney fee. ORS 656.386(1). Yet, finding that no "statement of services" had been received at that time, we held that we were unable to do so. See former OAR 438-15-010(5).

Inasmuch as our order was neither appealed, abated, stayed, republished nor withdrawn within 30 days of its issuance, it has become final by operation of law. ORS 656.295(8). International Paper Co. v. Wright, 80 Or App 444, 447 (1986). We have previously concluded that we retain jurisdiction to consider a request for an attorney fee even after the order on the merits has become final by operation of law. See Jane E Stanley, 40 Van Natta 831 (1988), rev'd on other grounds, Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (1989). However, in order to retain jurisdiction over the attorney fee request, our prior order must not have addressed either the entitlement to, or the amount of, an attorney fee. See Orozco v. U & I Group, Inc., 103 Or App 634 (1990).

Here, our February 13, 1989 order addressed claimant's counsel's entitlement to an insurer-paid fee. Since that order has become final by operation of law, we lack jurisdiction to consider the attorney fee request. See Orozco v. U & I Group, Inc., supra. Accordingly, the request is denied.

In reaching this conclusion, we acknowledge claimant's former attorney assertion that he submitted his statement of services prior to the issuance of our February 13, 1989 order. Furthermore, a review of the record reveals a statement of service from claimant's former attorney which was received by the Board on March 10, 1988. When the "statement of services" rule was applicable, every effort was made to process statement of services which were received while the Board retained jurisdiction over a case. Unfortunately, in this particular instance, the statement of services did not come to our attention prior to the expiration of the 30-day appeal period from our February 13, 1989 order. Inasmuch as our order addressed claimant's counsel's entitlement to an attorney fee and the time to seek reconsideration or appeal of that order has long since expired, we lack jurisdiction to further consider this matter.

Finally, claimant's former attorney accurately notes that he was not mailed a copy of our February 13, 1989 order. This action was prompted by a change of claimant's attorney of record which occurred prior to the issuance of our order. Specifically, such an action was taken in response to a September 7, 1988 letter from claimant's new counsel announcing the change because claimant's former attorney was "apparently no longer in practice." Based on this representation, claimant's new counsel was mailed a copy of the Board's eventual order.

Assuming that claimant's former attorney should have also been mailed a copy of the Board's order, an assumption we do not accept, our failure to do so would not invalidate the order. The Board may republish an order if it finds that it failed to mail a copy of its prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988); Mary J. Gates, 42 Van Natta 1813 (1990). An attorney is not a party. ORS 656.005(19); Berliner, supra, page 266, n. 1; Bryan Thompson, 42 Van Natta 2299 (1990). Inasmuch as the record does not support a finding that a party to our February 13, 1989 order was not mailed a copy of the order, we are not authorized to republish the order. Berliner, supra; Thompson, supra.

Accordingly, based on the foregoing reasoning, the request for reconsideration is denied.

IT IS SO ORDERED.

October 9, 1991

Cite as 43 Van Natta 2307 (1991)

In the Matter of the Compensation of

THOMAS W. LUNDY, Claimant

WCB Case No. 90-07272

ORDER ON REVIEW

Ackerman, et al., Claimant Attorneys

Phillip Nyburg, Defense Attorney

Reviewed by Board Members Westerband and Crider.

The insurer requests review of those portions of Referee McCullough's order that: (1) increased claimant's unscheduled permanent partial disability for a back condition from 8 percent (25.6 degrees), as awarded by a Determination Order, to 16 percent (51.2 degrees); (2) awarded temporary partial disability on a procedural basis for the period from December 11, 1989 through February

26, 1990; and (3) assessed a penalty for unreasonable claims processing. On review, the issues are extent of unscheduled permanent disability, temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

We affirm and adopt that portion of the Referee's order that addressed the extent issue, with the following comments.

The insurer contends that claimant's testimony is insufficient to establish that his post-injury work was modified. We do not agree. A claimant's testimony concerning self-imposed modifications, if unrebutted, can be sufficient to establish the nature of the work to which the claimant returned. In particular, such modifications can be sufficient to support a finding that the claimant did not return to usual and customary work. See Bill R. Harrison, 42 Van Natta 1565 (1990) (work modifications described by the claimant were not sufficiently significant to establish that he did not return to usual and customary work).

Here, while performing his work activities as a stamper, claimant refrained from unclogging the trough. This task was ordinarily performed by the stamper several times per hour. This self-imposed limitation, in conjunction with other work activities in which claimant required assistance that was not needed prior to his injury, supports a finding that claimant returned to modified work.

Temporary Disability/Penalty

We reverse that portion of the Referee's order that found that claimant was entitled to temporary partial disability (TPD) from December 11, 1989 through February 26, 1990. We also reverse the penalty and related attorney fee assessed by the Referee for the insurer's failure to pay these benefits.

We decide the temporary disability issue under the Workers' Compensation Act as amended effective July 1, 1990. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Oregon Laws 1990 (Special Session), SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). Moreover, neither party argues that the temporary disability issue should be decided under the law in effect prior to the amendments. Accordingly, we decide this issue under the current law.

Dr. Serbu, claimant's treating physician, released claimant to "full duty" effective December 11, 1989. Claimant did not return to his full duties. The insurer did not pay temporary disability benefits during the disputed period (December 11, 1989 through February 26, 1990).

The Referee concluded that the 1990 amendments to ORS 656.268 do not control claimant's right to TPD because the amended provision only authorizes unilateral termination of temporary total disability (TTD). Noting that claimant had returned to part-time work and was receiving TPD prior to his physician's "full duty" release, the Referee reasoned that the insurer was required to

continue paying TPD under OAR 436-60-030(3) and (4) until one of three events occurred: (1) claimant's attending physician returned claimant to TTD status; (2) claimant's TPD was terminated by a Determination Order or Notice of Closure in accordance with ORS 656.268; or (3) TPD had been paid for two years. Inasmuch as none of the three events had occurred during the time in question, the Referee held that claimant was entitled to TPD, and that the insurer's failure to provide such benefits was unreasonable. We disagree.

As amended effective July 1, 1990, ORS 656.268(3) provides that TTD shall continue until whichever of three events first occurs. Those events are: (1) the worker returns to regular or modified employment; (2) the attending physician gives the worker a written release to return to regular employment; or (3) the attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. See ORS 656.268(3)(a), (b), and (c).

Here, claimant's attending physician provided claimant with a release to "full duty" work activities effective December 11, 1989. This is evidence that claimant was no longer disabled. This evidence can be rebutted at claim closure when substantive entitlement to temporary disability is determined. Nevertheless, while the claim remains in open status, claimant is no longer procedurally entitled to TTD once he is released to regular work. ORS 656.268(3)(b).

We recognize that ORS 656.268(3)(b) does not expressly authorize the insurer to unilaterally terminate TPD, as distinct from TTD, upon receipt of a release to regular work. Indeed, the law does not address termination of temporary partial disability compensation at all. The statute simply provides that temporary partial should be paid when a claimant is partially disabled.

Nevertheless, the statute does expressly authorize the insurer to unilaterally terminate TTD when a worker is released to regular work. There is no procedural obligation to pay any further temporary disability benefits after that point. It logically follows that if a release to work justifies termination of TTD, even if the worker does not actually return to work, the same event should also justify termination of TPD.

Consequently, we hold that claimant was not entitled to TPD between December 11, 1989 and February 26, 1990. Furthermore, in light of our previous discussion, we do not consider the insurer's failure to provide such benefits during the time in question to have been unreasonable. Accordingly, we reverse the Referee's award of TPD and the related penalty and attorney fee.

Claimant's attorney is entitled to a reasonable assessed fee for his services on review concerning the insurer's unsuccessful appeal of the Referee's permanent partial disability award. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the permanent disability issue is \$600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the issue as represented by claimant's respondent's brief and statement of services, and the value to claimant of the interest involved.

ORDER

The Referee's order dated October 4, 1990, as modified on November 6, 1990, and amended on November 21, 1990, is affirmed in part and reversed in part. That portion of the order that awarded temporary partial disability for the period December 11, 1989 through February 26, 1990 is reversed. That portion of the order that awarded an out-of-compensation attorney fee based on

those benefits is reversed. The Referee's assessment of a penalty and related attorney fee for failure to pay those benefits is also reversed. The remainder of the Referee's order is affirmed. For services on Board review concerning the permanent disability issue, claimant's attorney is awarded a reasonable assessed fee of \$600, to be paid by the insurer.

October 10, 1991

Cite as 43 Van Natta 2310 (1991)

In the Matter of the Compensation of
JESSE ASH, Claimant
WCB Case No. 90-08256
ORDER ON RECONSIDERATION
Merrill Schneider, Claimant Attorney
Hallock & Bennett, Defense Attorneys

Claimant requests reconsideration of our September 26, 1991 Order on Review that vacated a Referee's order and dismissed claimant's request for hearing on the basis of lack of jurisdiction. The insurer opposes claimant's request.

In our prior order, we concluded that the only issue at hearing was penalties and attorney fees. Relying upon amended ORS 656.262(10), as well as our decision in Ronald A. Stock, 43 Van Natta 1889 (1991), we concluded that exclusive jurisdiction of such a proceeding rests with the director. On reconsideration, claimant argues that entitlement to an assessed attorney fee for prevailing over a "de facto" denial of medical bills was "implicitly raised" by claimant's request for attorney fees.

We do not agree. Both at hearing and on Board review, claimant solely asserted entitlement to an attorney fee under ORS 656.382(1) for the insurer's unreasonable resistance to the payment of compensation. (Tr. 3; Appellant's Brf. p. 2). No claim for a fee payable under ORS 656.386(1) was made. Although the Board had previously concluded that no ORS 656.386(1) fee was due under such circumstances, nothing prevented claimant from asserting, and thereby preserving, this issue for appeal. However, claimant did not assert entitlement to an ORS 656.386(1) fee; therefore, we decline to address entitlement to such a fee for the first time on Board review by way of a request for reconsideration. See Linda A. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (request for penalties and attorney fees only addressed on those grounds expressly raised at hearing).

The request for reconsideration is granted and our prior order withdrawn. Upon further review, as supplemented herein, we adhere to and republish our prior order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK S. HOGLAND, Claimant
WCB Case No. 90-16701
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Thye's order that set aside its denial of claimant's occupational disease claim for his bilateral degenerative knee arthritis. In his brief, claimant argues that the insurer's denial is unreasonable and requests penalties and related attorney fees. On review, the issues are compensability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

On July 25, 1989, the insurer accepted as compensable only temporary symptoms and did not accept claimant's preexisting bilateral degenerative knee arthritis condition or a worsening of his preexisting disease.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded, in part, that the insurer was precluded from denying claimant's condition under Georgia Pacific v. Piowar, 305 Or 494 (1988), because the insurer's July 1989 acceptance of "temporary exacerbation of bilateral knee symptoms" was an acceptance of the underlying degenerative disease. We disagree.

The employer in Piowar accepted a claim for "back pain," which was initially diagnosed as a sprain. After the acceptance, the medical experts determined that the accepted back pain was, in fact, attributable to a noncompensable ankylosing spondylitis. The Court held that the carrier could not deny the previously accepted claim simply because it discovered claimant's symptoms were attributable to a noncompensable disease. At first glance, Piowar appears to be analogous to the present case. However, an insurer's acceptance of a claim includes only those conditions specifically accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987).

In the present case, on June 19, 1989, claimant filed an "801" claim form for "increased pain [in both knees] after carrying furniture for long periods." (Ex. 3). The employer indicated on its portion of the "801" form, that claimant "has arthritis in both knees according to his doctor - Injury as of 6/3/89." The insurer initially accepted claimant's claim by checking the boxes labeled "accepted," "nondisabling," and "injury" on claimant's "801" claim form. Thereafter, the insurer received a report from claimant's treating physician, Dr. Hazel, orthopedist, in which Dr. Hazel stated that claimant's degenerative joint disease was not caused by his occupation and that claimant was suffering from a temporary exacerbation of his degenerative condition. Additionally, in this report, Dr. Hazel indicated that he informed claimant that the insurer/employer "may accept at least this temporary exacerbation as industrially related." (Ex. 1-1). The insurer sent claimant a Notice of Claim Acceptance in July 1989, stating only that it accepted a "temporary exacerbation of bilateral knee symptoms." (Ex. 4).

Considering these facts, we conclude that the scope of the insurer's acceptance was specifically limited to temporary bilateral knee symptoms and was not an acceptance of a preexisting bilateral knee disease or a worsening of the underlying disease. Further, the insurer is not trying to relitigate the compensability of the accepted temporary symptomatic exacerbation. We conclude that the insurer's denial is procedurally proper. See Kenneth L. Orr, 43 Van Natta 1432 (1991). Accordingly, we turn to the merits of the insurer's denial.

After the July 1989 acceptance and claim closure, claimant periodically received medical treatment for pain in his knees. On July 24, 1990, the insurer issued a denial of claimant's advanced bilateral degenerative knee arthritis condition. The Referee concluded that claimant's condition is the result of a series of traumatic events or occurrences at work which were the major contributing cause of a worsening of his degenerative arthritis. We agree.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Claimant must prove that his employment conditions in the form of a series of traumatic events or occurrences were the major contributing cause of the worsening of his preexisting bilateral degenerative knee arthritis disease. ORS 656.802(1)(c) & (2). Additionally, claimant must prove the worsening of his preexisting bilateral knee condition by medical evidence supported by objective findings. ORS 656.802(2).

We adopt that portion of the Referee's conclusion under "Compensability on the merits." Further, we add that the medical evidence cited in the Referee's conclusion is medical evidence supported by objective findings.

Penalties and Attorney Fees

The Referee concluded that the insurer's July 24, 1990 denial was not unreasonable. We agree.

At the time the insurer issued its July 24, 1990 denial, it had received Dr. Hazel's July 6, 1990 letter informing the insurer once again that claimant's need for surgery "is not a necessity or in reference to an injury of his knees, nor of an occupational disease." (Ex. 14). By virtue of the conflicting evidence and the changing law at the time of the denial, we conclude that the insurer had a legitimate doubt as to its liability for claimant's condition. Therefore, a penalty is not warranted.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$900, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 8, 1991 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of \$900, to be paid by the insurer.

October 10, 1991

Cite as 43 Van Natta 2313 (1991)

In the Matter of the Compensation of

GLENN R. ISHIE, Claimant

WCB Case No. 90-07020

ORDER ON REVIEW

Olson, Rowell, et al., Claimant Attorneys

Scheminske, et al., Defense Attorneys

Reviewed by Board Members Westerband and Moller.

The insurer requests review of Referee Harri's order which set aside its denial of claimant's occupational disease claim for right side hearing loss and tinnitus. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the exception of the last paragraph.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's right-side hearing loss and tinnitus were compensable. We disagree.

The Referee concluded that claimant's work exposure was a material contributing cause of his hearing loss and tinnitus. In reaching this conclusion, he relied on Donna E. Aschbacher, 42 Van Natta 1242 (1989). Subsequent to the Referee's order, the Court of Appeals held that, under former ORS 656.802(1), to establish a claim for an occupational disease, claimant is required to prove that work exposure was the major cause of his condition. Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991).

The issue of whether claimant's right-side hearing loss and tinnitus are related to his work exposure is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

There are two opinions in the record concerning causation. The first is from Dr. Pribnow who is an industrial medicine specialist and claimant's treating physician. The second is from Dr. Maurer, a clinical audiologist. In August 1990, Dr. Pribnow stated, "Unless someone can offer a better explanation, I would say [claimant's] work exposure to grinders is a material contributing cause of his hearing loss; lacking other explanation, the medical probability is that work exposure is the major contributing cause." In October 1990, Dr. Pribnow opined that if the measured noise levels were less than claimant's actual exposure, then the medical probability is that claimant's work exposure was the major cause of claimant's hearing loss. Dr. Pribnow again qualified his opinion by assuming no other history than work exposure. Finally, Dr. Pribnow reported that he could not make any statement regarding the cause of claimant's tinnitus.

Dr. Maurer opined that neither claimant's hearing loss nor his tinnitus were related to his exposure to noise at work. Dr. Maurer explained that noise level testing at claimant's employment indicated that noise levels for two of the grinders on which claimant worked were at or below risk level. He also explained that these noise levels were reduced further by the fact that claimant wore ear plugs while working. Finally, Dr. Maurer noted that if claimant's work exposure was causally related to his hearing loss, the hearing loss should be bilateral rather than one-sided.

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 65 Or App 810 (1983). Here, we find persuasive reasons not to rely on Dr. Pribnow. Dr. Pribnow's opinion is conclusory and he qualifies it with the assumption that claimant's had no off-work noise exposure. Further, Dr. Pribnow does not address the fact that claimant wore earplugs while working. By contrast, Dr. Maurer offers a persuasive explanation for his opinion that claimant's right-side hearing loss and tinnitus are not work-related. Under these circumstances, we conclude that claimant has failed to establish that his work exposure was the major contributing cause of his right-side hearing loss and tinnitus.

ORDER

The Referee's order date January 18, 1991 is reversed. The insurer's denial is reinstated and upheld. The Referee's award of a \$2,000 assessed attorney fee to claimant's counsel is reversed.

October 11, 1991

Cite as 43 Van Natta 2314 (1991)

In the Matter of the Compensation of

G. T. BABICH, Claimant

WCB Case No. 90-17366

ORDER ON REVIEW

Bennett & Durham, Claimant Attorneys

Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Mills' order that declined to award a carrier-paid attorney fee under ORS 656.386(1) when the insurer rescinded its denial of claimant's medical services claim prior to hearing. The Referee relied on the Board's holding in Duane L. Jones, 42 Van Natta 875 (1990). Essentially contending that the Jones holding has been superceded by Senate Bill 540 (approved June 19, 1991), claimant seeks remand. We deny the motion for remand and reverse the Referee's order.

FINDINGS OF FACT

In September 1990, the Board received a hearing request from claimant's attorney. The request raised the following issues: (1) "8/8/90 de facto" denial; (2) compensability; (3) temporary partial and temporary total disability; (4) medical services; and (5) aggravation.

In November 1990, the insurer submitted to the Hearings Division copy of 22 exhibits. These exhibits consisted of claims documents concerning the processing of claimant's 1984 compensable injury claim. In addition, a copy of the insurer's August 8, 1990 denial was also included. In December 1990, the insurer submitted two additional exhibits. (Exhibits 23 & 24). One of the exhibits was a November 1990 medical report from claimant's attending physician to

the insurer. The other exhibit was a December 20, 1990 Own Motion Order denying claimant's request for relief because the record failed to demonstrate that claimant would require surgery or hospitalization for his condition or that he was in the work force at the time of his worsening. The Own Motion Order further provided that claimant's entitlement to medical services resulting from his compensable injury was not affected.

The hearing convened on January 15, 1991. At that time, the parties acknowledged that the insurer had rescinded its August 8, 1990 medical services denial on January 7, 1991. Submitting his firm's billing (Exhibit 25), claimant's attorney sought an attorney fee for his efforts in prompting the rescission of the insurer's denial. The billing totalled 29.95 hours.

Stating that the billing included efforts in two claims (one of which pertained to a hearing request which was being withdrawn), claimant's attorney represented that 14.55 hours had been expended in obtaining the rescission of the insurer's medical services denial. Relying on the Board's decision in Jones, the insurer argued that claimant's attorney was not entitled to a fee under ORS 656.386(1). Furthermore, the insurer challenged claimant's attorney's billing, noting that claimant's attorneys had expended a significant amount of time in claimant's unsuccessful attempt for own motion relief and that several other hours had been devoted to conferences between claimant's attorneys.

Without objection from the parties, the Referee admitted all 25 exhibits. In addition, neither party objected to the closure of the record.

FINDINGS OF ULTIMATE FACT

Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW

Relying on Jones, supra, the Referee concluded that no attorney fee was available for a denial rescinded prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even if a hearing is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540 3. Such is the case here.

In light of the recent amendment to ORS 656.386(1), claimant asks that this case be remanded to the Referee for further development. Remand is appropriate when it is determined that a case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). In addition, to merit remand for the consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986).

Here, claimant contends that the amendment to ORS 656.386(1) provides an explanation for the alleged inadequacy and insufficiency of the record concerning his attorney's efforts in securing the rescission of the insurer's denial without a hearing. We are not persuaded by claimant's contention.

To begin, the record consists of claimant's attorney's hearing request and 25 exhibits (including a billing from claimant's attorney's firm which sets forth a variety of services provided on claimant's behalf), as well as claimant's attorney's representations at hearing regarding the amount of hours

devoted to this particular matter. Inasmuch as the sole issue at hearing concerned claimant's attorney's entitlement to an attorney fee pursuant to ORS 656.386(1) for obtaining the rescission of the insurer's denial, and since claimant's attorney's efforts in achieving such a result would be relevant evidence in determining the amount of a reasonable fee, we are not persuaded that the subsequent amendment to the statute establishes that additional evidence regarding the attorney fee issue was unobtainable with the exercise of due diligence at the hearing. In any event, we do not consider the current record improperly, incompletely or otherwise insufficiently developed. Consequently, we decline to grant the request.

We turn to the issue of whether claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. Considering claimant's attorney's September 1990 hearing request concerning the insurer's August 1990 denial and claimant's attorney's billing statement, as well as the insurer's January 7, 1991 pre-hearing rescission of its denial, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of the insurer's denial prior to the scheduled hearing. Consequently, we hold that claimant is entitled to an insurer-paid attorney fee under amended ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable attorney fee concerning the rescission of the insurer's denial is \$750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the nature of the proceedings, the time devoted to the issue (as represented by the record and claimant's attorney's billing statement), the value of the interest involved, and the risk that claimant's attorney's efforts might go uncompensated.

ORDER

The Referee's order dated January 16, 1991 is reversed. For services rendered in conjunction with the rescission of the insurer's medical services denial, claimant's attorney is awarded an assessed attorney fee of \$750, payable by the insurer.

October 11, 1991

Cite as 43 Van Natta 2316 (1991)

In the Matter of the Compensation of
ROBERT A. CRAVENS, Claimant
WCB Case No. 90-15039
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Quillinan's order that affirmed a Notice of Closure which awarded 4 percent (6 degrees) scheduled permanent disability for his left leg (knee) condition. The SAIF Corporation cross-requests review of those portions of the Referee's order that: (1) found that res judicata barred it from asserting an overpayment of temporary disability; and (2) awarded claimant an assessed attorney fee for successfully defending on the issue of offset. On review, the issues are extent of scheduled permanent disability, offset and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINIONScheduled permanent disability

We adopt the Referee's "Opinion" on the issue of scheduled permanent disability. See also Ronald R. Robinette, 42 Van Natta 1056 (1990).

Offset

The Referee concluded that res judicata barred SAIF from asserting an overpayment of temporary disability as SAIF had entered into a stipulation at a time when it knew or should have known that it was paying claimant at an incorrect rate. The Referee further concluded that, by not raising the issue at the time of the October 1989 stipulation, SAIF waived its right to challenge the overpayments at a later date. We disagree.

The doctrine of res judicata applies to workers' compensation cases and precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). The doctrine of res judicata has two aspects; "claim preclusion" and "issue preclusion". White, supra.

Under the res judicata doctrine of "claim preclusion," litigation of a claim or cause of action to final judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Drews v. EBI Companies, 310 Or 134 (1990); Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Restatement (Second) of Judgments, Sections 17-19, 24 (1982). For claim preclusion to apply, the subsequent litigation must include: (1) the same parties (or those in privity); (2) the same claim (or a second claim arising from the same transaction or series of connected transactions out of which the first claim arose); and (3) a valid and final judgment on the first claim. Drews v. EBI Companies, supra at 140.

The key elements of issue preclusion are: (1) the same parties; (2) a valid and final judgment; (3) actual litigation of an issue of fact or law; and (4) a determination of that issue which is essential to the judgment. Jimmy M. Campo, 42 Van Natta 903 (1990).

We conclude that issue preclusion does not apply to bar SAIF from raising the offset issue. Although the parties entered into the October 1990 stipulation following claimant's request for hearing, the issue of rate of temporary disability benefits was not essential to that judgment. Rather, the stipulation resolved only the issue of SAIF's untimely payment of temporary disability and the amount of the penalty for the untimely payment. Moreover, because the stipulation did not address the issue of rate of temporary disability, the parties cannot contend that the stipulation constituted "actual litigation" of that rate. Accordingly, issue preclusion is not applicable.

We also conclude that claim preclusion does not bar SAIF from raising the issue of offset. In Drews v. EBI Companies, supra, the Court held that, where a statutory scheme contemplates that the contentions arising from a transaction or series of connected transactions may be split, splitting as contemplated by the statutory scheme is not merged in or barred by a former adjudication concerning the overall transaction. Drews, supra at 2185, citing Restatement (Second) of Judgments 26(1)(d) (1982).

In the present case, ORS 656.210 provides for payment of temporary total disability. Additionally, former ORS 656.268(10) (renumbered 656.268(13), May 7, 1990) provides that an offset of temporary disability may be taken against permanent disability awards. Here, the stipulation did not make any disability awards and, as provided by statute, SAIF was not entitled to an overpayment offset until permanent disability existed against which an offset could be made. Moreover, SAIF paid claimant temporary disability benefits subsequent to the stipulation. Under the circumstances, we conclude that the offset issue is not merged in or barred by a stipulation that provided claimant with a penalty for SAIF's untimely payment of temporary disability. Accordingly, claim preclusion does not apply.

Finally, we conclude that waiver does not bar SAIF from asserting an overpayment issue. In Drews, the Court held that a claimant should not be denied the right to raise the issue of the correct rate of payment on the ground that the claimant could have done so in the prior hearing. Drews, supra, 310 Or at 137. The Court concluded that waiver could only be applied if it could be shown that the party against whom waiver was asserted had intentionally relinquished a known right. Drews, supra.

In this case, we are unable to find evidence that SAIF intentionally relinquished its right to an offset by entering into a stipulation that provided only for a penalty for SAIF's late payment of temporary disability. We also agree with SAIF that, because the overpayment was not discovered until approximately six months after the stipulation was entered into, SAIF could not have possibly waived its right to an offset as it was not yet aware of its overpayment. We, therefore, conclude that waiver does not bar SAIF from asserting a claim for offset.

Because we agree with SAIF that res judicata and waiver do not operate to preclude it from asserting the issue of offset, and claimant has not denied the existence of the overpayment or the amount of overpayment, we conclude that SAIF is entitled to offset the stated overpayment of temporary disability benefits against future awards of permanent disability made to claimant. Finally, we also reverse the Referee's attorney fee award to claimant's counsel on the issue of offset.

ORDER

The Referee's order dated November 29, 1990 is affirmed in part and reversed in part. That portion of the Referee's order that affirmed a Notice of Closure which awarded claimant 4 percent (6 degrees) scheduled permanent disability for his left leg (knee) condition is affirmed. That portion of the Referee's order that declined to grant the SAIF Corporation an offset is reversed. SAIF is granted an offset of its stated overpaid temporary disability benefits against future awards of permanent disability. The Referee's attorney fee award of \$500 to claimant's counsel on the issue of offset is also reversed.

In the Matter of the Compensation of
BRYAN EUBANKS, Claimant
WCB Case Nos. 90-13651 & 89-16631
ORDER ON REVIEW
Barnett et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Douglas L. Minson, Attorney
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Schultz' February 8, 1990 Order Withdrawing Opinion and Order of January 11, 1990. Additionally, claimant requests review of that portion of Referee Neal's order which upheld the SAIF Corporation's denial, on behalf of a noncomplying employer, of claimant's low back injury claim. On review, the issues are propriety of the Order Withdrawing Opinion and Order and compensability.

The Board affirms and adopts Referee Schultz's Order Withdrawing Opinion and Order and Referee Neal's order, with the following supplementation.

On January 11, 1990, Referee Schultz set aside SAIF's denial of claimant's low back injury claim. On January 18, 1990, the noncomplying employer moved for reconsideration, reopening of the record, inclusion of new evidence and rehearing. On January 29, 1990, SAIF moved for reconsideration and abatement for submission of newly discovered evidence. On January 29, 1990, Referee Schultz issued an Order of Abatement. On February 8, 1990, Referee Schultz issued an Order Withdrawing Opinion and Order. Claimant's motion for reconsideration of the Order Withdrawing Opinion and Order was denied. On April 18, 1990, the noncomplying employer moved for joinder of another employer. On May 30, 1990, Referee Mills issued an Order of Joinder.

On November 13, 1990, a hearing was held on the merits of claimant's low back injury claim before Referee Neal.

Referee Schultz concluded that ORS 183.413 controlled the matter before him on reconsideration, and that because the noncomplying employer had not been informed of its rights pursuant to ORS 183.413, the January 11, 1990 Opinion and Order would be withdrawn and a new hearing held.

Contested cases determine liabilities of the parties. In the administrative process, the agency is required to advise the parties of their respective rights in a contested case. ORS 183.413. Before commencing a contested case, a party who is not represented by an attorney must be informed either orally or in writing of the nature of the hearing, including the order of presentation of evidence, what kinds of evidence are admissible, whether objections may be made to the introduction of evidence and what kinds of objections may be made and explanation of the burden of proof or burden of going forward with the evidence. ORS 183.413(2)(a). Prior to the commencement of the contested case hearing, the party not represented by an attorney must be informed that he may request a recess during the proceedings to obtain representation by an attorney. ORS 183.413(2)(f).

The record indicates that the noncomplying employer was not represented by independent legal counsel. The record indicates that the noncomplying employer was not given, either orally or in writing, the information required by ORS 183.413. Accordingly, we conclude that the Referee, upon motion for reconsideration, retained jurisdiction to review the hearing procedures and correctly withdrew his order.

ORDER

Referee Schultz' order dated February 8, 1990 is affirmed. Referee Neal's order, dated November 23, 1990, as reconsidered December 26, 1990, is affirmed.

October 11, 1991

Cite as 43 Van Natta 2320 (1991)

In the Matter of the Compensation of

CAROLYN S. PERKINS, Claimant

WCB Case No. 90-18556

ORDER ON REVIEW

Scott M. McNutt, Claimant Attorney

Charles J. Cheek (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerland.

Claimant requests review of Referee T. Lavere Johnson's order that: (1) declined to assess penalties and attorney fees for an allegedly unreasonable denial; and (2) declined to award assessed attorney fees for a pre-hearing denial rescission. On review, the issues are penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. The 801 form incorporated an accident report which indicated that claimant's condition was the result of an injury caused by falling pieces of wood at work. (Ex. 2-2, 3). The SAIF Corporation received the accident report on September 4, 1990. (Ex. 2-2). The employer representative noted on the 801 form that the injury occurred at work. SAIF denied the claim as an occupational disease on September 12, 1990.

Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing through the pre-hearing denial rescission.

CONCLUSIONS OF LAW AND OPINION

Penalties and Attorney Fees for Unreasonable Denial of Injury Claim

The Referee did not find the denial by SAIF to be unreasonable and did not assess penalties or associated attorney fees. We disagree.

The standard for determining an unreasonable denial is whether the carrier has a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977); see Carol J. Knapp, 41 Van Natta 851, 854 (1989).

SAIF denied the claim on the basis of an occupational disease even though the accident report, which was incorporated into the 801 form, clearly indicated that claimant was injured at work by falling wood. (Exs. 2-2, 3). In addition, the employer stated that the injury occurred at work. (Ex. 3, item 4). Further, on September 4, 1990, SAIF received Dr. Williams' August 30, 1990 chart note which indicated a connection between the injury and claimant's work activities. (Ex. 2-1). Finally, there is no evidence in the record suggesting that the injury occurred anywhere but at work.

Accordingly, based on the record before us, we find nothing that would have provided SAIF with a legitimate doubt concerning the compensability of claimant's injury claim at the time of its denial. Consequently, we conclude that claimant is entitled to a penalty pursuant to ORS 656.262(10). Considering

the circumstances of this case, we conclude that an appropriate penalty is 25 percent of the amounts then due at the time of the rescission of SAIF's denial. Pursuant to ORS 656.262(10)(a), one-half of the penalty amount shall be awarded to claimant's attorney, in lieu of an attorney fee. See Harry E. Forrester, 43 Van Natta 1480 (1991).

Attorney Fees for a Pre-Hearing Denial Rescission

Claimant argues that she is entitled to an attorney fee for her counsel's services in obtaining the rescission of the denial of her right wrist sprain and tendonitis condition prior to hearing. We agree.

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available under ORS 656.386(1) for a denial rescinded prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even though a hearing is not held. See ORS 656.386(1) (effective June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540, 3. Such is the case here.

Considering claimant's counsel's efforts in submitting a hearing request and preparing a case concerning the SAIF Corporation's denial, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of SAIF's denial prior to hearing. Therefore, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee concerning the rescission of SAIF's denial prior to hearing is \$500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 7, 1991 is reversed. Claimant's attorney is awarded a \$500 fee for services in obtaining the pre-hearing denial rescission, to be paid by the SAIF Corporation. Claimant is awarded a penalty of 25 percent of the amounts then due at the time of the rescission of SAIF's denial. Claimant's attorney shall receive one-half of that penalty.

October 11, 1991

Cite as 43 Van Natta 2321 (1991)

In the Matter of the Compensation of
LORENE E. YOST, Claimant

WCB Case No. 90-18126

ORDER ON REVIEW

Welch, et al., Claimant Attorneys

Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Moller and Neidig.

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

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

On review, claimant disagrees only with those portions of the Referee's order that assigned values for skills and adaptability. Accordingly, we adopt the Referee's conclusions on the issues of age, education, training and impairment.

Skills

The Referee found that claimant's highest SVP in the past ten years was 4, as a psychiatric nurse's aide. He, therefore, concluded that the appropriate value for claimant's skills was 3.

Claimant contends that she worked as an aide for six months and she was on call during that time. Claimant asserts that, because she only worked part-time, she has not "successfully performed" the job of nurse's aide. Claimant argues that her prior work as a packer and a cook's helper should be considered as her highest SVP in the past ten years. We disagree.

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. See Michael W. Davison, 42 Van Natta 1820 (1990). The DOT provides that, for an SVP of 4, the length of time to proficiency is "over 30 days, up to and including 6 months."

Here, claimant testified that she worked for approximately six months as a nurse's aide. Although claimant, on occasion, worked less than 40 hours a week, we conclude that she remained at the job the length of time necessary to meet the specific vocational preparation time required for that job. Accordingly, we agree that claimant successfully performed the job of nurses' aide, and the Referee correctly assigned a skills value of 3.

Adaptability

The Referee concluded that, before her injury, claimant performed work in the medium range. He further concluded that claimant had returned to modified work in the light category. He, therefore, assigned an adaptability value of 2.

Claimant contends that she has not received a work offer and has not returned to modified work. Claimant argues that the Referee should have determined her adaptability value under former OAR 436-35-310(4). We disagree.

Although claimant was not employed at the time of hearing, the fact that she was not working was due to a layoff, rather than to her injury. (Ex. 25-3). Claimant had previously returned to modified work for the employer. (Tr. 4, Ex. 25-3). Accordingly, we conclude that the Referee properly applied former OAR 436-35-310(3), in determining that claimant was entitled to an adaptability value of 2. See Cleophas C. Chambliss, 43 Van Natta 904 (1991).

ORDER

The Referee's order dated February 8, 1991 is affirmed.

In the Matter of the Compensation of
JAMES S. FRANKLIN, Claimant
WCB Case No. 90-11665
ORDER ON REVIEW
Olsen & Pahl, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Brazeau's order that: (1) found that claimant's right leg (knee) injury claim was not prematurely closed; (2) reversed a Determination Order award of 31 percent (99.2 degrees) unscheduled permanent disability for a low back condition; (3) upheld the insurer's denial of claimant's aggravation claim; and (4) affirmed a Determination Order award of 11 percent (16.5 degrees) scheduled permanent disability for a right leg (knee) injury. Claimant also contends that the Referee was without jurisdiction to modify the Determination Order award of unscheduled permanent disability. If we find that the Referee had jurisdiction to modify the unscheduled permanent disability award, claimant requests that we remand that issue to the Referee for further development of the record. On review, the issues are premature closure, aggravation, jurisdiction, remand, and the extent of unscheduled and scheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. On August 23, 1990, claimant's range of motion in his right knee was active through the range of 110 degrees through 155 degrees. (Ex. 60-13).

Claimant initially raised the issue of extent of unscheduled permanent disability in his pre-hearing "specification of issues." At hearing, claimant: (1) did not specify extent of unscheduled permanent disability in his list of issues; (2) objected to certain exhibits submitted by the insurer that related to unscheduled permanent disability; and (3) asserted that the insurer could not raise the issue of extent of unscheduled permanent disability because it had not previously cross-requested a hearing on that issue. The Referee admitted the exhibits and allowed the insurer to cross-request for a reduction in the unscheduled permanent disability awarded by a Determination Order.

FINDINGS OF ULTIMATE FACT

At claim closure, there was no reasonable expectation of improvement in claimant's right knee condition either through medical treatment or the passage of time.

The issue of extent of unscheduled permanent disability involved the same claim as claimant's initial hearing request. With due diligence, claimant could have requested a continuance of the hearing if he was surprised by the insurer's litigation of this issue.

Claimant's low back condition is not related to his right knee injury.

Claimant's condition did not worsen since the last arrangement of compensation. The work injury is not the major contributing cause of any functional overlay condition from which claimant may suffer.

Claimant has sustained a 12 percent loss of use or function of his right leg (knee).

CONCLUSIONS OF LAW AND OPINION

In 1990, the legislature amended the workers' compensation law. Or Laws 1990 (Special Session), Ch. 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matters at issue relating to premature closure, jurisdiction and aggravation are not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result in regard to those issues inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze those issues under the Workers' Compensation Act as amended, effective July 1, 1990.

However, in regard to the extent of permanent disability issues, we note that the 1990 amendments to ORS 656.283(7) and 656.295(5) do not apply because claimant became medically stationary before July 1, 1990. See Or Laws 1990, Ch. 2, 54(3); Stephen A. Roberts, 43 Van Natta 1815 (1991).

Premature Closure

We affirm and adopt the Referee's ruling on this issue, as supplemented below.

In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J. R. Simplot & Co., 84 Or App 622, 625, rev den 303 Or 590 (1987).

Here, none of the reports relied on by claimant address his condition at the time of closure. Accordingly, for this and other reasons discussed by the Referee, we find that claimant has not proved that his claim was prematurely closed.

Jurisdiction

At hearing, claimant withdrew his request for a hearing on the issue of extent of unscheduled permanent disability; thus, he argues, the Referee had no jurisdiction over that issue. Claimant cites Thomas E. Harlow, 38 Van Natta 1406, 1408 (1986), and the cases cited therein to support this argument. However, the cases cited in Harlow refer to instances where the claimants were the only parties to request a hearing, and they subsequently withdrew their requests for hearing on all issues. Under those circumstances, the Board found that the referees had no jurisdiction. See Charles W. Roller, 38 Van Natta 50 (1986); Jimmie Parkerson, 35 Van Natta 1247, 1250 (1983). Here, claimant did not withdraw his request for a hearing on all issues, but only withdrew a single issue that he had previously raised.

Furthermore, the Harlow decision itself is inapposite. In Harlow, the claimant requested a hearing on a Determination Order, and then raised at hearing three additional Determination Orders issued under different claims. The Board found that the Referee was without jurisdiction over those three additional Determination Orders. Here, no new claim was raised at hearing. See Cary O. Miller, 42 Van Natta 618 (1990). Furthermore, claimant initially raised the issue of extent of unscheduled permanent disability in his pre-hearing specification of issues.

Finally, OAR 438-06-031, the administrative rule applicable to these proceedings, was adopted after Harlow was decided. OAR 438-06-031 provides that if, at hearing, evidence supports an issue not previously raised, the referee may allow the issue to be raised. If the adverse party is surprised and prejudiced as a result, the Referee may continue the hearing upon a motion of the adverse party. Thus, claimant's remedy, in the event of surprise, was to request a continuance at hearing. Although claimant objected to the admission of certain exhibits and claimed surprise, he made no showing of prejudice and made no motion for a continuance. Therefore, we conclude that the issue of extent of unscheduled permanent disability was properly before the Referee.

Remand

Claimant requests that, if we find that the Referee had jurisdiction over this issue, we remand this issue to the Referee to allow the development of a more complete record.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). 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. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Or App 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Here, we find that any additional evidence would have been obtainable with due diligence at the time of the hearing if claimant had requested a continuance. Therefore, we conclude that remand is not merited.

Unscheduled Permanent Disability

We affirm and adopt the Referee's ruling on this issue.

Aggravation

We affirm and adopt the Referee's ruling on this issue.

Scheduled Permanent Disability

The Referee assigned a value of 7 percent for loss of right knee range of motion and 3 percent for a partial medial meniscectomy, for a total value of 10 percent. However, as the insurer did not request a decrease in the Determination Order award of 11 percent, the Referee affirmed the award.

Claimant relies on a December 1989 physical capacities evaluation to establish that his range of motion is more limited than the 7 percent value calculated by the Referee. He also argues that this report establishes a compensable weakness in his right leg. (Ex. 43-3). However, this report related to claimant's condition before he became medically stationary. Thus, we do not rely on it. Furthermore, reports after claimant became medically stationary do not document weakness. (Ex. 59-4).

Accordingly, we affirm and adopt the Referee's 7 percent value for loss of range of motion; and we award no value for weakness.

Claimant further argues that he is entitled to five percent impairment for his partial medial meniscectomy, rather than 3 percent as found by the Referee.

We agree. Former 436-35-230(4)(d). The Orthopaedic Consultants provide the only rating of this surgery and they rate it at five percent. (Ex. 46-7).

Accordingly, combining the loss of range of motion (7 percent) with 5 percent impairment for his partial medial meniscectomy, we find that claimant has suffered a 12 percent loss of use or function of his right leg due to the work injury.

ORDER

The Referee's order dated October 22, 1990 is modified in part and affirmed in part. In addition to the 11 percent (16.5 degrees) scheduled permanent disability awarded by a Determination Order, claimant is awarded 1 percent (1.5 degrees) scheduled permanent disability, giving him a total award to date of 12 percent (18 degrees) scheduled permanent disability for his right leg (knee) injury. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800.

October 15, 1991

Cite as 43 Van Natta 2326 (1991)

In the Matter of the Compensation of

BARBARA J. GILLETTE, Claimant

WCB Case No. 90-20357

ORDER ON REVIEW

Karen M. Werner, Claimant Attorney

Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Seifert's order which set aside its denial of claimant's injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

At the beginning of her shift on September 29, 1990, claimant and another employee became involved in an argument concerning who would take care of a particular patient that day. In order to settle the argument and avoid further problems, the co-worker agreed to care for the patient. The charge nurse instructed claimant that the co-worker would care for the patient. The day prior to the altercation at work, claimant and the same co-worker were involved in a disagreement.

While the co-worker was toileting the patient, claimant entered the bathroom, alleging that the co-worker was abusing the patient. It is unclear who struck whom first, but claimant and the co-worker came to blows. Both employees were terminated from their jobs.

On October 5, 1990, claimant sought medical treatment for pain in her back, shoulder and knee.

Claimant was not a reliable witness.

The altercation between claimant and her co-worker began with a dispute about a job assignment concerning a particular patient. Claimant did not confront the co-worker solely to prevent imminent injury or harm to the patient.

Claimant was an active participant in an assault or combat that was not an actual part of her job.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had suffered a compensable injury while engaged in an altercation with a fellow employee at work. We do not agree.

ORS 656.005(7)(a)(A) excludes from the definition of compensable injury:

"Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties."

The Court of Appeals has recently held that an injury incurred by an active participant in an assault or combat that is not an actual part of the job is not compensable. SAIF v. Barajas, 107 Or App 73 (1991). Here, the Referee has concluded, and we agree, that claimant was an active participant in the assault or combat.

However, the Referee further concluded that the altercation was connected with the job assignment i.e., care of the patient. We disagree.

In Kessen v. Boise Cascade Corp., 71 Or App 545 (1984), the court interpreted the phrase "connected with the job assignment" to apply when the job entailed assaultive conduct, such as in the case of a boxing instructor or bouncer. Kessen, supra at 548. Here, claimant's job entailed caring for patients. The confrontation with the co-worker was a deviation from claimant's usual duties. Accordingly, because the injury was incurred by claimant who was an active participant in an assault or combat that was not an actual part of her job, we conclude that it is not compensable.¹ Barajas, supra at 76.

ORDER

The Referee's order dated January 23, 1991 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's \$,1500 attorney fee award is reversed.

¹ We would have reached a different conclusion if the evidence showed that claimant had confronted the co-worker only as necessary to protect the patient from suffering some imminent bodily harm at the co-worker's hands. However, that was not the evidence. Claimant deviated from her duties as a health care worker on this record.

October 15, 1991

Cite as 43 Van Natta 2327 (1991)

In the Matter of the Compensation of
CARY J. HALBACK, Claimant
WCB Case No. 90-10814
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Thye's order which found that the issue of compensability of his urinary and bowel dysfunction condition was barred by issue and claim preclusion. On review, the issue is res judicata. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation.

Claimant's bowel and bladder dysfunctions began in August 1989.

FINDINGS OF ULTIMATE FACT

Claimant's compensable low back injury is not the major contributing cause of claimant's bowel and bladder dysfunctions.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusion that the claim is barred by issue preclusion. Thus, the Referee's order can be affirmed on this basis alone.

Even if the doctrine of issue preclusion did not apply, the Referee's order must be affirmed because of claimant's failure to establish a causal relationship between the low back injury and his bowel and bladder problems.

The relationship between the two conditions is a complex medical question, the resolution of which primarily turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420 (1987); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

To establish a causal relationship, claimant relies solely on the medical opinion of his physician, Dr. David Winchester. We are not persuaded by Dr. Winchester's opinion.

First, the opinion consists entirely of a letter to the doctor from claimant's attorney which summarizes a conversation between the two individuals. Furthermore, Dr. Winchester based his opinion largely on his erroneous understanding that claimant's dysfunctions began "shortly" after the January 1989 low back injury. We have found that his problems began seven months later, in August 1989. Furthermore, the opinion addresses the complex question of causation in a conclusory fashion. For these reasons, and in light of all the evidence, we are not persuaded by it. See Miller v. Granite Construction, Co., 28 Or App 473 (1977) (a medical opinion is no greater than the history upon which it is based). Accordingly, we conclude that the claim is not compensable on the merits.

ORDER

The Referee's order dated October 17, 1990 is affirmed.

In the Matter of the Compensation of
GILBERT T. HALE, Claimant
WCB Case No. 90-03823
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of those portions of Referee Livesley's order that: (1) awarded additional temporary disability; (2) assessed penalties and attorney fees for unreasonable failure to pay temporary disability; and (3) denied the employer's request to offset the temporary disability paid pursuant to a Determination Order against future permanent disability benefits. On review, claimant moves to: (1) correct the record; and (2) strike portions of the employer's brief. The issues on review are motion to correct the record, motion to strike, temporary disability compensation, penalties and attorney fees. We deny the motions to correct the record and to strike and affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

FINDINGS OF ULTIMATE FACT

We adopt the Referee's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Motion to Correct the Record

Claimant moves to correct the record and offers Exhibit 8 which the employer initially offered at hearing and then withdrew. Claimant did not attach a copy of this exhibit and there is no copy in the record. However, claimant contends that it shows that the employer was aware in June 1986 that claimant had attempted to work in construction, contrary to the employer's assertion that it had no information prior to hearing indicating that claimant worked anywhere after his termination other than the two weeks worked at Lyons Restaurant in 1984. We treat such a request as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Keinow's Food Stores v. Lyster, 79 Or App 416 (1986). 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. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Or App 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Because the information was clearly available at hearing, we find that claimant has not made a showing of good cause or due diligence that would merit remand. At no time during the hearing did claimant object to the withdrawal of this exhibit or attempt to offer it himself, even after it was clear that the employer was questioning claimant's employment history before the aggravation date. Furthermore, the record is not insufficiently developed without this evidence. The relevant issue is whether claimant had withdrawn from the workforce at the time of the August 24, 1989 aggravation; evidence of his attempts to work in 1986 are relevant but not dispositive. There is a great deal of evidence in

the record concerning claimant's later work history. Under these circumstances, we deny the motion to correct the record.

Motion to Strike Portions of the Employer's Brief

Claimant moves to strike portions of the employer's brief on the basis that these portions are irrelevant and only asserted for their prejudicial value. Claimant cites no authority for his motion.

The Board is a professional factfinder and is capable of disregarding irrelevant or unsupported assertions of fact. Claimant's motion is denied.

Temporary Disability and Offset

We adopt the Referee's "Conclusions of Law and Opinion" concerning the issue of temporary disability with the exception of the last paragraph of the section on "Entitlement to temporary disability" and with the following supplementation.

Even if the employer relied on its interpretation of the Supreme Court decision rather than the Court of Appeals decision in Dawkins v. Pacific Motor Trucking, 91 Or App 562 (1988), rev'd, 308 Or 254 (1989), this does not account for the fact that the employer did not act on the October 20, 1989 letter from Dr. Schachner which established that claimant remained in the workforce. (Ex. 22-2). Instead, the employer continued to assert that claimant had withdrawn from the workforce.

Furthermore, because we agree with the Referee that claimant remained in the workforce and was entitled to temporary disability compensation, we also agree that the employer is not entitled to authorization to offset the temporary disability that it paid pursuant to the Determination Order against future awards.

Penalties and Attorney Fees

We adopt the Referee's "Conclusions of Law and Opinion" concerning the penalty and attorney fee issue with the following supplementation.

The employer contends that its failure to pay interim compensation was not unreasonable because claimant allegedly informed it that he had last worked in 1984 and that he relied on his wife for financial support. Although these alleged remarks are relevant, they alone, do not indicate that claimant had withdrawn from the workforce. The employer did not ask the dispositive question, i.e., was claimant willing to work, which is necessary to determine whether claimant had withdrawn from the workforce. See Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). Accordingly, we agree with the Referee that the employer's failure to pay interim compensation was unreasonable. See Kari Mercurio, 41 Van Natta 809, 811 (1989).

Attorney Fee/Board Review

The self-insured employer has requested review of an order awarding compensation. We have found that compensation should not be disallowed. Hence claimant is entitled to an assessed fee. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) we find that a reasonable fee for claimant's counsel's services on review concerning the temporary disability issue is \$800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's

respondent's brief), the complexity of the issue, and the value of the interest involved.

We note that claimant is not entitled to an attorney fee for defending against the penalty-related attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Furthermore, the Board has previously concluded that an offset does not reduce compensation within the meaning of ORS 656.382(2). See Randy Strazi, 42 Van Natta 1116 (1990); Aff'd Strazi v. SAIF, 109 Or App 105 (1991); Lawrence N. Sullivan, 39 Van Natta 88, 97 (1987). Accordingly, claimant is not entitled to an assessed fee regarding the denial of the offset. Christine L. Davis, 42 Van Natta 397, 398 (1990); Darin S. Hayes, 43 Van Natta 1171 (1991).

ORDER

The Referee's order dated September 17, 1990 is affirmed. The motions to correct the record and to strike portions of the employer's appellant brief are denied. For services on review, concerning the temporary disability issue, claimant's attorney is awarded an assessed fee of \$800, payable by the employer.

October 15, 1991

Cite as 43 Van Natta 2331 (1991)

In the Matter of the Compensation of
JOHN E. MEANS, Claimant
WCB Case No. 90-10262
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a cervical condition; and (2) declined to assess penalties and attorney fees for an alleged discovery violation. On review, the issues are aggravation, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following correction and supplementation. We do not adopt the last sentence of the Referee's findings.

On January 12, 1989, SAIF accepted claimant's cervical thoracic strain. (Ex. 6). On May 19, 1989, claimant was examined by Dr. Farris, orthopedic surgeon, and Dr. Platt, neurologist, both from the Orthopaedic Consultants, who found that claimant had excellent muscle strength (5/5) and exhibited no muscle spasms. (Ex. 13-4).

At the time of the June 1989 Stipulated Order, claimant was capable of performing medium work. He was limited to lifting up to 50 pounds occasionally with limits on heavy lifting or jerking that may involve the cervical spine. (Ex. 13A).

FINDINGS OF ULTIMATE FACT

Claimant experienced a symptomatic worsening, supported by objective medical findings, since his last arrangement of compensation (the June 29, 1989 Stipulated Order).

Claimant's symptomatic worsening resulted in a diminished earning capacity below the level fixed at the time of the last arrangement of compensation.

The Stipulated Order did not contemplate future periods of increased symptoms accompanied by a diminished earning capacity.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee found that claimant's condition had not worsened since his last arrangement of compensation. Therefore, the Referee concluded, claimant had not established a compensable aggravation claim.

On review, SAIF contends that the 1990 amendments to the aggravation statute apply to this case, and that the claim is not compensable under the amended statute. Claimant argues that because the applicability of the 1990 amendments was first raised on review, this issue was not timely raised. Therefore, claimant argues, the 1990 amendments do not apply to his case. We disagree.

Application of the correct law is a fundamental element of the Board's deliberative process. It need not be expressly raised by the parties. Here, claimant requested a hearing in this case after May 1, 1990 and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). Finally, neither party contends that application of the 1990 amendments would produce an absurd result. See Ida M. Walker, 43 Van Natta 1402 (1991). Therefore, we conclude that the 1990 amendments to ORS 656.273 apply. Or Laws 1990, Special Session, Ch. 2, 54.

To establish an aggravation claim, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, he has suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Perry v. SAIF, 307 Or 654 (1989); Gwynn v. SAIF, 304 Or 345 (1987); Smith v. SAIF, 302 Or 396 (1986); Leroy Frank, 43 Van Natta 1950 (1991). See Larry L. Bowen, 43 Van Natta 1164 (1991). Furthermore, the major contributing cause of the worsened condition cannot be an injury occurring outside the course and scope of employment. ORS 656.273(1).

Claimant argues that he experienced both a symptomatic and a pathologic worsening supported by objective medical findings since his last arrangement of compensation. Claimant relies on a cervical myelogram and a CT scan which revealed a protruded disc at C5-6 to establish that he has suffered a pathological worsening. However, we do not find these tests dispositive because claimant had no prior baseline myelogram or CT scan. On the other hand, we agree that he experienced a symptomatic worsening.

Prior to the June 1989 Stipulated Order, no medical reports indicated that claimant suffered from muscle spasms or loss of strength. In fact, on May 19, 1989, the Orthopaedic Consultants found that claimant had no muscle spasms and excellent muscle strength. (Ex. 13-4). However, on February 12, 1990, claimant's current treating chiropractor, Dr. Roberts, noted that claimant had muscle

spasms. (Ex. 16B-1). Dr. Tindall, examining chiropractor, also noted muscle spasms on May 25, 1990. (Ex. 22-2). Furthermore, strength tests performed on May 24, 1990 indicated that claimant suffered a loss of strength. (Exs. 19, 20, 21, 23, 24).

ORS 656.005(19) lists muscle spasm and muscle strength as examples of objective findings in support of medical evidence. Thus, we find that the medical evidence documenting muscle spasms and loss of strength during the current flare-up constitute medical evidence of a symptomatic worsening supported by objective findings.

We further conclude that the exacerbation resulted in further diminished earning capacity. At the time of the June 1989 Stipulated Order, claimant was capable of performing medium work. At that time, he was limited to lifting up to 50 pounds occasionally with limits on heavy lifting or jerking that may involve the cervical spine. (Ex. 13A). By comparison, claimant was released from all work after his alleged aggravation. (Ex. 17D-2). Accordingly, we conclude that claimant's symptomatic exacerbation resulted in diminished earning capacity below the level fixed at the time of the June 1989 Stipulated Order.

We next consider whether the Stipulated Order contemplated future periods of increased symptoms accompanied by a diminished earning capacity. Citing Edward D. Lucas, 41 Van Natta 2271 (1989), SAIF argues that the fact that claimant suffered a flare-up in December 1988 after he had been declared medically stationary determines that future flare-ups were considered by the June 1989 Stipulated Order. We disagree.

In Lucas v. Clark, 106 Or App 687 (1991), the court reaffirmed its position that "if there was medical evidence of the possibility of future flare-ups, the assumption is that the parties considered that evidence, unless there are indications to the contrary." Id. at 690. However, the court concluded that mere evidence of past flare-ups is not enough to establish that future flare-ups were contemplated given the fact that: (1) the Stipulated Order made no reference to the prognosis of the claimant's back condition and made no additional award for that condition; and (2) prior to the Stipulated Order no doctor had predicted future flare-ups of the condition. Id. at 691.

We find Lucas v. Clark, supra, dispositive on the issue of whether future flare-ups were contemplated by the June 1989 Stipulated Order. Here, the June 1989 Stipulated Order did not reference future flare-ups. Also, prior to this Stipulated Order, no physician predicted future flare-ups. Therefore, we conclude that the June 1989 Stipulated Order did not contemplate future periods of increased cervical symptoms accompanied by diminished earning capacity.

Finally, the record does not indicate and SAIF does not contend that claimant suffered any injury outside the course and scope of employment that was the major contributing cause of his worsened condition. ORS 656.273(1).

On the basis of the above reasoning, we reverse the Referee on this issue and find that claimant has established a compensable aggravation claim.

Penalties and Attorney Fees for the Discovery Violation

We adopt the Referee's reasoning and conclusion that SAIF committed an unreasonable discovery violation by not forwarding a copy of Exhibit 25 to claimant's counsel until more than two months after SAIF received it. However, the Referee applied former ORS 656.262(10) and 656.382 in determining that no award of penalties or attorney fees was due. Because the Referee found that claimant had not proved an aggravation claim, she found no amounts "then due" upon which

to base a penalty. Furthermore, she did not award an attorney fee because she erroneously concluded that the Oregon Administrative Rules do not provide that an insurer's failure to provide discovery may be considered an unreasonable delay or refusal under ORS 656.262(10).

As noted above, the time lines of this case bring it within the 1990 amendments; therefore, ORS 656.262(10) and 656.382(1), as amended, apply here. See Harry E. Forrester, 43 Van Natta 1480 (1991).

OAR 438-07-015(5) provides that failure to comply with the discovery rule shall, if found unreasonable, be considered delay or refusal under ORS 656.262(10). ORS 656.262(10)(a) provides in pertinent part:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, * * * the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. * * * If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee. * * *"

Because we find that claimant has established an aggravation claim, there are "amounts then due" upon which to base a penalty. We assess a penalty of 25 percent of the amounts "then due" at the time of hearing for the unreasonable discovery violation. This amount would include the interim compensation and medical bills related to his accepted cervical-thoracic sprain. Inasmuch as the claim in issue included medical services on an accepted injury, as opposed to medical services from an initial claim, we find the medical services in question to be compensation then due. See ORS 656.005(8); 656.262(6); Kurt Kraal, 42 Van Natta 2634 (1990); Clinton F. Seals, 42 Van Natta 268 (1990). This penalty will be split between claimant and his attorney. See ORS 656.262(10)(a).

Attorney Fees at Hearing and on Board Review

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is \$2,350, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 10, 1990 is reversed in part and affirmed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant is awarded a penalty of 25 percent of the interim compensation and medical bills due; as of the date of hearing one-half of this penalty is to be paid to claimant and one-half is to be paid to claimant's attorney in lieu of an attorney fee for the discovery violation issue. For services at hearing and on Board review, concerning the aggravation issue claimant's attorney is awarded an assessed fee of \$2,350, to be paid by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
BEVERLY J. RAMEY, Claimant
WCB Case No. 90-13082
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Michael Johnson's order that: (1) increased her unscheduled permanent disability from 13 percent (41.6 degrees), as awarded by Determination Order, to 18 percent (57.6 degrees) unscheduled permanent disability for her low back condition; and (2) declined to award scheduled permanent disability for loss of use or function of her left leg. Claimant contends that, if she is entitled to an award of scheduled permanent disability, that award should be paid at the rate of \$305 per degree. On review, the issue is extent of unscheduled and scheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant was 48 years old at the time of hearing. She has a GED degree and two years of correspondence and college courses. Claimant's highest SVP for the ten years prior to the date of hearing was 3, as a typist. Claimant has acquired training sufficient to perform other than entry-level work.

At the time of her compensable injury in May 1988, claimant worked as a Clerk Typist II. Her job required her to frequently lift up to 40 pounds. Following her injury, claimant returned to work as a Clerk Typist II; however, she did not perform any lifting.

As a result of her compensable injury, claimant has loss of range of motion in the thoracolumbar area, unoperated disc bulges at L4-5 and L5-S1, and a chronic condition limiting repetitive use of the low back.

CONCLUSIONS OF LAW AND OPINION

Unscheduled permanent disability

The Referee concluded that claimant was entitled to 18 percent unscheduled permanent disability under the "standards." We apply the standards in effect on March 20, 1990, the date of the Determination Order, and modify.

Age

The appropriate value for claimant's age of 49 years is 1. Former OAR 436-35-290(4).

Formal education

The appropriate value for claimant's high school education is 0. Former OAR 436-35-300(3)(a).

Skills

Claimant's highest SVP value during the ten years prior to the date of hearing was 3 as a typist (DOT# 203.582-066). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4)(b).

Training

We have concluded that competence in a "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990). Here, claimant has worked as a clerk typist for the employer with an SVP of 3, which is more than entry-level. See Jean H. Humphrey, 42 Van Natta 2542 (1990). Therefore, the appropriate training value is 0. Former OAR 436-35-300(5)(b).

Adaptability

The Referee concluded that claimant had returned to regular work. We disagree.

Claimant testified that, before her injury, she frequently lifted up to 40 pounds. However, following her injury, even though her doctor had released her to regular work, claimant did not perform any lifting at work. Claimant's testimony is un rebutted.

We conclude that, regardless of the doctor's release, claimant returned to modified work. "Modified work" means some job other than the job held at the time of injury or the job held at the time of injury with any modification of duties or the conditions under which those duties are performed. Former OAR 436-35-270(3)(b). Also see Edward L. Sullivan, 43 Van Natta 932 (1991) (where a claimant's usual and customary work required the physical capacity to perform heavy work, and where the claimant's attending physician released him to return to heavy work, the fact that claimant actually performed modified work upon his return to work after the injury was sufficient to find that, for purposes of an adaptability value, claimant had returned to modified work, rather than his usual and customary work).

Here, claimant's usual and customary work required the physical capacity to perform between heavy and medium work. Claimant's modified work falls within the sedentary range. Accordingly, the appropriate adaptability value is 2.5 Former OAR 436-35-310(3).

Impairment

Claimant contends that the impairment value should be determined by using the findings of Dr. Fechtel's January 13, 1990 report, as it was authored near the time of closing and was concurred in by claimant's treating doctors, Dr. Mang and Dr. Bert. The insurer argues that Dr. Mang's April 20, 1989 range of motion findings should be used to determine claimant's impairment.

We note that, although the insurer asserts that Dr. Mang's report was authored after Dr. Fechtel's report, the converse is true. Although Dr. Fechtel's report is dated January 13, 1989, the incorrect year is apparently attributable to a typographical error, and the report was actually authored on January 13, 1990. See Ex. 10-1 (insurer's date stamp), Ex. 10-2 (reference to a May 31, 1989 chart note), Ex. 16 (reference to Dr. Fechtel's report of January 13, 1990). Accordingly, we agree with claimant that Dr. Fechtel's report contains the most recent impairment findings, and Drs. Mang and Bert concurred in those findings.

For reduced thoracolumbar flexion (from 90 degrees to 70 degrees), claimant is entitled to an impairment value of 2 percent. Former OAR 436-35-360(6). For reduced thoracolumbar extension (from 30 degrees to 25 degrees), claimant is entitled to an impairment value of .5 percent. Former OAR 436-35-360(7). For

loss of right flexion (from 30 degrees to 16 degrees), claimant is entitled to an impairment value of 2.8 percent. Former OAR 436-35-360(8). For loss of left flexion (from 30 degrees to 22 degrees), claimant is entitled to an impairment value of 1.6 percent. Former OAR 436-35-360(8). For loss of right rotation (from 30 degrees to 25 degrees), claimant is entitled to an impairment value of 1 percent. Former OAR 436-35-360(9). Claimant's values for loss of range of motion in the thoracolumbar area are added for a total value of 7.9 percent. Former OAR 436-35-360(10).

In addition to reduced spinal motion, claimant is entitled to impairment values for her unoperated disc bulges. Former OAR 436-35-350(2). For her unoperated disc bulges at the L4-5 and L5-S1 levels, claimant is entitled to a value of 4 percent each. Claimant's total general spinal findings, therefore, equal 8 percent.

Finally, claimant also has a chronic condition which limits her ability to repetitively use her low back. For her chronic condition limiting repetitive use, claimant is entitled to an impairment value of 5 percent. Former OAR 436-35-320(4).

The impairment values for claimant's lost range of motion (7.9), general spinal findings (8), and chronic condition (5), are combined for a total impairment value of 19.4.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to her education value, 3, the sum is 4. When that value is multiplied by claimant's adaptability value, 2.5, the product is 10. When that value is added to claimant's impairment value of 19.4, the result is 29.4 percent unscheduled permanent disability. That value is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 30 percent.

Scheduled permanent disability

Claimant argues that she is entitled to an award for scheduled disability, as Dr. Fechtel reported claimant had atrophy in the left thigh and claimant testified to a "foot drop." Claimant also contends that she is entitled to an award for numbness in the left foot.

We agree with the Referee that neither the medical records nor claimant's testimony establishes that claimant has ratable, permanent loss of use or function of the left leg or foot. Accordingly, we agree that an award of scheduled impairment is not warranted.

ORDER

The Referee's order dated January 9, 1991 is modified in part and affirmed in part. In addition to the Referee's award and the Determination Order award, claimant is awarded 12 percent (38.4 degrees), giving her a total award to date of 30 percent (96 degrees) unscheduled permanent disability for her low back condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney by the insurer. However, the total attorney fees awarded by the Referee and Board orders shall not exceed \$3,800. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ROBERT W. STERLING, Claimant
WCB Case No. 91-07003
ORDER DENYING MOTION TO DISMISS
Ainsworth, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Claimant has moved the Board for an order dismissing the insurer's request for review of the Referee's August 29, 1991 order, which concluded that claimant's scheduled permanent disability award should be paid at the rate of \$305 per degree. Contending that the insurer's appeal is "absurd" and "frivolous," claimant seeks the dismissal of the insurer's request and the assessment of penalties and attorney fees. We deny the motions.

FINDINGS OF FACT

In June 1991, claimant submitted a hearing request in which the issue was the rate of scheduled permanent disability. The matter was heard based on stipulated facts. On August 29, 1991, the Referee issued an Opinion and Order. Relying on the Board's rationale in Alan G. Herron, 43 Van Natta 1097 (1991), the Referee concluded that claimant's rate of scheduled permanent disability should be paid at \$305 per degree.

On September 16, 1991, the insurer mailed a request for Board review of the Referee's order to the Board. The request included a certificate of personal service by mail upon claimant and the employer.

CONCLUSIONS OF LAW AND OPINION

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 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 August 29, 1991 order was September 28, 1991, a Saturday. Therefore, the final day to timely request review was Monday, September 30, 1991. ORCP 10A; ORS 174.120. The insurer's request for review was mailed to the Board and copies were mailed to the other parties to the proceeding on September 13, 1991. Inasmuch as such submissions were made within 30 days of the issuance of the Referee's August 29, 1991 order, we have jurisdiction to consider this case. See ORS 656.289(3); 656.295(2).

Claimant seeks dismissal of the insurer's request, asserting that the insurer "appealing the Referee's Order at this time is absurd." The basis for claimant's contention is his apparent misunderstanding that the Court of Appeals has affirmed the Board's decision in Herron and has "decided that the \$305.00 per degree amendment applies to all scheduled awards made after May 7, 1990." To date, no appellate decision concerning the Herron order or any other case involving the "rate of scheduled permanent disability" issue has issued. In any event, claimant provides no authority for his assertions that an otherwise timely request for Board review should be dismissed for an allegedly absurd request for Board review. Finding no authority for such a proposition, we disagree with claimant's contentions. Walter F. Drews, 41 Van Natta 2426 (1989).

Because the insurer timely requested Board review, the Referee's order has not become final. ORS 656.289(3). Furthermore, after conducting our review, we

are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(6). Thus, the rate of scheduled permanent disability issue considered by the Referee remains viable on Board review.

Claimant also seeks an attorney fee "for prevailing against the carrier's frivolous appeal of the Opinion and Order." We have previously held that the authority for the assessment of a penalty for vexatious, unreasonable, or frivolous requests or appeals rests with the Referee pursuant to ORS 656.382(3) or the appellate courts under ORS 656.390. Donald G. Messer, 42 Van Natta 2085 (1990). Consequently, we are without authority to assess penalties and attorney fees for an alleged frivolous appeal in this case.

Finally, claimant requests penalties and attorney fees for the insurer's allegedly unreasonable refusal to comply with the Referee's order. The sole issue on Board review pertains to the rate of claimant's scheduled permanent disability award, not the insurer's actions in processing the claim following the Referee's order. Inasmuch as claimant seeks consideration of an issue which was not raised at hearing, it will not be considered on review. Sheila A. Cress, 42 Van Natta 216 (1990). Should claimant disagree with the insurer's processing of the claim in response to the appealed Referee's order, there are alternative avenues available to him. ORS 656.262(10); Nicolasa Martinez, 43 Van Natta 1638 (1991).

Accordingly, claimant's motions are denied. The transcript has been ordered. Upon its receipt, copies will be provided to the parties, and a briefing schedule implemented. After completion of the briefing schedule, this case will be docketed for review.

IT IS SO ORDERED.

October 16, 1991

Cite as 43 Van Natta 2339 (1991)

In the Matter of the Compensation of
SUSAN J. BUTLER, Claimant
WCB Case No. 90-13974
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Bethlahmy's order which upheld the insurer's denial of claimant's occupational disease claim for irritative bronchitis. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

With the exception of the finding that claimant did not have a coughing problem prior to transferring to the employer's new building in Tigard, we adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant's fellow worker, Lutzke, testified that she began to work in the employer's new building in May 1989. Lutzke testified that claimant did not start working in the new building until three weeks after Lutzke, because claimant went to training in Washington before she transferred to the new building. (Tr.9). Claimant testified that she began to work in the new building in May

1989. (Tr. 25-26). Claimant had been inside the new building twice in April 1989. (Tr. 26).

On March 9, 1989, claimant went to her family physician, Dr. Anderson, complaining of chest congestion and swelling behind her right ear. (Ex. 1). On April 27, 1989, Dr. Anderson prescribed "robitussin AC 480 ml," a cough suppressant, along with other medications. (Ex. 1). On May 25, 1989, Dr. Anderson examined claimant for an "annoying cough" that claimant had had for two months. (Ex. 2).

A doctor's chart note on October 11, 1989 indicates that claimant had the flu in May 1989, and that "she has actually had the cough now for eight to 12 months." (Ex. 5).

Claimant was examined by Dr. Keppel, pulmonologist, on October 22, 1989. (Ex. 8). Dr. Keppel noted that claimant had experienced a "severe infection" with a "temperature to 104," sore throat and cough in June 1989. (Ex. 8).

On February 2, 1990, claimant saw Dr. Anderson for a headache condition. She had been coughing "earlier in the week" and had been running a fever. (Ex. 11). These conditions resolved. After she returned to work she felt better except for the headaches. (Ex. 11).

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Montanaro, the Referee found that claimant's work environment was not the major contributing cause of claimant's irritative bronchitis. See ORS 656.802(1)(a) and (2). We agree with the Referee that claimant has not established that her work environment was the major contributing cause of claimant's condition, but we do so for different reasons than the Referee.

Claimant argues that her condition is the result of her exposure to dust in the employer's new building in which claimant began work in May 1989. It is not clear whether claimant began work in the new building in May or June 1989. However, the record does indicate that on May 25, 1989, claimant had had a chronic cough for two months. Accordingly, regardless of whether claimant began to work in the new building in May or June, we conclude that claimant's cough preceded her transfer to the employer's new building.

Dr. Keppel and Dr. Anderson, claimant's treating physicians, opine that claimant's condition is the result of her work environment -- "sick building syndrome." However, neither physician has provided an explanation of the basis of their respective opinions.

Dr. Keppel's initial examination of claimant took place in October 1989. Although he evaluated her "Environmental History," including the fact that claimant was working "in a new office since May," he did not, at that time, consider claimant's work environment as an active factor in her condition. Dr. Keppel did not consider claimant's work environment a factor until May 2, 1990. Dr. Anderson did not consider claimant's work environment a factor in her condition until May 29, 1990. Importantly, there is no indication that either Dr. Keppel or Dr. Anderson knew exactly when claimant began to work in the new building. There is no indication that either physician took into consideration the fact that claimant's "chronic cough" condition preceded her transfer to the employer's new building. In addition, neither Dr. Keppel nor Dr. Anderson address the nonwork-related factors raised by Dr. Montanaro.

Furthermore, the record indicates that in February 1990, claimant was off work because of a bout with the flu which included a fever and cough condition. She sought treatment from Dr. Anderson at that time. Yet, after returning to work, to the allegedly causative building, claimant told Dr. Anderson that she felt better except for a headache. Claimant did not complain of a cough after

returning to the employer's building in February 1990. Therefore, we are not persuaded by the conclusory statements of claimant's treating physicians, that claimant's condition is the result of her working environment.

Accordingly, we conclude that claimant has not carried her burden to prove that her employment is the major contributing cause of her irritative bronchitis and chronic cough condition.

ORDER

The Referee's order dated December 27, 1990 is affirmed.

October 16, 1991

Cite as 43 Van Natta 2341 (1991)

In the Matter of the Compensation of

PENNY L. HANSON, Claimant

And, In the Matter of the Compliance of

Joseph Michael Henderson, owner DIET CENTERS OF EUGENE, Employer

WCB Case Nos. 90-16732, 90-16465 & 90-20904

ORDER OF DISMISSAL

Robert L. Guarrasi, Claimant Attorney

Kevin L. Mannix, Defense Attorney

Nancy Marque (Saif), Defense Attorney

Cummins, et al., Defense Attorneys

Employers Defense Counsel, Attorneys

The SAIF Corporation, claimant, the alleged noncomplying employer, and the Department of Insurance and Finance requested review of Referee McWilliams' order that: (1) set aside SAIF's denial of claimant's injury claim issued on behalf of the alleged noncomplying employer; (2) dismissed the alleged noncomplying employer's hearing request from a noncompliance order because of invalid service; (3) found that the alleged noncomplying employer did not have coverage with Farmers Insurance; (4) upheld Farmers' denial of claimant's injury claim; (5) declined to assess penalties and attorney fees against SAIF and Farmers for allegedly unreasonable claims processing; and (6) awarded an assessed attorney fee of \$17,500, to be paid by SAIF.

SAIF, claimant, the alleged noncomplying employer, and the Department have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable in this matter. Specifically, the parties agree that SAIF's denial "shall remain in full force and effect" and that claimant's claims against the alleged employers and insurers "shall be dismissed with prejudice."

The agreement further provides that an amended order finding Diet Centers of Eugene to be a noncomplying employer because Farmers had failed to notify the Department pursuant to ORS 656.419 shall stand. Page 9. Under such circumstances, the settlement declares that the individuals doing business as Diet Centers of Eugene are a noncomplying employer. The agreement states that these individuals shall be allowed to litigate the workers' compensation insurance coverage question with Farmers should litigation be instituted and, if it is determined that Farmers should have provided coverage and should have notified the Department pursuant to ORS 656.419, the Department will seek recovery from Farmers for any costs and administrative charges associated with the settlement expended by SAIF or the Department.

Farmers has not executed the proposed settlement. In fact, it objects to the settlement because the parties agree to withdraw their requests for Board

review, while simultaneously effectively modifying the Referee's order in a manner "which is designed to be prejudicial to one or two parties in later litigation."

In reply to Farmers' response, claimant and SAIF represent that the agreement is intended to have no effect of any kind upon Farmers' interests. The other parties to the settlement agree with claimant's and SAIF's representations. Specifically, the alleged noncomplying employer (Diet Centers of Eugene) states that Farmers' participation is unnecessary, while it is the position of the Department that the settlement "affirms the Referee's determination regarding SAIF as the insurer and Farmers as well."

Pursuant to the settlement, claimant, SAIF, the alleged noncomplying employer, and the Department agree to withdraw their respective requests for Board review. We have approved the agreement, thereby fully and finally resolving this matter. In granting this approval, we wish to emphasize that this action should not be interpreted as a decision, either expressed or implied, concerning any issue pertaining to Farmers Insurance that is either contrary to or inconsistent with decisions rendered by the Referee. Instead, our approval is solely designed to resolve any and all issues pending between the parties who have executed the settlement. Since those parties are the only parties to have requested review and because they have withdrawn their respective requests pursuant to the settlement, we dismiss the request for Board review with prejudice.

IT IS SO ORDERED.

October 16, 1991

Cite as 43 Van Natta 2342 (1991)

In the Matter of the Compensation of
RONALD H. HOWARD, Claimant
WCB Case Nos. 89-24929, 89-24923, 90-10529 & 90-10528
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Kevin L. Mannix, Defense Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Liberty Northwest Insurance Corporation requests review of Arbitrator Harri's order which: (1) set aside its denial of claimant's "new injury" claim for a thoracic and lumbar back condition; and (2) upheld the Fireman's Fund Insurance's denial of an aggravation claim for the same condition. Claimant has moved for an order dismissing Liberty Northwest's request for Board review contending that the request for review seeks review based on errors in the findings of fact which exceeds the Board's scope of review in arbitration proceedings under ORS 656.307. On review, the issues are standard of review and responsibility. We deny claimant's motion to dismiss, and affirm.

FINDINGS OF FACT

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

Claimant filed claims with two insurers, Liberty Northwest and Fireman's Fund, concerning responsibility for his neck and low back condition. On November 9, 1989, Liberty Northwest issued its responsibility denial and, on December 7, 1989, Fireman's Fund issued its responsibility denial. (Exs. 49 & 52-1). In December 1989, claimant filed requests for hearing challenging the denials

issued by Liberty Northwest and Fireman's Fund. The insurers conceded compensability and an Order Designating Paying Agent, pursuant to ORS 656.307, issued on May 15, 1990. The Order Designating Paying Agent directed Fireman's Fund to pay claimant's temporary total disability. On June 25, 1990, a hearing concerning the insurer's denials was convened and continued. On August 23, 1990, pursuant to the ".307" order, an arbitration hearing was held before a Referee. That hearing was convened in consolidation with the June 25, 1990 continued hearing. On December 4, 1990, the Referee, acting as an arbitrator, found Liberty Northwest responsible for the claim.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters

In its brief, Liberty Northwest argues that the Board lacked authority to convene an accelerated hearing on this matter on June 25, 1990. As we concluded in John K. French, 43 Van Natta 836 (1991), there is no statutory provision that prohibits the Board from rescheduling or accelerating the date of a hearing, provided that it gives 10 days prior notice of the time and place to all parties in interest by mail. See ORS 656.283(5). Furthermore, the Board is charged with overall responsibility to refer a request for hearing to a Referee for determination as expeditiously as possible, and that hearing is to be scheduled for a date not more than 90 days after the receipt by the Board of the request for hearing, except in extraordinary circumstances. ORS 656.283(4). Accordingly, we conclude that the parties in the present case were given timely notice and that the hearing convened on June 25, 1990, was procedurally legal and proper. See John K. French, *supra*.

Claimant has moved for an order dismissing Liberty Northwest's request for Board review. Claimant argues that because Liberty Northwest's brief raises arguments based only on alleged errors in the Arbitrator's findings of fact, the present case is unreviewable. We deny claimant's motion for the following reason.

Following the issuance of an order designating a paying agent under ORS 656.307, the Director shall request the Board to appoint a Referee to act as an arbitrator to determine the responsible paying party. An Arbitrator'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. The determination of the arbitrator may be reviewed by the Board, and then the Court of Appeals, within the same period of time as provided for review of an order after hearing. ORS 656.307(2). Review of the determination of the arbitrator by the Board and the Court of Appeals is limited to questions of law and is not thereafter subject to review by any other court or administrative body. *Id*; see Anastasis Samojlovski, 40 Van Natta 1815 (1988).

Here, Liberty Northwest timely complied with the aforementioned statutory requirements in requesting Board review of the order issued by the Referee acting as the Arbitrator. Claimant has not cross-requested review alleging that questions exist concerning his claim, as defined in ORS 656.704(3). See John L. Riggs, III, 42 Van Natta 2816, 2817 (1990). Therefore, the scope of our review is determined not by the parties' briefs, but by statutory law pursuant to ORS 656.307(2). Accordingly, we proceed to review the Arbitrator's order solely on questions of law. ORS 656.307(2).

Responsibility

The Arbitrator first concluded that the law, as it existed prior to the 1990 legislative amendments, applied to this matter. Accordingly, the Arbitrator applied the "last injurious exposure rule," and found that claimant's

employment, insured by Liberty Northwest, had independently contributed to claimant's current low back and neck condition. In the alternative, the Arbitrator concluded that even if the law, as amended by Oregon Laws 1990 (Special Session), Chapter 2, applied, Liberty Northwest remains responsible because, during the employment period when Liberty Northwest was the insurer on risk, claimant experienced an identifiable "incident" with objective signs and symptoms to qualify as a new "injury" under amended ORS 656.005(7).

The matter on review follows an arbitration proceeding before an arbitrator. The ".307" order which initiated the arbitration proceeding issued on May 15, 1990, the ".307" order was received by the Board on May 16, 1990, and the arbitration proceeding convened on August 23, 1990. Inasmuch as the ".307" order was received after May 1, 1990 and since the arbitration proceeding was convened after July 1, 1990, the 1990 amendments to ORS Chapter 656 apply retroactively to the determination of responsibility. See Oregon Laws 1990, Special Session, Chapter 2 54; Ida M. Walker, 43 Van Natta 1402 (1991); Concetta M. Crowder, 43 Van Natta 1741 (1991); Timothy R. Schroeder, 41 Van Natta 568 (1989).

The current version of Chapter 656 states that when a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. Oregon Laws 1990, Special Session, Chapter 2 49. There is no explicit reliance on the last injurious exposure rule in order to determine responsibility.

Inasmuch as the Arbitrator alternatively applied the standard of proof in effect since the 1990 amendments to Chapter 656, we find the Arbitrator applied the applicable law. Moreover, we further conclude that the Arbitrator correctly applied that law to the facts that he found. Accordingly, we find no legal error.

ORDER

The Arbitrator's order dated December 4, 1990 is affirmed.

October 17, 1991

Cite as 43 Van Natta 2344 (1991)

In the Matter of the Compensation of
JAMES A. ARCHIBALD, Claimant
Own Motion No. 89-0423M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Vick & Gutzler, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 18, 1991 Own Motion Order on Reconsideration that denied his request for temporary disability compensation on the ground that he was not in the work force at the time of knee surgery in April 1989. Claimant submits an affidavit averring that, before the surgery, he founded a mining business and filed several mining claims with the intent of working those claims after his medical release following surgery.

In order to qualify for the payment of temporary disability compensation under our own motion authority, claimant must be in the work force at the time of the surgery. See Fred Lotfi, 43 Van Natta 430 (1991). Claimant is deemed to be in the work force if, although he is not actively working, he is willing to

work and making reasonable efforts to obtain work. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

It is undisputed that claimant founded a mining company and filed mining claims before the April 1989 surgery. It is also undisputed that he filed the mining claims with the intent of working those claims after his medical release following surgery. Indeed, following his medical release for work, he began managing and working for his company. Under these circumstances, we find that, at the time of surgery, claimant was willing to work and making reasonable efforts to obtain work. We find that claimant was in the work force and therefore qualifies for the payment of temporary disability compensation. See Fred Lotfi, supra; Dawkins v. Pacific Motor Trucking, supra.

Accordingly, our September 18, 1991 order is withdrawn. On reconsideration, inasmuch as we find that claimant's compensable injury has worsened requiring surgery, claimant's claim is reopened for the payment of temporary disability compensation beginning the date he was hospitalized for surgery. SAIF shall continue paying temporary total disability compensation until one of the following events occurs: (1) claimant is medically stationary and the claim is closed; (2) claimant returns to regular or modified work; (3) the attending physician gives claimant a written release to return to regular employment; or (4) the attending physician gives claimant a written release to return to modified work, such employment is offered in writing to claimant and claimant fails to begin such employment. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed \$1,050, payable by SAIF directly to claimant's attorney. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved. See OAR 438-15-010(4). 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 SAIF pursuant to OAR 438-12-055.

IT IS SO ORDERED.

October 18, 1991

Cite as 43 Van Natta 2345 (1991)

In the Matter of the Compensation of
JEAN M. BATES, Claimant

WCB Case No. 89-13041

ORDER DENYING RECONSIDERATION

Claudette L. Yost, Claimant Attorney

Cowling & Heysell, Defense Attorneys

The insurer requests abatement of our October 8, 1991 Order on Review that set aside its denial of claimant's occupational disease claim for her psychological condition. We treat claimant's request as one for reconsideration under OAR 438-11-035.

The Board's rule requires that a request for reconsideration include a concise statement of the reason reconsideration is requested. OAR 438-11-035. Here, the insurer has failed to comply with the rule as it has provided no reason for its reconsideration request. Additionally, we note that OAR 438-05-046(2)(a) and (b) provide that copies of any documents delivered for filing under the Board rules must be mailed to the other parties. In this case, the insurer has apparently not provided claimant with a copy of its request for reconsideration.

For the reasons enumerated above, we deny the insurer's request for reconsideration. We adhere to our October 8, 1991 order. The parties' rights of appeal shall continue to run from the date of our October 8, 1991 order.

IT IS SO ORDERED.

October 18, 1991

Cite as 43 Van Natta 2346 (1991)

In the Matter of the Compensation of
DAVID J. DEERING, Claimant
WCB Case No. 90-00730
ORDER ON RECONSIDERATION
Douglas D. Hagen, Claimant Attorney
Wallace & Klor, Defense Attorneys

On September 18, 1991, we abated our August 27, 1991 Order on Review that found that claimant's request for hearing was untimely filed. We took this action in light of our discovery of an envelope in the record which bore a postmark date of January 8, 1990. Our discovery of the envelope contravened that portion of our order on review which concluded that there was no evidence of an envelope or postmark indicating the date on which claimant mailed his request for hearing. Having received additional written memoranda from the parties, we proceed with our reconsideration.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the exception of his finding that the 1981 injury was a material contributing factor to the need for chiropractic treatment in 1989. In addition, we add the following supplement.

We take official notice of the fact that the envelope containing claimant's request for hearing was postmarked January 8, 1990.

CONCLUSIONS OF LAW AND OPINION

In our prior Order on Review, we concluded that claimant's request for hearing was not timely filed and claimant had not shown good cause for his failure to timely file. Following the issuance of our Order on Review, we discovered a postmarked envelope that contained claimant's request for hearing and was relevant to the issue of timely filing. Under the circumstances, we reconsider our decision on the issue of timeliness of filing of claimant's hearing request.

ORS 656.319(1) requires "filing" of a request for hearing within 60 days of notification of a denial, and ORS 656.283(3) provides that a request for hearing "may be made by any writing...mailed to the board." In accordance with OAR 438-05-046(1)(b), if a request for hearing 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. 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, claimant's hearing request concerning the insurer's denial was received by the Board on either January 9, or January 10, 1990. Because the request was not mailed by registered or certified mail and January 9 or January 10 are both more than 60 days after the mailing date of the insurer's denial, the

hearing request is presumed untimely unless claimant establishes that the mailing is timely. OAR 438-05-046(1)(b).

The envelope containing claimant's hearing request is postmarked January 8, 1990. The record establishes that the insurer's denial was mailed on November 7, 1989. Claimant had 60 days from that date within which to file his request for hearing from the denial. ORS 656.319(1)(a). The sixtieth day from November 7, 1989, was Saturday, January 6, 1990. Because the sixtieth day fell upon a Saturday, the last day for filing of the request for hearing was Monday, January 8. ORCP 10A; ORS 174.120; Anita L. Clifton, 43 Van Natta 1921 (1991). Accordingly, we conclude that the envelope from claimant bearing a postmark date of January 8, 1990, establishes that the request for hearing was timely filed.

The insurer does not contest our finding that the envelope containing claimant's hearing request was postmarked January 8, 1990. Rather, the insurer argues that, because the Board discovered the postmarked envelope, claimant has not established that the mailing is timely. Regardless of who discovered the postmarked envelope, the fact is that claimant's timeliness has been proven and claimant has met his burden of proof in this regard. Inasmuch as claimant's request was timely filed, we reinstate his hearing request and address the issue raised by the request.

The Referee concluded that, although the report of Dr. Gemmer, claimant's treating chiropractor, was based upon incomplete facts and should be given little weight, it was the only medical evidence in the record and the Referee was required to rely upon it. We disagree.

On November 7, 1989, the insurer denied claimant's request for additional medical service on the ground that claimant had an intervening on-the-job injury. Claimant bears the burden of proving by a preponderance of the evidence that his 1981 injury materially contributes to his current need for medical treatment. Further, because claimant sustained an intervening injury to his low back, the resolution of the causation issue involves a complex medical question which largely turns on an analysis of the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 106, 109 (1985).

Here, claimant testified that, although he continued to experience low back pain following his 1981 injury, the last treatment he received for that injury was in February 1985. X-rays taken following the 1981 injury were "entirely within normal limits without evidence of trauma or congenital abnormality."

In December 1987, while employed with a Washington company, claimant again injured his low back. The claim was accepted and claimant followed a doctor's instructions to remain in bed for 30 days. Claimant's back pain became more intense following the 1987 incident.

In September 1989, claimant treated with Dr. Gemmer, chiropractor, for headaches, neck pain, and low back pain radiating into his legs. Claimant did not inform Dr. Gemmer of his 1987 back injury and Dr. Gemmer did not review records or x-rays of claimant's 1981 or 1987 injuries. Dr. Gemmer diagnosed lumbar spine strain with disk produced pain in the hip and legs. Dr. Gemmer also reported that claimant had a disk injury at L-5.

In May or June of 1990, claimant informed Dr. Gemmer of his 1987 injury. Claimant told Dr. Gemmer that the 1987 injury was a "continuation" of the 1981 injury.

In June 1990, Dr. Gemmer reported that claimant needed chiropractic care after his 1981 accident and did not receive such treatment. Dr. Gemmer further reported that the treatment claimant received in his office was "exclusively because of this accident and his long term lack of proper treatment for that accident." Dr. Gemmer estimated that claimant's future chiropractic care would require 35-50 visits.

We are not persuaded by Dr. Gemmer's conclusory report that claimant's current need for treatment is related to his compensable 1981 injury. Dr. Gemmer has not reviewed records from either the 1981 or 1987 injury and has not explained why he believes claimant's current need for treatment is related to the 1981 incident. Moreover, Dr. Gemmer testified that his conclusion was based entirely upon claimant's report that the condition was related to the 1981 injury although he could not remember whether claimant had informed him that, from 1985 until his injury in 1987, he had not sought any treatment for his low back.

Under the circumstances, we conclude that claimant has failed to prove that his compensable 1981 injury materially contributed to his current condition. Although we note that Dr. Gemmer's report is the only medical opinion in the record, we decline to rely upon Dr. Gemmer's unpersuasive and incomplete report to satisfy claimant's burden of proof in this case. ORS 656.266.

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 27, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

October 18, 1991

Cite as 43 Van Natta 2348 (1991)

In the Matter of the Compensation of

JEFFRY D. MORGAN, Claimant

WCB Case No. 90-17473

ORDER ON REVIEW

Michael B. Dye, Claimant Attorney

Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerbund.

Claimant requests review of Referee Brazeau's order that upheld the SAIF Corporation's denial of his aggravation claim for a left carpal tunnel syndrome (CTS) condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. After the April 4, 1988 left CTS surgery, claimant's nocturnal numbness disappeared. (Ex. 7-2). At claim closure, claimant suffered continuing symptoms which included some aching in the thenar eminence, some numbness over the surgical incision, and some aching and tenderness over the incision. (Ex. 7-2).

After claim closure, claimant's symptoms worsened. His nocturnal numbness returned and he had intermittent daytime numbness and tingling in his left hand which increased with activity. (Exs. 7-5, 7-6, 18-4). Claimant now suffers from a chronic condition which limits his ability to perform hand intensive activities and to withstand concussion, vibration and cold exposure in the left hand.

FINDINGS OF ULTIMATE FACT

As a result of his compensable CTS condition, claimant experienced a symptomatic worsening since the July 27, 1988 Determination Order. This worsening was supported by objective medical findings. As a result of this worsening, claimant sustained an increased loss of use or function of his left hand.

CONCLUSIONS OF LAW AND OPINION

Claimant relies on the opinion of Dr. Ellison, his current treating orthopedist, to establish that his CTS condition had worsened. The Referee found that no persuasive "objective findings" supported Dr. Ellison's December 17, 1990 report and, on that basis, found that claimant had not established that his condition had worsened. We disagree.

In deciding this matter, the Referee applied the law as amended by Or Laws 1990 (Special Session), Ch 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the compensable condition. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of a scheduled body part, claimant must show that he is more disabled, i.e., has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. ORS 656.214; International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988). Further, the medical worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Dr. Ellison gave the only opinion as to whether claimant's condition had worsened since claim closure. Ellison found that claimant had intermittent numbness and tingling in the left hand and nocturnal numbness in the left hand. (Ex. 18-4). The record shows that after surgery and before claim closure, claimant only had numbness around the incision line, rather than in his entire left hand. (Ex. 7-2, 7-5, 7-6). Also, the nocturnal numbness in claimant's left hand disappeared after his surgery and was not reported again until March 1989, well after claim closure. (Exs. 7-2, 7-5, 7-6). On the basis of his examination and his acceptance of claimant's subjective complaints, Ellison determined that claimant's left CTS condition had worsened. (Exs. 18, 25).

Claimant argues that his subjective complaints as relied on by Dr. Ellison in formulating his opinion constitute "objective findings" under the new law. We agree. We have recently concluded that, where a physician performs a physical examination and determines that claimant does, in fact, suffer from a condition such as numbness, the doctor's report will constitute medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991); Herb R. Davidson, 43 Van Natta 1820 (1991). In the absence of any contrary medical evidence, we find that Dr. Ellison's opinion, based on claimant's subjective complaints, is sufficient to establish that claimant has suffered a worsening of his left CTS.

Furthermore, we note that a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition, provided that no off-the-job injury is the major contributing cause of the condition. ORS 656.273(1); Robert E. Leatherman, 43 Van Natta 1678 (1991). SAIF does not contend, and there is no evidence, that any off-the-job injury is the major contributing cause of claimant's worsened condition. In fact, Dr. Ellison stated that the original occupational exposure was the major contributing cause of the worsened condition. (Ex. 25-1).

We further conclude that claimant has sustained a loss of use or function of his left hand since claim closure. Claimant did not receive any award of permanent partial disability at claim closure. Therefore, as a matter of law, claimant had no loss of use or function at that time. Dr. Ellison opined that, as a result of the original occupational exposure, claimant now suffers from a chronic condition which limits his ability to perform hand intensive activities and to withstand concussion, vibration and cold exposure. (Ex. 25). This opinion is un rebutted. Hence, claimant has met his burden of proof.

Finally, SAIF argues that, although the Determination Order did not award any permanent disability, the record indicates that claimant had permanent residuals at closure that account for his current symptoms. SAIF further argues that these current symptoms are merely a waxing and waning and as such do not constitute a compensable aggravation. However, because claimant did not receive a prior award, he need not establish that the worsening was in excess of any disability for which he was previously compensated. See ORS 656.273(8); Louis A. Duchene, 41 Van Natta 2399 (1989).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is \$3,100, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 23, 1991 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of \$3,100, payable by SAIF.

October 18, 1991

Cite as 43 Van Natta 2350 (1991)

In the Matter of the Compensation of

JAMES A. SLOVER, Claimant

WCB Case No. 90-15196

ORDER ON REVIEW

Black, Chapman & Webber, Claimant Attorneys

Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Brown's order that:

- (1) awarded 19 percent (60.8 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order awarded 20 percent (64 degrees); and
- (2) declined to award an assessed attorney fee for claimant's allegedly successful defense to the self-insured employer's contention that the Determination

Order award should be reduced. On review, the issues are extent of disability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. The May 8, 1990 Determination Order awarded 20 percent unscheduled permanent disability and no scheduled permanent disability. (Ex. 38). The employer cross-petitioned for a hearing via its "supplemental response to issues" dated October 31, 1990, in which it contended that the Determination Order award of permanent disability was excessive. At hearing, the employer requested that the Referee decrease claimant's unscheduled disability award and offset any scheduled disability the Referee might award against this decrease. (Tr. 2). The Referee decreased the unscheduled disability to 19 percent, awarded 5 percent scheduled disability, and allowed the requested offset.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's order with the following correction and supplementation.

Because claimant became medically stationary before July 1, 1990, we apply the workers' compensation law in existence prior to its amendment by the Legislature on May 7, 1990. See Or Laws 1990 (Special Session), Ch. 2, Sec. 54(3). Specifically, we apply the "standards" effective at the time of the May 8, 1990 Determination Order. Former OAR 436-35-001 et seq. (WCD Admin Order 7-1988). Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability. We note that, although the Referee applied the correct standards, he incorrectly stated that the law as amended in 1990 applied to this case.

Relying on a report from Dr. Grant, treating physician, claimant argues that he is entitled to an adaptability value of 6. However, we do not find this report persuasive. The Referee found claimant not credible. Dr. Grant's opinion is based on claimant's subjective symptoms and restrictions, which are not reliable. Further, Dr. Grant's opinion was issued three weeks before claimant was medically stationary. Therefore, we are not persuaded that, as of claimant's medically stationary date, his limitation exceeded light duty work.

ORDER

The Referee's order dated January 3, 1991, as reconsidered January 30, 1991, is affirmed.

In the Matter of the Compensation of

WALDEN J. BEEBE, Claimant

WCB Case Nos. 90-10539, 90-12292, 90-05832, 90-07913, 89-25231 & 90-07288

ORDER ON REVIEW

Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Charles Cheek (Saif), Defense Attorney
Cummins, et al., Defense Attorneys
Beers, et al., Defense Attorneys
Pamela Schultz, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

EBI Companies requests review of those portions of Referee Brazeau's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld denials of claimant's "new injury" claims for the same condition issued by Liberty Northwest Insurance Corporation, and the SAIF Corporation on behalf of BB & L Cutters, P.J.'s Logging and Pitts Logging. In his respondent's brief, claimant requests review of that portion of the order that declined to assess penalties and related attorney fees for EBI's allegedly unreasonable denial. Claimant also contends that the Referee erred in analyzing this case under the 1990 amendments to the Workers' Compensation Law. The issues on review are applicable law, compensability, responsibility, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. Claimant's injury with Western Timber Cutters occurred on March 1, 1986, not 1990.

Applicable Law

We affirm and adopt the Referee's ruling on this issue with the following comment.

The "litigation savings clause" contained in SB 1197, Section 54(2), does not apply in this case because the hearing was convened after July 1, 1990. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). The Referee, therefore, applied the 1990 amendments to the Workers' Compensation Law. Or Laws 1990, ch. 2, 54(1) and (2).

Because the hearing was first scheduled for April 19, 1990, evidence in the case was initially developed under the assumption that the old law would apply. On review, claimant argues that application of the new law requires him to prove his case by a higher standard which could not have been anticipated at the time the body of evidence was developed. He argues that this result would be absurd and unreasonable and, on this basis, contends that the new law should not be applied. See Ida M. Walker, 43 Van Natta 1402 (1991).

We are not persuaded by claimant's argument. The hearing in this case was postponed and reset on June 25, 1990. Thus, claimant had more than one month to further develop the evidence in the case in response to the new law. Furthermore, if claimant required more time to develop the case, he could have requested a postponement or a later hearing date. He did neither. Under these circumstances, application of the new law would not produce an absurd or unjust result, or clearly be inconsistent with the purposes and policies of the

workers' compensation law. Id. Accordingly, we conclude that the Referee correctly analyzed this case under the new law.

Compensability

We affirm and adopt the Referee's order on this issue with the following comment.

The Referee correctly applied the aggravation analysis set forth in Edward D. Lucas, 41 Van Natta 2275 (1989). See Leroy Frank, 43 Van Natta 1950 (1991). Claimant's increased pain, as verified by her treating physician, is sufficient to establish a compensable aggravation. Suzanne Robertson, 43 Van Natta 1505 (1991). Moreover, claimant also exhibited lost range of motion, which is an objective finding.

Responsibility

The Referee concluded that EBI Companies remained responsible because it did not prove that claimant's subsequent employment independently contributed to a pathological worsening of the accepted condition. We affirm the Referee's ultimate ruling based on the following rationale.

Under the 1990 amendments to the Workers' Compensation Law, responsibility rests with EBI Companies unless claimant sustained a new compensable injury or occupational disease as a result of the subsequent work exposure. Or Laws 1990 (Special Session), Chapter 2, Section 49; Ricardo Vasquez, 43 Van Natta 1678 (1991).

There is no evidence of a discrete, injurious event during claimant's subsequent employment with SAIF's various insureds. When claimant's condition worsened in 1989, his physicians attributed his increased symptoms to the 1986 injury with EBI. Thus, claimant has not established a new compensable injury under ORS 656.005(7)(a). Nor has claimant established a new occupational disease under ORS 656.802. No physician has opined that the subsequent work activity was the major contributing cause of a pathological worsening of claimant's condition.

Accordingly, on this basis, we affirm the Referee's assignment of responsibility to EBI.

Penalties and Attorney Fees

We affirm and adopt the Referee's conclusions and reasoning concerning the penalty and attorney fee issue.

Attorney Fees/Board Review

Claimant is entitled to an assessed fee for prevailing over EBI Companies' request for review regarding the compensability of his current condition. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is \$750, to be paid by EBI Companies. In reaching this decision, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 31, 1990 is affirmed. For services on review, claimant's attorney is awarded a \$750 assessed attorney fee, payable by EBI Companies.

In the Matter of the Compensation of

LEO R. COX, JR., Claimant

WCB Case No. 88-16052

ORDER ON REMAND

Francesconi & Associates, Claimant Attorneys

Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Aetna Casualty Company v. Cox, 107 Or App 780 (1991). The court has reversed our prior order, which found claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS) compensable because claimant had established that his work activities were a material contributing cause of his bilateral CTS. The court remanded for reconsideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991) and Liberty Northwest Insurance Corporation v. Damm, 107 Or App 764 (1991), which held that a claimant must establish that his employment was the major contributing cause of his condition. We proceed with our reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in the Referee's December 20, 1988 order, as amended December 28, 1988.

CONCLUSIONS OF LAW AND OPINION

In our prior Order on Review, relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989) and Carole J. Damm, 42 Van Natta 225 (1990), we found that claimant had proven that his work activities were a material contributing cause of his bilateral CTS. Consequently, we affirmed that portion of the Referee's order that set aside the insurer's denial of claimant's occupational disease claim. However, the Court of Appeals has recently held that to establish the compensability of an occupational disease under former ORS 656.802, claimant must prove that his work activities were the major contributing cause of his condition or of the worsening of his underlying condition. See Aetna Casualty Co. v. Aschbacher, *supra*; Liberty Northwest Insurance Corporation v. Damm, *supra*. Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983); David K. Boyer, 43 Van Natta 561 (1991).

We adopt those portions of the Referee's "Conclusions and Opinions" which address the causation issue, with the following supplementation and comment.

Due to the number of potential causes for claimant's bilateral CTS, the causation issue is a complex medical question. Resolution of the issue requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 *rev den* (1985) 300 Or 546 (1986). We rely on medical evidence that is well reasoned and based on an accurate history. See Somers v. SAIF, 77 Or App 259 (1986). In the present case, the only medical evidence comes from Dr. Button, treating physician.

We continue to find Dr. Button's opinion regarding the cause of claimant's bilateral CTS to be persuasive. In reaching this conclusion, we note that Button related a number of factors to claimant's bilateral CTS problems. First, Button considered that claimant is a 59-year-old male with a very stocky build. He also considered repetitive work and avocational pursuits, including sports, as potential causal factors. Button further reported

that he had an opportunity to tour the plant where claimant worked and opined that there is a "strong relationship" between claimant's bilateral CTS and his occupation. (Ex. 3-2).

Button was unwilling to conclude that any one cause was "the materially contributing cause" of claimant's bilateral wrist problems. (Ex. 5). However, noting claimant's approximately thirty-two year history of repetitive work duties for the employer as a "feeder hustler," Button opined: "If one tends to quantitate [sic] the total number of hours as well as the total output of a job, realizing in [claimant's] instance that it requires repetitive feeding of plate, lifting, etc., then probably the job is a very important contributing factor in the entire equation." (Id.).

"Magic words" are not required. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Here, Button's uncontradicted opinion, which was based on an understanding of claimant's work activities as well as the potential nonwork contributors, supports the conclusion that it is more likely than not that work activities were the major cause of claimant's bilateral CTS. Consequently, we hold that the claim is compensable.

Accordingly, as supplemented and modified herein, we adhere to and republish our April 20, 1990 order.

IT IS SO ORDERED.

October 21, 1991

Cite as 43 Van Natta 2355 (1991)

In the Matter of the Compensation of
CAROLYN ETTINGER-CHARLEY, Claimant
WCB Case No. 90-05519
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Crider and Tenenbaum.

Claimant requests review of Referee Brown's order that upheld the self-insured employer's partial denial of her medical services claim for cervical surgery. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS" with the following modification. Instead of the Referee's finding that no trauma was reported to Dr. Campagna, we substitute the following: We do not find that any trauma which claimant allegedly sustained to her neck during the fall in November 1989 was reported to Dr. Campagna.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that, as a result of surgery for the compensable left shoulder injury, she has symptoms of multiple sclerosis, including epileptic seizures. She further asserts that she fell and injured her neck during an epileptic seizure in November 1989 and that the neck injury materially contributed to her need for cervical surgery in March 1990. The Referee found no causal relationship between the compensable injury and the cervical surgery. We agree with the Referee based on the following reasoning.

To establish the compensability of medical treatment for a condition, claimant must prove that the compensable injury was a material contributing cause of the need for treatment. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987); Jordan v. SAIF, 86 Or App 29, 32 (1987). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. Van Blokland, supra, 87 Or App at 698.

Claimant must prove, among other facts, that she sustained a neck injury from the fall in November 1989 that materially contributed to her need for cervical surgery. She seeks to prove that fact primarily by her testimony and Dr. Swank's opinions.

The parties stipulated to claimant's testimony at hearing. It is her testimony that, in late November 1989, she suffered an epileptic seizure, fell and struck her head. It is also her testimony that, after the fall, she had neck pain and increased left arm symptoms, which persisted until she sought treatment and ultimately required cervical surgery in March 1990 (Tr. 5-6). However, the record shows that claimant did not report the November 1989 incident to any physician until June 19, 1990, more than three months after the insurer's denial, despite the fact that claimant was treating with Dr. Campagna for neck pain from December 1989 through March 1990.

Claimant's seven-month delay in reporting the fall undercuts the reliability of her history, as well as her testimony, regarding the onset of neck symptoms following the fall. That delay may have clouded claimant's recollection of the significance of the fall as a causative factor in the onset of her neck problems, particularly in the face of the insurer's denial. Indeed, the delay suggests, if anything, that the fall was not as significant an event as she now asserts it was; it evidently was not significant enough to report to her doctors while treating for her neck condition. Claimant's history is further undercut by the fact that she has longstanding cervical spondylosis for which she has been treating with Dr. Campagna. Even if claimant's history regarding the fall and its sequelae were accepted, given the spondylosis, the matter of causation is complex and would remain one requiring expert medical evidence.

Dr. Swank, the neurologist who treats claimant's multiple sclerosis, opined that claimant injured her neck in the November 1989 fall and that the cervical surgery was necessary to repair the "damaged cervical vertebra injury" (Ex. 115). We are not persuaded, however, because it is based on claimant's unreliable history. Furthermore, Dr. Swank did not have the correct diagnosis of claimant's cervical condition. Whereas Swank believed that claimant had a herniated cervical disc (Ex. 114-2), an MRI scan revealed cervical spondylosis (Exs. 107, 108). Swank never addressed the role of the spondylosis in claimant's condition and need for surgery. Inasmuch as Swank's opinion is based on an incorrect diagnosis and unreliable history, we discount his opinion.

Dr. Campagna, the neurosurgeon who performed the cervical surgery, has treated claimant for cervical spondylosis since 1983. His reports before the March 1990 surgery indicate that the surgery was required to relieve nerve root compression secondary to cervical spondylosis (Exs. 106, 108, 109). Those reports do not mention any recent trauma to claimant's neck. On his operative report, Campagna wrote that claimant's pre-operative and post-operative diagnoses were "[p]ost-traumatic aggravation of cervical spondylosis at C5-6 left" (Ex. 112). However, Campagna does not identify the trauma to which he refers. Accordingly, we find the operative report insufficient to prove that claimant's need for surgery was materially related to claimant's fall in November 1989.

We find the record is insufficient to sustain claimant's burden of proving a material relationship between the compensable injury and the cervical surgery.

ORDER

The Referee's order dated August 30, 1990, is affirmed.

October 21, 1991

Cite as 43 Van Natta 2357 (1991)

In the Matter of the Compensation of

JACQUALYN L. HETRICK, Claimant

WCB Case No. 90-17555

ORDER ON REVIEW

Philip H. Garrow, Claimant Attorney

Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Crider.

Claimant requests review of Referee Spangler's order that: (1) upheld the SAIF Corporation's denial of her aggravation claim for a left shoulder condition; and (2) upheld SAIF's denial of her medical services claim for scalenectomy surgery. On review, the issues are aggravation and medical services. We affirm.

FINDINGS OF FACT

Claimant worked for the employer as a hotel maid. In January 1988, she injured her left shoulder when she tripped over a phone cord, fell and landed on her side and extended left arm. She sought medical treatment from Dr. Paul Johnson, a neurosurgeon, who diagnosed muscle strain and recommended physical therapy. SAIF later accepted claimant's claim for a left trapezius muscle strain.

Claimant continued to have upper back and shoulder problems. On February 22, 1988, Dr. Johnson removed claimant from work and subsequently referred her to Dr. MacCloskey, an orthopedic surgeon, who suspected that claimant was suffering from thoracic outlet syndrome. He recommended physical therapy with medication and believed that claimant should not work for three weeks.

In May 1988, claimant was examined by Dr. Goldsmith, M.D., who also diagnosed thoracic outlet syndrome. He reported that, while claimant had prior problems in her left upper extremity, she was able to work with minimal difficulties until her compensable injury. He concluded that, given her prior history, the injury aggravated her preexisting condition.

On June 28, 1988, Dr. Goldsmith performed a left first rib resection in an effort to relieve claimant's thoracic outlet syndrome. The surgery reduced claimant's upper extremity symptoms, and Dr. Goldsmith declared claimant medically stationary on September 7, 1988.

Claimant returned to Dr. MacCloskey on October 7, 1988. She reported hot and cold sensations and some point tenderness over her thoracic spine, with occasional spasms and tightness around her upper arm. Dr. MacCloskey recommended physical therapy and facial mobilization.

A Determination Order closed claimant's claim on October 13, 1988, with an award of temporary total and temporary partial disability, but no permanent disability.

On November 18, 1988, claimant was examined by Dr. Staver, an orthopedist, and Dr. Gancher, a neurologist, at the offices of the Western Medical Consultants. They diagnosed thoracic outlet syndrome by history, post left first rib resection, cervicothoracic strain and depression. They concluded that claimant was medically stationary with mild permanent partial disability due to the loss of abduction of her left shoulder.

In February 1989, the parties entered into a Stipulation and Order of Disputed Claim Settlement, which awarded claimant 15 percent scheduled permanent disability, and 10 percent unscheduled permanent disability for her left shoulder condition.

Claimant began doing clerical work in April 1989. Due to her left arm symptoms, she favored her right arm while performing work activities.

In September 1989, claimant sought treatment from Dr. Wesley Johnson, an orthopedist, for continuing neck and shoulder complaints. He suspected that claimant was reexperiencing her thoracic outlet syndrome and referred her to Dr. Goldsmith. Dr. Goldsmith reported that claimant's gradual recurrence of symptoms were similar to those that she had originally experienced.

In November 1989, claimant was reexamined at the offices of the Western Medical Consultants, this time by Dr. Coletti, an orthopedist, and Dr. Barth, a neurologist. The doctors found decreased sensation over claimant's left fore-quarter but concluded that claimant was objectively no worse. They recommended exercise and work-site modification.

About that time, claimant filed an aggravation claim, asserting a worsening of her left shoulder condition. SAIF denied the claim on December 8, 1989. In May 1990, the parties entered into a Disputed Claims Settlement, which affirmed SAIF's aggravation denial.

On May 31, 1990, claimant was examined by Dr. Buchholz, M.D., who performed nerve conduction studies. He diagnosed continuing paresthesia and pain, which he believed may have been secondary to scarring at claimant's surgical site.

On June 18, 1990, Dr. Goldsmith requested authorization to perform a left anterior scalenectomy in an attempt to reduce claimant's symptoms, although he acknowledged there was a limited likelihood that such a surgery would be helpful. The following month, Dr. Sanford, an orthopedic surgeon, reviewed claimant's medical history and questioned the proposed operation. In August 1990, claimant also was examined by Dr. Porter, a surgeon, who referred her to Dr. Mertens, a neurologist, for additional nerve conduction testing.

On August 24, 1990, SAIF denied claimant's medical services claim for the surgery requested by Dr. Goldsmith, asserting that it was not reasonable and necessary medical treatment for claimant's compensable condition.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The issue is whether claimant has established a compensable aggravation of her left shoulder condition. Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is properly analyzed under the 1990 amendments to the Workers' Compensation Law. See Or Laws 1990 (Special Session), ch. 2, 54(2); Ida Walker, 43 Van Natta 1402 (1991).

Under the current version of ORS 656.273, an injured worker is still entitled to compensation for a "worsened condition" resulting from the compensable injury since the last arrangement or award of compensation. Furthermore, the traditional definition of a "worsened condition," i.e., an increase in symptoms or a pathological change resulting in diminished earning capacity, remains intact. See Leroy Frank, 43 Van Natta 1950 (1991). The worsened condition, however, must be established by medical evidence supported by objective findings. ORS 656.273(1).

In this case, claimant contends that her shoulder condition worsened after undergoing a rib resection to relieve her upper extremity symptoms. She relies solely on the opinion of Dr. Goldsmith, who, in August 1990, reported:

"Approximately five months after the operation [of June 1988,] the patient began to have a recurrence of symptoms. For that reason, I believe that her course is typical for a patient who develops a scar tissue attachment between the divided end of the scalenus anterior muscle and the fascia overlying the brachial plexus. This is a clinical assumption which can not be established by any objective means. (Ex. 35). (Emphasis supplied.)

The Referee concluded that Dr. Goldsmith's report was insufficient to establish a compensable aggravation. The Referee evidently believed that, because Dr. Goldsmith conceded that the "scarring" diagnosis was a clinical diagnosis only, claimant had failed to establish a worsening by medical evidence supported by objective findings.

"Objective findings" in support of medical evidence are defined to include, but are not limited to, "range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." Amended ORS 656.005(19). In Suzanne Robertson, 43 Van Natta 1505 (1991), we construed that statutory definition to require a determination by a physician, based on an examination of the injured worker, that the worker has a disability or need for medical services. Such a finding may be based on a physically verifiable impairment, but may also be based on a physician's evaluation of the worker's description of the pain that she is experiencing.

Accordingly, contrary to the Referee's implied holding, a clinical diagnosis incapable of objective physical verification may be sufficient to meet the statutory definition of "objective findings," if it is based on a physician's objective evaluation of a worker's subjective complaints of pain. Nonetheless, we agree with the Referee's ultimate conclusion that claimant failed to establish a compensable aggravation of her condition.

Although our review of the medical evidence persuades us that claimant experienced a worsening of her condition approximately five months after the June 1988 first rib resection, as indicated by Dr. Goldsmith in his report quoted above, for the purposes of claimant's aggravation claim, the last award or arrangement of compensation was the February 1989 Stipulation, which awarded her 10 percent unscheduled permanent disability and 15 percent scheduled permanent disability. We are not persuaded that claimant's condition has worsened since that stipulation. Claimant's current symptoms, including a "peculiar alteration of sensation in her hands," date back to 1986. These symptoms are documented in the reports of Dr. Goldsmith, claimant's treating physician, and of Dr. MacCloskey. Dr. Wesley Johnson reported in October 1989, that claimant continued to have the same symptoms that she had prior to her last surgery. Moreover, Dr. Coletti and Dr. Barth reported that claimant's symptoms were not a worsening of her condition, based on objective medical evidence.

After our review of the record, we conclude that claimant has failed to establish by a preponderance of the evidence that her shoulder condition has worsened. Accordingly, SAIF's aggravation denial of claimant's shoulder condition is upheld.

Medical Services

The Referee concluded that claimant had failed to establish the compensability of the proposed scalenectomy surgery. We agree.

Claimant is entitled to medical services for conditions resulting from the compensable injury "for such period as the nature of the injury or the process of the recovery requires." ORS 656.245. Claimant carries the burden of proving by a preponderance of the evidence that the proposed surgery is reasonable and necessary. West v. SAIF, 74 Or App 317 (1985).

Of the numerous expert opinions introduced in the matter, only Dr. Goldsmith believes that the proposed surgery is reasonable and necessary. However, even Dr. Goldsmith expressed some reservations about the procedure. In his August 1990 report, he noted:

"There is no way that anybody could guarantee the result of any such procedure, and the recommendation for and against that operation more or less depends on one's philosophy in looking at a recurrent problem of this variety." (Ex. 35).

Dr. Porter expressed the opinion that claimant was not a good candidate for further surgery. After neurological testing proved normal, Dr. Porter opined:

"Based on [claimant's] current normal nerve conduction test and neurologic examination, I think there is very little chance that she would receive any benefit from an additional thoracic outlet surgical procedure, namely scalenectomy." (Ex. 32).

Dr. Sanford, Dr. Coletti and Dr. Barth also concluded that further surgery was not warranted.

In light of the substantial contrary evidence, and the noted reservations, we are not persuaded by Dr. Goldsmith's opinion that the proposed surgery is reasonable and necessary. Accordingly, we conclude that claimant has failed to establish the compensability of the proposed scalenectomy surgery.

ORDER

The Referee's order dated December 26, 1990 is affirmed.

Board Member Crider concurring.

I concur in the Board's decision to uphold the denial of surgery not because the SAIF Corporation has marshalled a number of doctors who recommend against surgery, but rather because I am not persuaded that claimant actually suffers from TOS, the condition for which the surgery is appropriate.

In the Matter of the Compensation of
DANIEL A. JACKSON, Claimant
WCB Case Nos. 90-14464 & 90-06376
ORDER ON REVIEW (REMANDING)
Parker & Bush, Claimant Attorneys
Cooney, et al., Defense Attorneys
Pamela Schultz, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for a mental disorder and related physical symptoms; and (2) upheld Alexsis Risk Management's denial (on behalf of the self-insured employer) of claimant's new injury claim for the same condition. Claimant contends that the Referee erred in refusing to reopen the record for admission of an Arbitrator's decision and to reconsider her opinion in light of the additional evidence. In its respondent's brief, Liberty Northwest moves to strike those portions of claimant's brief which refer to the Arbitrator's decision. On review, the issues are evidence, remand, compensability, and responsibility. We reverse on the evidentiary issue, vacate, and remand.

FINDINGS OF FACT

Claimant worked for Fred Meyer for a total of 12 years, although his period of service was interrupted in 1979 when he quit to go to college. He was rehired in 1980.

Fred Meyer was insured for workers' compensation by Liberty Northwest until February 1, 1987, at which time the employer became self-insured. The employer's workers' compensation program, as a self-insured employer, was administered by Alexsis Risk Management.

During the time claimant worked for the employer, he was represented by a union that had a collective bargaining agreement with the employer. In the early 1980's, claimant received several verbal warnings. Under the collective bargaining agreement, verbal warnings were not grievable.

In September 1986, claimant experienced anxiety, depression, and chest pain due to problems at work. He treated with his family physician, Dr. Bohme, M.D., who prescribed medications and referred him to Dr. Labby, psychologist. Claimant filed a workers' compensation claim which was accepted by Liberty Northwest.

Claimant's condition flared up in October 1987, when claimant was taken off his regular job. Claimant treated briefly with Dr. Bohme and returned to work in November.

Claimant did not treat for anxiety, depression or related chest pain for a period of 15 months following the 1987 episode.

In December 1989, claimant was detained as he was leaving work one day. Security personnel suspected that he was removing company property. Claimant was questioned and searched. Nothing was found; he was released. Although the individuals conducting the interrogation apologized, claimant was angry.

During January 1990, claimant's supervisor, Bill Clay, spoke to him on several occasions, urging him to be more productive. Claimant believed that his production was adequate.

On January 25, 1990, a second shift supervisor, Mark Bezzant, gave claimant a "written verbal warning" for wasting company time. Again, claimant believed the action to be unjustified. A verbal warning, whether or not reduced to writing, was not grievable under the union contract.

Finally, on February 8, 1990, Bezzant sought volunteers to accept training and to take work in a "moving" position. Bezzant spoke with claimant. Claimant indicated he wished to be trained for the position but did not wish to perform the job unless it was the only position open to him. Bezzant replied that he would not train anyone on the job who did not wish to perform it.

Bezzant recorded his version of the conversation in his daily diary. Bezzant recorded that the conversation had concluded as follows:

"[Bezzant]--That's the way it's going to be on the moves.
[Claimant]--You think so huh? You think a lot of things around here, but that doesn't mean it's so. You've gotta go home some time too and I'm gonna be waiting for you. You fucking son of a bitch."

The following day, Bezzant discussed the episode with the Superintendent. The Superintendent called claimant in and questioned him about his conversation with Bezzant. Bezzant was not in attendance. Claimant denied that any hot words had been spoken, although he agreed that he had wished to be trained but not to take the job. The Superintendent told claimant he was faced with a choice between believing claimant or believing Bezzant. He indicated that he would believe Bezzant and that claimant's employment was terminated. Claimant was handed a discharge notice which had been prepared before the meeting. The notice stated that claimant's employment was terminated for gross insubordination. He was also given his final paycheck.

Claimant filed a grievance through his union under the "just cause" provisions of the collective bargaining agreement. The grievance was processed, and an arbitration hearing took place before this workers' compensation matter went to hearing. At the time of the workers' compensation hearing, the arbitrator had not issued a decision.

During January and early February 1990, claimant had begun to have increasingly frequent headaches. The day after the discharge, he also began to suffer chest pain. He saw Dr. Bohme about these issues on February 14, 1990. Dr. Bohme diagnosed acute situational depression and anxiety. He referred claimant to Dr. Labby once again. Claimant treated with Dr. Labby for several weeks. The chest symptoms improved, but claimant continued to have some psychological difficulties.

Following the discharge, claimant suffered anxiety and depression, which required medical treatment. The condition was caused by the manner of the discharge and the events leading up to it.

The symptoms claimant suffered in 1990 were similar to those he suffered in 1986 and 1987. Nevertheless, claimant's anxiety/depression disorder in 1990 was not caused in material part by his anxiety/depression disorder in 1986 and 1987.

Referee Bethlahmy's Opinion and Order issued on September 13, 1990. The following day, claimant requested abatement and reconsideration of that order in light of newly discovered evidence that claimant's termination was rescinded by a September 13, 1990 Arbitrator's order. Claimant requested that the Referee abate her September 13, 1990 Opinion and Order and conduct an evidentiary hearing on the rescission of claimant's termination. Claimant also requested that

the Arbitrator's Order, which he marked as "Exhibit 50", be received into the record. Liberty Northwest and Alexis Risk Management objected to claimant's motion.

Referee Bethlahmy issued an Order Denying Claimant's Motion to Abate. She stated that the rescission of claimant's termination did not alter her conclusion that claimant's anxiety neurosis was the result of claimant's job termination and, therefore, that his condition was not compensable.

FINDINGS OF ULTIMATE FACT

Claimant suffers from a mental disorder, anxiety and depression, which is generally recognized in the medical and psychological communities. The condition caused the need for medical treatment.

Employment conditions, including the events leading directly to the discharge and the discharge meeting, were the major contributing cause of the mental disorder.

The employment conditions producing the mental disorder exist in a real and objective sense and are not generally inherent in every work situation; the conditions were not the mere fact of the discharge and cessation of employment. The manner of the discharge, including the accusation of gross insubordination underlying it, was the primary stressful event leading to the need for treatment.

The Arbitrator's order is relevant and material to the issues in this proceeding. The order was not obtainable with due diligence at the time of hearing. Without the Arbitrator's order, the record has been incompletely developed.

CONCLUSIONS OF LAW

Compensability

To establish a compensable occupational disease claim for a mental disorder under ORS 656.802, claimant must prove that work activities or exposures are the major contributing cause of the condition. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). Moreover, such a claim will not be compensable unless the following is established:

"(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.

(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.

(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment." ORS 656.802(3).

On review, Liberty Northwest and the self-insured employer argue that the Referee's order should be sustained because the claimant has failed to satisfy several of the statutory requirements. We take the issues serially.

Liberty Northwest contends that claimant has failed to establish that he suffers from a mental disorder that is generally recognized in the medical or psychological community. However, Dr. Labby, the treating psychologist, persuasively opined that claimant suffers from an anxiety neurosis, a diagnosis which is recognized in DSM-III-R. Although Dr. Turco, who examined claimant for Liberty Northwest declined to diagnose a psychiatric condition, he concurred that claimant exhibited symptoms which characterize Dr. Labby's diagnosis. We are less persuaded by Dr. Turco's opinion than by Dr. Labby's, not only because Dr. Turco has not had the opportunity to work with claimant extensively, but also because he did not examine claimant until his symptoms had diminished somewhat. Based on Dr. Labby's diagnosis, we reject the insurer's argument.

That hurdle satisfied, neither Liberty Northwest nor the self-insured employer contends that claimant has failed to establish by clear and convincing evidence that the mental disorder arose out of employment or, indeed, that employment-related factors were the major (or the sole) cause of the disorder. Neither contends that the employment conditions producing the disorder were not real and objective or that they were generally inherent in every work situation.

The sole question seriously at issue is whether the employment conditions which caused the disorder were either cessation of employment or reasonable disciplinary, corrective or job performance evaluation actions by the employer. Liberty Northwest and the self-insured employer argue that the claim is not compensable because the mental disorder was caused by discipline and termination. The issues cannot be so easily disposed of.

A mental disorder which is caused by a job termination may be compensable provided that the disorder arises out of the circumstances and manner of the discharge rather than from the mere fact of loss of employment. Elwood v. SAIF, 298 Or 429 (1985).

We find that it was the circumstances and manner of the discharge rather than the mere cessation of employment which produced claimant's anxiety and depression. We do so based on the issues raised by claimant when he spoke with his treating doctors and the examining physician, on claimant's own testimony at hearing, and the assessment of the medical experts.

When claimant sought medical treatment from Dr. Bohme in February 1990, he did so because of physical symptoms that arose immediately after the discharge. There is no evidence that the symptoms arose from fear of the consequences of unemployment. Rather, they came from a sense of being abused. On the form 827 the worker stated that the cause of his injury was "constant and continual harassment by supervision". When he described the problem to Dr. Turco, the examining physician, he described the most difficult aspects of his relationship with his employer. His emphasis was on the 1986 demotion, the December 1989 accusation that he had stolen company property, the February 1990 accusation that he had threatened and sworn at a supervisor, and his summary dismissal for gross insubordination.

Dr. Turco's assessment was that claimant's condition was "related to the termination and to some extent to some of the activities that have preceded the termination..." Dr. Labby did not disagree. Moreover, he indicated that a vindication by the Arbitrator would improve claimant's condition--not only because it would stabilize his financial condition, but because it would restore claimant's "personal credibility with an employer for whom he worked faithfully for more than ten years, and with whom he intended to pursue a career."

The importance to claimant of his personal credibility with his employer is underscored by claimant's statement, on cross-examination at hearing, that he

attributed his need for medical help not to a need to cope with finding another job, but to a loss of self-esteem resulting from the discharge and his inability to do his chosen work.

Claimant's concerns were not directed to the cessation of employment, but to his sense of having been wronged. Therefore, we conclude that his condition was not caused by cessation of employment within the meaning of ORS 656.802(2)(b).

Therefore, claimant's condition is compensable unless the termination and events surrounding it constitute "reasonable disciplinary, corrective or job performance evaluation actions by the employer." ORS 656.802(3)(b). We conclude that the record is insufficiently developed on this issue.

Evidence/Remand

The Referee, in her initial order, concluded that the claim was not compensable for two reasons: First, claimant's anxiety and depression were caused by the termination of employment; and second, they were caused by reasonable disciplinary action. In denying claimant's request that the record be reopened for consideration of the Arbitrator's order, the Referee held that her finding that the condition was caused by the termination of employment was dispositive. Inasmuch as the finding would not be altered by the Arbitrator's decision, she declined to receive the evidence.

We hold that a binding arbitrator's award addressing a contractual grievance concerning a job performance evaluation, a corrective or disciplinary action, or a discharge that is alleged to be without "just cause" is relevant. Indeed, it is the most probative evidence which may be adduced on the question of whether the employer conduct which is alleged to have caused a mental disorder was a reasonable disciplinary, corrective or job performance action. If, as in this case, a relevant arbitration award is not available at the time of hearing but becomes available thereafter, the record is incompletely developed without it. If the award becomes available after a referee's order issues, we will ordinarily remand for further development of the record.

In making this decision, we recognize that we have held that ORS 656.802(2) assigns to us the responsibility to make a number of findings of fact based on all of the evidence and informed by our expertise in employment-related matters. See Leo Campbell, 43 Van Natta 1087 (1991); Louis Orman, 43 Van Natta 226 (1991). The reasonableness of employer disciplinary conduct is one of those findings which we are required to make. Nevertheless, ORS 656.802(2)(b) does not envision that the Board will, in each and every case, measure employer conduct solely against some kind of abstract, natural law of labor relations. Rather, we may consider a variety of evidentiary matters bearing on the reasonableness of an employer's conduct. We may consider evidence that an employer's treatment of a claimant was inconsistent with governing employment law; that it was not consistent with its treatment of other employees; and that it was not consistent with its own policies.¹ When an employer has entered into a collective bargaining agreement, we may consider evidence that the employer's treatment of a claimant violated that agreement. If the employer and the union have agreed to a provision for arbitration of disputes arising under the collective bargaining agreement, and if an arbitrator's award is directly on point, then the arbitrator's award is highly persuasive on the question of the reasonableness of the employer's conduct.

Because the Referee declined to reopen the record to receive the Arbitration award, we remand the case with directions to admit the award and such rebuttal as the other parties may wish to offer. After receiving the evidence,

the Referee shall make findings concerning the reasonableness of the discipline/discharge and shall determine, in view of the new evidence and the findings and conclusions we make in this order, whether the claim is compensable and, if so, whether Liberty Northwest or the self-insured employer (Alexsis) is responsible.

ORDER

The Referee's order dated September 13, 1990, is vacated. The case is remanded for further proceedings consistent with this opinion.

Board Member Gunn, specially concurring:

I agree with the majority's disposition of this case. I write only to express my view regarding the weight to be given a Labor Arbitrator's award, and to consider the definition of "reasonable" in ORS 656.802(2)(b).

Where the reasonableness of an employer's conduct is an issue in a workers' compensation proceeding, and an Arbitrator's award addresses that issue, the Board should defer to that award. Binding arbitration is an effective, expeditious and legislatively favored means of resolving labor disputes. Deferring, where appropriate, to arbitration decisions advances the legislative purpose and is a proper exercise of quasi judicial authority. West Linn Ed. Assn. v. West Linn School District No 3JT, 3 PECBR 1864 (1978); Siegel v. Gresham Grade Teachers, 32 Or App 541, 546-549 (1978).

In the absence of an Arbitrator's award, I believe that the Board should adopt a standard by which the term "reasonable" as it is used in ORS 656.802(2)(b) is clearly defined. A standard of reasonableness is not set forth in either statute or rule. Further, there is not any legislative history or prior Board decisions which define this standard. Rather, the determination of what is reasonable conduct in this context has been decided on a case-by-case basis with no enunciated standard to guide the fact-finder or the parties.

In Brown v. Oregon College of Education, 52 Or App 251 (1981), the court provided guidelines relevant to the determination of "reasonableness" with regard to an employer's conduct. These factors have been further expanded upon by the Employment Relations Board in Oregon School Employees v. Klamath County School District, 9 PECBR 8832 (1986), which is set forth in footnote 1 of the majority opinion. I would, in the absence of a collective bargaining agreement, urge the adoption of these factors in order to provide a standard for determination of "reasonable" under ORS 656.802(2)(b).²

¹ The Workers' Compensation Board is not the only administrative agency which is charged with assessing the reasonableness of employer conduct. The Employment Relations Board (ERB) reviews certain disciplinary actions of public employers; in doing so, it must determine whether or not a "reasonable employer" would have taken the challenged disciplinary action. See Brown v. Oregon College of Education, 52 Or App 251 (1981). ERB, quoting one member's opinion in Brown, has announced some of the factors it will consider in making its determination:

"There is no explicit and comprehensive recipe that describes the traits of the reasonable employer. The ingredients must be discerned, and sometimes inferred, from a variety of sources. The Oregon Legislature, courts and this Board have enunciated some of the traits possessed by the reasonable employer; for example, it:

Does not take action based on political, religious or racial reasons, or because of sex, marital status, or age;

Disciplines in good faith and for cause;

Does not impose sanctions disproportionate to the offense or discipline for inconsequential offenses;

Considers the employee's length of service and prior service record, warns employees about what conduct is improper and generally is consistent in applying disciplinary sanctions;

Takes disciplinary action in a timely manner;

Gives an employee who is being dismissed notification of the charges against him and of the kinds of sanctions being considered, and at least an informal opportunity to refute the charges to someone authorized to make or effectively recommend the final decision;

Bears the burden of proving all elements necessary to justify the discipline exacted; and

Adopts and enforces reasonable regulations governing the work and conduct of its employees and imposes appropriate forms of discipline where it has good cause.

My own experience in the field of employment relations and a review of some literature in the field lead me to conclude that the reasonable employer also incorporates other traits. For example, it:

Makes a fair and objective investigation before administering discipline, except in extraordinary circumstances; obtains substantial evidence before imposing sanctions; uses progressive discipline, except where the offense charged is gross or the employee's behavior probably will not be improved through such measures; and does not, through its own actions, exacerbate disciplinary problems."

Oregon School Employees Association v. Klamath County School District, 9 PECBR 8832 (1986).

These factors are also relevant to our determination of reasonableness. Therefore, evidence directed to these issues is relevant and material in mental disorder cases under ORS 656.802.

² These same factors would be applied by the Employment Relations Board to the Workers' Compensation Board, as a public employer, to any conduct taken in the discipline or discharge of a referee. See ORS 656.724(3)(d).

In the Matter of the Compensation of

BAHMAN M. NAZARI, Claimant

WCB Case No. 90-11477

ORDER ON REVIEW

Welch, et al., Claimant Attorneys

Stoel, Rives, et al., Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of that portion of Referee Mills' order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, a 42 year old computer specialist, first had low back pain while working for the employer, Tektronix, in 1983. No claim was made against the employer at that time and claimant did not receive any medical treatment for his back thereafter until 1989.

From 1987 to 1989, claimant was employed as a laboratory technician and performed metallurgical testing. In August 1989, he began working in the mechanical department assembling circuit boards. This job involved various activities, including occasional lifting of stacks of circuit boards weighing up to 40 pounds and placing them in racks above the shoulder level.

As a result of this heavier work, claimant began to have symptomatic flare-ups of his back condition. He first sought medical treatment from Dr. Azhar, his treating physician, on January 5, 1990. Dr. Azhar diagnosed a low back strain related to lifting at work and long periods of standing. (Ex. 7). Claimant again sought treatment for low back pain on February 2, 1990. No claims were filed with respect to those two visits and claimant did not miss any work.

On April 4, 1990, claimant felt a sharp pain in his low back while lifting circuit boards. He did not report a specific injury to the employer at that time, nor did he report a low back injury to Dr. Azhar, who examined claimant later that day during a previously scheduled appointment for chest pains.

Claimant reported to work the following day and informed his supervisor that he could not perform certain work activities because of his low back pain, which had become severe. The supervisor told claimant that, if he was refusing work due to back pain, he needed to obtain a doctor's excuse and suggested that he should file a claim if he was injured. Claimant did not tell his supervisor about the specific injury at that time; however, he did file a claim for a back "strain" later that day and, on the claim form, described the April 4, 1990 lifting incident. (Ex. 8).

The next day, April 6, 1990, claimant saw Dr. Azhar, who diagnosed a lumbosacral strain and related the condition to claimant's lifting activities at work. Dr. Azhar took claimant off work and prescribed medication. X-rays of his lumbar spine proved normal; a MRI showed degenerative disc changes at L4-5 and foraminal stenosis at L5-S1.

Dr. Azhar issued his first narrative report on April 23, 1990. He indicated that claimant had a lumbosacral strain in addition to a preexisting degenerative disc disease. He further indicated that claimant would be medically stationary in 4-6 weeks, and that claimant could return to work with restrictions. (Ex. 14).

On May 7, 1990, claimant was examined by Dr. McKillop, an orthopedic surgeon. Dr. McKillop diagnosed mild degenerative disc disease and backaches associated with lifting at work.

On May 18, 1990, the employer denied claimant's claim, asserting that his low back symptomatology was not directly related to his activities at work. (Ex. 16). At hearing, it raised two defenses to the claim, the first being that claimant's injury did not arise out of and in the course of his employment. In the alternative, it argued that if claimant did sustain an injury at work, the claim was not compensable because claimant's need for treatment was caused, in major part, by his preexisting degenerative disease process.

FINDINGS OF ULTIMATE FACT

On April 4, 1990, claimant suffered an accidental low back injury, which arose out of and in the course of employment and was a material contributing cause of his disability or need for medical services. This injury combined with claimant's preexisting degenerative disc disease to cause or prolong claimant's disability or need for treatment. However, the injury remained the major contributing cause of his disability and need for treatment for his resultant condition.

CONCLUSIONS OF LAW AND OPINION

In determining the compensability of claimant's low back strain, the Referee first concluded that the cause of the strain was an injury rather than an occupational disease. We agree.

An accidental injury is generally unexpected and sudden in onset. An occupational disease, on the other hand, develops gradually over a period of time and cannot be said to be an unanticipated result of a worker's continuous exposure to conditions in particular kinds of employment. James v. SAIF, 290 Or 343 (1981). In this case, claimant credibly testified that, although his back had hurt periodically before, he felt a sharp pain in his back while lifting a stack of circuit boards between 2:00 and 3:00 p.m. on April 4, 1990. Thus, claimant points to an identifiable event that caused a sudden onset of disabling pain. Accordingly, we conclude that claimant's back strain was the result of an injury, rather than an occupational disease. Valtinson v. SAIF, 56 Or App 184 (1982).

Turning to the merits of the claim, the Referee next concluded that claimant had established a compensable back strain, because the April 4, 1990 work incident was the major contributing cause of his disability and need for medical treatment. We agree with the Referee's ultimate conclusion, but offer the following analysis.

On May 7, 1990, the Oregon Legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Act. Or Laws 1990 (Special Session), ch. 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See, e.g., Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

As amended, ORS 656.005(7)(a) provides, in pertinent part:

"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: an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"(A) No injury or disease is compensable as a consequence of of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

"(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." Or Laws 1990 (Special Session), ch. 2, section 3.

We find no ambiguities in the statute as applied to this situation. Therefore, we construe it according to its plain meaning. Perez v. State Farm Mutual Ins. Co., 289 Or 295 (1980).

The new statutory provision clearly retains the traditional definition of a compensable injury, i.e., an accidental injury arising out of and in the course of employment. Accordingly, as in the past, an injured worker establishes a compensable injury by proving that the accident is a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). However, the need for medical services or disability must be established by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991). Furthermore, by adding subsections (A) and (B), the legislature has subjected a compensable injury to certain "limitations." By virtue of the first limitation, a worker who suffers a second injury as a consequence of the original compensable injury will be compensated for the second condition only if the compensable injury is the major contributing cause of that injury. ORS 656.005(7)(a)(A); see Julie K. Gasperino, 43 Van Natta 1151 (1991).

ORS 656.005(7)(a)(B) creates a similar limitation. Under that provision, a worker who suffers a compensable injury, yet who also suffers from a preexisting condition or disease that combines to cause or prolong disability or need for treatment, will be compensated for disability and treatment only if the compensable injury is the major contributing cause of that disability or need for particular treatment. Thus, although the injury is compensable, a worker may not be entitled to claimed compensation for particular medical services or disability if his preexisting disease or condition is the major contributing cause of that disability or need for medical services.

A carrier shall not deny an initial injury claim to take advantage of the limiting feature of subsection (B). Rather, after accepting the claim as compensable under ORS 656.005(7)(a), the carrier may partially deny such treatment as it reasonably believes is caused in major part by the preexisting disease rather than the accidental injury. Similarly, for example, if the carrier obtains evidence that a claimant's disability is not then caused in major part by the injury, but rather by the preexisting condition, the carrier may partially deny disability compensation for the then-current condition. In the appropriate case, a carrier may accept an injury and partially deny disability and/or treatment in a single document.

In this case, the employer issued a single denial, which provided, in pertinent part:

"We have received your claim for your low back occurring on or around April 4, 1990.

"However, information in your file indicates that your current low back symptomatology is not directly related to your work activities[.] Therefore, we must respectfully deny your claim.

"We must notify you that we will be unable to accept your claim. Our denial is based on the fact that it does not appear your condition was worsened by or arose out of and in the course of your employment, either by accident or occupational disease, within the meaning of the Oregon Workers' Compensation Law." (Ex. 16).

From the plain language of the denial, as well as the employer's presentation of the issue at hearing, it is clear that the employer wished to challenge the compensability of the entire claim on the ground that it did not arise out of and in the course of employment. Therefore, we must first determine the compensability of the injury itself under amended ORS 656.005(7)(a) by answering the following question: Was the injury sustained in the course and scope of the employment and was it a material contributing cause of claimant's disability and need for medical services?

The primary medical evidence in this case comes from Dr. McKillop, who performed an independent medical examination on May 7, 1990. He concluded that claimant's work incident caused the development of low back symptoms, which led to his disability and need for medical treatment. He also reported that, as a result of the injury, claimant had restrictions of lumbar motion on certain orthopedic maneuvers, i.e., flexion limited to 60 degrees and extension to 20 degrees. The report is sufficient to establish, by medical evidence supported by objective findings, that there was an injury. Moreover, we find the report sufficient to establish that the injury was work-related. There is no contrary evidence.

Therefore, we conclude that claimant has established a compensable injury. Accordingly, we affirm the Referee's order setting aside the employer's denial.

Assuming arguendo, that the employer's denial also raised an issue about the right to compensation for specific treatment or disability, we also find that, because the injury was the major contributing cause of his disability and need for treatment, claimant is entitled to all claimed compensation for that injury, his preexisting condition notwithstanding.

The employer requested review, and we have found that claimant's compensation should not be disallowed or reduced. Nevertheless, claimant's attorney is not entitled to an assessed attorney fee under ORS 656.383(2), because the respondent's brief was not timely submitted. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated September 10, 1990 is affirmed.

Board Members Westerband, Kinsley, and Neidig specially concurring.

The majority has reached the correct result, but for the wrong reason. Claimant's claim is compensable, but only because the evidence establishes that

his compensable injury rather than his preexisting condition is the major contributing cause of his disability and need for medical treatment.

On page 4 of its opinion, the majority begins its analysis with a correct description of the effect of the 1990 amendment to ORS 656.005:

"Under that provision [ORS 656.005(a)(B)], a worker who suffers a compensable injury, yet who also suffers from a preexisting condition or disease that combines to cause or prolong disability or need for treatment, will be compensated for disability only if the compensable injury is the major contributing cause of the disability or need for treatment. Thus, although the injury is compensable, a worker may not be entitled to claimed compensation for medical services or disability because his preexisting disease or condition is the major contributing cause of the disability or need for medical services." (Emphasis added).

Like the statute itself, that statement of law is clear and simple enough. However, from that statement onward, the majority proceeds to enact its own legislation governing claims processing. The majority opinion states:

"A carrier shall not deny an initial injury claim to take advantage of the limiting feature of subsection (B). Rather, after accepting the claim as compensable under ORS 656.005(7)(a), the carrier may partially deny such treatment as it reasonably believes is caused in major part by the preexisting disease rather than the accidental injury. Similarly, for example, if the carrier obtains evidence that a claimant's disability is not then caused by the injury, but rather by the preexisting condition, the carrier may partially deny disability compensation for the then current condition. In the appropriate case, a carrier may accept an injury and partially deny disability in a single document." (Emphasis added).

The majority has missed the point. ORS 656.005(7)(a)(B) is not a claims processing statute. It is substantive, in purpose and effect. When the claimed for condition results from the combination of an industrial accident and a preexisting condition, the statute says that "the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." Thus, when because of a preexisting condition, the industrial accident is not the major contributing cause of the disability, the disability is simply not compensable, notwithstanding the "material contribution" of the employee's work activities.

The purpose and policy of the legislature are clear. The legislature has decided that where a preexisting condition is, in major part the problem, the "material contribution" of the industrial accident is not enough to entitle the worker to workers' compensation benefits, and the resultant medical problem is for some other system of health care. Consequently, where the carrier's investigation establishes that a preexisting condition is the major contributing cause of the worker's disability and need for medical treatment, the carrier may simply deny the claim on that basis. The carrier has no obligation under ORS 656.005(7)(a)(B), contrary to the majority opinion, to accept the accidental injury before denying the worker's claim in the same or in some other document. Rather, the claim may simply be denied on the ground that the industrial accident is not the major contributing cause of the disability or need for treatment.

Furthermore, where the effect of the preexisting condition was raised, as it was in the present case, it must be reached and decided by this Board. We

cannot properly discharge our statutory responsibilities by parsing the words of the carrier's denial in order to find a way to determine the compensability of the claim based on the less stringent "material contributing cause" standard. Under ORS 656.005(7)(a)(B), the question of "material contribution: (i.e., whether there was an industrial accident) is only the threshold question which must be answered affirmatively in our analysis in order to reach the ultimate question, upon which the compensability of the claimed condition depends. The legislature did not add this analytical second step in order to give this Board the opportunity to apply the threshold "material contributing cause" standard and set aside the denial on that basis. The question here, which the denial raised, was of major contributing causation. Claimant's condition is compensable only because the evidence satisfied that test.

October 21, 1991

Cite as 43 Van Natta 2373 (1991)

In the Matter of the Compensation of

EMERY A. REBER, Claimant

WCB Case No. 89-20293

ORDER ON REVIEW

Lindsay, et al., Claimant Attorneys

Larry Schucht (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of claimant's cervical injury and quadriplegia. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was 53 years of age at the time of hearing. He has a history of hypertension for which he was prescribed medication. Claimant also has an aortic stenosis condition. In addition, he has received treatment for chest pain and heart palpitations. He has several high risk factors for coronary artery disease. A potential side effect for any of these conditions is fainting. Nonetheless, prior to claimant's August 1989 fall at work, he had never fainted.

While performing his duties at work on August 3, 1989, claimant leaned over a second story deck in order to drop a five to six foot piece of two-by-ten ceiling joist to a wood pile on the ground below. The deck was approximately 5 to 6 feet above the ground. Claimant was in the process of removing debris from a recent fire. While leaning over the deck, claimant lost his balance. He fell, while still holding the piece of charred lumber. Claimant landed on the top of his head on the wood pile, sustaining a "Jefferson fracture" to his spine, which has rendered him a quadriplegic.

Prior to the fall, claimant did not appear to be in any physical distress. The deck was dirty due to the debris from the fire. Near the edge of the deck was a small mound or "berm," which is installed for water control purposes. The day before claimant's fall, a co-worker had lost his footing on the berm and had nearly fallen off the deck. Later on the day of the fall, the co-worker observed scuff marks on the edge of the deck where claimant had fallen.

Claimant's treating neurosurgeon was Dr. Wright. According to Dr. Wright, claimant was at risk for fainting because of his aortic stenosis and other cardiac abnormalities. Nevertheless, testing did not indicate that claimant had suffered a myocardial infarction or any cardiopulmonary abnormality.

Furthermore, drug testing revealed no toxic chemicals or compounds in claimant's bloodstream. Although claimant's evaluation did not reveal a specific cause for claimant's fall, Wright testified by deposition that it would be "probably overstating it to say we completely ruled out all of those possibilities [seizure, cardiac event, hypoglycemia, drug use]." Finally, Wright concluded that it was equally plausible that claimant had fallen because he had lost his footing as it was that he had fainted.

Dr. Toren, neurosurgeon, reviewed claimant's medical record. Because claimant had fallen without flailing his arms or crying out, Toren concluded that it was likely that claimant had fainted prior to his fall. Based on claimant's aortic stenosis, hypertension, and risk factors for coronary artery disease, Toren concluded it was at least as probable that the fall occurred as a result of claimant's fainting from these idiopathic conditions as that the fall resulted solely because claimant fainted from performing his work activities.

FINDING OF ULTIMATE FACT

Claimant fell when he lost his balance while performing his work activities. The fall was a material contributing cause of his disability and need for medical treatment. The second story height, from which claimant fell, aggravated the effect of his fall. Claimant's fracture would not have occurred had claimant fallen from a standing position on the ground.

CONCLUSIONS OF LAW AND OPINION

Claimant has the burden of proving by a preponderance of the evidence that his injury arose out of and in the course of his employment. ORS 656.005(7)(a) (formerly ORS 656.005(8)); ORS 656.266. The Supreme Court has adopted a unitary work-connection approach: "If the injury has sufficient work relationship, then it arises out of and in the course of employment and the statute is satisfied." Rogers v. SAIF, 289 Or 633, 643 (1980).

The unitary work-connection analysis, as explained in Phil A. Livesley Co. v. Russ, 296 Or 25 (1983), adopted the "quantum" theory of work-connection as articulated in I Larson, Workmen's Compensation Law, 29.10 at 5-355. The quantum approach permits a proportional application of the "course of employment" and "arising out of employment" factors in establishing the sufficiency of the work relationship to a worker's injury.

Under the unitary work-connection approach, it is not sufficient that an injury occurs due to a fall which happened at work ("in the course of employment"). To prove compensability, a worker must also establish that the injury was linked in some way to a risk of employment. The employment link may be made in one of two ways.

Where an at-work fall is unexplained, the law assumes that the cause is work-related provided that idiopathic causes have been ruled out. See Phil A. Livesley Co. v. Russ, *supra* (claimant walking down a crowded aisle from his work station to the time-clock on a level surface unaccountably fell and broke his hip; the cause of the fall was not idiopathic; therefore, compensable). In the case at bar, the Referee concluded that claimant's fall was unexplained, and that claimant had failed to eliminate idiopathic causes as the reason for his unexplained fall.

We conclude, however, that an injury caused by a fall may be compensable even though idiopathic causes for the fall have not been ruled out. To establish compensability under such circumstances, the worker must demonstrate that the injury was related to some work-related risk, although the fall itself was

not. Professor Larson, in his treatise on workers' compensation law, explains that an injury which occurs due to an at-work fall may be compensable even though the fall is not unexplained, but rather is related to an idiopathic cause:

"Injuries arising out of risks or conditions personal to the claimant do not arise out of the employment unless the employment contributes to the risk or aggravates the injury. When the employee has a preexisting physical weakness or disease, this employment contribution may be found either in placing the employee in a position which aggravates the effect of a fall due to the idiopathic condition, or in precipitating the effects of the condition by strain or trauma."

I Larson, supra, Sec. 12.00 at 3-308 (1985).

This approach, known as the "increased danger rule,"¹ was recently adopted by the Court of Appeals in Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991). The court applied the rule to the increased risk of injury attendant to driving a motor vehicle. We see no reason why this same approach should not be applied to the unexplained fall at issue in the case before us.

Therefore, to place the risk of loss on the employer due to an idiopathic fall requires a showing of substantial employment contribution to the risk or to the extent of harm. See I Larson, supra, Sec. 12.14(b), at 3-325.

In this case, there is no question that claimant's injury occurred in the course of employment. He was at the edge of a second story roof, dropping lumber onto a pile on the ground as directed by his employer. His fall from the roof was observed by two employees standing on the ground nearby, who related that claimant fell clutching a long and heavy piece of lumber. The second story height from which claimant fell, aggravated the effect of his fall. Dr. Wright, claimant's treating neurologist, stated that the "Jefferson's fracture" suffered by claimant was the result of a direct hit on the top of his head, thereby transferring the thrust of the fall directly along the axis of the spine. (Ex. 25-35).

Such a hit and fracture would not have occurred had claimant fallen from a standing position on the ground instead of from a height. Accordingly, we find that claimant has established the required "substantial employment contribution" to his injury. We therefore conclude that claimant has established that his injury arose out of and in the course of employment. Rogers v. SAIF, supra.

Claimant has prevailed in a rejected case. Therefore, he is entitled to a fee under ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$12,000, to be paid by SAIF. In reaching this

¹ We saw no reason to adopt this doctrine previously. See Roy I. Powers, 42 Van Natta 353 (1991). In Powers it was referred to as "the positional risk doctrine." We prefer to reserve that terminology for the situation in which an employee is placed in a location where he or she is injured by some neutral force, for instance a stray bullet or lightning, in accord with I Larson at 3-6, 6.50. Accordingly, we here refer to the doctrine as the "increased danger rule," which, although analogous to the "positional risk doctrine," differs because of the element of a possible idiopathic condition, i.e., a condition personal to the claimant.

conclusion, we have particularly considered the time devoted to the case as represented by the lengthy hearing and the record as a whole (including claimant's appellate brief), the significant complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 25, 1990 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of \$12,000, payable by SAIF.

October 21, 1991

Cite as 43 Van Natta 2376 (1991)

In the Matter of the Compensation of
CHRISTINE SUTTON, Claimant
WCB Case No. 90-04254
ORDER ON REVIEW
Malagon et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Crider and Tenenbaum.

The SAIF Corporation requests review of those portions of Referee Livesley's order that: (1) set aside its denial of claimant's injury claim for a cervical strain; (2) assessed a penalty and related attorney fee for unreasonable denial; (3) assessed a penalty and related fee for failure to timely pay interim compensation; and (4) assessed an attorney fee for failure to timely accept or deny the claim. On review, the issues are compensability and penalties and related fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

Claimant requested a hearing on February 26, 1990, and the hearing was convened on June 12, 1990. Accordingly, this matter is properly analyzed under the law in effect prior to July 1, 1990. See Or Laws 1990 (Special Session), ch. 2, 54(2); John K. French, 43 Van Natta 836 (1991).

Compensability

Based on their demeanor, the Referee found claimant and Sylvia Gosline credible. We defer to those determinations, because of the Referee's opportunity to observe the witnesses. Humphrey v. SAIF, 58 Or App 360 (1982). Relying on their testimony and the medical evidence, the Referee concluded that claimant had established a compensable injury. We agree.

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(7)(a). To establish a compensable injury, claimant must show that: (1) she exerted herself in performing her job; and (2) the exertion was a material contributing cause of the resultant disability or need for medical treatment. The first is a question of legal causation; the second concerns medical causation. Harris v. Farmers' Co-op Creamery, 53 Or App 618

(1981). Claimant carries the burden of proving both legal and medical causation by a preponderance of the evidence. Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981).

SAIF first contends that claimant failed to establish legal causation, because her injury occurred when she simply turned her head at work. It explains:

"The issue raised is really whether or not the turning of one's head is sufficiently work-related to pass [the] legal causation test. SAIF submits that it is not. If a claimant is stretching during a yawn and injures himself would that body movement have sufficient work relatedness to satisfy legal causation? The total lack of stress in an unforced neck turn should not satisfy legal question." (App. brief at 4).

We agree with SAIF that, for an injury to arise out of employment, it must be traceable to the nature of the work or to some risk of the work to which a claimant is exposed. Hubble v. SAIF, 56 Or App 154 (1982). However, where a specific work activity, whether isolated or repetitive, is part of a claimant's job, the risk of injury from that activity is a risk of that job. Folkenberg v. SAIF, 69 Or App 159 (1984). In this case, claimant turned away from her computer terminal to write something down at her desk when she heard a "pop" in her left shoulder and neck and felt the immediate onset of pain. The evidence shows that turning from her computer to her desk was a part of claimant's job. Therefore, the risk of injury from that activity, albeit minor, was a risk of her employment. We conclude that claimant has met her burden of proving legal causation.

SAIF next contends that claimant has failed to establish medical causation. It relies on the opinions of Dr. Brooks, a neurologist, and Dr. Staver, an orthopedist, who examined claimant at the offices of the Western Medical Consultants. They reported that, in their opinion, claimant's employment was not a material contributing cause of her condition because the injury occurred when she simply turned her head. The Consultants explained:

"By this, we mean that the action she describes is an action that is carried out by most people many times a day. She simply turned. *
* * If she does have a condition, in other words, it occurred at her place of work but it would not appear to us that her work was the inherent cause of these symptoms. This would seem to be a more legal than medical question, however." (Ex. 10).

We do not find the opinions of Dr. Brooks and Dr. Staver persuasive. As they evidently recognized themselves, they confuse legal causation with medical causation and, consequently, do not explain their conclusion in terms of medical causation. Accordingly, we give their opinions little weight.

We find the opinion of Dr. Johnson, claimant's treating physician, to be the most persuasive. Based on his numerous opportunities to see and treat claimant during her disability, Dr. Johnson reported:

"It is my view that the medical probabilities are extremely high and the history in my view substantiates the twisting incident as the material cause of her neck and shoulder condition, and its need for treatment." (Ex. 9).

Based on that report, as well as Dr. Johnson's deposition testimony, we find that claimant's work activity was a material contributing cause of her cervical strain. Accordingly, we conclude that claimant also has established

medical causation and affirm the Referee's determination that the claim is compensable.

Penalties and Related Fees--Unreasonable Denial

A penalty and related attorney fee may be assessed when an insurer "unreasonably delays or unreasonably refuses to pay compensation." Former ORS 656.262(10) and 656.382(1). The reasonableness of an insurer's denial of compensation must be determined in light of all the information available to the insurer at the time of its denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

In this case, the Referee found that SAIF's denial of claimant's injury claim was unreasonable and awarded a penalty and related fee. He relied on the fact that, at the time of the denial, SAIF had in its possession a 827 form that had related claimant's condition to work. He further noted that the employer had noted on the 801 form that the injury had taken place at work.

Based on that evidence, we agree that SAIF did not have a legitimate doubt whether the claimed injury occurred during work hours on the employer's premises. Moreover, it is well-established that exertion at work need not be extraordinary in order to satisfy the legal causation requirement. Therefore, we agree with the Referee's conclusion that the denial was unreasonable and the penalty and attorney fee awards were appropriate.

Penalty and Attorney Fee--Failure to Timely Pay Interim Compensation

We adopt the conclusions and reasoning concerning claimant's entitlement to a penalty and related fee for SAIF's alleged failure to timely pay interim compensation as set forth in the Referee's order.

Attorney Fee--Untimely Denial

In addition to awarding penalties and related attorney fees for SAIF's allegedly unreasonable denial and failure to timely pay interim compensation, the Referee assessed a \$200 attorney fee for SAIF's failure to accept or deny claimant's claim within 60 days. On review, SAIF admits that it failed to timely deny the claim. It argues, however, that claimant is not entitled to a fee because claimant failed to establish that she was prejudiced by the late denial. We disagree. In order to be awarded attorney fees under former ORS 656.382(1), a claimant need only establish that the insurer unreasonably resisted the payment of compensation. Gray v. SAIF, 70 Or App 313 (1984). Lack of prejudice is not a defense. Lester v. Weyerhaeuser, 70 Or App 307 (1984).

Attorney Fees on Board Review

Because SAIF initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$1,200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for defending on the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 22, 1991 is affirmed. For services on Board review concerning the compensability issue, claimant's counsel is awarded a reasonable attorney fee of \$1,200, to be paid by SAIF.

October 21, 1991

Cite as 43 Van Natta 2379 (1991)

In the Matter of the Compensation of
ERVIN E. YOUNG, Claimant
WCB Case No. 89-25185
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Crider and Tenenbaum.

The insurer requests review of Referee Schultz' order that: (1) set aside its backup denial of claimant's toxic exposure/acute central nervous system depression claim; (2) set aside its partial denial of claimant's psychological condition and continuing physical disorder; (3) awarded claimant's attorney a penalty-related fee of \$500 for an allegedly unreasonable backup denial; and (4) awarded claimant's attorney an assessed fee of \$20,902.50 for prevailing against the insurer's denials. Should we conclude that claimant's psychological condition is compensable, claimant requests that the Board award his counsel a 50 percent enhanced assessed fee. On review, the issues are backup denial, compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant became afraid for his life when informed by the medical staff in the emergency room that he had central nervous system depression as the result of exposure to toxic fumes at work.

On November 2, 1990, the insurer issued a denial revoking its September 19, 1989 acceptance of claimant's toxic exposure and resultant acute central nervous system depression. On November 6, 1990, claimant requested a hearing from that denial. The hearing was held on November 6, 1990.

FINDINGS OF ULTIMATE FACT

The insurer's November 2, 1990 revocation of its September 19, 1989 acceptance of claimant's toxic exposure/acute central nervous system depression was issued within two years of claim acceptance.

Claimant's toxic exposure at work was a material contributing cause of the onset of his conversion reaction and need for medical treatment.

CONCLUSIONS OF LAW AND OPINIONPropriety of Backup Denial of Acute Central Nervous System Depression

We affirm and adopt the Referee's reasoning and conclusions, holding that the insurer's backup denial must be set aside, with the following comment regarding applicable law.

On review, as at hearing, the insurer asserts that its denial was permissible under the 1990 legislative amendments to ORS 656.262(6). Claimant originally requested a hearing from the November 1989 partial denial of his psychological condition on December 12, 1989 and that hearing initially convened on April 23, 1990. Therefore, the Referee properly analyzed that partial denial in accordance with the Workers' Compensation law in effect before the 1990 amendments. See Or Laws 1990, (Special Session), ch. 2, 54(2).

On November 2, 1990, the insurer issued a backup denial revoking its September 19, 1989 acceptance of claimant's toxic exposure and resultant acute central nervous system depression. Claimant requested a hearing from that denial on November 6, 1990, the same date on which the reconvened hearing on the partial denial was held. Therefore, the insurer contends, the 1990 amendments to the Workers' Compensation Law apply such that it had up to two years from the date of claim acceptance to revoke its acceptance. See Or Laws 1990, (Special Session), ch. 2, 15 (amending ORS 6546.262(6)). We agree.

Where a request for hearing is filed after May 1, 1990, and the hearing is convened after July 1, 1990, as is the case with regard to the backup denial, the 1990 amendments to the Workers' Compensation Law are generally applied retroactively, unless retroactive application produces an absurd or unjust result inconsistent with the purposes and policies of the Workers' Compensation Law. Ida M. Walker, 43 Van Natta 1402, 1405 (1991); see also Or Laws 1990, (Special Session), ch. 2, 54(1), (2). The matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, 54(3). Moreover, we do not find that application of this change retroactively to this case will produce an absurd or unjust result inconsistent with the purposes and policies of the Workers' Compensation Law. Ida M. Walker, supra. Accordingly, we analyze the backup denial under the Workers' Compensation Law as amended, effective July 1, 1990.

Under the new law, the insurer had two years, rather than 60 days, from the date of claim acceptance to revoke such acceptance and issue a formal notice of claim denial. However, because claimant has requested a hearing from such a denial, the insurer "must prove by clear and convincing evidence that the claim is not compensable. . . ." ORS 656.262(6). (Emphasis supplied). Since the insurer initially accepted claimant's toxic exposure and resultant acute central nervous system depression claim on September 19, 1989, and because it issued its denial revoking acceptance on November 2, 1990, the denial was timely. Therefore, the insurer can prevail if it proves by clear and convincing evidence that claimant did not experience a compensable physical injury as a consequence of fume exposure.

We find, as did the Referee, that claimant has established by a preponderance of the evidence that he was exposed to styrene fumes on August 18, 1989. The emergency room physicians who treated claimant at the time of injury diagnosed "vinyl benzene exposure" and "central nervous system depression." (Ex. 17). Although later testing showed no continuing organic problem, Dr. Curtis, one of the emergency room physicians, was unwilling to say claimant never experienced an acute physical reaction. (Ex. 60).

Thus, the insurer has not proven "by clear and convincing evidence that the claim is not compensable. . . ." ORS 656.262(6). Accordingly, the insurer's November 2, 1990 backup denial revoking its prior acceptance of claimant's toxic exposure claim must be set aside. Claimant's previously accepted toxic fume exposure and central nervous system depression remains an accepted, compensable condition.

Compensability of Conversion Reaction Disorder

As a preliminary matter, we note that claimant requested a hearing from the November 14, 1989 partial denial on December 12, 1989, and that a hearing on that matter was originally convened on April 23, 1990. Therefore, as did the Referee, we analyze this issue in accordance with the Workers' Compensation Law in effect before the 1990 amendments. Turning to the merits, we affirm and adopt the Referee's reasoning and conclusion that claimant's conversion reaction is compensable, with the following clarification concerning the requisite standard of proof.

The Referee found that claimant's exposure to toxic fumes at work was the "sole triggering event" for claimant's conversion reaction. Thus, he found the claim compensable. On review, the insurer renews its argument that claimant has failed to satisfy the requirements of former ORS 656.802(2)(a) through (d) and establish by clear and convincing evidence that he suffers from a mental condition, the major cause of which was exposure to styrene fumes at work.

The insurer's argument presumes that the conversion reaction is compensable, if at all, as an occupational disease. We disagree. Claimant's reaction came on acutely following the events of August 18, 1989. We, therefore, analyze the claim as one for an industrial injury. James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982).

Thus, to establish the compensability of his claim, claimant has the burden of proving by a preponderance of the evidence that exposure to styrene fumes on August 18, 1989 was a material contributing cause of the onset of his conversion reaction and need for medical treatment. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). We find that toxic exposure at work was a material contributing cause of the onset of claimant's conversion reaction and need for medical treatment. Hence, claimant has carried his burden of proof and established the compensability of his psychological disorder.

Penalty-Related Attorney Fee for Backup Denial

The Referee found that there were no "amounts then due" upon which to assess a penalty. Nevertheless, finding that the insurer's November 2, 1990 denial was an impermissible backup denial as noted in Bauman v. SAIF, 295 Or 788 (1983), which constituted an unreasonable resistance to the payment of compensation, he assessed a penalty-related attorney fee of \$500. We have affirmed the Referee's conclusion that the insurer's November 2, 1990 backup denial must be set aside, albeit pursuant to ORS 656.262(6) as amended, rather than to the Bauman rule. We find, however, no basis upon which to assess a penalty for the insurer's backup denial.

Claimant does not contend that any compensation was delayed because of the insurer's backup denial. Where no penalty is warranted, ORS 656.382(1) allows an attorney fee if an insurer "unreasonably resists the payment of compensation." Richard J. Stevenson, 43 Van Natta 1883 (1991). Absent a showing that the insurer's backup denial affected some obligation to pay compensation due in the past, present or future, it cannot be said that there was any resistance to such payment. Inasmuch as claimant concedes that the central nervous system depression was transient, we cannot find that the backup denial amounted to a resistance to the payment of compensation. Therefore, an attorney fee is not authorized by ORS 656.382(1). Accordingly, we reverse the Referee's award of a \$500 assessed fee.

Attorney Fees at Hearing and on Review

The Referee awarded claimant an assessed fee of \$20,902.50 for prevailing at hearing against the insurer's denials. On review, the insurer argues that the fee is excessive. We disagree.

In determining an appropriate fee for claimant's counsel's services at hearing, we consider the factors set out in OAR 438-15-010(4). Those factors include: "(a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill and standing of the attorneys; (e) the nature of the proceeding; (f) the result secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses."

The hearing in this matter was conducted over three days before two referees. In addition, claimant's attorney found it necessary to attend three deposition hearings held on separate days and to assist in securing a stipulated statement from an unavailable subpoenaed witness. Both counsel submitted lengthy, well reasoned arguments following the hearing. Claimant's counsel devoted slightly over 90 hours attorney time and 26 hours staff time to this case at hearing.

This matter involves a complex toxic exposure claim with resultant physical and psychiatric disorders. Because the claim was found to be compensable, claimant will be entitled to necessary medical care for his psychiatric condition.

It was necessary for claimant's attorney to do a greater amount of work than would ordinarily be required in such a case due to the insured's conduct in withholding internal memos from examiners and from claimant's attorneys.

Both counsel are skilled and each demonstrated that skill during these proceedings. Ten witnesses testified during this strongly adversarial hearing; the issues were strenuously and competently litigated by both attorneys.

Claimant's counsel bore a significant risk of his efforts going uncompensated in this complicated case.

Considering the above factors and applying them to this case, we find that the fee awarded by the Referee on the compensability issue was appropriate.

Furthermore, after applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability and back-up denial issues is \$5,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by claimant's respondent's brief, the complexity of the issues and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated December 19, 1990 is affirmed in part and reversed in part. That portion of the order that awarded claimant's counsel a penalty-related fee of \$500 is reversed. For services on review concerning the compensability and back-up denial issues, claimant's counsel is awarded a reasonable assessed fee of \$5,000, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
LYMAN K. HAMPTON, Claimant

WCB Case No. C1-01091

ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT

Emmons, Kropp, et al., Claimant Attorneys

Brian L. Pocock, Defense Attorney

Reviewed by Board Members Neidig and Moller.

By order dated October 4, 1991, the Board disapproved the parties' Claim Disposition Agreement (CDA) upon a finding that the proposed disposition is "unreasonable as a matter of law." Specifically, the Board found that the proposed attorney fee for this structured settlement exceeds the strictures of OAR 438-15-052(1), without any indication of extraordinary circumstances which would justify the excessive fee. The parties have submitted an addendum to the CDA reciting that the proposed attorney fee has been reduced to within the strictures of OAR 438-15-052(1). The parties therefore request reconsideration of our prior order.

The Board may consider a motion for reconsideration of final orders issued under ORS 656.236 if such a motion is filed in accordance with OAR 438-09-035. Finding the parties' request for reconsideration was timely filed and in accordance with the applicable rule, we consider the motion for reconsideration. OAR 438-09-035(2).

In support of their motion for reconsideration, the parties have submitted an addendum reciting that the proposed attorney fee has been reduced, and moving that we reconsider the original CDA as amended. Our review on reconsideration is generally limited to information in the record before the Board at the time our final disapproval order was mailed. OAR 438-09-035(3). However, we may consider additional information in our review if we find good cause for allowing the additional submission. OAR 438-09-035(3).

Here, the parties contend that they have mutually agreed to reduce the proposed attorney fee to within the strictures of OAR 438-15-052(1), and have submitted an addendum evidencing that change. Therefore, the Board will consider this additional information on reconsideration. See OAR 438-09-035(3); Robert S. Robinson, 43 Van Natta 1893 (1991).

Accordingly, we grant the motion for reconsideration. On reconsideration, we find that this agreement is now in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We do not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of this agreement as modified by addendum is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
DELBERT R. HICE, Claimant
WCB Case No. 89-00752
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Davis' order that: (1) declined to grant permanent total disability; and (2) awarded 25 percent (80 degrees) unscheduled permanent disability for an April 1987 low back injury, whereas a Determination Order had awarded no unscheduled permanent disability beyond the 12.5 percent (40 degrees) claimant had been previously granted. On review, the issues are extent of unscheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" in his order, as well as the findings in the "Discussion" portion of the Referee's Order on Reconsideration, except for those portions pertaining to impairment, and as further supplemented.

Claimant's general range of motion for the back was decreased by 50 percent, except for extension which was decreased by 75 percent.

Claimant has undergone an L4-5 lumbar laminectomy with discectomy twice.

ULTIMATE FINDINGS OF FACT

We adopt the Referee's "Findings of Ultimate Fact," with the exception of the first finding, and as supplemented.

Claimant is not permanently and totally disabled for medical reasons alone, nor is he permanently and totally disabled as a result of a combination of medical and nonmedical factors from regularly performing gainful and suitable employment. Work search efforts are not futile for claimant. Claimant has not established that he has made reasonable efforts to seek regular gainful employment, nor has he established that he is willing to seek work.

Claimant has suffered a 70 percent loss of earning capacity due to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Permanent total disability

The Referee concluded that claimant was not permanently and totally disabled as a result of the compensable injury. We agree.

Claimant has the burden to establish that he has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that such efforts would be futile. See ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1985). A finding of futility is reserved for the extreme situation where, for example, the record shows that the individual is physically totally disabled or not capable of retraining. See Georgia-Pacific Corp. v. Perry, 92 Or App 56 (1988). However, even if a work search would be futile, such a claimant must establish that, but for the compensable injury, he would have been willing to seek regular gainful employment. SAIF v. Stephen, 303 Or 41 (1989).

Claimant has not sustained his burden of proof that he is permanently totally disabled. The medical evidence indicates that claimant is able to perform sedentary work, albeit with significant restrictions. The vocational record indicates that claimant has the mental capacity, education, training and transferable skills to return to work. Claimant's vocational counselor testified to specific jobs that claimant could do that were available in the labor market. Dr. LeFrance also opined that claimant was physically capable of performing certain jobs. Therefore, we find that claimant is capable of performing at least regular part-time sedentary work, and that such work is available in the normal labor market. We do not find that a work search would have been futile. See Georgia-Pacific Corp. v. Perry, supra.

Claimant, however, has not made reasonable efforts to seek regular gainful employment. Since the April 27, 1987 injury claimant has not returned to work. Claimant testified that he made no attempts on his own to seek employment. Because of pain and difficulty with sleeping, claimant believes he would be unable to get up in the morning and go to work. Although we do not dismiss the sincerity of claimant's opinion concerning his own capabilities, the medical and vocational record does not support this self-assessment. See Theodore E. Lance, 42 Van Natta 1895 (1990).

The reports of Doctors Throop and LeFrance, as well as the physical capacities examination in November 1988, indicate that claimant is capable of sedentary work with limitations. Dr. LeFrance opined that claimant was capable of limited employment and could engage in vocational training. Dr. Throop recommended that claimant return to work from both a physical and mental perspective. Dr. Parvaresh also felt from a psychiatric viewpoint that employment would be in claimant's best interest.

Claimant has not taken those measures by which he could learn to live with his pain problem. Dr. Throop recommended that claimant attend a pain center in order to develop techniques for controlling and living with his chronic pain syndrome. Although claimant did attempt one week at the Northwest Pain Center, he withdrew because of pain and lack of sleep. Dr. Throop also recommended a regime of exercises in order for claimant to stay conditioned. Claimant testified that he did not attempt the home exercises.

With respect to vocational efforts, due to his premature discharge from the Northwest Pain Center, vocational counseling was never initiated. Claimant also voluntarily withdrew from the vocational rehabilitation program he had started at Columbia Rehabilitation because of his chronic pain and inability to concentrate. Thus, a complete assessment of claimant's vocational options was never fully explored.

Moreover, even assuming a finding of futility, we further find that claimant has not demonstrated a willingness to seek work. Neither the aforementioned record nor claimant's testimony reflect that, but for the injury and accompanying chronic pain, claimant would be willing to seek employment. Accordingly, we find claimant is not permanently totally disabled.

Unscheduled permanent disability

The Referee awarded claimant 25 percent unscheduled permanent disability. This figure was determined based upon a 40 percent rating under the standards, which was increased by 25 percent under clear and convincing evidence for a total award of 65 percent. Taking into account prior awards for the low back, the Referee offset 40 percent against the current award of 65 percent.

Claimant argues this award should be increased. On the other hand, the carrier requests that the Referee's award be affirmed. Finding that the award should not be increased, we do not disturb the Referee's award.

Because claimant's condition became medically stationary on November 11, 1988, and his claim was closed by Determination Order on January 9, 1989, we apply the standards effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Social and vocational factors

The Board adopts the Referee's findings and conclusions regarding age, education, training and adaptability. Therefore, we find that the value for social and vocational factors is 30.

Impairment

We adopt the Referee's finding regarding claimant's chronic condition limiting repetitive use for a value of 5.

In October 1985, claimant underwent a lumbar laminectomy with discectomy at the L4-5 level. In June 1988 he had a repeat lumbar laminectomy with discectomy at the same site. Claimant, however, is entitled to a value for only one surgical procedure unless there is evidence that claimant suffered a greater degree of impairment as a result of the second procedure. We find no such evidence in this case. Therefore, we conclude that claimant is entitled to a 5 percent value for his surgery. See Claudia J. Percy, 42 Van Natta 1209 (1990).

Based on Dr. Tsai's October 1988 report the Referee found claimant's range of motion value to be 4.5. However, we find the report from the Northwest Pain Center to be both reliable and more recent. Accordingly, we base claimant's impairment on that report and find claimant's range of motion value is 18.5 percent.

For a total rating of multiple residuals, the values are combined, not added. Former OAR 436-35-350(11). We combine the values for claimant's loss of range of motion, loss of repetitive use and surgeries, for a total impairment value of 28.47. See Roger F. Slade, 43 Van Natta 631 (1991); Jesse D. Starr, 43 Van Natta 473 (1991). Rounded to the next whole percentage, claimant's total impairment value is 29. Former OAR 436-35-280(7).

Computation of unscheduled disability

When claimant's social and vocational value of 30 is added to claimant's impairment value of 29, the product is 59 percent unscheduled permanent disability. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is therefore 59 percent.

Clear and convincing

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent disability suffered by claimant is more or less than the entitlement indicated by the standards. ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must be established that the truth of the asserted fact is highly probable. Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390 (1987).

We conclude that claimant is entitled to a greater award than the 59 percent provided by the standards. The cumulative medical evidence suggest that claimant's impairment is in the moderately severe range. Claimant credibly testified that, due to his injury, he suffers from a chronic pain syndrome, which in turn limits his ability to sit or stand for extended periods. In addition, claimant must lie down several times during the day in order to relieve the pain. We conclude that claimant has established by clear and convincing evidence that 70 percent represents claimant's loss of earning capacity due to the compensable injury. See Richard Gonsalves, 42 Van Natta 1787 (1990).

Application of ORS 656.214(5)

ORS 656.214(5) provides that an injured worker is entitled to that unscheduled permanent disability which results from the injury in question. However, the worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question, but which had already been produced by an earlier accident and compensated by a prior award. See ORS 656.214(5); Albert Lakey, 43 Van Natta 30 (1991); Mary A. Vogelaar, 42 Van Natta 2846 (1990).

Previously, claimant received a total award of 50 percent for his July 1986 low back injury in a May 1987 Opinion and Order. Subsequent to that injury, he was unable to return to his regular job as a maintenance man, but was able to, and did, return to modified work performing office duties on a full-time basis. In April 1987, he fell off his chair at work and injured his low back again. Claimant was found medically stationary and released to similar sedentary work in August 1987 by Dr. Tsai. Dr. Tsai concurred with Dr. Horniman's range of motion findings which indicated flexion at 15 degrees, extension at 5 degrees and noted that "Side bending was poorly performed." By a November 1987 stipulation claimant was awarded a total of 12.5 percent disability for the April 1987 injury. In April 1988 the claim was reopened for surgery. The aggravation claim was closed by a January 9, 1989 Determination Order which awarded no further unscheduled permanent disability.

We find that much of claimant's current disability has been considered in the previous awards. We conclude that claimant's restriction to sedentary work with limitations, loss of spinal range of motion, L4-5 surgeries, and chronic pain condition have been adequately compensated by the prior orders.

Consideration of claimant's prior awards in determining the current award can not be performed with mathematical precision. We also refrain from undertaking a mechanical offset. Norby v. SAI, 303 Or 536 (1987). We conclude that this previous loss of earning capacity approximates 60 percent. To avoid doubly compensating claimant for the same loss of earning capacity, we reduce claimant's current disability of 70 percent by 60 percent. Accordingly, we conclude that 10 percent of the current award represents claimant's permanent disability which was not present prior to the 1988 aggravation.

Although we have found that claimant is entitled to an award of 10 percent, the carrier has not requested a reduction of the Referee's award. We therefore affirm the Referee's award of 25 percent additional unscheduled permanent disability award for claimant's low back.

ORDER

The Referee's order dated July 19, 1990, as reconsidered November 26, 1990, is affirmed.

In the Matter of the Compensation of
RONALD C. KENDALL, Claimant
WCB Case No. C1-101776
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Gatti, Gatti, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

On August 26, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. The agreement further provides that claimant's attorney shall be paid a reasonable fee for services, payable out of the settlement proceeds, in an amount within the strictures of OAR 438-15-052.

On September 26, 1991, the Board received a "Notice of Lien" for attorney fees from claimant's former counsel, Evohl F. Malagon. Counsel's petition states that he represented claimant from February 1, 1990 through May 23, 1991. Counsel also recites in his petition that he performed in excess of 40 hours of work on claimant's behalf and "negotiated offers from [the] SAIF [Corporation] and [another insurer, not a party to this agreement], . . . which would have resulted in attorney's fees of \$9,125.00." Therefore, counsel claims a lien in that amount from the proceeds of any future benefits payable to claimant as a result of any settlement, hearing, or appeal.

On September 27, 1991, the Board requested that the parties, including claimant's current counsel, Jean Fisher LeDoux, respond to the petition within ten days. In response, claimant's current counsel acknowledges that claimant was previously represented in this matter by attorney Malagon. In addition, she notes that her office has expended eight hours representing claimant and restructuring the settlement agreement. She requests, therefore, that the attorney fee generated by this agreement be disbursed between counsels equally. Former counsel has not responded to current counsel's representations. In addition, SAIF has indicated by letter that it takes no position with regard to this dispute.

Under such circumstances, we find the manner in which the fee is to be distributed to claimant's current and former counsel is a matter to be decided between the two of them, and not by this forum. Fred L. Snider, 43 Van Natta 577 (1991). However, in no event shall the total attorney fees payable out of the settlement proceeds exceed \$4,225, the amount set forth in and agreed to by the parties to the disposition agreement.

This agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee totaling \$4,225, payable to claimant's current counsel, Jean Fisher LeDoux, and to claimant's former counsel, Evohl F. Malagon, is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY D. LUCKY, Claimant
Own Motion No. 91-0473M
AMENDED ORDER POSTPONING ACTION ON OWN MOTION REQUEST ON RECONSIDERATION
Hollander, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our October 1, 1991 Order Postponing Action on Own Motion Request on Reconsideration. Claimant contends that we should postpone action until WCB Case No. 91-12850 resolves the issues of premature closure, temporary partial disability compensation, and permanent total disability, rather than WCB Case No. 91-06726, as specified in our order.

We accordingly modify our October 1, 1991 order and will continue to postpone action until the litigation pending in WCB Case No. 91-12850 is also resolved at hearing. Thereafter, Referee Bethlamy, as well as Referee Spangler, shall submit a copy of her order to the Board and the parties shall advise us of their respective positions regarding own motion relief and penalties and attorney fees.

Accordingly, we abate and withdraw our October 1, 1991 order. As supplemented and amended herein, we adhere to and republish our October 1, 1991 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

October 22, 1991

Cite as 43 Van Natta 2389 (1991)

In the Matter of the Compensation of
VERNEDA L. RAMER, Claimant
WCB Case No. 90-15347
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Michael Johnson's order that affirmed a Determination Order award of 14 percent (44.8 degrees) unscheduled permanent disability for her low back condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had no impairment resulting from her compensable low back injury. However, because the employer did not ask for a reduction, the Referee affirmed the Determination Order award of 14 percent unscheduled permanent disability. We affirm.

Range of motion

On review, claimant acknowledges that she was unable to successfully perform range of motion tests. However, claimant contends that a value should be

assigned for impairment because her inability to perform the tests was due to pain from her back injury. We disagree.

In March 1990, Dr. Lubcke, chiropractor, performed an independent medical examination and reported that claimant functionally interfered with the testing process. Dr. Lubcke reported that inconsistencies existed between the physical exam findings and the mechanical testing. (Ex. 35-4).

In May 1990, claimant was examined by the Western Medical Examiners who reported that her "presentation of back pain is not entirely straightforward." The Examiners concluded that claimant's current complaints of back pain were not related to her industrial injury. (Ex. 43-4).

In May 1990, claimant's treating chiropractor, Dr. Lusby, reported that it was difficult to evaluate claimant's disability as the tests involved active motion and claimant complained of pain. Dr. Lusby noted that there were "no subjective [sic] findings to substantiate claimant's complaints." (Ex. 44). On May 24, 1990, Dr. Lusby concurred in the report authored by the Western Medical Consultants. (Ex. 49).

In July 1990, Dr. Lusby reported that claimant suffered permanent disability as a result of her industrial accident. However, Dr. Lusby further reported that claimant's range of motion was hard to evaluate due to the fact that claimant would not actively go through normal range of motion tests. (Ex. 51-3).

Finally, in October 1990, Dr. Lusby reported that her July 1990 report was based upon claimant's subjective complaints and objective findings were difficult to obtain as claimant was in pain with any movement that she performed. Dr. Lusby again stated that she felt that there was a great deal of functional overlay in claimant's case. (Ex. 52).

Under the circumstances, we agree with the Referee that claimant is not entitled to an award of unscheduled permanent disability for her loss of range of motion. We are unable to find that her lost range of motion is attributable to impairment resulting from injury to a body part. See former OAR 436-35-320(2); Debra A. Buel, 42 Van Natta 1950 (1990). Finally, even if claimant's loss of motion is due to functional overlay, there is no evidence that claimant has a psychological component resulting from her compensable injury. Accordingly, an impairment value for lost range of motion is not warranted.

Disc bulge

The Referee concluded that claimant had not established that her disc bulge at L5-S1 was related to her compensable injury. The self-insured employer argues that the Referee should have also found that claimant's disc bulge was not compensable because there is no evidence of herniation or nerve root compromise and, additionally, Dr. Peterson, orthopedist, reported that a bulge at L5-S1 may be considered normal by some physicians.

We do not agree that, under the applicable standards, claimant is required to establish clinically-related symptoms resulting in specific impairment. Timothy W. Fletcher, 43 Van Natta 1359 (1991). An injury-related unoperated rupture, bulge or other disc derangement entitles claimant to a value of 4 percent under former OAR 436-35-350(2). In the present case, however, we agree with the Referee that claimant has not proven that the disc bulge at L5-S1 is causally related to the compensable injury. Under the circumstances, we decline to award an impairment value for claimant's disc bulge at the L5-S1 level.

Chronic condition limiting repetitive use

Claimant contends that Dr. Lusby's report establishes that she has a chronic condition which limits repetitive use of her low back. Claimant, therefore, argues that an impairment value should be assigned under former OAR 436-35-320(4). We disagree.

Although Dr. Lusby reported that claimant's condition limited repetitive use of her back, she also agreed that functional overlay was involved and claimant's permanent disability was based upon her subjective complaints. Under the circumstances, we conclude that claimant has failed to establish that her chronic condition limiting repetitive use is attributable to impairment resulting from injury to a body part. Accordingly, we decline to award an impairment value for claimant's chronic condition limiting repetitive use of her low back.

ORDER

The Referee's order dated January 23, 1991 is affirmed.

October 22, 1991

Cite as 43 Van Natta 2391 (1991)

In the Matter of the Compensation of
DANIEL C. REDDEKOPP, Claimant
WCB Case No. 89-09956
ORDER ON REMAND
Michael B. Dye, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Reddekopp v. SAIF, 108 Or App 183 (1991). The court reversed our order that had adopted a Referee's order which upheld a denial of medical benefits. Reasoning that the Referee had relied on certain medical reports that had not been admitted as evidence, the court concluded that the Referee's findings and conclusions, which we had adopted, were not based on evidence in the record. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of the last five paragraphs. We make the following supplemental findings.

Following claimant's October 1986 low back surgery, he experienced leg "give way," prompting him to increasingly lose his balance and to fall. Such a fall occurred in approximately May 1987, when claimant fell on his porch while entering his house. (Tr. 7).

Subsequent to the aforementioned fall, claimant began experiencing upper back pain and upper torso / arm complaints. Prior to this fall, there was no indication that claimant was suffering from the effects of spasticity attributable to a cervical cord lesion or pathology. Since the fall, a cervical cord pathology has been detected which has resulted in a spastic gait. Cervical decompression surgery has been recommended to treat claimant's upper back, extremity, and spasticity problems.

FINDINGS OF ULTIMATE FACT

Claimant's August 1983 compensable low back injury was a material contributing cause of claimant's cervical condition and need for surgery.

CONCLUSIONS OF LAW

The Referee upheld the SAIF Corporation's denial of claimant's cervical condition and surgery request. In reaching such a conclusion, the Referee found that claimant was not a credible witness. The Referee based this determination on claimant's demeanor, as well as certain inconsistencies concerning claimant's description of the circa May 1987 fall and the lack of a reference to the fall in contemporaneous chart notes from Dr. Hoda, his then attending surgeon. This latter observation was based on Exhibit 8, which the Referee had not admitted into evidence at the hearing. On review, we affirmed and adopted the Referee's order.

Reasoning that the Referee had relied on certain medical reports that had not been admitted as evidence, the court has concluded that the Referee's findings and conclusions, which we had adopted, were not based on evidence in the record. Consequently, the court has reversed and remanded for reconsideration.

To begin, SAIF's respondent's brief before the court suggests that we may wish to remand this matter to the Referee for introduction of the excluded exhibits. In the event that such a reference is considered to be a motion for remand, it is denied.

Remand is an appropriate action when the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). To merit remand, it must be shown that the evidence was not obtainable with due diligence before the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Here, we do not consider the present record to be improperly, incompletely, or otherwise insufficiently developed. Moreover, we note that neither party objected to the Referee's ruling to exclude certain exhibits from the record. Under such circumstances, remand would not be appropriate. Accordingly, we proceed with our reconsideration of the record developed at hearing.

In conducting our reconsideration, we have not considered any of the exhibits which the Referee excluded from the record (Exhibits 1 - 15, except Exhibit 4-19), including Dr. Hoda's chart notes from April 2, 1985 through July 30, 1987 (Exhibit 8). Furthermore, since the Referee's adverse credibility finding was based on the Referee's observation of claimant's testimony and demeanor, we defer to that determination. International Paper Co. v. McElroy, 101 Or App 61 (1990).

Notwithstanding our deference to the Referee's adverse credibility finding, the issue of whether claimant's compensable August 1983 low back injury is a material contributing cause of his cervical disability is a complex medical question. Consequently, while the Referee's observations concerning claimant's testimony are probative, the resolution of the issue largely turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Moreover, since the issue of the causal relationship between claimant's cervical condition and his compensable low back injury primarily centers on the reason for his leg problems prior to the approximately May 1987 fall rather than to the specific date or location of the fall, we do not consider the alleged inconsistencies concerning the timing and description of claimant's fall to be particularly noteworthy. Instead, we evaluate the medical opinions based on their analysis of claimant's cervical condition and its relationship, if any, to claimant's approximately May 1987 fall and 1983 compensable low back injury.¹

We turn to a review of the medical opinions. Dr. Collada, claimant's treating neurosurgeon, concluded that claimant was experiencing a spastic gait, excessive mobility at C3-4, and foraminal stenosis. Reasoning that

decompressive surgery might be beneficial to claimant's overall back condition, Collada sought authorization from SAIF.

SAIF referred the request to its medical advisor, Dr. Norton. After reviewing claimant's medical record, Norton attributed claimant's lack of leg control, unsteadiness, and falls to a cervical cord compression problem which was an independent cause of claimant's spasticity or gait disturbance. Therefore, Dr. Norton concluded that the major contributor to claimant's current problem was his cervical cord compression which was unrelated to his compensable low back condition.

Dr. Collada initially concurred with Dr. Norton's opinion. However, Dr. Collada subsequently explained that if it could be established that claimant's lower extremity problems preceding the 1987 fall were related to his low back condition and not to spasticity from a cervical cord pathology, claimant's cervical condition would be related to the compensable low back injury.

Thereafter, claimant's counsel contacted Dr. Hoda, claimant's former attending surgeon. According to Dr. Norton's chronology of claimant's medical history, Hoda had treated claimant from shortly before claimant's first surgery in May 1985 through July 1987. In answer to counsel's inquiry, Hoda reported that there was no evidence to indicate that claimant was suffering from the effects of a cervical cord lesion while he was under Dr. Hoda's care. Furthermore, Dr. Hoda opined that the lower extremity difficulties claimant was experiencing while under Hoda's care were attributable to claimant's low back injury and complaints.

To establish the compensability of his cervical condition, claimant bears the burden of proving that his August 1983 compensable low back injury is a material contributing cause of his cervical disability and need for medical services. Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1987). After conducting our reconsideration of this matter, we are persuaded that claimant has satisfied his burden of proof. We base this conclusion on the following reasoning.

Initially, Dr. Collada concurred with Dr. Norton's opinion that claimant's cervical condition was attributable to a cervical cord pathology entirely unrelated to claimant's compensable low back condition. Yet, Collada subsequently concluded that he would relate claimant's cervical condition to the compensable low back condition provided that it could be established that claimant's leg problems prior to the 1987 fall were not the result of spasticity from cervical cord pathology.

Dr. Hoda, claimant's attending surgeon who treated claimant between 1985 and July 1987, provides the confirmation that Dr. Collada was seeking. Hoda states that there was no evidence to indicate that claimant was suffering from

1. In this regard, we note that the Referee found that, in approximately May 1987, claimant's leg gave way while claimant was in his house, causing him to fall to the floor. Yet, claimant testified that his approximately May 1987 fall occurred when he stumbled and fell on his porch. There is an explanation for this apparent discrepancy. The Referee's reference to a fall while claimant was in his house appears to be based on an earlier Referee's finding concerning claimant's December 1987 fall while in his kitchen. We are persuaded that the Referee confused the circumstances surrounding the two separate 1987 events. In any event, for the reasons previously discussed, we do not consider this alleged inconsistency to be determinative concerning the resolution of this complex medical issue.

cervical cord pathology during the time claimant was under his care. Moreover, Dr. Hoda opined that the lower extremity problems claimant was experiencing during that time were attributable to his low back injury and complaints.

When medical experts disagree, more emphasis is placed on opinions that are well-reasoned and based on the most complete information. Somers v. SAIF, 77 Or App 259 (1986). Here, we consider the opinion of Dr. Collada to satisfy the aforementioned description. Rather than interpreting his apparent change of opinion as an "equivocation" (as the Referee did), we interpret his latest report as a clarification that his opinion was dependent on whether claimant's prior leg weakness and unsteadiness was due to spasticity or to low back problems. Dr. Hoda subsequently confirmed that during the time in question there was no indication of a cervical cord pathology and that claimant's lower extremity problems were related to his low back condition. Because of Hoda's firsthand exposure to and knowledge of claimant's condition, we also find this opinion persuasive in supporting Dr. Collada's theory and dispelling the contrary theory espoused by Dr. Norton.

Accordingly, on reconsideration, we reverse the Referee's order dated September 28, 1989. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing in accordance with law.

Inasmuch as claimant has finally prevailed over a denial of compensability following remand, he is entitled to an attorney fee for services rendered before every prior forum. ORS 656.388(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services before every prior forum is \$4,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs, and statements of service), the moderate complexity of the issue, and the value of the interest involved. Therefore, for services at the hearing and appellate levels in finally prevailing against SAIF's denial, claimant's attorney is awarded \$4,500, to be paid by SAIF.

IT IS SO ORDERED.

October 22, 1991

Cite as 43 Van Natta 2394 (1991)

In the Matter of the Compensation of
RAYMOND M. SASSE, Claimant

WCB Case No. 90-09631

ORDER ON REMAND

Merrill Schneider, Claimant Attorney
Cooney, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. The court has reversed our prior order, which reversed a Referee's order that granted a \$1,000 carrier-paid attorney fee when the self-insured employer rescinded its denial of claimant's claim prior to hearing. The court has reversed and remanded for reconsideration in light of Jones v. OSCI, 108 Or App 230 (1991).

The parties have submitted a proposed "Settlement, Stipulation and Order," which is designed to resolve all issues raised or raisable in this matter. Specifically, SAIF agrees to pay claimant's attorney a \$1,100 reasonable attorney fee for services rendered in prevailing on the employer's withdrawn denial.

Inasmuch as claimant has not signed the stipulation, the agreement will not be approved. Nevertheless, considering the employer's acknowledgment that

claimant's attorney is entitled to an attorney fee, we interpret the unsigned stipulation as a concession from the employer that the Referee's attorney fee award may be reinstated and affirmed. Accordingly, based on this interpretation, the Referee's \$1,000 attorney fee award, to be paid the self-insured employer, is affirmed.

IT IS SO ORDERED.

October 23, 1991

Cite as 43 Van Natta 2395 (1991)

In the Matter of the Compensation of
GREGORY J. CAMERON, Claimant
WCB Case No. 90-21404
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Parks, et al., Defense Attorneys
Kathryn L. Wilske (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Fink's order that declined to award an assessed attorney fee following dismissal of the non-complying employer's request for hearing concerning claimant's rate of temporary disability payments.

The Board affirms and adopts the order of the Referee with the following comment. The Referee did not make a decision on the merits of issues that could have affected claimant's compensation. Therefore, there is no basis for an award of attorney fees under ORS 656.382(2). Wise v. Gary-Adams-Trucking, 106 Or App 654 (1991).

ORDER

The Referee's order dated February 8, 1991 is affirmed.

October 23, 1991

Cite as 43 Van Natta 2395 (1991)

In the Matter of the Compensation of
RONALD O. CANDLER, Claimant
WCB Case No. 90-19366
ORDER ON REVIEW
Douglas S. Hess, Claimant Attorney
Janice M. Pilkenton, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Daron's order which: (1) increased claimant's scheduled permanent disability for a left knee condition from 14 percent (21 degrees), as awarded by Determination Order, to 25 percent (37.5 degrees); and (2) found that claimant's scheduled permanent disability award was to be paid at the rate of \$305 per degree. On review, the issues are extent of scheduled permanent disability and rate of disability compensation. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Dr. Hanley, orthopedic surgeon, performed a debridement of the left knee and partial meniscectomy on May 22, 1989.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The Referee found that claimant was entitled to 25 percent scheduled permanent disability for loss of use or function of his left leg (knee). We modify the Referee's award.

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

Because claimant's condition became medically stationary on October 30, 1989, and his claim was closed by Determination Order on May 9, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

We conclude that claimant is entitled to five percent disability for a chronic condition limiting repetitive use of his left leg and adopt that portion of the Referee's "Opinion and Conclusions."

The parties stipulated that claimant is entitled to a value of 6 percent disability for loss of range of motion of claimant's left leg under former OAR 436-35-220.

Basing his opinion in part upon his interpretation of Dr. Hanley's March 1, 1990 letter, and in part on his evaluation of "clear and convincing" evidence, the Referee assigned a value of 10 percent for claimant's left knee joint instability. We disagree. Under former OAR 436-35-230(3), knee joint instability is assigned if there is evidence of a joint opening and then by the size of the joint opening. There is no evidence that claimant's instability stems from a joint opening. Therefore, claimant is not entitled to a value under former OAR 436-35-230(3). See Steven A. Murphy, 42 Van Natta 2414 (1990); Robert M. Fisk, 42 Van Natta 1164 (1990). Additionally, "clear and convincing evidence" means that the truth of the facts is highly probable. The evidence must be free from confusion, fully intelligible and distinct. Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 407 (1987). Moreover, the record is viewed as a whole to determine whether claimant's permanent disability in total exceeds that indicated by the "standards." Former ORS 656.283(7) and 656.295(5); Thomas L. Swanger, 42 Van Natta 887 (1990). Accordingly, the "clear and convincing" evidence standard is not used to sort out ambiguous medical facts or to determine a single value. We can find no evidence that claimant is entitled to a value for joint instability under the standards.

The Referee assigned 7 percent impairment for claimant's partial meniscectomy of his left knee. Claimant's meniscectomy is described in the record only as, "partial meniscectomy." (Exs. 5, 16). Former OAR 436-35-230(4)(c) provides rating for a complete meniscectomy. Former OAR 436-35-230(4)(d) states: "Proportionate losses will be allowed for less than a complete removal." Considering the lack of clarity in the record, we assign a value of 5

percent for claimant's partial meniscectomy. See Cap T. Jessup, Jr., 42 Van Natta 2016 (1990); Robert M. Fisk, *supra*.

To find a total rating for impairment to claimant's left knee, the rating for decreased motion, 6 percent, is combined with the value for the partial meniscectomy, 5 percent, for a total of 11 which is combined with the value for the chronic condition, 5 percent, for a total combined value of 15 percent. Former OAR 436-35-240(5). The Referee's award shall be modified accordingly.

Rate of Permanent Disability

We adopt that portion of the Referee's order concluding that claimant is entitled to payment of \$305 per degree of scheduled disability.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the rate of disability issue is \$200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 21, 1991 is affirmed in part and modified in part. In lieu of the Referee's increased award and in addition to the Determination Order award of 14 percent (21 degrees) scheduled permanent left knee disability, claimant is awarded 1 percent (1.5 degrees), giving him a total award to date of 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of his left leg (knee). In lieu of the Referee's out-of-compensation attorney fee award, claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800, payable directly to claimant's attorney. The remainder of the order is affirmed. For services on review concerning the rate of disability issues, claimant's attorney is awarded an assessed fee of \$200, to be paid by the insurer.

October 23, 1991

Cite as 43 Van Natta 2397 (1991)

In the Matter of the Compensation of
DORIS J. HORNBECK, Claimant

WCB Case Nos. 90-16507 & 90-16506

ORDER ON REVIEW

Richard F. McGinty, Claimant Attorney

Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Myzak's order which: (1) dismissed her request for hearing regarding the compensability of her psychological condition; and (2) affirmed the July 3, 1990 and July 26, 1990 Determination Orders that awarded claimant a total of 26 percent (83.2 degrees) unscheduled permanent disability. On review, the issues are compensability and extent of unscheduled permanent disability. We reinstate claimant's request for hearing, affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

In February 1989, claimant started treatment with Dr. Burns, psychologist. SAIF first began to receive Dr. Burns' chart notes on July 17, 1989. (Ex. 13B-1). All medical bills for claimant's psychological condition have been paid. (Tr. 5). The hearing in this matter convened on December 27, 1990.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

The hearing transcript indicates that no exhibits were received into the record at that time. (Tr. iii). On March 5, 1991, the Referee wrote to the parties' attorneys requesting that they stipulate to the admission of certain exhibits, including Exhibit 13B, 31 pages of chart notes from Dr. Burns, psychologist. The Referee indicated that she had considered Exhibit 13B except for pages 18 and 19, which were missing. The parties stipulated to the inclusion of the exhibits as listed in the Referee's March 5, 1991 letter with the exception of pages 18 and 19 of Exhibit 13B. The exhibits are included in the record as certified by the Referee to us under former ORS 656.295(3). Therefore, we consider them a part of the record for purposes of our review. ORS 656.295(5).

Jurisdiction

The Referee concluded that SAIF had neither denied nor accepted claimant's dysthymia claim. Therefore, the Referee concluded that there was no claim before her and she dismissed claimant's request for hearing with regard to claimant's dysthymia condition. We disagree.

The Referee based her opinion upon Syphers v. K-M Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981). In Syphers, the court concluded that, although ORS 656.283(1) provides that any party may request a hearing on a claim at any time, nevertheless, the statutory scheme does not reasonably permit a hearing on the compensability of the claim prior to a timely acceptance or denial by the carrier. Syphers, supra. In the present case, we conclude that claimant's request for a hearing was not premature, but rather, was filed after a "de facto" denial.

Claimant requested a hearing in this matter after May 1, 1990. The hearing was convened after July 1, 1990. Neither party contends that former law is controlling. Therefore, the statutory amendments, Or Laws 1990 (Special Session), ch 2, 54, apply. See Ida M. Walker, 43 Van Natta 1402 (1991). Bryan L. Dunn, 43 Van Natta 1673 (1991).

ORS 656.262(6) allows an employer/insurer 90 days in which to accept or deny a claim after it has notice or knowledge of the claim. A "claim" is a written request for compensation, including payment for medical services, from a subject worker or someone on the worker's behalf. ORS 656.005(6) & (8). Such a request does not have to take any particular form. For example, a doctor's chart notes or bill submitted to an insurer is a claim. Billie J. Eubanks, 35 Van Natta 131 (1983).

In the present case, claimant's treating psychologist, Dr. Burns, submitted chart notes to SAIF which SAIF started receiving on July 17, 1989. (Ex. 13B). Dr. Burns' chart notes reflect that he was treating claimant for dysthymia-depression -- which he related to her compensable injuries. We conclude that Dr. Burns' chart notes were claims pursuant to ORS 656.005(6). Therefore, SAIF was required to either accept or deny the dysthymia/psychological claim within 90 days of its receipt of Dr. Burns' chart notes -- by October 17, 1989.

For purposes of requesting a hearing, a claim is deemed denied "de facto" after expiration of the 90-day period, if the employer/insurer has not accepted or denied it. See Barr v. EBI Companies, 88 Or App 132, 134 (1987); Syphers, supra.

Here, the Referee concluded that there was no "de facto" denial because SAIF paid all medical bills for claimant's dysthymia condition. We disagree with the Referee's conclusion that there was no "de facto" denial. Although an insurer's refusal to pay a medical bill can constitute a "de facto" denial, payment of the medical bill does not negate a finding of a "de facto" denial where the claim has not been officially accepted. See ORS 656.262(9).

The record shows that SAIF began to receive chart notes from Dr. Burns on July 17, 1989 and was, therefore, obligated to accept or deny the dysthymia condition claim no later than October 17, 1989. SAIF had not denied or accepted the condition at the time of the December 1990 hearing. We conclude that SAIF denied "de facto" claimant's dysthymia condition claim and that the matter was properly before the Referee. Accordingly, we reinstate claimant's hearing request with regard to the dysthymia condition and proceed to the merits.

Compensability

Claimant is asserting the compensability of a psychological condition as a consequence of her compensable back, neck, shoulder and right arm injuries. Because claimant alleges the condition is a "consequence" of conditions previously deemed compensable, the dysthymia condition is a "secondarily consequential condition," and claimant must show that the compensable injury is the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Julie K. Gasperino, 43 Van Natta 1151 (1991). The issue of whether claimant's compensable injuries are the major contributing cause of claimant's 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).

In a thorough, well-reasoned report, Dr. Burns, claimant's treating psychologist, explained claimant's history and current condition. Dr. Burns diagnosed claimant's condition as a "dysthymia condition secondary to chronic pain and physical limitations." (Ex. 13B-8). Throughout his notes, Dr. Burns describes claimant's anxiety and depression as an affective condition stemming from her compensable injuries. There is no evidence to the contrary. Accordingly, we conclude that claimant's current dysthymia condition is a secondary consequence to her compensable injuries and the compensable injuries are the major contributing cause of her dysthymia.

Extent of Unscheduled Disability

We have found that claimant's dysthymia condition is compensable. Claimant challenges that portion of the Referee's calculations under the "standards" in which she concluded that claimant is not entitled to a value for her dysthymia condition. The Referee concluded that claimant has not shown that she has sustained permanent impairment as a result of the dysthymia condition. We agree. Claimant provides no evidence of permanent impairment due to her dysthymia condition.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the "de facto" denial of claimant's dysthymia condition, is \$700, to be paid by SAIF. In reaching this conclusion,

we have particularly considered the time devoted to the case, (as represented by the record and claimant's brief on review), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 14, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that dismissed claimant's request for hearing with regard to the dysthymia condition is reversed. Claimant's request for hearing is reinstated. The SAIF Corporation's "de facto" denial of claimant's dysthymia condition is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the dysthymia condition, claimant is awarded a reasonable assessed attorney fee of \$700, to be paid by SAIF.

October 23, 1991

Cite as 43 Van Natta 2400 (1991)

In the Matter of the Compensation of
JOAN V. HUNTLEY, Claimant
WCB Case No. 90-20753
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Claimant requests reconsideration of our October 11, 1991 Order on Review that upheld the self-insured employer's denial of her injury claim. Specifically, claimant contends that, in light of a recent Board case, Fred H. Jacobson, 43 Van Natta 1420 (1991), her claim should be found compensable.

We do not agree that the Jacobson case controls the outcome of the present case. We agree that the claimant in Jacobson was injured during an unpaid lunch break in a restaurant. However, the claimant worked away from the employer's premises and could not eat at home or on the employer's premises because he was required to travel during the workday. Under the circumstances, we concluded that the risk of injury to the claimant during his lunch hour was not unanticipated or outside the risk of his particular off-premises employment. Finally, we also concluded that the claimant was not on a personal mission of his own while eating his lunch, unlike a situation in which a worker uses a lunch hour to do errands that are unconnected to the employer's business. Jacobson, supra.

In the present case, claimant was not an employee required to work off the employer's premises. Moreover, claimant was not injured while taking her lunch hour or break in the hospital cafeteria in which the employer's workers were given discounts. Accordingly, we agree with the Referee's conclusion that the risk of tripping and falling in an off-premises bakery was not a risk that was anticipated by the employer. Finally, we conclude that there is not sufficient evidence to establish that claimant's errand during a 15-minute break was connected to the employer's business. Claimant testified that she would buy something for herself to eat and she would also shop for bread for her family.

Under the circumstances, we conclude that claimant's case is distinguishable from Jacobson, and we agree with the Referee's conclusion that her injury claim is not compensable.

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 11, 1991 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRIS C. SMITH, Claimant
WCB Case No. 90-05628
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Westerband.

Claimant requests review of Referee Kinsley's order that: (1) upheld the self-insured employer's denial of his medical services claim for a work hardening program; (2) declined to assess a penalty and related attorney fee for the employer's allegedly unreasonable denial; (3) declined to set aside a July 13, 1990 Determination Order as premature; (4) affirmed the Determination Order award of no unscheduled permanent partial disability for a low back injury in addition to claimant's prior award of 25 percent (80 degrees); and (5) denied claimant's motion for a continuance. On review, the issues are medical services, penalties and attorney fees, premature closure, permanent disability and continuance. We affirm.

FINDINGS OF FACT

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

Claimant initially received physical therapy for the period March 1989 through May 1989. The employer paid for this treatment. Providence Rehabilitation Center evaluated claimant in May and June 1989 and opined that a work hardening program would not be appropriate unless claimant participated in pain center therapy.

Claimant then began treating with Dr. Seeley. On August 2, 1989, Dr. Seeley completed and signed a treatment plan for a work hardening program, five times a week, for three months. The employer received a copy of Dr. Seeley's treatment plan in September 1989. Claimant began the work hardening program, and the employer paid for the first 20 work hardening sessions. The employer repeatedly wrote Dr. Seeley requesting a narrative report advising the employer of claimant's current condition, the improvement achieved to date from the work hardening program, and the need for further treatment. Dr. Seeley provided several conclusory reports that did not adequately respond to the employer's request for information.

On April 25, 1990, the employer denied " . . . all medical treatment and referrals of treatment by Dr. Seeley as unreasonable and unnecessary"

CONCLUSIONS OF LAW AND OPINION

Continuance

On review, claimant contends that the Referee erred in denying his motion for a continuance. He requested the continuance to allow the introduction of evidence from a doctor who claimant had intended to see as his treating physician.

OAR 438-06-091 provides that the parties shall be prepared to present all evidence at the time of hearing. The Referee, however, is allowed the discretion to grant a continuance for submission of further evidence provided that the party requesting the continuance can show, inter alia, extraordinary circumstances for failure to submit the evidence prior to or at hearing. See OAR 438-06-081 and 438-06-091(4).

In this case, claimant contends that the resignation of Dr. Seeley, his original attending physician, justified a continuance. However, Dr. Seeley resigned effective May 3, 1990. The hearing was convened on June 25, 1990, and held on July 23, 1990, some two months later. Under those circumstances, we conclude that claimant has not established extraordinary circumstances that would account for his failure to obtain, with the exercise of due diligence, the additional medical information prior to the hearing. Accordingly, we conclude that the Referee did not abuse her discretion in declining claimant's request for a continuance.

Medical Services/Penalties and Attorney Fees

In determining the propriety of the employer's denial of further work hardening treatment, the Referee relied on former OAR 436-10-040(4), which provides, in part:

"(a) Physical therapy, biofeedback or acupuncture shall not be reimbursed unless carried out under a written treatment plan prescribed prior to the commencement of treatment and which must be completed and signed by the attending physician within one week of the beginning of treatment. The treatment plan shall include objectives, modalities, frequency of treatment and duration. A copy of the progress notes shall be provided insurer."

"(b) The initial treatment plan shall be for no more than 20 therapy visits in the first 60 days. If more than 20 therapy visits are required in the first 60 days or more than four therapy visits a month after the first 60 days, the physician shall submit a report documenting the need for services in excess of the guidelines upon request of the insurer. If the insurer finds the report does not justify treatment in excess of the guidelines, the insurer shall either issue a partial denial of the disputed treatment to the worker with a copy to the medical provider, or request a medical panel."

In applying that rule to this case, the Referee determined that Dr. Seeley, the attending physician, properly submitted an initial treatment plan to support the payment of the first 20 treatments. The Referee further determined that Dr. Seeley had failed to supply subsequent reports justifying the need for continued treatments, as required by former OAR 436-10-040(4)(b). Accordingly, the Referee concluded those treatments were not compensable.

On review, claimant argues that the employer did not timely raise former OAR 436-10-040(4)(b) as a basis for its denial until closing argument. Thus, claimant argues that the Referee improperly set the denial aside under that provision. In support of the argument, claimant relies on the Board's decision in Edward A. Rankin, 41 Van Natta 2133 (1989).

In Rankin, the parties agreed at the beginning of the hearing that the issue was the causal relationship between a compensable injury and the denied medical services. In closing arguments, the insurer sought to challenge the medical services on reasonable and necessary as well as causation grounds. The Board concluded that the insurer could not raise the new reasonable and necessary issue in this manner.

The situation in the present case is distinguishable. The Referee's application of former OAR 436-10-040(4)(b) is not tantamount to addressing a reasonable and necessary issue first raised in closing argument. The Referee merely applied the applicable administrative rule to the medical services

dispute litigated at hearing. The employer's denial clearly states that it is based on reasonable and necessary grounds. The denial references the employer's unsuccessful efforts to solicit a report from Dr. Seeley setting forth claimant's progress and prognosis. The employer's numerous requests for that information are well-documented in the record.

Given this record, claimant's attorney should have understood that former OAR 436-10-040(4)(b) was relevant to the disposition of the medical services issue in this case. At hearing, claimant's attorney asked the claims examiner if the employer based its denial on former OAR 436-10-040(4)(b). The examiner's response clearly indicates that the employer issued its denial because Dr. Seeley did not provide justification for continuing treatment after the first 20 visits. On this record, we are not persuaded that the Referee erred in considering that rule in deciding this case.

In reaching this decision, we reject claimant's argument that reliance on former OAR 436-10-040(4)(b) is a violation of his rights under former ORS 656.245. That provision provides for continuing medical services, regardless of frequency, so long as they are reasonable and necessary. West v. SAIF, 74 Or App 317 (1985). The Director is empowered to promulgate rules for the effective and efficient administration of those medical services. We are bound by such rules insofar as they are consistent with the Workers' Compensation Act. See Miller v. Employment Division, 290 Or 285 (1980).

The court addressed guidelines regarding the frequency of medical services in Kemp v. Workers' Comp. Dept., 65 Or App 659 (1983), recon 67 Or App 270, rev den, 297 Or 227 (1984). In that case, the court scrutinized former OAR 436-69-202(2), which required physicians to submit reports justifying chiropractic treatment in excess of established guidelines. The court concluded that this rule was within the Department's delegated authority and was valid. It reasoned that the rule did not permit a limitation of the treatment which a claimant can receive, but merely required a physician to submit a report justifying further treatment. The court held that this requirement was consistent with the legislative policy of requiring medical services to be provided only for the period of time necessary. Kemp, supra, at 663.

The rule at issue in the present case is analogous to the guideline upheld by the court in Kemp, supra. Former OAR 436-10-040(4)(b) does not establish an absolute restriction on physical therapy treatments in excess of the recommended guidelines. Rather, it creates reasonable procedures for establishing that such treatment is necessary. The treatment at issue here is not noncompensable merely because it exceeds the frequency guidelines established in former OAR 436-10-040(4)(b). Rather, the treatment is noncompensable because the record as a whole does not establish that it is reasonable and necessary.

Accordingly, we conclude that former OAR 436-10-040(4)(b) is within the Department's delegated authority, and is valid. Accord Rager v. EBI Companies, 107 Or App 22 (1991) (procedure for establishing compensability of whirlpool treatment, requiring submission of a report justifying treatment, does not exceed Director's authority because it does not preclude provision of this treatment but establishes reasonable standard for approving it). Compare West v. SAIF, 74 Or App 317 (1985) (failure to justify treatment in excess of guidelines is not valid basis for denial where record otherwise establishes that treatment is reasonable and necessary); Charles M. Andersen, 43 Van Natta 463 (1991) (rule creating absolute restriction on reimbursement for out-of-state travel is invalid).

Finally, we reject claimant's contention that this case is controlled by our decision in Judith C. Brugger, 42 Van Natta 1237 (1990). There, we

concluded that the issue of whether claimant's physician had violated billing and reporting rules adopted by the Director was not relevant to the compensability of medical services provided to claimant. That decision is inapposite to the present case. Unlike the situation in Brugger, the report from the treating physician at issue in this case was necessary to establish that the treatment was reasonable and necessary. Without that report, claimant has not established the merits of his medical services claim.

In this regard, claimant argues that Dr. Seeley's reports, along with those of the Western Medical Consultants, Dr. Karsten and Dr. Engstrom, establish that further physical therapy was reasonable and necessary. We disagree. The employer has already paid for a significant amount of physical therapy and work hardening. Based on its evaluation in May and June 1989, Providence Rehabilitation Center opined that a work hardening program would not be beneficial without pain center treatment, which claimant has not received. The goals identified in Dr. Seeley's initial treatment plan included "general conditioning" and "cardiovascular conditioning" -- objectives which are unrelated to claimant's injury. When Dr. Seeley recommended treatment in excess of the guidelines established by former OAR 436-10-040(4)(b), the employer repeatedly requested, but did not receive, a report from Dr. Seeley justifying the additional treatment.

The reports from the Consultants, Dr. Karsten and Dr. Engstrom do not provide any explanation for the conclusion that further treatment is necessary. Moreover, the record does not indicate that the Consultants, Dr. Karsten or Dr. Engstrom were aware that claimant had previously received six months of physical therapy. Finally, Dr. Engstrom's opinion appears to address future treatment and not the treatment at dispute in this matter. For these reasons, we are not persuaded by the opinions of the Consultants, Dr. Karsten, or Dr. Engstrom. Given this record, we conclude that claimant has not established that further treatment is reasonable and necessary.

Accordingly, based on the above reasoning, we conclude that the Referee correctly upheld the employer's denial and declined to assess a related penalty and attorney fee.

Premature Closure and/or Permanent Disability

We adopt the conclusions and reasoning concerning the issues of premature closure and extent of permanent disability as set forth in the Referee's order.

ORDER

The Referee's order dated August 9, 1990 is affirmed.

October 25, 1991

Cite as 43 Van Natta 2404 (1991)

In the Matter of the Compensation of
LEROY FRANK, Claimant
WCB Case No. 90-09297
ORDER OF ABATEMENT
Max Rae, Claimant Attorney
Garrett, et al., Defense Attorneys

On September 26, 1991, we reversed a Referee's order which had upheld the insurer's denial of claimant's aggravation claim for a low back condition. The parties have now submitted a Disputed Claim Settlement for our consideration. In order to retain jurisdiction to consider this matter, we withdraw our

September 26, 1991 order. Upon completing our review of the parties' settlement, we shall issue our decision.

IT IS SO ORDERED.

October 25, 1991

Cite as 43 Van Natta 2405 (1991)

In the Matter of the Compensation of
JAMES A. ROUSE, Claimant
WCB Case No. 89-25719
ORDER ON REVIEW
Douglas D. Hagen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Fink's order that: (1) found that claimant's right knee and foot claim was not prematurely closed; (2) declined to grant permanent total disability; and (3) affirmed a Determination Order which found claimant entitled to no additional permanent disability beyond the 25 percent (37.5 degrees) scheduled permanent disability previously awarded for loss of use or function of the right leg (knee). On review, the issues are premature closure and extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following corrections and supplementation. We do not adopt: (1) the last two sentences in paragraph nine; (2) the third sentence in paragraph 12; and (3) the last sentence in paragraph 15.

In 1967, claimant had a medial meniscectomy on his right knee as a result of a non-industrial injury. In 1969, claimant began using illicit drugs and by 1970 he was a heroin addict. In the 1970's, he unsuccessfully participated in methadone programs four or five times. (Exs. 81A-12, 81A-13). During his participation in a drug rehabilitation program at CODA in 1973, his urinalyses revealed frequent illicit use of barbiturates. (Ex. 81). In 1975, he participated in a drug rehabilitation program at Freedom House. (Ex. 81A-13).

In May 1979, claimant sustained a compensable injury to his right knee. In 1982, claimant developed depression, a conversion disorder, and a pain disorder, all of which were related to his work injury. (Exs. 22-1, 23-4, 26B, 2902, 29A, 47). The conversion disorder manifested itself as a tremor in his right leg. This tremor was not continuous but dramatically increased during observation and physical examination. Also, the tremor occasionally occurred in the left leg.

Dr. Watkins, psychiatrist, treated claimant intermittently from December 1982 through August 1983. (Exs. 29, 30, 34, 34A, 37A, 42). Claimant received no psychiatric treatment after he discontinued his treatment with Dr. Watkins in August 1983.

Claimant has a preexisting personality disorder that was not worsened by the work injury. (Exs. 59, 80). The employer did not accept the personality disorder.

In 1986, claimant was diagnosed with diabetes mellitus. (Exs. 76A, 77). He developed diabetic neuropathy, which causes pain in his lower extremities and

feet. The pain, inactivity, and stress caused by the work injury made the diabetic condition more difficult to control. (Exs. 78, 96).

Claimant's claim was last opened on February 25, 1987. At that time claimant suffered from an injury-related painful right knee; an injury-related conversion disorder, pain disorder in the right lower extremity, and depression; and a noncompensable personality disorder.

Claimant was provided with vocational services in 1980, 1981, 1982. An authorized training program with Sho-Craft, a sheltered workshop, was ended in 1982 and claimant's case closed due to high absenteeism. (Exs. 23A, 23B).

From May 1984 to February 1987, Mr. Lipnicki, vocational counselor, provided vocational services to claimant. (Exs. 51, 54, 58, 63, 68A, 68B, 68C, 68F, 73A). Claimant continually missed appointments and did not contact Mr. Lipnicki to reschedule them. In February 1987, claimant's vocational services were placed on medical hold. In April 1990, Mr. Lipnicki contacted claimant to reevaluate him for vocational services and warned him that failure to attend a scheduled appointment could negatively effect his vocational services. (Ex. 91A). Claimant rescheduled the appointment, then did not show up or contact Mr. Lipnicki. Vocational services were terminated for lack of cooperation. (Ex. 99).

FINDINGS OF ULTIMATE FACT

The major contributing cause of claimant's relapse into heroin addiction was his noncompensable personality disorder. This relapse was not materially caused by his work injury.

Claimant's compensable psychological conditions were medically stationary at the time of claim closure.

Claimant is not willing to work but for his injury.

To date, claimant has sustained a 25 percent loss of use or function of his right leg (knee) as a result of his compensable injuries.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

Claimant requested a hearing prior to May 1, 1990, the hearing convened prior to July 1, 1990, and he was last medically stationary prior to July 1, 1990. Therefore, the law in effect prior to the 1990 amendments applies in this case. Or Laws 1990 (Special Session), SB 1197, Sections 54(2), 54(3).

Premature Closure

The Referee did not address the premature closure issue other than to declare that claimant's claim was not prematurely closed by the September 1989 Determination Order. On review, claimant argues that his claim was prematurely closed because physicians continued to recommend psychiatric treatment and drug treatment. We disagree.

In deciding whether a claim was prematurely closed, we determine whether the claimant's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985).

"Medically stationary" means no further material improvement would reasonably be expected from medical treatment, or the passage of time. Former ORS 656.005(17). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981); Dale R. Bennett, 40 Van Natta 843 (1988).

Personality Disorder

We first consider whether claimant's preexisting personality disorder should be considered in resolving the premature closure issue. Claimant does not dispute that his preexisting personality disorder was not caused or worsened by the work injury. However, relying on Georgia-Pacific v. Piowar, 305 Or 494 (1988), claimant argues that the employer accepted the preexisting personality disorder when it accepted claimant's "psychiatric problems." (Exs. 26B, 29A). Thus, claimant argues, the personality disorder is part of his claim. We disagree.

The employer in Piowar accepted a claim for "back pain," which was initially diagnosed as a sprain. After the acceptance, the medical experts determined that the accepted back pain was, in fact, attributable to a noncompensable ankylosing spondylitis. The Court held that the carrier could not deny the previously accepted claim simply because it discovered claimant's symptoms were attributable to a noncompensable disease.

Here, claimant had several diagnosed psychiatric disorders when the employer accepted claimant's "psychiatric problems." (Exs. 22-1, 23-4, 29-2). Because there was more than one psychiatric disorder, we cannot determine that the underlying personality disorder was specifically accepted. See Johnson v. Spectra Physics, 303 Or 49 (1987). See also Kenneth L. Orr, 43 Van Natta 1432 (1991).

Because we do not find that the employer specifically accepted the personality disorder, we do not consider this condition in determining whether claimant was psychiatrically medically stationary at claim closure.

Depression, Pain Disorder, and Conversion Disorder

We disagree with claimant's argument that his compensable depression, pain disorder, and conversion disorder were not medically stationary when his claim was closed. (Exs. 22-1, 23-4, 26B, 29-2, 29A, 47).

Dr. Watkins, psychiatrist, treated claimant intermittently from December 1982 through August 1983. (Exs. 29, 30, 34, 34A, 37A, 42). This treatment focused on his depressive disorder. In January 1985, Watkins concluded that claimant had undergone a sufficient trial of antidepressants to rule out any affective component, leaving him with a primary psychiatric diagnosis of dependent personality disorder. (Ex. 47).

In October 1985, Watkins concluded that the work injury lead to conversion symptoms as a manifestation of the preexisting personality disorder. (Ex. 59). Dr. Gritzka, claimant's treating orthopedist, opined in August 1985 that claimant's conversion reaction had remained stationary during his observation of claimant, and Gritzka considered that it would not yield to treatment and should be considered permanent. (Ex. 55-2). Claimant received no psychiatric treatment after he discontinued his treatment with Dr. Watkins in August 1983.

On March 22, 1989, Dr. Turco, independent examining psychiatrist, examined claimant. On March 23, 1990, Dr. Turco re-examined claimant and stated that he is "now psychologically medically stationary." (Ex. 90-3). Turco stated in the

1990 exam that claimant appears "much the same as previously," and when deposed Turco stated that claimant's psychological condition in 1989 and 1990 were "relatively the same." (Exs. 90-1, 92-25). Although the March 1990 examination occurred more than six months after the Determination Order issued, we find that these statements address claimant's condition at the time of claim closure. Scheuning v. J. R. Simplot & Co., 84 Or App 622, 625, rev den 303 Or 590 (1987).

We find that Dr. Watkins' reports as a whole, supported by Dr. Gritzka's report and the more recent reports of Dr. Turco, establish that claimant's compensable psychiatric conditions were medically stationary at claim closure. Although Dr. Watkins never declared claimant psychiatrically medically stationary, such "magic words" are not required.

Claimant argues that he was not psychiatrically medically stationary because physicians continued to recommend psychological treatment after he discontinued his treatment with Dr. Watkins. Dr. Duvall, a clinical psychologist with the Portland Pain Center, found that claimant continued to suffer from a depressive disorder as of August 1985. (Ex. 53-5). Dr. Duvall thought that it would be possible to treat claimant's depression with antidepressants. (Ex. 53-6). However, we do not rely on Dr. Duvall's opinion because he did not explain why he thought antidepressants would help when the treating psychiatrist had found that antidepressants had been given a sufficient trial. Furthermore, Duvall's opinion occurred more than four years before claim closure.

In February 1985 and January 1987, Dr. Gritzka, claimant's treating orthopedist, recommended that claimant receive psychological treatment. (Exs. 48, 72A-2). However, Gritzka does not indicate whether this psychological treatment is required for claimant's compensable depression, pain disorder, and conversion disorder, or his noncompensable personality disorder. Thus, we conclude that claimant has failed to prove that his compensable depression, pain disorder, and conversion disorder conditions were not stationary at claim closure.

Relapse Into Drug Addiction

Claimant argues that: (1) his relapse into drug addiction was caused in material part by his work injury; and (2) he was not medically stationary at claim closure because he received drug treatment in 1988 and 1990. We disagree that the record shows that the work injury materially contributed to his relapse into drug addiction.

Dr. Larsen, psychiatrist with the CODA drug treatment program, and Dr. Turco gave the only opinions regarding the relationship between the work injury and claimant's relapse into drug addiction. (Exs. 80, 81, 90, 92).

Dr. Larsen first opined that the pain medication prescribed for claimant was not in sufficient quantities to account for his opiate dependence. (Ex. 81-1). Later, he opined that the pain secondary to claimant's work injury and the subsequent administration of codeine exacerbated his heroin use and lead to opiate dependence. (Ex. 81-2). Because of this unexplained change of opinion, we do not find Dr. Larsen's opinion persuasive.

Dr. Turco opined that claimant's drug addiction was not related to a "stress disability" induced by the 1979 injury. (Ex. 90-3). Instead, he found that the major factor was claimant's noncompensable personality disorder. Based on an assumption that claimant was drug free at the time of the injury, Dr. Turco opined that the right leg pain was also a material contributing factor in claimant's relapse into drug addiction. (Exs. 90-3, 90-4, 92-9, 92-10, 92-29, 92-30, 92-34).

However, the record does not establish that claimant was drug free at the time of the injury. Given claimant's extensive history of prior drug addiction and drug rehabilitation failures, we are not persuaded that Dr. Turco based his opinion on an accurate history. Thus, we find that claimant has failed to prove that his relapse into heroin addiction was materially caused by the work injury. Therefore, we conclude that claimant has not established that his claim was prematurely closed.

Permanent Total Disability

In order to establish permanent total disability, claimant must prove either that: (1) he is completely physically disabled and therefore precluded from gainful employment; or (2) his physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd-lot" doctrine. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. Former ORS 656.206; SAIF v. Simpson, 88 Or App 638, 641 (1987); Welch, supra. Findings of futility are reserved for the extreme situation where, for example, the record shows the individual is physically totally disabled or is not capable of re-training. See Georgia Pacific Corp. v. Perry, 92 Or App 56 (1988).

The Referee concluded that claimant was neither completely physically disabled nor permanently and totally disabled as a result of a combination of medical and nonmedical factors. Claimant does not challenge the Referee's conclusion that he is not completely physically disabled. (Appellant's Brief p.30). Thus, we limit our review to consideration of whether claimant has demonstrated that he is permanently and totally disabled under the "odd-lot" doctrine.

Here, the determinative factor is whether claimant is willing to work and has made reasonable efforts to find work. Claimant's vocational expert, Mr. Ross, reviewed the record and met with claimant one day for three and a half hours. Mr. Ross testified that claimant was motivated based on the test results obtained that day and claimant's statements to him. (Tr. 60, 82). Mr. Ross also gave examples from the record of claimant's motivation in the period from 1985 and prior. (Tr. 68).

Mr. Lipnicki began providing vocational services to claimant in May 1984. (Ex. 51). These services were placed on medical hold in early 1987, and the employer contacted Mr. Lipnicki in April 1990 to provide vocational evaluation again. Mr. Lipnicki testified that claimant had continual problems with dependability and often would not show up for appointments. (Tr. 92). Claimant received a written warning that failure to keep an April 23, 1990 appointment would be considered lack of interest in returning to work and could negatively affect his claim status. (Ex. 91A). Claimant rescheduled this appointment but failed to show up and made no further contact with Mr. Lipnicki. (Tr. 97-98). Based on claimant's history of unreliability, Mr. Lipnicki closed claimant's case for lack of interest and cooperation. (Tr. 99, Ex. 99). Mr. Lipnicki concluded that claimant was not motivated to return to work, based on his contacts with claimant. (Tr. 101). Furthermore, Mr. Lipnicki testified that if claimant had been motivated, Lipnicki would have been able to interest specific existing employers in him even given his mental and physical limitations. (Tr. 102, 108, 140).

We find Mr. Lipnicki's opinion as to claimant's motivation to return to work more persuasive than that of Mr. Ross. Mr. Lipnicki actually provided vocational services to claimant and worked with him over a period of time, whereas Mr. Ross only performed a short evaluation and a record review. Furthermore, there is no evidence that relates claimant's lack of motivation to his compensable psychological conditions. On this record, we find that claimant has not established that he is willing to work but for his work injury; therefore, we conclude that he is not permanently and totally disabled under the odd-lot doctrine.

Permanent Partial Disability

The Referee found that claimant was not entitled to any additional scheduled permanent partial disability (PPD) beyond the 25 percent (37.5 degrees) previously awarded for the loss of use or function of claimant's right leg (knee). Claimant argues that he is entitled to unscheduled PPD for his psychiatric impairment, drug addiction, and diabetes, and additional scheduled PPD for his right knee and foot.

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010. Because claimant's condition became medically stationary on July 28, 1989, and his claim was last closed by Determination Order on September 5, 1989, we apply the January 1, 1989 Standards (WCD Admin. Order 7-1988). Former OAR 436-35-001 et seq.

Unscheduled Permanent Disability

The test for determining the extent of a worker's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. Former ORS 656.214(5); see also former OAR 436-35-270 et seq. Where the claimant fails to establish any measurable impairment resulting from his compensable condition, no award of disability is allowed. Former OAR 436-35-280(1); see Suzanna L. Staehly, 42 Van Natta 283 (1991).

Diabetes Mellitus

Claimant argues that his diabetic condition was worsened by the injury; therefore, he argues, he is entitled to an impairment rating pursuant to former OAR 436-35-430(6). We agree that the work injury made the diabetic condition more difficult to control. (Exs. 78, 96). Nevertheless, claimant is not entitled to a value under former OAR 436-35-430(6).

That rule requires that the injury cause impairment of the pancreas which results in diabetes. Former OAR 436-35-430(6). There is no evidence in this record that the work injury caused any impairment to claimant's pancreas. Therefore, we conclude that claimant has not proved that he is entitled to an impairment rating under the standards for his diabetic condition.

Personality Disorder

Claimant argues that Dr. Turco's statements support a disability rating of 45 percent for his personality disorder under former OAR 436-35-400(3)(c)(B). However, as discussed in the premature closure section, claimant's personality disorder is not ratable.

Relapse Into Drug Addiction

Claimant's relapse into drug addiction was not materially caused by the work-injury; therefore, it is not ratable.

Conversion Disorder and Depressive Disorder

A permanent psychoneurosis diagnosed by a psychiatrist or psychologist is ratable under former OAR 436-35-400(4). No psychiatrist or psychologist diagnosed the conversion disorder as permanent. Dr. Watkins opined that the work injury lead to conversion symptoms and noted that these symptoms were not a permanent impairment. (Ex. 59). Dr. Turco noted that there was no evidence of conversion symptoms when he found claimant psychiatrically medically stationary. (Exs. 80, 90). Thus, claimant is not entitled to a value for his conversion disorder.

As for the depressive disorder, Dr. Watkins provided the only psychiatric treatment and, in 1985, he concluded that claimant's antidepressant treatment had ruled out any affective component of his psychiatric problems, leaving him with a primary diagnosis of dependent personality disorder. (Ex. 47). Drs. Larsen and Turco provide the psychological reports closest to the hearing, and neither of these psychiatrists discuss the depressive disorder. (Exs. 80, 81, 90, 92). Thus, on this record, claimant has not established that he has sustained permanent impairment as a result of his compensable depressive disorder.

Pain Disorder

In 1982, Dr. Smith, examining psychiatrist, opined that claimant had a moderately severe pain disorder that might prove to be unchangeable. (Ex. 22). Because we rate disability at the time of hearing, we do not find Dr. Smith's eight year old opinion persuasive evidence as to claimant's impairment at hearing. Gettman v. SAIF, 289 Or 609 (1980). The only other evidence relating to a pain disorder is Dr. Turco's May 1990 opinion that claimant had a chronic pain disorder that was materially caused by the work injury. (Ex. 92-9). However, Dr. Turco did not quantify this pain disorder. Therefore, we are unable to rate the pain disorder under the standards.

Scheduled Permanent Disability

A worker's extent of scheduled permanent disability is determined by the degree of loss of use or function of the injured member. Former ORS 656.214(2); see also former OAR 436-35-010 et seq.

Right Leg (Knee)

Citing medical reports from 1982, 1986, and 1987, claimant argues that he is entitled to 5 percent impairment for loss of repetitive use of his right leg due to restrictions on standing, walking, stooping and kneeling. (Exs. 24-3, 69-5, 74-2). However, in rating permanent disability, we make our decisions based on the facts at the time of the hearing. Gettman v. SAIF, supra. Claimant was found medically stationary as of July 28, 1989 and since that date no physician has limited claimant's ability to do these activities. Therefore, we do not find that claimant has proven he is entitled to an impairment rating for loss of repetitive use.

Claimant's arthroscopic debridement is not ratable under the standards. See OAR 436-35-230(4). Nor is claimant's leg tremor. Although claimant suffers pain in his right knee, pain is considered in the standards only to the extent

that it results in measurable impairment. Claimant is not entitled to a separate impairment value for pain. Former OAR 436-35-010(2)(b).

Finally, only the permanent loss of use or function of the right knee due to the industrial injury is compensable. Former ORS 656.214(2); Nomeland v. City of Portland, 106 Or App 77 (1991); Reine R. Webb, 42 Van Natta 477 (1990), on recon 42 Van Natta 611 (1990). Here, only Dr. Olmscheid noted a ratable impairment (loss of range of motion), and he did not separate the effects of the noncompensable meniscectomy from the effects of the work injury. (Ex. 87A-2). Thus, we find that claimant has not established the degree to which his impairment is caused by the work injury as opposed to the noncompensable meniscectomy. Therefore, claimant has not established that he is entitled to an award under the standards for permanent disability of the right knee.

Right Foot

As a result of the injury, claimant's knee gave out causing him to fall and fracture the base of his right fifth metatarsal. This fracture developed a nonunion which required a bone graft surgery. (Ex. 39). Citing former OAR 436-35-170(2)(b), claimant argues that he is entitled to an impairment value of 25 percent of his fifth toe on the basis of this surgery. We disagree. Former OAR 436-35-170(2)(b) applies to joint surgery requiring a joint prosthesis. This is not the procedure claimant underwent; the standards do not rate the type of surgery that claimant required.

Next, claimant argues that he is entitled to 5 percent impairment for a chronic condition limiting repetitive use of his right foot. However, there are no medical reports in the record after claimant became medically stationary that limit repetitive use of his right foot. Gettman v. SAIF, supra.

Citing a December 1986 medical report, claimant argues that he is entitled to a rating for loss of range of motion of his right great toe. (Ex. 69-4). However, this loss was measured before claimant last became medically stationary. The medical reports after his medically stationary date do not include any range of motion measurements for the great toe. In addition, the Orthopaedic Consultants who performed the December 1986 examination noted that an accurate examination was impossible due to severe interference from the tremor of the right leg. (Ex. 69-5). On this record, claimant has not proved any ratable impairment of his right foot.

Therefore, we conclude that the Referee correctly affirmed the September 1989 Determination Order that awarded no additional scheduled permanent disability.

ORDER

The Referee's order dated October 5, 1990 is affirmed.

In the Matter of the Compensation of
MICHAEL J. SWIRBUL, Claimant
WCB Case No. 90-10682
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Moller and Gunn.

Claimant requests review of Referee Quillinan's order which upheld the insurer's denial of his occupational disease claim for right knee and bilateral ankle arthritis conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of the second full paragraph on page two and add the following supplementation.

On May 1, 1990, Dr. Cronk performed claimant's knee surgery for a torn right medial meniscus. He also carried out a synovial biopsy that indicated acute and chronic inflammation.

FINDINGS OF ULTIMATE FACT

Claimant's work activities involving a series of repetitive traumatic events were the major contributing cause of at least a temporary pathological worsening of claimant's preexisting arthritic condition, resulting in disability and a need for treatment. This pathological worsening is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Claimant bears the burden of proving by a preponderance of the evidence that his work exposure in the form of a series of traumatic events or occurrences was the major contributing cause of a worsening of his preexisting arthritic condition resulting in his disability or need for medical treatment. ORS 656.802(1)(c) & (2). A worsening of symptoms alone is not sufficient unless the medical evidence supports the conclusion that the manifested symptoms are the disease. Georgia-Pacific v. Warren, 103 Or App 275, 278 (1990). However, the underlying condition need not permanently worsen to establish compensability. Rather, a temporary worsening is sufficient. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); see also Wheeler v. Boise Cascade, 298 Or 452, 457 (1985). Here, the Referee concluded that claimant had failed to meet his burden. We disagree.

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 65 Or App 810 (1983). We find the

opinion of Dr. Cronk particularly persuasive as he performed the knee surgery which disclosed claimant's arthritic problem.

Dr. Cronk stated that claimant's work exposure contributed to both a symptomatic and objective worsening of his underlying arthritic condition. (Exs. 20, 25-3, 4, 6). In the context of his opinion, we interpret Dr. Cronk's reference to an "objective worsening" to mean a pathological worsening of the underlying condition. (Ex. 25-13). Additionally, Dr. Cronk stated that claimant's underlying arthritic process was worsened or accelerated by his work activities, at least on a temporary basis. (Exs. 20, 25-10, 14). Although Dr. Cronk's opinion is not without some ambiguity, we find no persuasive reason not to rely on it.

Accordingly, we conclude that claimant has met his burden of proving that work activities caused at least a temporary worsening of his underlying arthritic condition.

For prevailing on the issue of compensability, claimant's counsel is entitled to an assessed attorney fee. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on Board review is \$2,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue and the value of the interest concerned.

ORDER

The Referee's order dated January 30, 1991 is reversed. The insurer's denial is set aside and the claim remanded for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of \$2,200, to be paid by the insurer.

October 29, 1991

Cite as 43 Van Natta 2414 (1991)

In the Matter of the Compensation of
MELVA D. ARMITAGE, Claimant
Own Motion No. 91-0607M
OWN MOTION ORDER
Employers Insurance of Wausau, Insurance Carrier

The insurer submitted to the Board claimant's claim for an alleged worsening of her November 25, 1984, industrial injury. Claimant's aggravation rights expired March 5, 1991. The insurer has accepted responsibility for the surgery and recommends that claimant's claim be reopened for the payment of temporary disability compensation.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenerberger v. Howard's Plumbing, 93 Or App 475 (1988). Here, claimant's claim was reopened under ORS 656.273 for an aggravation which occurred in July of 1990. The insurer contends claimant was again medically stationary in November of 1990, but through an oversight by their clerical department, the claim was not closed until October 16, 1991. Nevertheless, ORS 656.268 does require an insurer to either issue a Determination Order or request the Department of Insurance and Finance to issue a Determination Order. Claimant's claim was, therefore, in open status at the time of her March 21, 1991 surgery. Inasmuch as claimant's claim was not closed, it follows that her aggravation rights had not expired at the time of her worsened condition. Parenthetically, even if the insurer had

closed claimant's claim in November of 1990, there is evidence the insurer had notice of a claim for aggravation prior to claimant's aggravation rights expiring.

Accordingly, we lack own motion jurisdiction to consider claimant's current request for claim reopening and temporary disability benefits. Instead, the insurer should process claimant's request as a claim for aggravation under ORS 656.273.

IT IS SO ORDERED.

October 29, 1991

Cite as 43 Van Natta 2415 (1991)

In the Matter of the Compensation of

ROBERT L. BIGGS, Claimant

WCB Case No. 90-17988

ORDER ON REVIEW

Philip H. Garrow, Claimant Attorney

Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of Referee Spangler's order that: (1) found that claimant's low back injury claim was not prematurely closed; (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition; (3) upheld SAIF's partial denial of claimant's medical services claim for medical treatment after May 8, 1990; and (4) upheld SAIF's partial denial of claimant's claim for a psychological condition. On review, the issues are premature closure, aggravation, medical services, and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, a 33-year-old carpenter, injured his back in September 1989, while carrying construction materials. He sought treatment from Dr. Kranz, an osteopath, who diagnosed acute thoracic strain and lumbar spasm. He treated claimant with manipulations and recommended physical therapy. (Ex. 3).

In October 1989, Dr. Kranz referred claimant to Dr. Newby, a neurosurgeon, for evaluation. Dr. Newby diagnosed musculoskeletal strain without radiculopathy and recommended that claimant continue with physical therapy. (Ex. 5).

On November 15, 1989, SAIF accepted claimant's claim for an interscapular musculoskeletal strain. (Ex. 7). Thereafter, claimant continued to seek treatment from Dr. Newby for recurring back, arm and leg pain.

At SAIF's request, claimant was examined by Dr. Woolpert, an orthopedic surgeon, on May 8, 1990. Dr. Woolpert diagnosed dorsal lumbar strain and found no objective findings of impairment and noted that claimant displayed non-organic pain behavior upon examination. He also felt that claimant was medically stationary. (Ex. 16). Dr. Newby concurred. (Ex. 17).

A Determination Order issued on July 12, 1990, awarding claimant temporary disability with no permanent disability. The Determination Order also declared claimant medically stationary on May 8, 1990. (Ex. 19).

On the same day the Determination Order issued, claimant was involved in a physical altercation with the police, during which he was forcibly restrained by

handcuffs and taken into custody. Following his release, he presented himself to Dr. Newby with increased back and arm pain. (Ex. 14-1).

In August 1990, Dr. Newby referred claimant to Dr. Dimitman, a psychiatrist, for treatment of depression.

On September 5, 1990, SAIF issued an aggravation denial, asserting that claimant's increased mid-scapular and back pain was not related to the compensable injury, and that the July altercation with the police was the major contributing cause of his increased back pain. (Ex. 22). SAIF also advised claimant's attorney that it was denying all medical treatment after May 8, 1990 as not being related to claimant's industrial injury due to the intervening July incident. (Ex. 26).

At SAIF's request, claimant was examined by Dr. Holland, MD, on October 2, 1990.

On November 2, 1990, SAIF issued a partial denial of treatment for claimant's depression. (Ex. 27).

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Premature Closure

We adopt the conclusions and reasoning concerning the premature closure issue as set forth in the Referee's order.

Aggravation

This case comes to us in a peculiar procedural posture. On September 5, 1990, SAIF issued a denial of a worsening of claimant's condition, asserting that the July 1990 altercation with the police was the major contributing cause of claimant's current condition. (Ex. 22). It is unclear, however, whether claimant, in fact, filed a claim for aggravation. In a letter dated October 8, 1990, claimant's attorney questioned SAIF's denial, explaining that claimant had not lost time from work as a result of any worsening of his condition and that there had been no request to reopen the claim due to a worsened condition. (Ex. 24). The issue was again raised by claimant's attorney during opening arguments at hearing. (Tr. 5). Nonetheless, claimant's attorney, on the hearing request form, checked the space marked "Aggravation ORS 656.273," and challenged the propriety of SAIF's aggravation denial at hearing and on review.

Based on these peculiar facts, we conclude that an aggravation claim was raised and litigated and is now properly before us. After our review of the record, however, we conclude that claimant has failed to establish a compensable aggravation.

In an unscheduled disability case, a claimant is entitled to additional compensation, including medical services, when, as a result of either a pathologic or symptomatic worsening of his compensable condition, he is less able to work than at the time of the last award or arrangement of compensation. ORS 656.273(1). Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds, Lucas v. Clark, 106 Or App 687 (1991). In this case, claimant experienced a symptomatic "flare-up" of his back symptoms on July 12, 1990, after a physical altercation with the police. There is no evidence in the record, however, that, as a result of the symptomatic flare-up, claimant was less able to work. Claimant testified that the incident did not cause any change in his condition, that he was working the day of the incident and continued to work thereafter. (Tr. 17). He further testified that he went to Dr. Newby's office that day only for a refill of his prescriptions. There is no contrary medical evidence.

Based on the totality of the evidence, we are not persuaded that, as a result of the July 12, 1990 altercation with the police, claimant's earning capacity was diminished below that fixed at the time of the Determination Order. We find that the medical record and lay testimony support a finding that claimant had not sustained a compensable aggravation of his back condition. Given our conclusion that claimant did not sustain a "worsening," we need not and do not address SAIF's contention that the worsening is not compensable because the July 1990 off-the-job incident was the major contributing cause of claimant's condition. See ORS 656.273(1).

Medical Services

In addition to denying a worsening of claimant's condition, SAIF denied payment for all medical treatment after May 8, 1990 as not being related to claimant's industrial injury. The Referee upheld that portion of the denial, concluding that the July altercation with the police "broke the chain of causation between claimant's September 1989 compensable back strain and his current need for medical treatment." In reaching his conclusion, the Referee relied upon a letter dated September 14, 1990, in which Dr. Newby said:

"It is my opinion that [claimant's] treatment and evaluation in my office on July 12, 1990, was due primarily to the injury he suffered in an altercation with law enforcement officers." (Ex. 23).

On review, claimant contends that the Referee's reliance on Dr. Newby's opinion was misplaced. He contends that the above quoted letter shows only that the July 12 office visit was occasioned by the police incident and does not establish an intervening event that breaks the chain of causation for continued medical treatment.

After our review of the record, we agree that the Referee's reliance was misplaced. In a subsequent letter dated October 25, 1990, Dr. Newby reported:

"[Claimant's] need for follow up and treatment stems from his industrial accident on September 22, 1989." (Ex. 25A).

That letter, when read in conjunction with the earlier report, persuades us that, while the July 12 office visit was primarily caused by the off-the-job police incident, claimant's compensable injury was and remains a material contributing cause of his condition after that date. There is no contrary medical evidence. Accordingly, we conclude that claimant has established the compensability of his continuing medical treatment.

Psychological Condition

We adopt the conclusions and reasoning concerning the compensability of claimant's psychological condition as set forth in the Referee's order.

Attorney Fees

Because claimant has prevailed against SAIF's partial denial of medical treatment, claimant's counsel is entitled to an assessed fee under ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on Board review concerning the medical services issue is \$1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, transcript, and appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 27, 1990, as supplemented January 16, 1991, is affirmed in part and reversed in part. The SAIF Corporation's partial denial of claimant's medical treatment after May 8, 1990 is set aside, except as to the July 12, 1990 office visit. The claim is remanded to SAIF for further processing according to law. For services at hearing and on Board review concerning the medical services issue, claimant's attorney is awarded \$1,500, to be paid by SAIF. The remainder of the Referee's order is affirmed.

October 29, 1991

Cite as 43 Van Natta 2418 (1991)

In the Matter of the Compensation of

PEGGY L. RENNIE, Claimant

WCB Case No. 90-18558

ORDER ON REVIEW

Pozzi, et al., Claimant Attorneys

Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Otto's order that upheld the insurer's denial of her injury claim for a right trapezius strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On April 24, 1990, while performing her housekeeping duties for the employer, claimant pulled an elderly woman backward about five inches, from a bed to a commode. Claimant felt an immediate sharp burning sensation below her right shoulder blade, which decreased somewhat after 10 or 15 minutes. Although claimant's trapezius area kept getting "sorer" thereafter, she continued working, hoping that the problem would resolve over the weekend.

Claimant's discomfort continued, so she reported the incident to the employer and sought treatment from Dr. Pagel the following week. She filed an injury claim on May 31, 1990, for a condition diagnosed as a right trapezius strain.

In 1980, claimant tore her right acromioclavicular joint, when she fell from a horse off-work. She has received continuing treatment for that problem. Claimant's shoulder symptoms are different from her trapezius strain symptoms.

Prior to this work incident, she did not have trapezius complaints. Claimant suffers from lupus, a preexisting condition which causes arm, neck and back symptoms.

During May and June of 1990, claimant also sought treatment from Drs. Howe and Lorish for continuing right shoulder and trapezius symptoms, among other problems. She received physical therapy at the Center for Occupational Health of St. Vincent's Hospital and Medical Center for her shoulder and trapezius symptoms.

FINDINGS OF ULTIMATE FACT

Claimant's April 24, 1990 injury, which arose out of and in the course of her employment, was a material cause of her current disability and need for treatment for a right trapezius strain.

Claimant's injury claim is established by medical evidence supported by objective findings.

Neither claimant's 1980 right shoulder injury nor her preexisting lupus condition affected, or was affected by, her 1990 work injury.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded:

"Based on claimant's chronic pre-April 1990 back and right shoulder pain, continuous medical treatment for those problems, failure to file a formal injury claim for more than a month, failure to report either the April incident or shoulder pain to Dr. Howe, inconsistencies in her reported symptoms and lack of objective findings, I do not find by a preponderance of the evidence that the April 24, 1990 incident was a material cause of her right trapezius strain." (O&O p 4.).

We disagree.

Under ORS 656.005(7)(a), claimant bears the burden of proving that a work injury is a material contributing cause of her disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The statute also requires that claimant's need for medical services or disability must be established by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991).

In this case, although the Referee found nothing in claimant's attitude, appearance or demeanor which led him to believe that she was not a credible witness, he concluded that she did not carry her burden, due, in part, to perceived inconsistencies between her testimony and the medical record. We read this as an implicit negative credibility finding.

When, as here, a credibility finding is not based on demeanor, we are in as good a position as was the Referee to evaluate a witness' truthfulness and reliability. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). After our review of the record in this case, we conclude that claimant's reporting is consistent with the medical evidence.

Claimant credibly testified that she reported her injury to her employer and her family doctor, upon discovering that her pain did not dissipate over the weekend following the incident. (Tr. 7). Although Dr. Pagel initially diagnosed a right shoulder strain and noted her old acromioclavicular injury, he

reported her trapezius symptoms separately. (Exs. 11 & 12). Moreover, although Dr. Howe commented that claimant did not tell him about her work incident in April or May 1990, (Ex. 14), we note that claimant sought treatment from Howe for lupus and a skin rash, rather than for her trapezius injury, during that time. (See Ex. 13).

Claimant and her physicians distinguish her trapezius symptoms from her continuing right shoulder symptoms. The new symptoms are in a location different from that of her continuing acromioclavicular symptoms. There is no evidence that claimant had trapezius problems prior to the April work incident. (See Tr. 8). Based on claimant's credible and consistent reporting and the medical evidence which identifies a new trapezius condition, we find that claimant's trapezius complaints represent a condition which is separable from her preexisting right shoulder condition. For these reasons, we are persuaded by the well reasoned opinion of Dr. Lorish and conclude that claimant's April 24, 1990 work incident caused her right trapezius strain. (Ex. 27-2, see Exs. 20A, 21 & 22).

The Referee also found that claimant failed to carry her burden, because claimant's reports of trapezius pain do not constitute objective findings. We disagree.

We have previously held that an injured worker's symptoms may be objective findings, within the meaning of ORS 656.005(7)(a) and 656.005(19), when the symptoms are reported by an examining physician pursuant to evaluating the worker's range of motion and muscle tenderness. See Suzanne Robertson, supra.

Here, on May 30, 1990, the physicians evaluating claimant's condition during her physical therapy treatment reported: "On palpation, [patient] has tenderness all along course of right trapezius muscle. . . [P]atient is unable to place her right hand behind her head without pain in trapezius muscle. . ." (Ex. 16-2). Based on this evidence, we conclude that claimant has carried her burden of establishing that the medical evidence which constitutes her claim is supported by objective findings. Inasmuch as we are persuaded by the medical and lay evidence supporting the requisite work relationship and objective findings, claimant's claim is compensable.

Claimant has prevailed in a rejected case. Therefore, she is entitled to an attorney fee under ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review is \$2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case as represented by claimant's statement of services and her appellant's brief, and the value to claimant of the interest involved.

ORDER

The Referee's order dated December 27, 1990 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of \$2,000, payable by the insurer.

In the Matter of the Compensation of
ALTON H. SHOTWELL, Claimant
WCB Case No. 90-00900
ORDER ON REVIEW
Popick & Merkel, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee McCullough's order that found that a Determination Order had prematurely closed claimant's low back condition claim. On review, the issues are premature closure, and alternatively, aggravation and extent of scheduled and unscheduled disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last two paragraphs in that section.

We add the following supplementation.

Claimant was 46 years of age at the time of hearing. He has a high school diploma and two years of community college coursework. Claimant's highest SVP during the ten years prior to hearing was 7, as a carpenter. He has acquired on-the-job training sufficient to perform other than an entry-level position.

Following his compensable injury, claimant's lifting capacity placed him between the light and sedentary categories. Claimant also is restricted from continuously sitting and standing without breaks.

As a result of his injury, claimant has undergone two lumbar surgeries. He has loss of range of motion in the thoracolumbar area and has a chronic condition limiting the repetitive use of his low back. Claimant also has a chronic condition limiting the repetitive use of both of his legs.

Claimant's low back condition was medically stationary at the time of the January 2, 1990 Determination Order.

CONCLUSIONS OF LAW AND OPINION

Premature closure

The Referee concluded that the medical treatment claimant received from January 1990 to June 1990 was provided for the purpose of improving his physical function level. The Referee also concluded that, at the time of the January 2, 1990 claim closure, claimant's back condition had not reached the point where no further material improvement would reasonably be expected from treatment. We disagree.

An injured worker is 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). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

Here, claimant argues that, although Dr. Franks, his treating physician, stated that claimant was medically stationary as of December 6, 1989, he also stated that, "it seems we have helped him some but certainly by no means 'cured him'." (Ex. 23-2). In addition, after claimant returned with symptoms of low back pain, Dr. Franks recommended further testing and prescribed medication and

pool therapy for claimant after the January 2, 1990 Determination Order issued. Claimant argues that Dr. Franks' statements that he was medically stationary in December 1989 are contradictory to the ongoing course of treatment, prescribed in part by Dr. Franks.

Claimant also contends that his family doctor's recommendation of additional physical therapy indicates that he was not medically stationary at the time of closure. Finally, claimant argues that the fact that Dr. Berkeley requested surgery in August 1990 is evidence that claim closure was premature.

We will consider post-closure medical reports if there is no post-closure change in claimant's condition and the only question is whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987). In the present case, however, we are not convinced that the post-closure medical reports and lay testimony indicate that claimant was not medically stationary at the time of closure.

On December 6, 1989, Dr. Franks stated that claimant was medically stationary at that time. Although claimant returned on January 8, 1990, and complained of pain in his low back with radiation into the buttocks and legs, an MRI ordered by Dr. Franks was negative. On January 12, 1990, Dr. Franks reported that claimant was frustrated "despite the MRI scan evidence and documentation of improvement...." Dr. Franks suggested a short course of medication and he recommended that claimant start pool therapy again.

On January 29, 1990, Dr. Franks reported that claimant continued to have low back pain, but he felt that claimant was medically stationary, "effective December 6, 1989." Dr. Franks stated that he would see claimant again on an as-needed basis, but he did not feel that any type of further neurosurgical management would be of value to him. (Ex. 27).

We conclude that Dr. Franks' recommendations of MRI testing and pool therapy in January 1990 are not inconsistent with his statements that claimant was medically stationary as of December 6, 1989. Fluctuating symptoms and/or a need for continuing medical treatment does not defeat a medically stationary status. Maarefi v. SAIF, 69 Or App 527 (1984). In addition, further testing and recommendations of physical therapy do not necessarily indicate that further improvement could have been reasonably expected at the time of closure. Bobby G. Todd, 42 Van Natta 1648 (1990).

We are also unconvinced that claimant's participation in a pain center program five months after claim closure establishes that he was not medically stationary at the time of closure. At the time claimant was discharged from the pain center, Dr. Steinhauer reported that claimant's lifting capacity fell "far short" of his short-term expectations and claimant did not demonstrate an ability to significantly improve his lifting ability. (Ex. 36-3). See e.g. Patricia A. Kingsland, 41 Van Natta 1702 (1989) (Supervised exercise program resulted in no curative benefits and did not establish a reasonable expectation of further material improvement in claimant's condition.)

We conclude that, as claimant's treating physician, Dr. Franks is in the best position to assess his medically stationary status. Dr. Franks has twice reiterated his prior opinion that claimant was medically stationary on December 6, 1989. (Exs. 27, 33). The record contains no medical opinions stating that claimant was not medically stationary at the time of the January 2, 1990 Determination Order. Under the circumstances, we conclude that, as of January 2, 1990, the record does not show that further material improvement could reasonably be expected from medical treatment or the passage of time. Accordingly, we reverse the Referee on the issue of premature closure.

Aggravation

The Referee concluded that, following his finding of premature closure, the issue of aggravation was moot. Because we have reversed the Referee's ruling on premature closure, we now proceed to address the issue of aggravation.

On review, claimant contends that the law in effect prior to July 1, 1990, should apply to his aggravation claim. We disagree.

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Oregon Laws 1990 (Special Session), Chapter 2, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The insurer contends that claimant experienced a symptomatic flare-up only, rather than a worsening of his underlying condition. Alternatively, the insurer argues that, if claimant had a worsening of his underlying condition, the major contributing cause of the worsening was claimant's slip on his steps at home, which was an incident that did not occur within the course and scope of employment.

Claimant is entitled to additional compensation for a worsened condition resulting from the original injury. ORS 656.273(1). To establish a compensable worsening of his unscheduled condition, claimant must show that, as a result of either a pathologic or symptomatic worsening of his compensable condition, he is less able to work than at the time of the last award or arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Here, claimant was admitted to a hospital emergency room on June 15, 1990 - three days after stepping down a set of stairs and "jamming" his left leg. Claimant reported low back pain radiating down his left leg, in addition to pain in the left groin area. Dr. Foley, M.D., diagnosed "chronic back pain - acute exacerbation," and prescribed medication and bed rest. (Ex. 39).

On June 27, 1990, Dr. Franks reported that claimant complained of pain, but he could not document any weakness. On July 6, 1990, Dr. Franks reported that an MRI scan revealed scarring at L4-5 and a "bit of a bulge at L5-S1." On July 18, 1990, Dr. Franks reported that claimant's L5-S1 "bulge" was not symptomatic and was not related to the compensable injury. Dr. Franks related claimant's incident to his compensable injury and concluded that claimant was clinically worsened "in the sense that he underwent a significant stress to his already abnormal lumbar spine on or about June 12, 1990." However, Dr. Franks further reported that the MRI scan did not reveal any abnormality which he felt would be benefitted by surgery. (Ex. 44).

We conclude that claimant experienced a symptomatic "flare-up" of his back symptoms following the incident in June 1990. There is no evidence in the record, however, that, as a result of the symptomatic flare-up, claimant was less able to work. At the time of the January 2, 1990 Determination Order, claimant had been off work for approximately four months, as a result of his low back injury. Claimant has not returned to work since his injury and he

testified that the June 1990 incident was a continuation of the ongoing symptomatology that he had from the industrial injury.

Based upon our review of the record, we are not persuaded that, as a result of the June 1990 incident, claimant's earning capacity was diminished below that fixed at the time of the Determination Order. We find that the medical record and lay testimony establishes that claimant has not sustained a compensable aggravation of his back condition. Given our conclusion that claimant did not sustain a "worsening," we need not and do not address the insurer's contention that the worsening is not compensable because the June 1990 off-the-job incident was the major contributing cause of claimant's condition. See ORS 545.273(1).

Extent of unscheduled permanent disability

The Referee did not reach the issue of extent as he set aside the Determination Order on the basis that it was premature. We have herein reinstated the Determination Order; therefore, we proceed to rate claimant's permanent disability. We apply the "standards" in effect on January 2, 1990, the date of the Determination Order.

The appropriate value for claimant's age of 46 years is 1. Former OAR 436-35-290(4).

The appropriate value for claimant's high school education is 0. Former OAR 436-35-300(a).

Claimant contends that he should be assigned an SVP of 4 as, although he has acted in a supervisory capacity, he has primarily worked as a laborer and a carpenter. We disagree. Claimant testified that he has worked as a carpenter for approximately 27 years. In addition, claimant concedes that he has also worked as a supervisor in the industry. Accordingly, we agree that claimant's highest SVP during the ten years prior to the date of hearing was 7 as a carpenter (DOT 860.381-022). Therefore, the appropriate value for skills is a 1. Former OAR 436-35-300(4).

Claimant argues that he has no specific training other than as a carpenter, which is a job he is no longer capable of performing. The "standards," however, do not distinguish between training in jobs which claimant is currently capable of performing and those he can no longer perform. Competence in a "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off-the-job to perform other than an entry-level position. We conclude that claimant's 27 years of experience as a laborer, carpenter and supervisor demonstrate that he has acquired sufficient experience and training to perform other than an entry-level position. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

As a result of his injury, claimant is not working and no employment has been offered. He is capable of: occasionally lifting up to 14 pounds, frequently lifting up to 10 pounds, and constantly lifting up to 5 pounds. Claimant's lifting capacity places him between the categories of sedentary (8) and light (4) for an average value of 6. Former OAR 436-35-310(4). However, because claimant has limited abilities to sit and stand, the adaptability value is the average of 6 and 8 (the value for the next lower category). See former OAR 436-35-310(4); Jesse D. Starr, 43 Van Natta 474 (1991). Accordingly, we conclude that claimant is entitled to an adaptability value of 7.

As a result of his compensable injury, claimant has undergone two discectomies. For each discectomy, claimant is entitled to an impairment value

of 4 percent. Former OAR 436-35-350(2). Claimant's total value for surgical procedures, therefore, equals 8 percent.

Claimant contends that he is also entitled to impairment values for unoperated disc bulges at L3-4, L4-5 and L5-S1. However, the insurer argues that the bulges are either unverified or have not been related to the compensable injury. We agree.

Dr. Franks opined that claimant's L5-S1 disc bulge was not related to the August 31, 1988 injury. (Ex. 44). Dr. Franks felt that there "might" be a lateral bulging disc component on the left at L4-5. (Ex. 55). Dr. Berkeley noted that an October 1989 MRI showed "suggestion of still a persisting central disc bulge at L4-5." He reported that, "(a)t L5-S1 there appears to be a small central disc protrusion." However, Dr. Berkeley did not list disc bulges at L3-4 and L4-5 under claimant's present pathology. Additionally, he did not relate any disc bulges to claimant's compensable injury. Accordingly, we decline to award an impairment value for claimant's unoperated disc bulges.

As a result of his injury, claimant has lost range of motion in the lumbar area. For loss of flexion in the thoracolumbar region (from 90 degrees to 45 degrees), claimant is entitled to an impairment value of 4.5 percent. Former OAR 436-35-360(6). For loss of extension in the thoracolumbar region (from 30 degrees to 20 degrees), claimant is entitled to an impairment value of 1 percent. Former OAR 436-35-360(7). For loss of flexion to both left and right (from 30 degrees to 20 degrees), claimant is entitled to an impairment value of 2 percent each, for a total of 4 percent. Former OAR 436-35-360(8). The values for lost range of motion in claimant's spine are added (not combined) to obtain a single value. Former OAR 436-35-360(10). In this case, the sum of the impairment values for lost spinal motion is 9.5.

Claimant contends, and the insurer concedes, that he is entitled to an impairment value of 5 percent for his chronic condition limiting repetitive use of the low back. We agree that claimant is entitled to an impairment value of 5 percent for his chronic condition limiting repetitive use. Former OAR 436-35-320(4).

To arrive at a total impairment finding, claimant's values for surgeries (8), are combined with the total impairment value for lost range of motion (9.5), and loss of repetitive use (5). Claimant's total impairment value, therefore, is 20.9.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 1, the sum is 2. When that value is multiplied by claimant's adaptability value, 7, the product is 14. When that value is added to claimant's impairment value, 20.9, the result is 34.9 percent unscheduled permanent partial disability. That value is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 35 percent.

Extent of scheduled permanent disability

Claimant contends that he is entitled to an award of scheduled permanent disability for loss of use or function of his lower extremities. The insurer agrees that claimant is entitled to an award of 5 percent each for a chronic condition limiting repetitive use of his left and right lower extremities.

Claimant argues that he is also entitled to an award for loss of strength in the left leg, as Dr. Steinhauer's report of June 1990 indicates that

claimant's "(l)eft leg strength was 4/5 compared to normal on the right side." We disagree. Claimant's treating doctor, Dr. Franks, reported on July 6, 1990, that claimant still limped, however, Dr. Franks concluded that there was "no weakness." (Ex. 40). We conclude that claimant has not established that he is entitled to an award for permanent loss of strength in the left lower extremity.

Claimant's total scheduled award, therefore, is 5 percent each for loss of use or function of the left and right lower extremities.

ORDER

The Referee's order dated January 23, 1991 is reversed. The insurer's aggravation denial is upheld. The January 2, 1990 Determination Order is reinstated and modified. In addition to the Determination Order award of 29 percent (92.8 degrees) unscheduled permanent disability, claimant is awarded 6 percent (19.2 degrees), for a total award to date of 35 percent (112 degrees) unscheduled permanent disability for his low back condition. Claimant is also awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left leg and 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800.

October 29, 1991

Cite as 43 Van Natta 2426 (1991)

In the Matter of the Compensation of

VICTOR T. WITHAM, Claimant

WCB Case No. 90-06441

ORDER ON REVIEW

Ackerman, et al., Claimant Attorneys

Jaqua, Wheatley, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Davis' order that: (1) increased claimant's scheduled permanent disability award for a bilateral forearm condition from 5 percent (7.5 degrees) for the left forearm, as awarded by a Determination Order, to 53 percent (79.5 degrees) for the left forearm and 8 percent (12 degrees) for the right forearm; and (2) awarded temporary partial disability from September 21, 1989 through February 8, 1990. Claimant cross-requests review on: (1) the Referee's order that increased claimant's scheduled permanent disability award for the left forearm; (2) entitlement to scheduled permanent disability paid at the award rate of \$305 per degree; (3) entitlement to interest on the compensation due pending appeal of the Referee's order; and (4) entitlement to an assessed attorney fee under ORS 656.382(2) for services on review. On review, the issues are extent of scheduled permanent disability, temporary disability, interest, award rate and attorney fees. We affirm in part, and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as supplemented.

By stipulation dated January 9, 1990 the insurer accepted the following conditions: (1) bilateral carpal tunnel syndrome; and (2) hypothenar hammer syndrome and industrial white finger disease involving the ulnar and radial arteries and digital arteries in the left upper extremity.

CONCLUSIONS OF LAW AND OPINIONExtent of permanent disability

The Referee concluded that claimant sustained 53 percent permanent disability in the left forearm, and 8 percent impairment in the right forearm. We modify the left forearm award.

The insurer contends that the Referee erred by including claimant's alleged preexisting hand and arm disabilities in evaluating the extent of permanent disability due to the compensable injury. Thus, the insurer reasons, it was incorrect for the Referee to assume, and to accordingly rate, claimant's disability based on "normalcy" of claimant's forearm anatomy without taking into account preexisting impairment.

As a preliminary matter, we begin by noting that the insurer, by stipulation, accepted claimant's bilateral carpal tunnel syndrome, and hypothenar hammer syndrome and industrial white finger disease involving the ulnar and radial arteries and digital arteries in the left upper extremity. However, that does not end the inquiry. The criteria for rating of disability shall be the permanent loss of use or function of the injured member due to the compensable injury. See ORS 656.214(2). Thus, we determine to what extent claimant's impairment is due to the compensable condition.

Although claimant testified that he had experienced some trouble with his hands in the past, the medical record does not reveal the nature of these problems. We find that the medical record does not indicate that a preexisting condition is responsible for claimant's current impairment. Rather, the medical evidence indicates that the converse is more accurate. Claimant's treating physician, Dr. Teal, has opined that work-related employment is the major contributing cause of her condition. He opines no other causal factor responsible for claimant's existing impairment. Therefore, we conclude that claimant's current impairment is due to the compensable condition.

The parties do not dispute the Referee's impairment findings regarding range of motion, protective sensation, grip strength and vascular disease. Nor do the parties dispute the body part to be rated, the forearm. Accordingly, we adopt those aspects of the Referee's order.

Claimant contends that he is entitled to an additional 5 percent for the left forearm for a chronic condition. An award of 5 percent impairment for a chronic condition limiting repetitive use of a body part is available whether or not a claimant is entitled to impairment values for any other conditions or restrictions. See Larry L. McDougal, 42 Van Natta 1544, 1547 (1990).

Claimant testified that his ability to drive a car for any period of time exceeding 30 minutes caused his hands to go numb and swelling to ensue. Claimant also experiences this "swelling" sensation with the use of tools and other forms of physical labor. In addition, he can not open a twist bottle, and it is difficult to lift up large items with his fingers. The medical record supports claimant's testimony. Dr. Teal opined that despite the surgery, claimant was at high risk of recurrence unless he limited repetitive use of his hands. He believed claimant was limited from running vibratory machinery or any job that involved repetitive heavy gripping or wrist manipulation. (Ex. 52-1). Accordingly, we find that claimant suffers from a chronic condition entitling him to an increased award of 5 percent for the left forearm.

Temporary disability

The Referee concluded that the insurer was required to pay temporary partial disability. We agree, and adopt the Referee's conclusions and opinion.

Rate of permanent disability and Interest

In his brief, claimant requests that his entitlement to scheduled permanent disability be paid at the rate of \$305 per degree. The insurer contends that we should not decide this issue as the issue was not raised at hearing. Secondly, claimant contends that he is entitled to interest on the compensation due for temporary and permanent disability stayed pending appeal. Both of these issues involve claims processing matters which may result in justiciable controversies in the future, but which are not ripe for review in this proceeding. Accordingly, we decline to address these issues.

Assessed attorney fees

Inasmuch as we have found that claimant's compensation should not be disallowed or reduced, he is entitled to an assessed fee. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the permanent and temporary disability issues is \$900, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issues, the time devoted to the issues as represented by claimant's attorney's statement of services and appellate brief, and the value of the interest involved.

ORDER

The Referee's order dated December 14, 1990 is affirmed in part and modified in part. In addition to the 53 percent (79.5 degrees) scheduled permanent disability awarded for the left forearm by the Referee's order, claimant is awarded an additional 5 percent (7.5 degrees) for a total of 58 percent (87 percent) permanent disability for the left forearm. Claimant's attorney is awarded 25 percent scheduled of the increased compensation created by this order. However, the total approved attorney fees awarded by the Referee and Board orders shall not exceed \$3,800. For services on review, claimant's attorney is awarded an assessed fee of \$900, payable by the insurer. The remainder of the Referee's order is affirmed.

October 30, 1991

Cite as 43 Van Natta 2428 (1991)

In the Matter of the Compensation of
MONA ALLISON, Claimant
WCB Case No. C1-02179
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Ronald A. Fontana, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

On October 17, 1991, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Entitlement to an attorney fee in connection with a CDA is expressly subject to OAR 438-15-052. When a claim disposition agreement is approved under the provisions of ORS 656.236 and OAR 438-09-020, an attorney fee may be approved by the Board in an amount up to 25 percent of the first \$12,500 of the agreement proceeds plus 10 percent of any amount of proceeds in excess of \$12,500. See OAR 438-15-052(1). Under extraordinary circumstances, a fee may be approved in excess of the strictures of OAR 438-15-052. Id.

Here, the attorney fee exceeds the amount allowed under OAR 438-15-052. Specifically, the agreement provides that the insurer will pay claimant a total of \$28,000 with \$6,000 of that amount as an attorney fee. Although claimant's attorney notes that "the fee requested is only \$825.00 in excess" of the regulatory provisions, based on our calculations, the proposed attorney fee exceeds the strictures of OAR 438-15-052 by \$1,325.

Claimant's counsel requests we approve the \$4,675 attorney fee. In support of this request, counsel asks that we take into consideration that this is a very complex claim, with complex medical and legal issues. Therefore, he requests an attorney fee in excess of the amount authorized under OAR 438-15-052 based upon extraordinary circumstances.

Accordingly, we consider the particular extraordinary circumstances proffered by counsel in support of the fee. Counsel contends that the fee is appropriate due to the fact this claim has been ongoing and actively litigated since 1984, that he was instrumental in gaining acceptance of an aggravation claim, that he has been practicing law for fifteen years, and that a significant number of his cases are workers' compensation related.

The circumstances cited as extraordinary are for prior legal services in connection with litigation and acceptance of an aggravation claim, or concern counsel's qualifications and experience in general. They are not related to the obtaining or formulation of the proposed claim disposition agreement. Therefore, we find the extraordinary circumstances cited by counsel are insufficient to justify a larger fee.

Consequently, we find the agreement is unreasonable as a matter of law. See ORS 656.236(2); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Accordingly, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, the parties may submit a revised agreement for our consideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
WALDEN J. BEEBE, Claimant
WCB Case No. 90-18757
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of Referee Gruber's order which: (1) declined to require the insurer to pay claimant temporary total disability benefits awarded by an earlier Referee's order, on the ground that payment of the benefits was stayed pending review by the Board; and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable refusal to pay the benefits. On review, the issues are stay of compensation pending Board review, penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant originally suffered a compensable low back injury while working for EBI's insured on March 1, 1986. The claim was closed by the insurer on September 17, 1986.

In September 1989, claimant left work and filed an aggravation claim with EBI. EBI denied responsibility for the aggravation claim on December 6, 1989, and discontinued payment of interim compensation benefits at that time. EBI denied compensability and responsibility on April 10, 1990.

Claimant requested a hearing concerning EBI's denials, as well as the denials of other insurers (WCB Case No. 90-12292). A hearing was held on August 9, 1990 to consider the responsibility and compensability issues relating to claimant's aggravation claim. An August 31, 1990 Opinion and Order set aside EBI's denials of responsibility and compensability and remanded the aggravation claim to EBI for acceptance and processing according to law.

Upon receipt of the August 31, 1990 Opinion and Order, EBI instituted payment of temporary total disability benefits from August 31, 1990 and continuing. EBI did not pay temporary total disability benefits for any period prior to August 31, 1990.

On September 14, 1990, EBI mailed, by first class mail, a Request for Board Review of the August 31, 1990 Opinion and Order. The Board acknowledged its receipt of the request on September 19, 1990.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the filing by the insurer of its request for Board review of the August 31, 1990 Opinion and Order stayed the payment of the temporary total disability benefits awarded by that order for the period from December 6, 1989 through August 30, 1990, because the insurer filed the request within 14 days after the order issued. Although we agree that payment of the compensation was stayed, we disagree with the Referee's analysis, and offer the following comment.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the

act's general applicability provision. See e.g. Section 54(3). Moreover, neither party contends that application of the 1990 amendments will produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, this case is analyzed under the Workers' Compensation Act as amended, effective July 1, 1990.

As amended, ORS 656.313(1)(a)(A) provides that the "[f]iling by an ... insurer of a ... request for board review stays payment of the compensation appealed," except for "[t]emporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs." In the present case, both parties agree that this statute did not stay payment of the temporary total disability benefits that accrued from August 31, 1990, the date of the prior referee's order; and it is also undisputed that the insurer promptly commenced payment of those benefits.

The issue here concerns the temporary total disability benefits that accrued from December 6, 1989, the date of the insurer's denial, through August 30, 1990. Based on ORS 656.262(4) and former OAR 436-60-150(3)(e), the Referee concluded that the insurer was obligated to pay those benefits, unless it had filed its request for review within 14 days of the August 31, 1990 Opinion and Order, i.e., by September 14, 1990. The Referee found, and we agree, that the insurer did file the request for review within 14 days, as the certificate of mailing attached to the request avers. We conclude, however, that the Referee's reliance on ORS 656.262(4) and former OAR 436-60-150(3)(e) was misplaced.

The time for filing a request for Board review of a Referee's order is governed by ORS 656.289(3), which provides that the 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 a review by the Board under ORS 656.295." In other words, a Referee's order is not a final order, if at any time within 30 days from its issuance, a request for review is filed. By virtue of amended ORS 656.313, the filing by the insurer stays the payment of the compensation appealed without any limitation or exception as to when, within the 30-day filing period, the insurer's appeal is filed.

ORS 656.262(4) does not provide otherwise. Indeed, this statute is inapposite. It establishes timelines for payment of compensation that is due. Here, the compensation at issue was stayed pursuant to ORS 656.313 because the insurer timely requested Board review of the referee's order. Thus, the compensation was not due, and ORS 656.262(4) does not apply.

We recognize that former OAR 436-60-150(3)(e) provided that timely payment of temporary disability benefits is made when paid no later than the 14th day after the date of any litigation order which orders temporary disability. When that rule was promulgated, however, ORS 656.313 expressly provided that payment of compensation was not stayed pending an insurer's appeal. Thus, the rule was consistent with the statutes as they existed at the time of its promulgation. Under amended ORS 656.313, payment of compensation is stayed upon filing by the insurer of an appeal. In the event that there is a conflict between the administrative rule and the statute, as amended, it is the statute rather than the rule which controls. Forney v. Western States Plywood, 66 Or App 155 (1983)

Since we conclude that payment of the compensation at issue was stayed under ORS 656.313, the insurer did not act unreasonably by withholding payment of the compensation pursuant to law.

ORDER

The Referee's order dated January 15, 1991 is affirmed.

October 30, 1991

Cite as 43 Van Natta 2432 (1991)

In the Matter of the Compensation of
LEROY FRANK, Claimant
WCB Case No. 90-09297
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Garrett, et al., Defense Attorneys

On October 25, 1991, we withdrew our September 26, 1991 order which had reversed a Referee's order that had set aside the insurer's denial of claimant's aggravation claim for a low back condition. We took this action to retain jurisdiction to consider the parties' Disputed Claim Settlement. The settlement is designed to resolve all issues raised or raisable in this matter, in lieu of all prior orders. Specifically, the parties agree that the insurer's denial "shall forever remain in full force and effect." In addition, the parties concur that this matter shall be dismissed with prejudice.

We have approved the parties' agreement, thereby fully and finally resolving this matter, in lieu of all prior orders. Accordingly, the request for review is dismissed with prejudice.

IT IS SO ORDERED.

October 30, 1991

Cite as 43 Van Natta 2432 (1991)

In the Matter of the Compensation of
KIMBERLY S. KAE LIN, Applicant
WCB Case No. CV-91009
CRIME VICTIM COMPENSATION ORDER OF REMAND
Depaolis, Evans, et al., Attorneys

This matter is before the Board pursuant to applicant's request for review concerning the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated March 19, 1991. By its order, the Department denied compensation to applicant under the Compensation of Crime Victims Act. (ORS Chapter 147).

Following our receipt of the request for Board review, applicant was advised that she was entitled to present her case to a hearing officer. To exercise her right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed her a copy of its record. The Department mailed a copy of its record to applicant on May 21, 1991. Applicant has requested that this case be considered based on the record and her written argument. See OAR 438-82-030(2).

Applicant has included with her written argument several documents which are not contained in the record submitted by the Department. In fact, in response to applicant's submission of these documents, the Department states that these materials "were never part of [the Department's] file" and the materials "were not considered by the Department when it made its decision not to accept this application."

Applicant's claim for benefits stems from injuries she sustained as a result of rape that occurred while she was performing an exotic dance for a customer of an escort service to which she was employed. The materials included with applicant's written argument are as follows: (1) documents concerning the assailant's 1977 convictions for assault with intent to commit rape and kidnapping (Applicant's Exhibit 23-1 through 12); (2) a "Stipulation of Facts Regarding Defense of Guilty Except for Insanity," which pertained to applicant's assailant's recounting of the events which resulted in applicant's injuries (Applicant's Exhibit 12A-1 through 6); and (3) reports of psychological and psychiatric evaluations concerning applicant's assailant (Applicant's Exhibit A-1 through 10; Exhibit B-1 through 4).

Inasmuch as these materials were not considered by the Department in reaching its decision, the Department has requested that these materials be excluded from our consideration. The Department relies on ORS 147.155(5), which states that no evidence is admissible before the Board that has not previously been considered by the Department. We agree that we are presently unable to consider these materials. Nevertheless, we are also empowered to conduct proceedings in any manner that will achieve substantial justice. Id.

As described above, each of the materials submitted by applicant has some relevance to her claim for benefits. In particular, we consider the assailant's stipulated rendition of the attack (which was developed in preparation for the assailant's trial) and the psychological/psychiatric evaluations to be noteworthy. Considering the relevance of the submitted materials to the issue currently on appeal, we conclude that substantial justice would be served by the Department's consideration of these materials. Consequently, we remand this matter to the Department for its review of these submitted materials.

In reaching this conclusion, we wish to emphasize that we are in no way passing judgment on the merits of applicant's claim for benefits. Rather, we are merely holding that, in the interests of substantial justice, the aforementioned relevant materials should be considered by the Department before it reaches its decision regarding the application for benefits.

Accordingly, this matter is remanded to the Department of Justice Crime Victims' Compensation Fund for further consideration of this record, consistent with this order. The Department is directed to reconsider this record, including the aforementioned submitted materials. Should applicant continue to disagree with the Department's decision following its reconsideration order, she may petition the Board for review of the Department's reconsideration order.

IT IS SO ORDERED.

October 30, 1991

Cite as 43 Van Natta 2433 (1991)

In the Matter of the Compensation of
DOLORES N. PETERS, Claimant
WCB Case Nos. 89-25315 & 89-14076
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

The insurer requests review of those portions of Referee T. Lavere Johnson's order that: (1) set aside its backup denial of claimant's right knee condition; (2) awarded claimant's counsel a \$4,500 assessed fee on the backup

denial issue; (3) awarded claimant's counsel a penalty-related attorney fee on the same issue; and (4) awarded claimant's counsel an assessed fee for prevailing against the insurer's request that claimant's permanent disability award be reduced. Additionally, claimant has filed a motion to admit additional evidence not in the record. On review, the issues are remand, backup denial, and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT," with the following supplementation.

The insurer did not file a formal cross-request for hearing seeking reduction of claimant's permanent disability award as granted by the Determination Order. However, at hearing, the insurer requested that the Referee reduce claimant's award on his "de novo" review of the Determination Order. The Referee declined to reduce claimant's award.

FINDINGS OF ULTIMATE FACT

The record is not improperly, incompletely or insufficiently developed without evidence concerning claimant's counsel's efforts at the hearing level.

Claimant's claim for a right knee injury was accepted as nondisabling on July 20, 1988 and as disabling on February 16, 1989.

Claimant's alleged misrepresentation of the history of her right knee condition was not material to the acceptance of her claim.

CONCLUSIONS OF LAW AND OPINION

Remand

After the hearing was closed, claimant filed a motion with the Board requesting permission to submit evidence concerning her counsel's efforts at the hearing level. Claimant states that the evidence would establish the nature of the services and the time expended on the issue of the compensability of claimant's claim. Our review is limited to the record developed before the Referee. Because the Board has no authority to consider evidence not in the record, claimant's request is in effect a request for remand. Former OAR 438-07-025(1) and (2); Judy A. Britton, 37 Van Natta 1262 (1985). The Board may remand a case to the Referee if it determines that a case has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). We conclude that the record is adequately developed and decline to remand to the Referee to admit this evidence.

Backup Denial

We affirm and adopt the Referee's opinion on this issue.

Attorney Fees--Backup Denial

The Referee awarded claimant's counsel an assessed fee of \$4,500 for his services in prevailing against the backup denial. The insurer contends that this award is excessive and should be reduced to \$2,000 or less. We modify the assessed fee.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that \$2,500 adequately and reasonably compensates claimant's counsel for his services at hearing regarding the backup denial

issue. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue and the value of the interest involved, as well as the risk in this case that the attorney's efforts may have gone uncompensated.

The insurer also contends that the Referee erred in awarding a penalty-related attorney fee for an unreasonable backup denial. We affirm and adopt the Referee's opinion on this issue.

Attorney Fees--Permanent Disability Award

The insurer contends that because it did not formally cross-appeal claimant's permanent disability award, the Referee's award of an assessed fee under ORS 656.382(2) should be reversed. We disagree. Claimant timely requested a hearing on the Determination Order. At the time the insurer raised the cross-request for reduction of the permanent disability award, claimant's hearing request had not been withdrawn. It was therefore within the Referee's discretion to consider the request. See former OAR 438-06-036 (WCB Admin. Order 4-1989). We interpret the insurer's action as effectively seeking reduction of claimant's award. To do otherwise would permit a carrier to delay its request for reduction or elimination of a claimant's award until hearing, while at the same time avoiding its potential liability for an attorney fee under ORS 656.382(2) should the award not be reduced or eliminated. See Shirley G. Helgeson, 42 Van Natta 1941 (1990). The insurer's reliance on Julio Oliveros, 41 Van Natta 67 (1989), is misplaced; for the rule relied on therein is no longer good law. Kordon v. Mercer Industries, 308 Or 290 (1989)

Attorney Fee on Review

The insurer requested review, and we have concluded that claimant's compensation should not be disallowed or reduced. Hence, a fee must be assessed under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the backup denial issue is \$800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, the value of the interest involved, and the risk that the attorney's efforts may go uncompensated.

ORDER

The Referee's order dated December 5, 1990 is modified in part and affirmed in part. That portion of the Referee's order that awarded claimant's counsel an assessed fee of \$4,500 for prevailing against the insurer's backup denial is modified to award an assessed fee of \$2,500. For services on review regarding the backup denial issue, claimant's attorney is awarded a \$800 assessed fee, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
IRVIN R. STORMS, Claimant
WCB Case No. 90-07971
ORDER ON REVIEW
Emerson, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

The SAIF Corporation requests review of Referee Quillinan's order that set aside its denial of claimant's right knee injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a 60-year-old welder and fabricator. On February 11, 1990, he and three other workers were engaged in carrying a 20-foot conveyor weighing approximately 350 pounds. One end had a motor attached to it with no supporting legs. Claimant and a co-worker carried that end, which weighed between 150 and 250 pounds. At one point, claimant's co-worker left the conveyor to fetch a barrel to support the conveyor. This left claimant holding the entire weight of his end of the conveyor. Claimant did not have any immediate pain. Two days later, however, he developed right knee pain and had trouble walking.

On February 13, 1990, claimant consulted Dr. Kemper, who noted slight swelling and medial joint line tenderness, but no effusion. He diagnosed an internal derangement of the knee and probable tear of the medial meniscus. A meniscus tear was later confirmed by an arthrogram.

Prior to the February 11, 1990 event, claimant had seen Dr. Kemper on January 18, 1990 for right knee pain. At that time, Dr. Kemper similarly identified medial joint line tenderness with no effusion and diagnosed the possibility of a meniscus tear. Claimant had attributed his knee symptoms to walking on concrete floors all day.

On February 27, 1990, claimant filed a claim seeking compensation for a right knee strain and identified the February 11, 1990 incident as the cause of the injury. SAIF denied the claim on March 14, 1990, asserting that there was insufficient evidence that claimant's right knee pain was the result of a work-related injury or disease.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had met his burden of proving by a preponderance of the evidence that he had sustained a compensable right knee injury on February 11, 1990. We disagree and reverse.

On May 7, 1990, the legislature enacted Senate Bill 1197, an extensive revision of the workers' compensation law. Because a hearing was convened on September 25, 1990, this matter is properly analyzed under those provisions, which generally became operative on July 1, 1990. Or Laws 1990 (Special Session), ch. 2, 54; Ida Walker, 43 Van Natta 1402, 1405 (1991).

In this case, all the medical evidence indicates that claimant had a right knee condition that preexisted the February 11, 1990 incident. Claimant does not dispute that fact. Inasmuch as claimant is attempting to establish the compensability of his right knee condition as an initial injury, claimant must prove by a preponderance of the evidence that the work-related incident was a

material contributing cause of his disability or need for medical services. ORS 656.005(7)(a); Bahman Nazari, 43 Van Natta 2368 (1991.)

Claimant relies solely on the opinion of Dr. Kemper, his treating physician, who, in response to a letter written by claimant's attorney, concurred with the following statement:

"Based on your training as a physician and upon your records regarding my client, do you agree that there is a reasonable medical probability that [claimant] could have had a preexisting injury and/or disease that was exacerbated or worsened on the date of injury due to the strain of heavy weight being put on the knee?" (Ex. 9).

We conclude that Dr. Kemper's opinion is not sufficient to establish that claimant sustained a compensable right knee injury. Notwithstanding the conclusory nature of his "check-the-box" concurrence, Dr. Kemper merely stated that there was a possibility that claimant's preexisting condition was aggravated by the incident. It does not establish that the incident was a material contributing cause of his disability or need for medical treatment.

After our de novo review of the record, we conclude that claimant has failed to establish by a preponderance of the evidence that he sustained a compensable right knee injury on February 11, 1990. Accordingly, SAIF's denial is reinstated and upheld.

ORDER

The Referee's order dated September 28, 1990 is reversed. The SAIF Corporation's denial of claimant's right knee injury claim is reinstated and upheld. The Referee's \$2,000 assessed attorney fee for overturning the denial is reversed.

October 31, 1991

Cite as 43 Van Natta 2437 (1991)

In the Matter of the Compensation of
JOSE L. CARLOS, Claimant
WCB Case No. 90-06682
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Seifert's order that increased his unscheduled permanent disability award for a low back injury from 11 percent (35.2 degrees), as awarded by Determination Order, to 16 percent (51.2 degrees). Additionally, claimant requests remand for the taking of additional evidence regarding the recent termination of his employment. The insurer contends that claimant's request for review is untimely as it relates to the extent of disability issue. On review, the issues are extent of permanent disability and remand. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for the finding that claimant returned to the same job after the injury and that no modifications were made to the job. Instead, we find that claimant occasionally lifted sofas as part of his work duties before the injury and that he has been unable to do so since the injury. We therefore find that, whereas claimant's job at injury

required medium physical capacity, following the injury, claimant returned to modified employment requiring sedentary physical capacity.

The Referee issued three orders in this case. By Opinion and Order dated August 9, 1990, the Referee affirmed the Determination Order award of permanent disability compensation. Claimant moved for reconsideration; and, on September 7, 1990, the Referee issued an Order on Reconsideration awarding additional permanent disability compensation. Finally, by Amended Order on Reconsideration dated September 24, 1990, the Referee approved an attorney fee payable to claimant's attorney out of the additional award of compensation. On October 24, 1990, claimant requested Board review of the Amended Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Request for Review

The insurer contends that claimant's request for review was timely only as to the September 24, 1990 Amended Order on Reconsideration, and that the scope of Board review is therefore limited to the attorney fee approved in that order. We disagree.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been stayed, withdrawn or modified. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986); Fischer v. SAIF, 76 Or App 656, 660 (1985), rev den 300 Or 605 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986).

It is evident from the title of the Amended Order on Reconsideration that the Referee intended to modify the previous order. Furthermore, the order was issued in response to claimant's motion for reconsideration of the previous order. Finally, by approving an attorney fee out of the additional award of compensation, the Referee actually reduced the amount of money that claimant would receive and altered the insurer's payment duties. That, in effect, modified the previous order. Therefore, the September 24, 1990 order tolled the appeal rights running from the date of the September 7, 1990 order. See Farmers Ins. Group v. SAIF, supra; Fischer v. SAIF, supra. Accordingly, claimant's request for review was timely as to all issues in the Referee's orders. The insurer's motion is denied.

Remand

Following issuance of the Referee's Amended Order on Reconsideration, Claimant requested reopening of the record by his Motion for Abatement and Reconsideration of the order for the taking of evidence regarding the termination of his employment following closure of the record. In support of the motion, claimant's attorney submitted an affidavit which avers that claimant "strongly believes based on comments from the employer at time of termination that the termination was caused by his inability to perform his work due to his industrial injuries." In response, the insurer alleges that claimant failed to appear for work for three days and did not call the employer and that, based on company policy, his absence was deemed a voluntary resignation. The Referee did not take any action on claimant's motion. On review, claimant again suggests that his employment was terminated because of the compensable injury and requests remand for further evidence taking. We deny the request.

We may remand to the Referee for further evidence taking if we determine that this case has been "improperly, incompletely or otherwise insufficiently

developed or heard by the referee." ORS 656.295(5). There must be good cause or some other compelling basis for remand. Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986).

We find no compelling reason to remand this case for further evidence taking concerning the termination of claimant's employment. We are not persuaded that evidence concerning claimant's job status following the hearing is material to a determination of claimant's permanent disability as it existed at the time of the hearing. See Amparo Cordero, 42 Van Natta 420, 421-22 (1990), rev'd on other grounds Cordero v. Moller's Nursery, 107 Or App 133 (1991). Accordingly, claimant's request for remand is denied.

Extent of Disability

The criteria for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. Former ORS 656.214(5). The sole criteria for rating claimant's loss of earning capacity is his permanent impairment as modified by the factors of age, education, and adaptability to perform a given job. Former OAR 436-35-270(2) (WCD Admin. Order 7-1988, effective January 1, 1988).

Finding that claimant had returned to his usual and customary work, the Referee declined to assign a value for the factors of education and adaptability under the standards for rating permanent disability. We disagree with that finding.

"Usual and customary work," as defined in the standards for rating unscheduled permanent disability, means the job held at the time of injury. Former OAR 436-35-270(3)(a). "Modified work" means some job other than the job held at the time of injury, or the job held at the time of injury with any modification of duties or the conditions under which those duties are performed. Former OAR 436-35-270(3)(b).

We find that, although claimant returned to the job held at the time of injury, his job duties were effectively modified to accommodate his back condition. See, e.g., Edward L. Sullivan, 43 Van Natta 932, 934 (1991). Notwithstanding his physician's release for regular work, claimant persuasively testified that he could not perform all of the duties of his job when he returned to work. Whereas he occasionally loaded and unloaded trailers of sofas before the injury, he could no longer do so after the injury (Tr. 8-9, 12). Instead, he requires help from co-workers for lifting heavier furniture, such as sofas and bags (Tr. 11-13, 23-24).

Although the employer testified that he knew of no occasion when claimant would have to move a sofa, he later conceded on cross-examination that claimant was lifting a sofa when he sustained his back injury and that he had possibly been asked to lift sofas on one or two other occasions (Tr. 28, 31-32). The employer also testified that claimant has been reluctant to lift and carry as much as he did before the injury, adding that claimant's job is less physically demanding because of the expanding work force (Tr. 33-34).

Given our finding that claimant returned to modified work, we must determine the adaptability factor by comparing the physical capacity necessary to perform the usual and customary work and the physical capacity required to perform the modified work. See former OAR 436-35-310(3). Based on claimant's testimony that he occasionally lifted sofas before the injury, we find that the job at injury required medium physical capacity, i.e., occasional lifting of up to 50 pounds. See former OAR 436-35-310(4)(b). In contrast, claimant's current duties, according to the employer's testimony, require frequent lifting of no

more than five pounds (Tr. 30). Therefore, we find his modified job following the injury required sedentary physical capacity. Based on the above findings, we assign a value of +2.5 for the adaptability factor. See former OAR 436-35-310(3).

Because claimant is less than 39 years of age, the age factor is given no value. See former OAR 436-35-290(3). The education factor consists of the elements of formal education, skills, and training. Claimant does not have a high school diploma or GED certificate; therefore, formal education has a value of +1. See former OAR 436-35-300(3)(a). The value for skills is measured by reviewing the jobs claimant has successfully performed. Claimant accomplished the highest specific vocational preparation (SVP) level as a button maker (DOT 734.687-046) (Ex. 20-3; Tr. 39). That SVP level is rated as 3 in the Index to Occupational Characteristics; therefore, the appropriate value for skills is +3. See former OAR 436-35-300(4). Finally, claimant receives no value for training because he has accomplished the SVP level of 3, which is more than entry-level employment. See former OAR 436-35-300(5)(a); e.g., Jean H. Humphrey, 42 Van Natta 2542 (1990). The sum of the age and education values is +4. See former OAR 436-35-280(4).

We adopt the Referee's analysis of the rating of claimant's permanent physical impairment, and his conclusion that the appropriate value for the impairment factor is 16.

When the age and education value of +4 is multiplied by the adaptability value of +2.5, the product is 10. When that value is added to claimant's impairment value of 16 the result is 26 percent unscheduled permanent partial disability. See former OAR 436-35-280(7). We modify the Referee's order accordingly.

ORDER

The Referee's order dated August 9, 1990, as reconsidered on September 7, 1990, and amended on September 24, 1990, is modified. In addition to the Referee's award, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability, giving him a total award to date of 26 percent (83.2 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, provided that the total of fees approved by the Referee and the Board shall not exceed \$3,800.

October 31, 1991

Cite as 43 Van Natta 2440 (1991)

In the Matter of the Compensation of
SILVERIO FRIAS-PEREZ, Claimant

WCB Case No. 90-18025

ORDER ON REVIEW

Michael B. Dye, Claimant Attorney

Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Quillinan's order which after assessing a penalty under ORS 656.262(10)(a) for the insurer's untimely payment of time loss, declined to award claimant an attorney fee under ORS 656.382(1) for the same conduct. On review, the issue is attorney fees.

We affirm and adopt the Referee's order with the following supplementation. When the factual basis in support of the penalty under ORS 656.262(10)(a) is

identical to the factual basis for which an attorney fee under ORS 656.382(1) might be awarded, the simultaneous assessment of an attorney fee under ORS 656.382(1) and a penalty would contravene the legislative intent expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991). That is the case here. Claimant was not paid time loss when due nor in the correct amount when it was paid. For the unreasonable processing, the Referee assessed a penalty under ORS 656.262(10) of 25 percent of all time loss payable at the correct pay rate from the date the payments were due. Pursuant to subsection (10)(a), claimant's attorney was awarded one-half the penalty amount, "in lieu of an attorney fee." Under such circumstances, claimant's counsel was not entitled to an attorney fee under ORS 656.382(1) in addition to the penalty awarded.

ORDER

The Referee's order dated January 30, 1991, as reconsidered March 12, 1991, is affirmed.

October 31, 1991

Cite as 43 Van Natta 2441 (1991)

In the Matter of the Compensation of

NANCY L. GROFF, Claimant

WCB Case No. 90-21116

ORDER ON REVIEW

Garlock, et al., Claimant Attorneys

David J. Lillig, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Peterson's order which set aside its partial denial of claimant's claim for bilateral endolymphatic hydrops and bilateral hearing loss. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant sustained two compensable injuries in January 1985. On her "801" claim form, claimant described her injuries as: "I was cutting material on the floor, with the cutter and I stood up and fell over a large roll of material (with the cutter in my hand) on the cement floor. (I also had a 60 lb. roll of material dropped on my left shoulder on...)." (Ex. 1). Claimant reported that her back was the body part affected by the injuries. (Ex. 1). At the time claimant received treatment in 1985, she complained of pain in her neck, head, shoulders, mid and lower back. (Ex. 2B-1). Claimant also complained of being "more irritable and tense," having trouble sleeping and having poor balance. (Exs. 2A, 2B). In April 1986, claimant complained of headaches in addition to poor balance. (Ex. 2C). An MRI or CT scan in December 1985 was negative. (Exs. 2C, 12-1). Claimant's claim was closed on February 24, 1986, with an award of 20 percent unscheduled permanent disability for her back condition. (Ex. 13).

On January 29, 1990, claimant filed a change of physician form and listed her then current complaints as "chronic pain in the neck, midback and lowback which has worsened over time." (Ex. 7). H. Segur, chiropractor, became claimant's treating chiropractor. On February 2, 1990, SAIF denied claimant's aggravation claim. (Ex. 8).

On March 21, 1990, claimant underwent a series of ear examinations at Good Samaritan Hospital. (Ex. 11). On April 3, 1990, Dr. Black, neuro-otologist, to

whom claimant was referred by chiropractor, Segur, diagnosed claimant with endolymphatic hydrops, "probably bilateral," and bilateral sensorineural hearing loss. (Ex. 12). Claimant told Dr. Black that her ear symptoms began in October 1985, after her compensable injury. (Ex. 12).

Claimant was examined by Dr. Kim, neurologist, and Dr. Glass, psychiatrist, for the insurer on July 27, 1990. (Ex. 22). On October 29, 1990, Dr. Kim reported that the echocochleographic tests performed for Dr. Black were negative. (Ex. 22-12).

Claimant began treating with Dr. Campbell, M.D., in July 1990. (Ex. 17). She described her 1985 injury to Dr. Campbell as involving a fall in which she hit her head on the cement floor. (Ex. 17-1). Claimant also reported to Dr. Campbell that she has suffered from ringing in her ears since the 1985 injury. (Ex. 17-4).

On November 15, 1990, SAIF denied claimant's bilateral endolymphatic hydrops and bilateral hearing loss condition. (Ex. 26).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's alleged inner ear condition is compensable as a direct result of her 1985 industrial injuries. We disagree.

Claimant bears the burden of proving by a preponderance of the evidence that her 1985 compensable injury materially contributed to her disability or need for medical treatment for her alleged ear condition. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979).

Given the length of time between claimant's compensable injury and the diagnosis of an inner ear condition, we find that the causation of claimant's inner ear condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Two medical experts address the issue of claimant's alleged endolymphatic hydrops and bilateral sensorineural hearing loss: Dr. Black, neuro-otologist, and Dr. Kim, neurologist.

Only Dr. Black diagnosed claimant with bilateral endolymphatic hydrops and bilateral sensorineural hearing loss. The tests, which were performed pursuant to Dr. Black's instructions, were negative. (Exs. 12, 22-12). Dr. Kim opined that the tests necessary to confirm Dr. Black's opinion were not performed. (Ex. 22). Dr. Black commented that because claimant's complaints began after the compensable injury and because claimant did not have these complaints before the injury, "one must assume that this is a post traumatic hydrops and is therefore, related to her on-the-job injury." (Ex. 12-5). At the time Dr. Black made this comment, he had not seen the 1985 injury report. (Ex. 12-5). Dr. Black refused to be consulted regarding his diagnosis by any person other than claimant, her immediate family and referring chiropractor. (Ex. 12-5).

Dr. Black's speculation regarding a causal relationship between claimant's alleged 1990 inner ear condition and her compensable 1985 injuries does not meet the level of preponderance of the evidence. See Allie v. SAIF, 79 Or App 284 (1986). Additionally, we do not find Dr. Black's unsupported diagnosis persuasive when the tests he prescribed to be performed proved negative and tests that may have confirmed his opinion were not performed. On the other hand, Dr. Kim recognized that claimant had been complaining of dizziness and vertigo since the compensable injury. However, because there was neither objective evidence, nor

laboratory confirmation of any disease process, Dr. Kim stated that he could not find a causal relationship between claimant's 1985 compensable injury and an alleged bilateral endolymphatic hydrops and bilateral sensorineural hearing loss.

Accordingly, we conclude that claimant has not sustained her burden to prove that she sustained a compensable bilateral endolymphatic hydrops condition and bilateral sensorineural hearing loss.

ORDER

The Referee's order dated February 12, 1991, is reversed. SAIF's partial denial is reinstated and upheld. The Referee's assessed attorney fee award is reversed.

October 31, 1991

Cite as 43 Van Natta 2443 (1991)

In the Matter of the Compensation of
MARTHA HYDE, Claimant
WCB Case No. 90-10482
ORDER ON REVIEW
Peter E. Baer, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) concluded that claimant's condition was medically stationary as of March 29, 1990, and that her claim had not been prematurely closed; (2) upheld the self-insured employer's denial of claimant's aggravation claim; (3) concluded that claimant was not entitled to benefits for temporary total disability; and (4) declined to grant benefits for permanent disability. On review, the issues are premature claim closure, aggravation, temporary total disability and extent of permanent disability, including permanent total disability. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Premature Claim Closure

We adopt the conclusions and reasoning concerning the premature closure issue as set forth in the Referee's order.

Aggravation

In order to establish an aggravation claim, a claimant must prove a worsened condition resulting from her compensable injury. ORS 656.273(1). "Worsened condition" means a change in condition that makes claimant more disabled, either temporarily or permanently, than she was when the original claim was closed. Smith v. SAIF, 302 Or 396 (1986).

In this case, the Referee concluded that claimant had not established a compensable aggravation, because there was no credible evidence in the record that established that her condition had worsened. We agree. As noted by the employer, claimant relies on four medical reports to support a compensable

worsening. However, none indicate a worsening of claimant's compensable condition. In fact, the only report that actually addressed claimant's compensable injury states that she had fully recovered from her surgery with no rateable impairment. Accordingly, we conclude that claimant has failed to prove a worsening since the original compensable injury.

Temporary Total Disability

The Referee concluded that claimant was not entitled to temporary total disability because she had retired prior to the filing of her claim for compensation. We agree.

A claimant who has voluntarily withdrawn from the work force is not entitled to temporary disability benefits, because such benefits are intended to replace lost income. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). The critical date for determining whether a worker has withdrawn from the work force is at the time of disability. Weyerhaeuser Co. v. Kepford, 100 Or App 410 (1990). In this case, claimant retired in March 1989, prior to May 15, 1989, the date of her surgery and subsequent disability. Accordingly, under those circumstances, she is not entitled to temporary total disability.

Relying on Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989), claimant contends that she is deemed to be in the work force because, while not currently employed, she is willing to work. The record does not support that argument. Claimant retired prior to the filing of her claim. When she was subsequently offered work within her physical capacities, she declined. Moreover, claimant testified at hearing that she wasn't looking for a job because she "was looking forward to so many years of retiring." (Tr. 81). Accordingly, we agree with the Referee that there is no evidence that claimant would have returned to work but for the compensable injury. See SAIF v. Stephen, 308 Or 41 (1989).

Extent of Permanent Disability

The Referee concluded that claimant had failed to establish that she is permanently and totally disabled under the "odd lot" doctrine. We agree and adopt the conclusions and reasoning concerning that issue as set forth in the Referee's order. We write separately, however, to address claimant's entitlement to permanent partial disability.

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Notice of Closure from which the hearing was requested control the evaluation of permanent partial disability. Former OAR 438-10-010.

The determination of permanent partial disability under the standards is made by determining the appropriate values assigned by the standards to claimant's age, education, adaptability and impairment. Former OAR 436-35-280. However, if the injury did not result in measurable impairment, no award of unscheduled permanent partial disability is allowed. Former OAR 436-35-320(1).

Claimant contends that she is entitled to an award of unscheduled permanent disability for the chronic residuals of her cystocele and rectocele surgery, that is, a permanent restriction of no lifting, carrying, pushing or pulling of over ten pounds. We agree that claimant has established a chronic condition; however, there is no evidence that the condition limits repetitive use of a body part or results in any rateable impairment. Accordingly, since claimant has no

rateable value for impairment under former OAR 436-35-270 through 436-35-440, she has no calculable disabilities under the standards. Former OAR 436-35-320.

However, while no permanent disability is awarded under the standards, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the standards. ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corporation, 303 Or 390 (1987).

After our review of the record, we find clear and convincing evidence that claimant is entitled to an award of unscheduled permanent disability. As a result of the physical restrictions identified above, and attributable to her compensable condition, claimant is precluded from returning to the work she has performed for over 25 years. We find this to be clear and convincing evidence that claimant has sustained a loss of earning capacity which we assess to be twenty percent.

ORDER

The Referee's order dated January 4, 1991 is affirmed in part and modified in part. Claimant is awarded 20 percent (64 degrees) unscheduled permanent partial disability for her compensable injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total amount of attorney fees awarded by the Referee and Board orders shall not exceed \$3,800. The remainder of the order is affirmed.

October 31, 1991

Cite as 43 Van Natta 2445 (1991)

In the Matter of the Compensation of
JESS R. JOHNSON, Claimant
WCB Case No. 90-08691
ORDER ON REVIEW
Cynthia Cumfer, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Galton's order which increased claimant's scheduled permanent disability award for loss of use or function of the left forearm/hand from 5 percent (7.5 degrees), as awarded by a Determination Order, to 17 percent (25.5 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant has 50 percent loss of sensation over the ulnar distribution of his left hand. (Ex. 48, 64, 66-2).

Claimant has a loss of function due to sensory deficit in the ulnar nerve above and below the left mid-forearm below the elbow.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that, in addition to the forearm award, pursuant to former OAR 436-35-110(3)(a), he is entitled to separate awards for decreased sensation

in the fingers, thumb and hand pursuant to former OAR 436-35-110(1)(a). We agree that the standards provide for an award in each instance, if the medical evidence shows such an award is warranted, as it is here.

A Determination Order awarded claimant 5 percent scheduled permanent disability for "sensory change ulnar aspect." Medical reports from Dr. Craven, claimant's treating physician, and the Orthopaedic Consultants indicate that claimant has decreased sensation in the left forearm, hand and fingers. (See, e.g. Exs. 11, 26, 45, 46, 48, 64, 66, 67).

With respect to sensory loss in the ulnar nerve distribution of the left hand, claimant relies on Dr. Craven's report (Ex. 67-4) which indicates that claimant has complete loss of sensation. We are not persuaded by that opinion with regard to this sensory loss for the following reasons.

The Orthopaedic Consultants, in an examination on December 6, 1989, stated that they would rate claimant's loss of sensation over the ulnar distribution of his hand at 50 percent. (Ex. 48-6). Dr. Craven concurred with that opinion. (Ex. 63-1). Additionally, in a note dated July 10, 1990, Dr. Craven stated that he did not believe that claimant was completely anesthetic over the ulnar nerve. Because Dr. Craven had opined on two different occasions that he did not believe claimant had complete loss of sensation over the ulnar distribution but then, subsequently, changed his opinion without a reasonable explanation, we do not find his last opinion persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987) (physician had reasonable explanation for change of opinion). Accordingly, we rely on the report of the Orthopaedic Consultants, with Dr. Craven's concurrence, and conclude that claimant has 50 percent loss of sensation over the ulnar distribution. Pursuant to former OAR 436-35-110(1)(d), this loss is rated at 5 percent of the hand/forearm. See Larry E. Kadrmas, 43 Van Natta 1926, 1927 (1991).

Dr. Craven noted that claimant showed some fairly marked sensory loss to pinprick over the ulnar side of the forearm. (Ex. 66-2). He estimated that claimant had a 50 percent loss of the maximum due to sensory deficit in the ulnar nerve both above and below mid-forearm below the elbow. (Ex. 67-4). Pursuant to former OAR 436-35-110(3)(a), this loss is equivalent to 5.5 percent impairment in the ulnar nerve above mid-forearm below the elbow and 5.5 percent impairment in the ulnar nerve below mid-forearm below the elbow for a total of 11 percent loss of the forearm.

Dr. Craven has also indicated claimant has loss of protective sensation in the left thumb and each of the left fingers. However, because his report (Exhibit 67-2, 3) is not specific as to location of the loss of sensation, we can only find that claimant has loss of protective sensation for 1/2 the distal phalanx of each finger and thumb. See Gary L. Waldrup, 42 Van Natta 2623 (1990) (when physician's report not specific as to location or quality of loss of sensation, we can only find that claimant has less than normal, but more than protective sensation for 1/2 the distal phalanx of each finger and thumb).

Loss of protective sensation in 1/2 the distal phalanx of the thumb equals 12 percent loss in the thumb (former OAR 436-35-110(1)(a)) which is equivalent to 5 percent of the hand. Former OAR 436-35-070(4).

Loss of protective sensation in 1/2 the distal phalanx of the index finger equals 18 percent loss in the index finger (former OAR 436-35-110(1)(a)) which is equivalent to 5 percent of the hand. Former OAR 436-35-070(5).

Loss of protective sensation in 1/2 the distal phalanx of the middle finger equals 20 percent loss in the middle finger (former OAR 436-35-110(1)(a)) which is equivalent to 4 percent of the hand. Former OAR 436-35-070(6).

Loss of protective sensation in 1/2 the distal phalanx of the ring finger equals 21 percent loss in the ring finger (former OAR 436-35-110(1)(a)) which is equivalent to 2 percent of the hand. Former OAR 436-35-070(7).

Loss of protective sensation in 1/2 the distal phalanx of the little finger equals 33 percent loss in the little finger (former OAR 436-35-110(1)(a)) which is equivalent to 2 percent of the hand. Former OAR 436-35-070(8).

Having determined each value necessary to compute claimant's scheduled permanent disability for loss of use of his left forearm/hand under the standards, we proceed to that calculation. The total value given pursuant to the standards for loss of function due to sensory deficit in the ulnar nerve both above and below mid-forearm below the elbow, 11 percent, is combined with the equivalent forearm value for 50 percent loss of sensation in the left ulnar nerve distribution, 5 percent, for a total of 15.4 percent. That total is then combined with the equivalent hand value of 5 percent for loss of protective sensation in the left thumb, for a total of 19.6 percent. That total is next combined with the equivalent hand value of 5 percent for loss of protective sensation in the left index finger for a total of 23.6 percent. That total is next combined with the equivalent hand value of 4 percent for loss of protective sensation in the left middle finger for an impairment value of 26.6. That total is next combined with the equivalent hand value of 2 percent for loss of protective sensation in the left ring finger for an impairment value of 28.0 percent. Finally, that total is combined with the equivalent hand value of 2 percent for loss of protective sensation in the left little finger for a total impairment value of 29.4 percent of the left forearm/hand. That figure is rounded to the next higher whole percentage. Former OAR 436-35-010(6). Accordingly, for loss of use or function of his left forearm/hand, claimant's scheduled permanent disability under the "standards" is 30 percent.

ORDER

The Referee's order dated November 20, 1990 is modified. In lieu of the Referee's award, and in addition to the Determination award of 5 percent (7.5 degrees), claimant is awarded 25 percent (37.5 degrees) scheduled permanent disability, giving him a total award to date of 30 percent (45 degrees) scheduled permanent disability for loss of use of his left forearm/hand. Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation awarded by this order, payable directly to claimant's attorney. However, the total attorney fee approved by the Referee's and Board orders shall not exceed \$3,800.

October 31, 1991

Cite as 43 Van Natta 2447 (1991)

In the Matter of the Compensation of
CAROLYN A. KETCH, Claimant
WCB Case Nos. 90-09245 & 89-22301
ORDER ON REVIEW
Depaolis, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Black's order which: (1) found that her claim had not been prematurely closed; (2) declined to assess a penalty for the self-insured employer's allegedly unreasonable failure to comply with a Stipulation; and (3) declined to assess a penalty for the employer's allegedly untimely aggravation denial. On review, the issues are premature closure and penalties. We affirm with correction.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following correction.

Claimant was medically stationary on September 6, 1989.

CONCLUSIONS OF LAW AND OPINIONPremature Closure

We adopt the Referee's conclusions and reasoning concerning this issue with the following clarification.

Claimant was medically stationary as of September 6, 1989. This is the date on which Dr. Becker agreed with the Orthopaedic Consultants that claimant was medically stationary.

Penalties/Failure to Comply

Claimant contends she is entitled to a penalty for the self-insured employer's failure to comply with Exhibit 51A, a stipulation. We disagree.

The stipulation is not signed by claimant and furthermore, is not signed by a Referee. Therefore, it is not a valid stipulation. We do not find the self-insured employer's failure to comply with an invalid stipulation unreasonable. Accordingly, a penalty is not warranted in this instance.

Penalties/Untimely Denial

We adopt the Referee's conclusions and reasoning concerning this issue.

ORDER

The Referee's order dated December 3, 1990 is affirmed with the following correction. Claimant became medically stationary September 6, 1989.

October 31, 1991

Cite as 43 Van Natta 2448 (1991)

In the Matter of the Compensation of
DALE E. MILLER, Claimant

WCB Case No. 90-15690

ORDER ON REVIEW

Malagon, et al., Claimant Attorneys

Meyers & Radler, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The self-insured employer requests review of that portion of Referee McCullough's order that set aside its denial of claimant's medical services claim for a left ankle condition. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the second to last paragraph and with the correction that claimant missed only a few hours of work as a result of the November 10, 1989 injury.

CONCLUSIONS OF LAW AND OPINION

The issue presented is whether the treatments provided by Dr. Hayes on April 10 and May 25, 1990 are compensable medical services under ORS 656.245.

The employer contends that the treatments are not compensable, because they were not provided for claimant's 1989 compensable ankle strain. It maintains that claimant was treated "for the residual effects of the varus instability resulting from [an] injury in 1981 and the corrective surgery in 1983." (App. Brief at 4). We agree.

In order to establish the compensability of treatment for her ankle condition, claimant must prove by a preponderance of the evidence that her compensable injury was a material contributing cause of that condition. Jordan v. SAIF, 86 Or App 29 (1987). Considering claimant's prior ankle injury, we conclude that the cause of her current ankle condition is a complex medical question. Thus, while claimant's testimony is probative, the resolution of the question primarily turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

In support of compensability, claimant relies on the medical reports submitted by Dr. Hayes, her treating physician. However, his only diagnosis of an ankle sprain/strain was on a standard billing statement. (Ex. 10A-2). Dr. Hayes primarily diagnosed claimant's condition as mild varus instability and failed to relate her need for treatment to her November 1989 industrial injury. Moreover, Dr. Hayes later reported that, when he examined her in May 1990, claimant had symptoms of ankle instability that were not supported by significant objective findings and, once again, failed to relate the condition to her compensable injury.

The other medical evidence comes from Drs. Wilson and Gritzka, who examined claimant in May 1990. They concluded that, in terms of reasonable medical probability, claimant did suffer an ankle sprain during her 1989 industrial injury and that it would be reasonable for claimant to have that evaluated. Dr. Wilson, however, later reported that, in his opinion, it was unusual for claimant to wait six months following her injury before seeking treatment, especially in light of the fact that an ankle sprain would normally resolve itself within a matter of weeks or months. He concluded that claimant's underlying varus instability was the cause of her need for treatment rather than the compensable ankle sprain she sustained in November 1989. We consider Dr. Wilson's opinion to be well-reasoned and based on complete information and, accordingly, we find it persuasive. Somers v. SAIF, 77 Or App 259 (1986). We find no contrary medical evidence. We recognize that claimant sustained a significant back injury on December 22, 1989, which predictably would become her focus; however, at that point, six weeks had passed and she had not sought treatment for her ankle. Testimony from her friend, who saw claimant's swollen ankle on November 10, was that there was nothing unusual about claimant's behavior between that time and her back injury.

Based on this record, we conclude that claimant has failed to establish by a preponderance of the evidence that her compensable injury was a material contributing cause of the condition for which she sought medical services from Dr. Hayes. Neither do we find that the two visits were necessary diagnostic services, as claimant suggests alternatively. Accordingly, we reverse the Referee and uphold the employer's denial of medical services.

ORDER

The Referee's order dated January 7, 1991 is reversed in part and affirmed in part. The self-insured employer's denial of claimant's medical services claim is reinstated and upheld. The Referee's assessed attorney fee of \$750 is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JAMES A. MORGAN, Claimant
WCB Case No. 88-22211
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Livesley's order that upheld the SAIF Corporation's denial of his occupational disease claim for his psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had a mental disorder generally recognized within the medical community and his mental disorder arose out of and in the course of employment. The Referee further concluded that stressful conditions existed in a real and objective sense. However, the Referee concluded that claimant failed to establish that he was subjected to conditions not generally inherent in every workplace and, accordingly, his psychological condition claim was not compensable. We agree that claimant has not established that his psychological condition is compensable, but we base our conclusion upon the following reasoning.

The date of "injury" for purposes of determining compensability of an occupational disease is the date upon which the claimant was last exposed to the employment conditions that caused the disease. Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986). Here, claimant's occupational disease claim for his current psychological condition alleges exposure to potentially causal employment conditions occurring after January 1, 1988. Accordingly, the occupational disease law which became effective January 1, 1988 is applicable.

Former ORS 656.802 provides; in part, that an occupational disease arising out of and in the course of employment which requires medical services will not be compensable:

"(2)(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.

" (b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.

" (c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

" (d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

Therefore, to establish that his psychological condition arose out of and in the course of his employment, claimant must prove by clear and convincing

evidence that his work conditions not otherwise excluded under former ORS 656.802(2)(a) & (b), were the major cause of his condition. Former ORS 656.802(2)(d); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991).

Here, claimant alleges that his psychological condition resulted from his exposure to several different stressors or conditions of his employment.

The Referee found that the employment conditions which caused claimant's mental disorder existed in a real and objective sense. We agree that the majority of claimant's stressors existed in a real and objective sense. Dr. Martin reported that claimant was "well-oriented" and had no delusions or hallucinations. (Ex. 17-1). Dr. Shulsinger, claimant's treating physician, also reported that claimant had no delusions or hallucinations. (Ex. 16-2). However, because claimant's condition resulted from several stressors, we examine each alleged causative factor separately in order to address the parties' arguments under the statute.

Criticism by supervisors

The record supports claimant's contention that he was criticized for his work and that criticism was one of the stressors which contributed to his condition. (Exs. 14, 24-1, 25-2, 26-2). We, therefore, agree that the criticism alleged by claimant existed in a real and objective sense. However, the record shows that the employer's criticism constituted reasonable corrective action.

In the present case, claimant's evaluation review concluded that, out of twenty-two mandatory cases claimant had worked on, nineteen were cited for errors. (Ex. 6). Shortly thereafter, the employer recommended a corrective work plan for claimant. (Ex. 7). At hearing, one of claimant's supervisors testified that claimant's work was somewhat deficient and, when informed of errors, claimant would acknowledge the error but then make the same mistake when working on a subsequent project. (Tr. II at 39).

Under the circumstances, we conclude that the employer's corrective actions, including the criticism of claimant and recommendation of a work plan, were reasonable corrective or evaluation measures. Because we have concluded that the employer's actions were reasonable and corrective, such actions may not be considered as work-related stressors contributing to claimant's current psychological condition. Former ORS 656.802(b); Gladys B. Britton, 42 Van Natta 1555 (1990).

Training

Claimant contends that a portion of his stress was attributable to the fact that he was undertrained and, as a result, had difficulty performing his job. SAIF argues that claimant received the same amount of training as other employees in his position.

We do not agree with SAIF's argument that the fact that claimant received the same training as other employees establishes that such training was adequate. The issue presented here is whether claimant was undertrained, and the evidence pertaining to other employees' training is not dispositive.

Although we disagree with SAIF's reasoning, we nonetheless conclude that claimant has failed to establish that the training he received was inadequate. The only indications in the record that claimant was insufficiently trained are claimant's statements in that regard and the opinions of the doctors who based their conclusions upon claimant's statements to them. Moreover, although claimant contends that his training as a jobs worker was inadequate, his performance

merit rating report dated two months after he began his job indicates that his performance was satisfactory.

Because the record does not establish that claimant's training as a jobs worker was inadequate, we conclude that claimant has not proven insufficient training as a real and objective stressor.

Excessive case load/difficulty with co-workers/high turnover of supervisors/poor morale of staff

The Referee concluded that, although these conditions capable of causing stress existed in a real and objective sense, claimant had not shown that such conditions were not generally inherent in every workplace. We do not agree that the stressors enumerated by claimant, such as an excessive case load, disparaging comments made to claimant by his co-worker, and a lack of support by supervisors, are conditions generally inherent in every workplace. See Housing Authority of Portland v. Zimmerly, 108 Or App 596 (1991). Kathleen M. Payne, 42 Van Natta 1900 (1990). Louis R. Orman, 43 Van Natta 226 (1991).

Although we agree that claimant's excessive caseload and difficulties with supervisors and co-workers may be considered as compensable stressors, the record does not establish that such stressors alone were the major cause of his psychological condition. Rather, Dr. Martin and Mr. Forbes listed numerous work stressors contributing to claimant's condition. Dr. Colbach, moreover, opined that criticism of claimant regarding his job performance was the primary work-related stressor.

We have concluded above that criticism of claimant was attributable to reasonable corrective actions by his supervisors. We have further concluded that claimant has not established that his training as a jobs worker was inadequate. Because the medical evidence does not clearly and convincingly show that the remaining stressors were the major cause of his psychological condition, we conclude that claimant has failed to establish compensability of his mental disorder. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated July 17, 1990 is affirmed.

October 31, 1991

Cite as 43 Van Natta 2452 (1991)

In the Matter of the Compensation of
NANCY L. ZIMMER, Claimant
WCB Case No. 90-14971
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of that portion of Referee Bethlahmy's order that assessed an attorney fee for its allegedly unreasonable claims processing of claimant's bilateral ulnar nerve condition. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

In deciding the attorney fee issue, the Referee applied the law in effect prior to Oregon Laws 1990 (Special Session), SB 1197. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). Moreover, the relevant 1990 amendments to ORS 656.262(6) merely extend by 30 days the time for acceptance or denial of a claim. Application of this change retroactively to this case will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991); Bryan L. Dunn, 43 Van Natta 1673 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Under the new law, the insurer had 90 days, rather than 60 days, from the date of the employer's notice or knowledge of claimant's injury claim within which to furnish claimant with written notice of its denial. ORS 656.262(6). Because the employer had notice of claimant's injury on April 27, 1990, and because the insurer issued its denial on July 9, 1990, the denial was timely.

The insurer contends that, because the ulnar nerve denial was rescinded, the only issue remaining at hearing was penalties and an "out-of-penalty" fee. The insurer argues that, under the current law, the Referee did not have jurisdiction over this matter. We disagree.

As amended, ORS 656.262(10)(a) now provides that the Director shall have exclusive jurisdiction over proceedings regarding solely the assessment of a penalty under that subsection. However, in the present case, in addition to her request for a penalty and an out-of-penalty fee, claimant also alleged entitlement to an attorney fee under ORS 656.386(1) for her counsel's efforts in obtaining the insurer's rescission of its denial of claimant's ulnar nerve condition claim. Accordingly, at hearing this proceeding did not involve solely the assessment of a penalty within the meaning of ORS 656.262(10). See Russell L. Ragland, 43 Van Natta 1829 (1991). Therefore, exclusive jurisdiction over this matter rests with the Board, not the Director. See ORS 656.704; ORS 656.283.

Finally, the insurer contends that the Referee incorrectly assessed an attorney fee for its failure to rescind the denial until November 30, 1990. We agree with the Referee's conclusion that, under the circumstances, the insurer's actions were unreasonable and an assessed attorney fee is appropriate. We, therefore, adopt the Referee's opinion on the "reasonableness" issue.

ORDER

The Referee's order dated February 8, 1991 is affirmed.

In the Matter of the Compensation of
LAVERNE J. BUTLER, Claimant
WCB Case No. 90-21443
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Nancy C. Marque (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Myzak's order that set aside its denial of claimant's claim for a right knee strain. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Dr. Lee, M.D., began to treat claimant's right knee on October 29, 1990. (Ex. 6).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had sustained a compensable injury to her right knee as a result of a work-related incident on October 26, 1990. SAIF argues that: (1) claimant's claim is not compensable because claimant's pre-existing condition combines with an on-the-job injury to create a resultant condition; and (2) the on-the-job injury is the major contributing cause of the resultant condition and need for medical treatment.

This case is governed by ORS 656.005(7)(a). The Board has recently held that, under ORS 656.005(7)(a), a determination of compensability is a two part test if there is a preexisting condition under ORS 656.005(7)(a)(B). Bahman M. Nazari, 43 Van Natta 2368 (1991). First, it must be determined whether there has been a compensable injury and then determined whether there is a preexisting condition that combines with the injury "to cause or prolong disability or a need for treatment." ORS 656.005(7)(a)(B). If it is shown that a preexisting condition combines with the injury to cause or prolong disability or need for treatment, claimant is entitled to disability compensation and treatment only if the compensable injury is the major contributing cause of that disability or need for particular treatment. ORS 656.005(7)(a)(B).

A carrier shall not deny an initial injury claim to take advantage of the limiting feature of subsection (B). Rather, after accepting the claim as compensable under ORS 656.005(7)(a), the carrier may partially deny such treatment as it reasonably believes is caused in major part by the preexisting disease rather than the accidental injury. See Bahman M. Nazari, supra.

In the present case SAIF denied claimant's claim on November 16, 1990 stating:

"You filed a claim for an alleged injury to your right knee which occurred on or about 10/26/90....

"We have reviewed the information in your file and find that there is insufficient evidence that your right knee strain is the result of either a work-related injury or disease. Therefore, we must deny your claim." (Ex. 5).

We conclude from the plain language of the denial, as well as the presentation of the issue at hearing, that SAIF denied that claimant sustained an injury within the course of her employment on October 26, 1990. The Referee viewed this as the limited issue before her, and we agree.

The Referee found claimant to be a credible witness. We agree with the Referee that claimant's witnesses corroborate claimant's testimony of the events surrounding the October 26, 1990 incident. Additionally, Dr. Lee, M.D., claimant's treating physician, attributes her knee condition to an on-the-job injury. We conclude, therefore, that claimant has sustained her burden to prove, by medical evidence supported by objective findings, that she suffered an accidental injury which arose out of and in the course of her employment on October 26, 1990 that was a material contributing cause of disability or need for treatment. ORS 656.005(7)(a); see Mark N. Wiedle, 43 Van Natta 855 (1991); Suzanne Robertson, 43 Van Natta 1505 (1991).

SAIF requested review, and we have found that claimant's injury claim should not be disallowed. Nevertheless, claimant's attorney is not entitled to an assessed attorney fee under ORS 656.382(2), because the respondent's brief was not timely submitted. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated March 11, 1991 is affirmed.

November 4, 1991

Cite as 43 Van Natta 2455 (1991)

In the Matter of the Compensation of

RONALD H. HOWARD, Claimant

WCB Case Nos. 90-10529, 89-24929, 90-10528 & 89-24923

ORDER ON RECONSIDERATION

Vick & Gutzler, Claimant Attorneys

Kevin L. Mannix, Defense Attorney

Cummins, et al., Defense Attorneys

Claimant requests reconsideration of the Board's Order on Review dated October 16, 1991, which affirmed the Arbitrator's order which: (1) set aside Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for a thoracic and lumbar back condition; and (2) upheld the Fireman's Fund Insurance's denial of an aggravation claim for the same condition. On reconsideration, claimant seeks an award of assessed attorney fees for services on review and an amendment ordering Liberty Northwest to accept and process claimant's claim, including payment of all stayed compensation, with interest.

Claimant seeks an assessed attorney fee under ORS 656.307(5), 656.382(2) and 656.386(1).

ORS 656.307(5) contains no provision for an award of attorney fees for participation on Board review. Therefore, no attorney fee under ORS 656.307(5) is awarded. Ernest C. Blinkhorn, 42 Van Natta 2597 (1990).

ORS 656.386(1) authorizes an award of an assessed attorney fee if (1) the claimant initiates the review or appeal; (2) the appeal is from an order denying the claim; and (3) the claimant "finally prevails" on the issue of entitlement to compensation. Shoulders v. SAIF, 300 Or 606 (1986). Here, where an ORS 656.307 order has issued, only responsibility is at issue, and claimant has not sought review, the three conditions are not met. See Howard v. Willamette Poultry, 101 Or App 584 (1990).

ORS 656.382(2) authorizes an assessed attorney fee when claimant's right to compensation is at risk of disallowance or reduction on review. Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991). Here, claimant's right to compensation was not at risk of disallowance because a ".307" order issued prior to hearing. Additionally, claimant's right to compensation was not at risk of reduction on review. Although claimant's rate of pay was higher at Liberty Northwest's insured, as demonstrated by the ".307" order, the record shows that he would receive the same rate of temporary disability at both employers, i.e., \$388.99. Therefore, claimant is not entitled to an insurer-paid attorney fee for services on review.

The second issue raised by claimant's motion for reconsideration, which requests an amendment ordering Liberty Northwest to accept and process claimant's claim, including payment of stayed compensation with interest, is adequately addressed by our Order on Review and statutory law. See ORS 656.313. If a processing dispute subsequently develops, litigation of an enforcement nature may be necessary. That is not at issue here.

Accordingly, our October 16, 1991 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 16, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 4, 1991

Cite as 43 Van Natta 2456 (1991)

In the Matter of the Compensation of

HEATHER I. SMITH, Claimant

WCB Case No. 90-20768

ORDER ON REVIEW

Francesconi & Associates, Claimant Attorneys

Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

The self-insured employer requests review of Referee Podnar's order that set aside its "de facto" denial of claimant's claim for a bilateral neck, shoulder and arm condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established the compensability of her bilateral neck, shoulder and arm condition. In reaching his decision, the Referee first determined that claimant had, in fact, made a claim for the condition and that the employer's failure to accept or deny the claim was a "de facto" denial. The Referee then set aside the "de facto" denial, concluding that the condition was compensable as a consequence of claimant's October 1988 compensable right wrist and forearm injury. See ORS 656.005(7)(a)(A).

The employer challenges both of the Referee's conclusions. It first contends that the Referee erred in concluding that claimant had made a claim for the condition. We disagree.

ORS 656.005(6) defines a "claim" as a written request for compensation for a subject worker or someone on the workers' behalf. ORS 656.005(8) defines "compensation" to include all benefits provided for a work-related injury, including medical services. Accordingly, a physician's report requesting medical treatment constitutes a claim. Walter E. McCarthy, 43 Van Natta 593 (1991); Billy J. Eubanks, 35 Van Natta 131 (1983).

In this case, there is no dispute that claimant filed a claim for tendonitis of the right wrist and forearm. The employer accepted that claim as a nondisabling injury and processed it to closure. However, as early as May 30, 1989, the employer received medical reports from Dr. Trieble that, in addition to pain in the right wrist and forearm, claimant had pain in her elbow, trapezius and shoulder. Trieble recommended a change in claimant's medication and that she begin stretching exercises and heat therapy. In December 1989, he reported that claimant continued to have pain in both wrists and her right elbow and subsequently requested a rheumatologic exam to rule out other etiology and referred her to Dr. Kemple. After subsequent examinations, Kemple reported right shoulder, neck and arm pain, as well as shooting pain down the left arm, and prescribed physical therapy and medication. In light of that evidence, we conclude that a claim was filed for claimant's bilateral neck, right shoulder and left arm condition.

The employer next challenges the compensability of the condition and asserts that the Referee's reliance on Dr. Fraback's opinion was misplaced. In his report dated January 22, 1991, Fraback concluded:

"I think that [claimant's] accepted right wrist and forearm condition is the major contributing cause of her current condition. I don't see any other explanation for her arm discomfort. There is nothing to suggest a systemic or inflammatory process." (Ex. 33).

The employer notes that, to support his opinion, Fraback stated that he could find no other explanation for claimant's arm discomfort. From that observation, the employer concludes that Fraback's opinion regarding claimant's "current condition" was, in fact, limited to claimant's right arm discomfort. We disagree.

As is the case with all documentary evidence, medical reports must be read as a whole and in the context in which they are given. In this case, Fraback was asked by the employer to examine claimant and to render an opinion on her condition. In his report, he first listed claimant's "Chief Complaint" as: "Pain in the right arm, extending to the neck, upper back, and to a lesser extent in the left arm." (Ex. 33-1). Later, under the heading "Current Complaints," he reported:

"When asked to describe her current symptoms, [claimant] says that she hurts in her right anterior shoulder, on the right side of her upper back, in her neck, and that she continues to have discomfort in her right wrist and palm. At times she gets tingling in the fingers. She has some discomfort in the right elbow. She says she does not have much discomfort in the left arm at this time." (Ex. 33-2).

He further reported that, during his evaluation of claimant, he examined her neck, shoulders, arms and wrists. He did not dispute any of claimant's subjective complaints and concluded that, in his opinion, claimant's condition was work related.

After our review of Fraback's report, we conclude that his opinion on medical causation included not only claimant's right arm discomfort, but also her

neck, right shoulder and left arm pain. We do not agree with the employer's interpretation of Fraback's opinion, which, in essence, would state: "I think that claimant's accepted right wrist and forearm condition is the major contributing cause of her right wrist and forearm condition." We find that interpretation illogical and redundant and do not adopt it. We find it more plausible that, in referring to claimant's arm pain, Fraback was simply emphasizing one of claimant's conditions or was referring to her bilateral arm pain.

We also rely on the opinion of Dr. Kemple, who, in a letter dated January 17, 1991, reported that all of the diagnoses listed in his earlier report were related to her work, with the exception of claimant's left shoulder pain which had resolved. We recognize that Kemple failed to explain why he believed claimant's work was the cause of her condition in that letter. When viewed in conjunction with his other medical reports, however, we find his opinion to be well-supported and persuasive. Kemple admitted that it was difficult to determine the exact etiology of claimant's condition and, in one report, considered other possible alternatives. Nonetheless, he consistently reported that, as a result of her initial right arm discomfort, claimant relied more heavily on her left arm and, consequently, had pain in her left thumb, wrist and elbow. He also recorded symptoms consistent with repetitive overuse upper extremity syndromes and noted an increase in claimant's symptoms with increased work activity.

In summary, relying on Drs. Fraback and Kemple, we agree with the Referee that claimant has established the compensability of her bilateral neck, shoulder and arm condition as a consequence of her October 1988 injury. Accordingly, as supplemented herein, we adopt the conclusions and reasoning concerning the compensability of claimant's condition as set forth in the Referee's order.

The employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant. However, claimant's attorney is not entitled to an assessed attorney fee under ORS 656.382(2), because the respondent's brief was not timely submitted. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated February 13, 1991 is affirmed.

November 5, 1991

Cite as 43 Van Natta 2458 (1991)

In the Matter of the Compensation of

DAVID D. ALLEN, Claimant

WCB Case Nos. 88-18698 & 88-18699

ORDER ON REVIEW

Welch, et al., Claimant Attorneys

Employers Defense Counsel, Defense Attorneys

Foss, et al., Defense Attorneys

Michael B. Dye, Attorney

Reviewed by the Board en banc.

Liberty Northwest Insurance Corporation, on behalf of Bohemia, requests review of Referee Brown's order that: (1) set aside its denial of responsibility for claimant's aggravation claim for a low back condition; and (2) upheld Liberty's denial of compensability and responsibility, issued on behalf of Gold Beach Plywood, of claimant's "new injury" claim for the same condition. In its Appellant's brief, Bohemia argues that the Referee erred in finding that its oral denial of compensability issued at hearing was an impermissible "back-up"

denial under Bauman v. SAIF, 295 Or 788 (1983). Claimant, in his respondent's brief, requests review of that portion of the Referee's order that declined to assess a penalty and related attorney fee for an allegedly unreasonable denial issued by Bohemia. On review, the issues are compensability, responsibility, and penalties and related attorney fees. We reverse.

FINDINGS OF FACT

Claimant compensably injured his low back in March 1985 while working for Liberty Northwest's insured (Bohemia). That claim was closed by a November 4, 1985 Notice of Closure, which awarded temporary disability only.

In November 1987, claimant began treating with a Lebanon, Oregon, chiropractor, Dr. Clifford, for back pain. Clifford found claimant's back condition medically stationary on May 27, 1988. Clifford treated claimant once in June 1988; once in July 1988; September 2, 6, 13, 14, 15, 16, 26, 27, 28, 29 and 30, 1988; October 3, 4, 5, 10, 11, 12, 19 and 26, 1988; November 1, 11, 17 and 29, 1988; and December 1 and 7, 1988.

Claimant began working for Gold Beach Plywood in July 1988. His home was in Lebanon, but he arranged to live during the week with his father and step-mother at their home in Gold Beach. Claimant underwent an employment-related drug screening and a pre-employment physical in early July 1988. The exam was performed by the employer's physician, Dr. Williams.

On September 2 and 6, 1988, claimant received routine manipulations from Clifford.

On September 7, 1988, claimant got into an altercation with his step-mother over her request that he begin paying rent. That same day, claimant phoned Dr. Williams for an appointment, complaining of personal and back problems. On September 8, 1988, claimant was seen by Dr. Williams. Claimant was scheduled to return to Williams on September 13, 1988; but claimant did not keep that appointment. (Ex. 13).

On September 9, 1988, at the end of claimant's work shift, claimant packed his work gear, emptied his work locker and returned to Lebanon. September 9, 1988 was his last day of work at Gold Beach Plywood. Claimant did not intend to return to work.

On September 13, 1988, claimant returned to Dr. Clifford complaining of severe back pain.

Two weeks later, Dr. Clifford filed a report stating that claimant had suffered a flareup of his 1985 injury and was unable to work.

On October 12, 1988, Bohemia issued a denial of compensability and responsibility of claimant's aggravation claim. The same day, Bohemia clarified its denial to deny responsibility only. Bohemia requested a ".307" order from Compliance, but none was issued.

On October 18, 1988, claimant filed a "new injury" claim with Gold Beach Plywood alleging a September 1, 1988 injury. (Ex. 17).

On October 26, 1988, Gold Beach Plywood denied compensability of and responsibility for claimant's "new injury" claim.

On November 7, 1988, Dr. Bolin, a chiropractor, performed an independent medical evaluation.

At hearing, Bohemia orally denied compensability of claimant's aggravation claim.

Claimant is not credible.

ULTIMATE FINDINGS OF FACT

Bohemia did not accept the aggravation claim.

Claimant did not sustain a new injury on September 1, 1988 while working for Gold Beach Plywood, nor did he experience a worsening of his compensable low back condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

The Referee concluded that Bohemia, because it requested a ".307" order, was procedurally barred from issuing an oral denial of compensability of claimant's aggravation claim at hearing. The Referee found that Bohemia's denial of compensability was barred as an invalid "back-up" denial under Bauman v. SAIF, 295 Or 788 (1983). Therefore, reasoning that Bohemia had conceded compensability, he found it was responsible for the claim as a matter of law. The Referee also noted that if he had proceeded to the merits, he would not have found a compensable new injury or aggravation.

Bohemia argues that the Referee erred in applying Bauman, asserting that it never issued a formal acceptance of claimant's aggravation claim. On the other hand, claimant argues that Bohemia's request for a ".307" order was a concession of compensability or a formal acceptance of claimant's claim and that Bohemia was precluded from issuing a subsequent oral denial of compensability at hearing.

The general rule of Bauman is that an insurer, after accepting a claim, cannot deny it absent a showing of fraud, misrepresentation or other illegal activity. In Judy Witham, 40 Van Natta 1982 (1988), we held in a compensability/responsibility context that, where an insurer concedes compensability yet disputes responsibility, a ".307" order acts as a formal concession of compensability and the insurer is precluded from thereafter denying compensability absent a showing of fraud, misrepresentation or other illegal activity by claimant. Noting the policy concerns supporting the rule of Bauman, we reasoned that an insurer could not subsequently deny the compensability of claimant's condition because such vacillation would encourage a degree of instability in the workers' compensation system that the statute does not contemplate.

The question we must answer is whether an insurer's request for a ".307" order has the same effect as the actual issuance of the ".307" order, i.e., whether such a request precludes a subsequent denial of compensability. We conclude that it does not have such an effect. Whereas issuance of a ".307" order operates to "specifically" and "officially" notify a claimant that compensability of a claim has been accepted by the parties, an insurer's ".307" order request, directed to the Compliance Section, does not operate as a specific, official acceptance to claimant of a claim. See Johnson v. Spectra Physics, 303 Or 49 (1987); Judy Witham, supra at 1985-86; OAR 436-60-180(7).

Moreover, until a ".307" order formally issues, compensability remains at issue even though one insurer has indicated its concession that the claim is compensable as to some employer. In this regard, the parties continue to prepare for a hearing where at least one insurer has continued to assert that the claim is not compensable or, at least, has not formally conceded compensability. Accordingly, the policy concerns enunciated by the Court in Bauman relating to delayed litigation and problems of proof do not arise.

Therefore, because a ".307" order never issued here, the Bauman rule does not apply, and Bohemia was free to clarify its denial and to deny compensability up to the time of hearing.

Moreover, we note parenthetically that the director's current administrative rule governing designation of paying agents (which is not applicable here) states that a request by a carrier for issuance of a ".307" order is not an admission of compensability as to the requesting carrier. Current OAR 436-60-180(7) provides:

"Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer shall request designation of a paying agent by applying in writing to Compliance. Such a request is not an admission that the injury is compensably related to that insurer's claim; it is solely an assertion that the injury is compensable against a subject Oregon employer." (emphasis added)

We note that claimant relies on Daniel R. Koplin, 41 Van Natta 909 (1989), in support of his position. In Koplin, EBI initially denied compensability. The other insurer, SAIF, denied responsibility only and requested a ".307" order from Compliance. In turn, Compliance requested that EBI state its position. In response, EBI indicated that it was denying the claim based on responsibility only and that issuance of a ".307" order was appropriate. Apparently, before such an order could issue, the hearing was held. At hearing, EBI issued an oral denial of compensability. On review, the Board found that: (1) the claim had been "accepted"; and (2) the 60-day period in ORS 656.262(6) in which to deny a claim had expired. Finding that these two findings were sufficient for Bauman to apply, the Board held that the oral denial was an impermissible "back-up" denial.

We conclude that the rationale expressed in Koplin conflicts with our decision here. Therefore, to the extent that Koplin is inconsistent with this decision, we disavow its holding.

Although the Referee relied on a procedural basis to find compensability, and thus, found Bohemia responsible, we note that the Referee proceeded to the merits to determine whether, in fact, there was a compensable new injury/aggravation. Therefore, we find the record sufficiently developed and that remand is not necessary. See ORS 656.295(5). Accordingly, we proceed to the merits.

New injury/aggravation

In order to establish the compensability of his September 1, 1988 injury claim with Gold Beach Plywood, claimant has the burden of proving that his work activity was a material contributing cause of his disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-67 (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).

To establish a compensable aggravation of his prior injury with Bohemia, claimant must show a worsening of his compensable low back condition since his last arrangement of compensation. "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Smith v. SAIF, 302 Or 296 (1986). Claimant's last arrangement of compensation was the November 5, 1985 Notice of Closure which awarded temporary disability only. Therefore, claimant must show increased symptoms or a worsened underlying condition and a diminished earning capacity since November 5, 1985.

While the Referee questioned claimant's ability to accurately relate the events of the fall of 1988, he did not make an express credibility finding. Because the medical evidence is based on claimant's history, claimant's credibility is crucial. Thus, in the absence of an express credibility finding by the Referee, we make the necessary credibility findings based on the substance of the witnesses' testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Dean A. Grudzinski, 42 Van Natta 597 (1990). After our de novo review of the record, we find significant inconsistencies between claimant's testimony, other witnesses' testimony and the medical record. We conclude that claimant is not credible.

Claimant filed a claim for a "new injury" on September 1, 1988 while working for Gold Beach Plywood. However, he denied any such injury to Dr. Clifford, his treating chiropractor, and to Dr. Williams, the employer's physician. (Exs. 28-32). Further, claimant did not complain or report to anyone that he sustained an injury while working at Gold Beach Plywood. (Tr. 53, 54, 59, 63, 65, 66, 77, 82, 88, 99, 109, 113, 114, 118). Even claimant admitted that he did not sustain a new injury at Gold Beach Plywood. (Tr. 17, 23). Moreover, Nurse Baum, also associated with the employer, specifically noted that claimant indicated that no injury occurred while at the employment. (Ex. 32). Finally, the medical evidence establishes that claimant did not sustain an injury on September 1, 1988. (Exs. 28-30). Therefore, we conclude that claimant has failed to meet his burden of proving his "new injury" claim.

Turning to the merits of the aggravation claim, the record is unclear when claimant's alleged symptoms actually began. Dr. Clifford reported that claimant had a flare-up of symptoms on September 8, 1988. However, that statement was based on claimant's oral reports to Clifford, as Clifford did not treat claimant on September 8, 1988. At that time, claimant was still in Gold Beach. Claimant testified that his symptoms gradually increased during August 1988, prior to his employment with Gold Beach Plywood. However, claimant, in filling out a "new injury" claim, indicated that his symptoms began on September 1, 1988. Clifford reported claimant's complaints of "severe" pain while pulling the green chain on September 8, 1988. There is no evidence to corroborate any version of claimant's complaints.

Claimant testified that he treated with Dr. Clifford every other week between the time he started at Gold Beach Plywood, in July 1988, and September 2, 1988. However, the record clearly establishes that claimant treated with Clifford only once during that time frame.

Claimant contended at hearing that he changed positions while at Gold Beach Plywood due to back pain. However, he admitted that he made no complaints of back pain to his supervisor.

Claimant also contended at hearing that Dr. Williams' opinion regarding a back condition was wrong in that Williams over-focused on groin pain. The medical record, however, indicates that claimant is the one who initiated the groin complaint.

Additionally, claimant asserts that Dr. Clifford released claimant from work on September 9, 1988. Claimant testified that he was in such bad shape when he saw Dr. Clifford on September 2 and 6, 1988, that, absent improvement, he knew Clifford would release him from work when he saw him on September 9, 1988. Claimant, however, did not see Clifford on September 9, 1988. Rather, he saw him on September 13, 1988, at which time claimant reported "severe" back pain beginning on September 8, 1988. Clifford's chart notes dated September 2 and 6, 1988 do not indicate anything other than routine adjustments. There was no reference to any injury occurring on September 1, 1988, as the 801 form indicated.

Finally, claimant's co-worker, Paxton, testified that on September 6, 1988, claimant confided in her that he intended to quit after payday, Friday, September 9, 1988, that he did not intend to give notice and that he would call in sick. (Tr. 107). The following day, claimant reiterated to Paxton that he intended to quit and that he had a physician in Lebanon (Clifford) that would "cover" for him. (Tr. 100, 106, 107). Claimant's father testified that claimant indicated to him that because Dr. Williams did not release him from work, claimant would get his own doctor to say otherwise. (Tr. 80, 81, 83). Claimant denied these conversations.

Claimant reported to Dr. Clifford, on September 13, 1988, that he was suffering "severe" back pain. However, claimant testified that when he saw Clifford at that time, the pain was not severe. (Tr. 34).

Based on the above listed inconsistencies in the record, we find claimant to be not credible. With this in mind, we turn to the medical evidence. Three physicians rendered opinions regarding the causation of claimant's current back condition: Dr. Clifford, claimant's treating chiropractor; Dr. Williams, M.D.; and Dr. Bolin, D.C., independent medical examiner.

The opinions rendered by Dr. Clifford and Dr. Williams were based, in substantial part, on claimant's history of the events of July through September 1988. Both Clifford and Williams reported that claimant's symptoms of September 1988 represented an exacerbation of claimant's 1985 compensable back injury. However, because a medical opinion is only as reliable as the history upon which it is based, we do not find the opinions of Clifford and Williams to be persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

The only remaining opinion is that of Dr. Bolin. After considering the inconsistencies in claimant's record, i.e., the inconsistent reports to various physicians of the onset and severity of the alleged back pain, Bolin concluded that claimant's 1985 compensable injury had resolved and that claimant's current back condition was caused by claimant's chronic obesity and poor muscle tone. Bolin concluded that claimant's current back complaints were not related to his compensable 1985 back injury. We find Bolin's opinion to be persuasive as it is based on a complete and accurate history. Miller, supra. Therefore, we conclude that there is no persuasive evidence that claimant experienced either a new injury with Gold Beach Plywood, or an aggravation with Bohemia.

Responsibility

Inasmuch as we have concluded the claimant has not proved a compensable claim, we do not reach the responsibility issue.

Penalties and related attorney fees

The Referee did not address claimant's contention of entitlement to penalties and related attorney fees for Bohemia's allegedly unreasonable oral denial. We proceed to consider that issue now.

We do not find that a penalty or related fee is appropriate. Inasmuch as we have found claimant's aggravation claim not compensable, there are no amounts then due on which to base a penalty. See Ellis v. McCall Insulation, 308 Or 74 (1989). In addition, there has not been an unreasonable resistance to the payment of compensation in light of our conclusion that claimant's aggravation claim is not compensable. Therefore, a penalty-related attorney fee is not warranted. See Lloyd L. Cripe, 41 Van Natta 1774 (1989). Accordingly, we decline to assess a penalty or related attorney fee.

ORDER

The Referee's order dated June 15, 1989, as reconsidered on July 12, 1989, is reversed. That portion of the Referee's order that set aside Liberty Northwest's responsibility denial, issued on behalf of Bohemia, and Bohemia's oral denial of compensability is reversed. Bohemia's denials are reinstated and upheld. Claimant's attorneys' assessed fees of \$2,400 to Mr. Green, and \$1,325 to Mr. Bohy, respectively, are reversed.

Board Members Neidig and Kinsley, specially concurring.

We agree with the majority that the rule of Bauman does not operate to procedurally bar EBI's oral denial of compensability at hearing. Moreover, we agree on the merits that claimant's claim is not compensable. However, contrary to our decision in Judy Witham, 40 Van Natta 1982 (1988), cited with approval by the majority here, we do not believe that the absence of an ORS 656.307 order is determinative with regard to the propriety of EBI's denial. Rather, under the facts of this case, we believe that EBI's compensability denial would be procedurally valid even had a ".307" order previously issued. This result would not only comport with existing case law but would also further significant policy considerations.

In Bauman, the Court concluded that "backup" denials, i.e., retroactive denials of previously accepted claims, are prohibited, except under limited circumstances not involved here. The Court stated:

"The insurer or self-insured employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decided to litigate the issue of compensability. We need not list all of the possible ramifications of such conduct but it is readily evident that problems involving lapsed memories, missing witnesses, missing medical reports, and a host of other difficulties would arise from the delayed litigation of the compensability of a claim." Bauman at 794.

Subsequently, the rule of Bauman has been applied several times by the courts in the general context of responsibility cases. See Ebbtide Enterprises v. Tucker, 303 Or 459 (1987); D Maintenance Company v. Mischke, 84 Or App 218, rev den 303 Or 483 (1987); Fred Shearer & Sons v. Stern, 77 Or App 607 (1986); Retchless v. Laurelhurst Thriftway, 72 Or App 729 (1985); and Jeld-Wen, Inc. v. McGehee, 72 Or App 12, rev den 299 Or 203 (1985). In all but the Fred Shearer & Sons v. Stern case, the rule of Bauman was applied to find a denial to be procedurally invalid. However, in each of these cases, the carrier attempting to retroactively deny the claim had accepted the claim and begun to provide benefits. Where the claim has been accepted, the policy considerations underlying the rule in Bauman are apparent. At that point, the incentive on the part of the injured worker, as well as other potential responsible carriers, to prepare to litigate the matter is removed. As stated by the Court of Appeals in Jeld-Wen, Inc. v. McGehee, supra at 15:

"If an employer is allowed to accept a claim and pay benefits for a substantial period of time * * * and then deny the claim, a claimant * * * would be required to make protective claims against all other employers who might be responsible to protect against the eventuality that the employer who has accepted the claim will later deny and [claimant] will lose any chance for compensation. * * * The resulting costs of time and resources for claimants, attorneys, employers, insurers and the whole system is obvious."

Similarly, in Ebbtide Enterprises v. Tucker, supra at 463, the Supreme Court explained:

"In reaching the conclusion in Bauman that backup denials are impermissible under the Workers' Compensation Law, * * * [w]e identified problems of proof and the need for stability in the system and for speedy resolution of claims as policies advanced by the rule of finality imposed by the statutes. * * * Having once accepted a claim an insurer may not, in the face of an aggravation claim, simply deny responsibility for the original claim and cast the burden of proving the insurer's responsibility upon an earlier insurer whose access to evidence regarding the later claim is necessarily inferior to that of the later insurer."

Under the facts here, however, the claim has not been accepted by any insurer or employer. Further, the claim would not have been accepted even if a ".307" order had issued prior to hearing. To the contrary, issuance of a ".307" order is evidence that the parties are intending to litigate the claim. To this end, on Board receipt of a ".307" order, an arbitrator is appointed to determine which carrier should be responsible for the claim. ORS 656.307(1).

In this regard, the distinction between acceptance of the claim and a concession of compensability (whether by request for a ".307" order or actual issuance of a ".307" order) is crucial. Acceptance of the claim ends litigation of the matter. A concession of compensability, on the other hand, removes only one aspect of the case, which otherwise continues to proceed to either a hearing or an arbitration proceeding. Presumably, the parties continue to marshal their evidence in preparation for that proceeding.

We do not mean to suggest that allowing a carrier to raise compensability as an issue following issuance of a ".307" order would not result in any delay or uncertainty. If compensability were to be first raised at hearing, for example, then a continuance of the hearing might be necessary to allow the parties to supplement the record on this issue. However, the sort of delayed litigation which concerned the Court in Bauman would not arise in a ".307" proceeding. Moreover, allowing carriers to raise compensability in such a context would advance the important policy objective of encouraging carriers to agree to issuance of a ".307" order in cases where the facts strongly, but not conclusively, support compensability. Currently, the only incentive to agree to a ".307" order under such circumstances is the possibility of a penalty under ORS 656.262(10) for an unreasonable denial.

In sum, we do not believe that the rule of Bauman should be applied to prohibit a subsequent denial of compensability where an ORS 656.307 order has previously issued. Existing case law does not require such application. In addition, the important policy consideration of providing compensation to an injured worker pending final resolution of a claim would be furthered by the opposite approach.

In the Matter of the Compensation of
BONNIE S. BURKE, Claimant
WCB Case No. 90-17749
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerbands.

The insurer requests review of Referee Tenenbaum's order that awarded 11 percent (35.2 degrees) unscheduled permanent disability for a mid-back injury, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of paragraphs four, six, nine and ten. Claimant has not sustained any loss of earning capacity as a result of her compensable injury.

CONCLUSIONS OF LAW AND OPINION

Because claimant became medically stationary prior to July 1, 1990, the issue of the extent of her unscheduled permanent disability is subject to a special exception to the 1990 Workers' Compensation Act's general applicability provision. See e.g. Section 54(3). Therefore, we analyze this issue under the Workers' Compensation Act in effect prior to the 1990 amendments.

For purposes of determining injury-related permanent partial disability, former ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to former ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010. We apply the standards in effect on July 18, 1990, the date of the Determination Order. (WCD Admin. Order 7-1988).

The Referee concluded that claimant was entitled to 11 percent unscheduled permanent disability under the standards. We adopt the Referee's reasoning and conclusion that claimant has not established that her loss of cervical range of motion is caused by her work injury. (Ex. 11). However, we disagree that the record establishes that, as a result of the work injury, claimant suffers from a chronic condition limiting repetitive use of her back.

The applicable standards define "impairment" as a decrease in the function of a body part or system, as measured by a physician. Former OAR 436-35-005(1). Former OAR 436-35-320(4) provides for a five percent disability award for chronic conditions which limit repetitive use of an unscheduled body part. However, the record contains no medical opinion documenting loss of repetitive use of claimant's back. In fact, all of the physicians who examined claimant released her to regular work without any restrictions. (Exs. 3, 5, 7-2, 9, 11, 12, 13). On this record, we find that claimant has not established that she has a chronic condition limiting repetitive use of her back. See Cheryl L. McCarthy, 43 Van Natta 654 (1991); Ovid D. Brown, 42 Van Natta 2767 (1990); Martha L. Brunner, 42 Van Natta 2587 (1990).

Where claimant fails to establish any measurable impairment resulting from her compensable injury, no award of disability is allowed. Former OAR 436-35-010(2)(b), OAR 436-35-280(1).

Here, claimant has failed to establish measurable impairment resulting from her compensable injury. Therefore, we find that claimant has failed to establish entitlement to an award of permanent disability.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards". Former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987).

On this record, given claimant's preexisting scoliosis condition, we do not find clear and convincing evidence that claimant has established any permanent loss of earning capacity due to the compensable injury. Former ORS 656.214(5).

ORDER

The Referee's order dated February 13, 1991 is reversed. The Determination Order is reinstated and affirmed.

November 5, 1991

Cite as 43 Van Natta 2467 (1991)

In the Matter of the Compensation of
MARK S. JONES, Claimant
Own Motion No. 91-0577M
OWN MOTION ORDER
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted to the Board claimant's claim for an alleged worsening of his January 18, 1985 industrial injury. The insurer has accepted responsibility for the surgery and recommends that claimant's claim be reopened for the payment of temporary disability benefits.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Claimant's aggravation rights expired September 9, 1991. Here, Dr. Baker, M.D., claimant's treating physician, noted on August 26, 1991, that claimant experienced a spontaneous onset of pain in the left buttock and lumbo-sacral area, accompanied by tingling of both feet, which had persisted for about seven weeks and was worsening. Examination revealed a flattened lumbar lordosis and tenderness generally over the lumbo-sacral area of claimant's back. Although tests, including the myelogram, were generally negative, Dr. Baker stated in the chart note that claimant's history and his own objective findings were compatible with loosened rods from claimant's 1989 fusion. Dr. Hockey, M.D., who examined claimant on referral from Dr. Baker, noted the same symptoms. His examination revealed decreased flexion, tenderness in the left lumbar and sciatic notch region, and positive left straight leg raising. He opined that claimant had experienced a possible recurrent left L4-5 herniated disc.

SAIF was in possession of both these reports on the day claimant's aggravation rights expired. We consequently examine the record to establish whether claimant had perfected an aggravation claim before his aggravation rights expired.

Claimant had ruptured an L4-5 disc in a 1985 industrial injury. Surgery at the L4-5 level had been performed twice in 1985, once in 1987, and again in

1989, when L4-5 was fused using Knodt rods. Claimant returned to work and was declared medically stationary in January 1990. His condition became worse again in June, 1991, which occasioned his return to Dr. Baker. In a September 18, 1991 letter, Dr. Flannery, orthopedic surgeon, concluded that the right upper hook from the fusion hardware was compromising the spinal canal and that claimant needed surgery to remove it and to inspect portions of the spine for possible further surgical intervention. This surgery is the same surgery for which the insurer requested reopening under our own motion authority.

A physician's report establishing a worsened condition by written medical evidence supported by objective findings is a claim for aggravation. ORS 656.273(1). In order to constitute an aggravation claim, a physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened. Herman M. Carlson, 43 Van Natta 963 (1991); see also Linda Coiteux, 43 Van Natta 384 (1991) (in order to perfect an aggravation claim, a physician's report must put the insurer on notice that requested medical services are for worsened, not continuing, conditions). Here, Dr. Baker's chart note and Dr. Hockey's letter establishing by objective findings that claimant's compensable condition had worsened qualify as a perfected claim for aggravation.

We accordingly conclude that the insurer had notice of a claim for aggravation prior to the September 9, 1991 expiration of claimant's aggravation rights. Consequently, because claimant's claim for a worsened condition occurred prior to the expiration of his aggravation rights, we lack jurisdiction to reopen claimant's claim under our own motion authority. ORS 656.273; 656.278.

We accordingly deny the request for own motion relief and direct SAIF to process this claim as a claim for aggravation under ORS 656.273.

IT IS SO ORDERED.

November 5, 1991

Cite as 43 Van Natta 2468 (1991)

In the Matter of the Compensation of
DAVID S. MATHEWS, Claimant
WCB Case No. 90-18756
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Gruber's order which: (1) found that claimant was not entitled to temporary disability benefits between May 31, 1990 and September 13, 1990; and (2) declined to assess a penalty and attorney fee for unreasonable failure to pay those benefits. On review, the issues are temporary disability compensation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant had previously been to hearing on June 19, 1990 at which time the Referee found a compensable aggravation of his November 1988 left shoulder and neck injury. By an Opinion and Order dated July 12, 1990, the Referee ordered SAIF to accept the claim for payment of compensation. (Ex. 4). SAIF notified

claimant on July 30, 1990 that his claim was being reopened and that all benefits related to his condition would be paid. (Ex. 4A).

On July 26 and 31, 1990, SAIF sent temporary disability compensation payments to claimant. The time loss payment summary indicated that those payments were for the time period February 2, 1990 through May 30, 1990. No further temporary disability benefit payments were made until SAIF again began paying them as of September 14, 1990. On September 28, 1990, claimant requested a hearing citing unilateral termination of benefits and penalties and attorney fees as issues.

FINDING OF ULTIMATE FACT

SAIF's unilateral termination of temporary disability benefits was in violation of the prior Referee's order and constituted an unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

At hearing on December 11, 1990, relying on Oregon Laws 1990 (Special Session), Chapter 2, Section 18, the Referee found that the SAIF Corporation had properly terminated temporary disability benefits effective May 31, 1990 because it had not received medical verification of claimant's inability to work due to his compensable condition, and because it did not receive such verification until September 14, 1990. In their briefs, the parties also argue the propriety of termination of temporary disability compensation pursuant to Oregon Laws 1990 (Special Session), Ch. 2. However, we do not agree that this case turns on application of 1990 Oregon Laws.

ORS 656.262(2) requires an insurer to pay compensation "periodically, promptly and directly" to the worker except when the right to compensation has been denied. The Director adopted a rule, pursuant to subsection (2), which requires an insurer whose denial has been set aside by order to commence payments of compensation within 14 days of the order unless the order has been appealed by the insurer. OAR 436-60-150(4)(e). OAR 436-60-150(5) requires additional payments to be made each 14 days thereafter. Here, SAIF's denial had been set aside by the first Opinion and Order dated July 12, 1990. Moreover, once a claim has been accepted, ORS 656.268 provides that temporary disability benefits may not be terminated until certain events, not present here, occur.

Further, after the prior Referee remanded claimant's aggravation claim to SAIF for acceptance and "payment of compensation," SAIF had a duty to investigate and process the claim. George B. Rossman, 41 Van Natta 1839, 1840-41 (1989); Frank R. Gonzales, 34 Van Natta 551 (1982). It did not do so.

Accordingly, we conclude that the prior Referee's order established the law in this case, remanding the claim to SAIF to be accepted for payment of compensation, including temporary disability compensation. Because SAIF did not comply with the original Referee's order, it unlawfully terminated claimant's temporary disability benefits.

Penalty for Unilateral Termination of Benefits

Because SAIF's termination of benefits was unlawful and in direct violation of the prior Referee's order, we conclude that the termination was unreasonable and assess a 25 percent penalty. ORS 656.262(10)(a). Pursuant to Or Laws 1990 (Special Session), Chapter 2, Section 15, claimant's attorney is entitled to one-half the additional amount, in lieu of an attorney fee. See Harry E. Forrester, 43 Van Natta 1480 (1991).

ORDER

The Referee's order dated January 22, 1991 is reversed. Claimant is awarded temporary disability benefits from May 31, 1990 through September 13, 1990. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800. The SAIF Corporation is assessed a penalty of 25 percent of the compensation made payable by this order. One-half that amount shall be paid to claimant and one-half shall be paid to claimant's counsel in lieu of an attorney fee.

November 5, 1991

Cite as 43 Van Natta 2470 (1991)

In the Matter of the Compensation of
BEVERLY R. TILLERY, Claimant

WCB Case Nos. 90-16423 & 90-14667

ORDER ON REVIEW

Malagon, et al., Claimant Attorneys
Janice M. Pilkenton, Defense Attorney
Debra Ehrman, Defense Attorney

Reviewed by Board Members Moller and Neidig.

SAFECO Insurance Company requests review of Referee Black's order that: (1) set aside its denial of claimant's aggravation claim for her low back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

SAIF accepted a contusion to claimant's lumbosacral spine. (Ex. 6-A).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions of Law and Opinion, with the following supplementation.

On review, SAFECO argues that it has never accepted claimant's low back condition. SAFECO contends that it accepted only a groin injury as a result of the April 1986 incident and that claimant's low back injury did not occur until October 1986, when SAIF was on the risk. In essence, SAFECO contends that claimant's low back condition is not compensably related to her employment while it was on the risk.

SAFECO's August 8, 1990 denial provided, in part:

"We have received your claim for benefits in reference to a low back injury that you sustained on April 21, 1986. Information that we have indicates that you have had a subsequent injury with SAIF Corporation which is the cause for your current need for treatment.

"Therefore, without waiving any additional issues of compensability, SAFECO Insurance Companies and their insured, Skyline Products, hereby respectfully denies responsibility of your current condition. (Emphasis supplied.)

In opening remarks at hearing, claimant's counsel stated that, "as far as SAFECO is concerned, they've issued a Denial Exhibit Number 19, August 8, 1990, with the date of injury April 21, 1986, indicating that they are not responsible for claimant's current condition, but it is only a responsibility denial." (Tr. 3). The Referee asked SAFECO's counsel if he agreed with the statement of the issues and SAFECO's attorney replied that he did. (Tr. 3). SAFECO's counsel stated that it was "going to be our position that this is, in fact, an occupational disease that SAIF's responsible for." (Tr. 4).

We conclude that, because SAFECO denied only responsibility at hearing, it has waived its right to assert a compensability defense on review. See John J. Alcantar, 42 Van Natta 617 (1990). (Board concluded that, where an insurer raised only the issue of responsibility at hearing, compensability was conceded. The Board held that, by not formally raising the issue of compensability at hearing, that defense is waived as a matter of practice and procedure. ORS 656.726(4)). Also see Donald A. Hacker, 37 Van Natta 706 (1985). (Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy). Under the circumstances, we conclude that it would be unfair to the other parties to allow SAFECO to raise a compensability defense that was not litigated at hearing. Moreover, even if we were to conclude that SAFECO had validly raised compensability as an issue, we nevertheless agree with the Referee's conclusion that claimant has established compensability of her claim as to SAFECO.

SAFECO next contends that, because claimant has a later, accepted low back claim with SAIF, it is therefore SAIF's burden to establish that its accepted injury did not contribute independently to a worsening of claimant's condition. SAFECO cites Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984) and Linda L. Wise, 42 Van Natta 115 (1990) in support of its position. We agree with SAFECO that, because claimant has experienced two accepted injuries to the same body part, pursuant to the Kearns analysis, SAIF bears the burden of proof on this issue. We conclude, however, that SAIF has met that burden. In reaching this conclusion we rely on the following factors. Claimant testified that her symptoms did not change following her October 1986 injury while SAIF was on the risk. (Tr. 18). During an independent medical examination shortly after the October incident, no mention was even made of the incident. (Ex. 7). SAIF accepted the October 1986 incident as nondisabling. There is no evidence that this characterization of the claim was ever challenged. Finally, Dr. Hacker relates claimant's need for surgery to the April 1986 incident and does not mention the October 1986 injury. Therefore, we conclude that claimant's October 1986 injury did not independently contribute to a worsened condition.

Finally, SAFECO argues that the Referee improperly applied the 1990 amendments to the Workers' Compensation Act made by Senate Bill 1197. In this regard, Section 49 of SB 1197 provides, in part:

"(1) When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

SAFECO contends that, because claimant sustained a new accepted injury while SAIF was on the risk, SAIF is now responsible for claimant's subsequent disability and medical services. However, we are persuaded here that the injury

while SAIF was on the risk did not involve the "same condition" as the injury while SAFECO was on the risk. To the contrary, the medical evidence establishes that claimant's April 1986 injury involved her preexisting spondylolisthesis condition, rendering it symptomatic. Claimant's October 1986 injury was reported, treated and accepted as a lumbosacral contusion. The evidence indicates that this incident had no effect on claimant's symptomatic spondylolisthesis condition resulting from the prior SAFECO injury. Because the second compensable injury while SAIF was on the risk did not involve the same condition but, rather, merely the same body part as the prior SAFECO injury, we conclude that Section 49 of SB 1197 is not applicable.

Therefore, we agree with the Referee that SAFECO remains responsible for claimant's current condition requiring treatment.

Attorney fees

We conclude that, because no order designating a paying agent pursuant to ORS 656.307 has issued, claimant's compensation was at risk at the Board level. See Thomas W. Williamson, 39 Van Natta 1147 (1987). Here, SAFECO requested Board review and sought to shift responsibility for claimant's claim to SAIF. 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 that initiated Board review. See Joel D. Turpin, 42 Van Natta 1736 (1989).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$500 is a reasonable assessed fee for claimant's counsel's efforts on review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue presented and the value of the interest involved.

ORDER

The Referee's order dated January 8, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable fee of \$500, payable by SAFECO.

November 6, 1991

Cite as 43 Van Natta 2472 (1991)

In the Matter of the Compensation of

G. T. BABICH, Claimant

WCB Case No. 90-17366

ORDER ON RECONSIDERATION

Bennett & Durham, Claimant Attorneys

Roberts, et al., Defense Attorneys

Claimant requests reconsideration of that portion of our October 11, 1991 order that awarded a \$750 insurer-paid attorney fee for obtaining compensation for claimant without a hearing. Submitting an affidavit concerning the amount of time devoted to this matter, claimant asks that the attorney fee award be increased.

The affidavit expands upon information previously documented in claimant's attorneys' firms' billing statement (Exhibit 25), as well as information provided by claimant's attorney at the hearing. This information concerning the time invested by claimant's attorney in pursuing this matter has already been considered. Furthermore, in specific response to an allegation contained in the

affidavit, we wish to emphasize that we did not find that claimant sought an attorney fee for time devoted to attorney conferences. Rather, we found that the insurer contended at the hearing that claimant's attorney was seeking an award for such time.

In any event, as stated in our prior order, our determination was based on the factors recited in OAR 438-15-010(4), one of which is the time devoted to the case. After conducting our further consideration of this matter, we continue to adhere to our prior conclusion that a reasonable attorney fee for prompting the rescission of the insurer's denial of medical services without a hearing is \$750. In reaching this conclusion, we further note that we have previously held that results obtained in the form of medical services are generally considered to be "rather modest." Dwight E. Fillmore, 40 Van Natta 794 (1988), aff'd 98 Or App 567 (1989); Clifford D. Howerton, 38 Van Natta 1425 (1986); Derry D. Blouin, 35 Van Natta 570 (1983).

Accordingly, we withdraw our October 11, 1991 order. On reconsideration, as supplemented herein, we adhere to and republish our October 11, 1991 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 6, 1991

Cite as 43 Van Natta 2473 (1991)

In the Matter of the Compensation of
STEPHEN C. BUTLER, Claimant
WCB Case Nos. C1-02135 & C1-02136
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Martin J. McKeown, Claimant Attorney
Breathouwer, et al., Defense Attorney

Reviewed by Board Members Neidig and Moller.

On October 11, 1991, the Board received the parties' claim disposition agreements in the above-captioned matter. Pursuant to those agreements, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injuries. We set aside the proposed dispositions.

We will not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of the existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). A proposed disposition agreement that does not provide any consideration is unreasonable as a matter of law. See ORS 656.236(2); OAR 436-60-145(3)(j); Gene H. Hansen, 43 Van Natta 46 (1991).

Here, the parties have submitted two disposition agreements concerning two separate injuries and claim numbers. However, the parties have proceeded as if the two disposition agreements together comprise one settlement agreement. Specifically, CDA number C1-02135 [claim number 84360053, file number A228941] includes a notice reciting that it is a part of a "package settlement" that includes claim number 86360156 [file number H361465, CDA number C1-02136]. Similarly, CDA number C1-02136 is cross-referenced to CDA number C1-02135.

CDA C1-02136 specifies that in consideration of the payment of \$10,000, claimant releases certain rights to future workers' compensation benefits, ex

cept medical services, for the December 1986 compensable injury. That agreement also provides for disbursement of \$8,500 to claimant and \$1,500 to his attorney.

CDA C1-02135 purports to release claimant's rights and obligations under his September 1984 compensable injury. This agreement, on the other hand, does not provide any consideration for release of those rights and obligations. Instead, the agreement notes that the "[t]he total payments to be made to dispose of both claims [CDA number C1-02135 and CDA number C1-02136] is \$10,000, with claimant to receive \$7,500 and claimant's attorney to receive \$2,500."

The Board's rules require that a claim disposition agreement include the total amount (excluding attorney fee) to be paid to claimant and, if any, the total attorney fee to be paid claimant's attorney. OAR 436-60-145(3)(j) and (i). Moreover, each claim disposition agreement must contain all of the information required by the rules for each claim, including the amounts to be paid to claimant and his attorney on each claim. OAR 436-60-145(1).

Here, CDA C1-02135 does not specifically provide claimant any consideration, or his attorney any fee, for releasing his rights and obligations under his September 1984 compensable injury. While CDA C1-02136 provides a total consideration of \$10,000 to dispose of both claims, neither disposition agreement provides all of the information required by the rule for each claim, including the amounts to be paid to claimant and his attorney on each claim.

Moreover, the disbursement plans identified in CDA C1-02135 and C1-02136 are inconsistent. Under these circumstances, even if this "package settlement" were to be approved, it is unclear how the settlement proceeds would be disbursed.

Because the two agreements are inextricably interdependent, we decline to approve one while disapproving the other. Under these circumstances, we find both agreements unreasonable as a matter of law and set them aside. See ORS 656.236(2); OAR 436-60-145(1); Gene H. Hansen, supra. Consequently, we decline to approve either agreement and return them to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed dispositions have been disapproved, the self-insured employer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed dispositions. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, the parties may submit revised agreements for our consideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES A. CROSS, Claimant
WCB Case No. 89-18760
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The SAIF Corporation requests review of that portion of Referee T. Laverne Johnson's order that granted claimant an award of permanent total disability. Claimant cross-requests review of that portion of the order that upheld SAIF's denial of claimant's medical services claim for cervical surgery. In its brief, SAIF also contends that the Referee abused his discretion in excluding certain testimony from vocational expert Bill Sakagawa. On review, the issues are admissibility of evidence, medical services and permanent total disability. We admit the excluded evidence and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Medical Services

We adopt the conclusions and reasoning concerning claimant's entitlement to the requested medical services as set forth in the Referee's order.

Permanent Total Disability

The initial question presented is whether the Referee erred in refusing to allow Bill Sakagawa, SAIF's expert vocational witness, to testify as to whether he believed claimant was currently employable. The Referee excluded the testimony because the witness's opinion was based, in substantial part, on facts that had not been admitted into evidence, *i.e.*, telephone conversations that he had had with claimant's treating physician and surgeon.

Oregon Rule of Evidence 703 specifies what information expert witnesses may rely upon for their opinion testimony:

"The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence."

The rule is identical to Rule 703 of the Federal Rules of Evidence, and was adopted to bring judicial practice into line with the practice of experts themselves when not in court. *See* Kirkpatrick, Oregon Evidence 458 (1989); Legislative Commentary to OEC 703. Professor Kirkpatrick explains:

"Rule 703 provides with regard to this last category that the facts or data upon which the expert relies need not have been admitted or even be admissible into evidence. Thus, it clearly rejects the 'facts in evidence' requirement for expert opinion, which was stated in some earlier Oregon cases." *Id.* at 460.

Kirkpatrick further explains that, while OEC 703 refers to only "facts or data" as a basis for an expert opinion, the Legislative Commentary makes it clear that an expert opinion may also be based on the opinions of other experts. Id. at 461.

In this case, Mr. Sakagawa testified that the telephone conversations he had had with claimant's treating physician and surgeon were the kind of information that experts in his field reasonably relied upon in forming their opinions. (Tr. 122). Claimant does not dispute that fact. Thus, under OEC 703, Mr. Sakagawa's opinion whether claimant was employable is admissible, regardless of the fact that it was based on information that had not been admitted into evidence. The question remains, however, whether the Referee abused his discretion in failing to admit such testimony at hearing.

Under ORS 656.283(7), a hearings referee is not bound by common law or statutory rules of evidence, or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. Thus, the Referee here had a measure of discretion in determining whether the evidence in question should be admitted. Nonetheless, the purpose of the flexibility given referees is to allow consideration of relevant evidence that a reasonable person might rely in conducting his most important affairs, even though such evidence would not be admissible in court. See Lucke v. Workers' Compensation Department, 254 Or 439 (1969); see also ORS 183.450(1). We have held that in some cases, it is error to exclude evidence that would be admissible in a court of law. See Froylan L. Zurita, 43 Van Natta 1382 (1991); Richard T. Bryant, 40 Van Natta 1802 (1988).

In this case, Mr. Sakagawa's testimony was offered in response to claimant's claim that he is permanently and totally disabled. The vocational expert's opinion on whether claimant was employable would have been worthy of consideration in determining the merits of claimant's assertion and, as indicated above, would have been admissible evidence in the courts of this state. Therefore, we conclude that, in serving the ends of substantial justice, the Referee abused his discretion in excluding the offered testimony. We reverse the evidentiary ruling and, inasmuch as the testimony was submitted in an offer of proof, proceed to decide the issue on the merits without remanding to the Referee.

In order to establish permanent and total disability, claimant must prove 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). There is no dispute that claimant does not exhibit total physical incapacity. Therefore, the question is whether claimant has established permanent and total disability with the "odd lot" doctrine, under which a disabled worker may remain capable of performing work of some kind but still be foreclosed from obtaining gainful employment due to a combination of medical and nonmedical disabilities. Welch v. Banister Pipeline, 70 Or App 699 (1984). Because claimant has some capacity for employment, he also is required to establish that he is willing to seek regular gainful employment and that he has made reasonable effort to obtain such work, unless such efforts would be futile. SAIF v. Stephen, 308 Or 41 (1989).

The Referee found claimant credible based on demeanor. We defer to that finding. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Claimant's testimony and the medical evidence indicate that he is significantly disabled as a consequence of his compensable injury. He has chronic symptoms of pain, restrictions in range of motion and limitations in climbing, stooping, kneeling, crouching and bending. He has undergone four surgeries to correct a cervical problem and currently has a failed fusion at the C5-6 level. Claimant, whose extensive work history consists primarily of heavy labor, cannot return to his

regular work. He is limited in his ability to sit or stand to no more than 30 minutes, must change positions frequently and is required to take medication for his pain. Dr. Knecht, claimant's treating physician, reported that, in effect, claimant would not be able to be employed in any form of work due to his subjective complaints of pain. (Ex. 100).

Considering the abovementioned medical and testimonial evidence, as well as the reasons relied upon by the Referee, we conclude that claimant is no longer able to obtain and hold gainful employment in the broad field of occupations. We are not persuaded by the testimony of Mr. Sakagawa, SAIF's vocational expert. Although he testified that claimant was capable of performing sedentary and light work and identified a number of jobs that claimant could perform, such as those in the delivery business or in telephone solicitation, his evaluation was based on the potential labor market as it exists in the state of Oregon. At the time of hearing, claimant lived in Troy, Montana, a small community with a limited labor market. There is no evidence that there are qualified jobs in claimant's geographical area. See Mary E. Messner, 43 Van Natta 14 (1991).

We also find that claimant has satisfied his work search requirement. Given claimant's physical incapacitation, we conclude that any attempt by claimant to locate work would have been futile. We also conclude that claimant has established, but for his compensable injury, he is willing to work. In reaching this latter conclusion, we relied on claimant's credible testimony that he would rather work than draw benefits, but that he does not feel capable due to his physical problems.

After our review of the record, we conclude that claimant has sustained his burden that he is permanently and totally disabled. Accordingly, the Referee's order is affirmed.

Because SAIF initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue and the value of the interest involved.

ORDER

The Referee's order dated January 8, 1991, as amended January 25, 1991, is affirmed. For services on Board review, claimant's counsel is awarded a reasonable attorney fee of \$1,000, to be paid by SAIF.

November 6, 1991

Cite as 43 Van Natta 2477 (1991)

In the Matter of the Compensation of
CRESENT HAYWARD, Claimant
WCB Case No. 90-21875
ORDER ON REVIEW
Paulson & Baisch, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Emerson's order that set aside its denial of claimant's right thumb injury and resulting treatment and/or

disability. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

The insurer's November 11, 1990 denial denied that claimant had sustained a compensable injury on July 4, 1990, as well as denied treatment and/or disability in connection with the injury.

At hearing, the insurer denied that the July 4, 1990 injury is compensable, and denied that an alleged July 4, 1990 injury is the major contributing cause of claimant's resulting condition, disability and need for medical services.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proven that she had sustained a compensable injury on July 4, 1990 which was a material contributing cause of her need for medical treatment. We agree and adopt the Referee's "Conclusions and Opinion." See Mark N. Wiedle, 43 Van Natta 885 (1991). However, the Referee did not address the issue of whether the compensable injury is and remains the major contributing cause of claimant's right thumb disability and need for treatment. Because we conclude that this issue was raised and litigated at hearing, we address the issue on review.

Claimant has a preexisting right thumb condition. Therefore, although claimant has proven that there was a compensable injury on July 4, 1990, to obtain compensation for her resulting condition claimant must, under ORS 656.005(7)(a)(B), also prove by a preponderance of the evidence that the compensable July 4, 1990 injury is the major contributing cause of her disability or need for medical services. See Bahman M. Nazari, 43 Van Natta 2368 (1991). We find that the causation of claimant's right thumb condition is of sufficient medical complexity that we cannot decide it without expert opinion. See Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Because claimant's right thumb condition was not responding well to treatment, her treating physician, Dr. Stanford, orthopedic surgeon, referred her to Dr. Button, hand surgeon. Dr. Button opined that "it is highly implausible that any significant injury could have occurred ...[on] July 1, [sic] 1990." (Ex. 6). Dr. Button further opined that the "major factor" contributing to claimant's right hand "symptomatology" are her "previous injuries." (Ex. 6).

When Dr. Stanford was first questioned by the insurer regarding the causation of claimant's right hand condition, he responded by deferring to Dr. Button for an opinion "because of [Dr. Button's] advanced expertise and because of the unusual aspect of the diagnosis...." (Ex. 7A). Later, in response to questions by claimant's attorney, Dr. Stanford reported that:

"The history I have from [claimant] and apparently it has been verified at work, is that she was lifting a heavy patient on the 1st [sic] of July of 1990 when she had the onset of pain. This certainly is the set of circumstances which can cause the kind of injury she has had and it is the major contributing cause for the treatment I had to provide for her for the thumb beginning July of 1990." (Ex. 8).

In light of his initial deference to Dr. Button's opinion, Dr. Stanford's revised opinion does not establish by a preponderance of the evidence that the

July 4, 1990 injury is the major contributing cause of claimant's right thumb condition for which she seeks medical treatment. Accordingly, although claimant has established the occurrence of a compensable injury on July 4, 1990, her claim for current medical treatment and/or disability is not compensable.

The Referee set aside the insurer's denial and awarded an assessed attorney fee. We are reinstating and upholding a portion of that denial. The Referee's assessed attorney fee shall be adjusted accordingly. In addition, claimant has, in part, successfully defended against the insurer's request for review. She is therefore entitled to an assessed attorney fee on review. ORS 656.382(2). In lieu of the Referee's assessed fee, we award a reasonable assessed fee for services at hearing and on review concerning the compensability of the July 4, 1990 injury, in the amount of \$1,800. We have arrived at this fee after considering the factors set forth in OAR 438-15-010(4), in particular the time devoted to this issue (as represented by the hearing record and claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated February 28, 1991, is affirmed in part and reversed in part. That portion of the Referee's order which set aside the insurer's denial insofar as it denied medical services and/or disability for claimant's right thumb condition is reversed and that portion of the insurer's denial is reinstated and upheld. In lieu of the Referee's assessed attorney fee award, claimant is awarded a reasonable assessed fee for services at hearing and on review concerning the compensability of the July 4, 1990 injury, in the amount of \$1,800, to be paid by the insurer. The remainder of the order is affirmed.

November 6, 1991

Cite as 43 Van Natta 2479 (1991)

In the Matter of the Compensation of
DONALD A. WILLIAMS, Claimant
WCB Case No. 89-17142
THIRD ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

On October 8, 1991, we withdrew our September 12, 1991 Second Order on Reconsideration. We took this action in response to the parties' representation that they had settled their dispute and would be submitting a proposed agreement for Board consideration.

The settlement is designed to resolve all issues raised or raisable in this matter. Specifically, the parties agree that the insurer's denial "shall be approved and remain in full force and effect." In addition, claimant acknowledges that the Board's Second Order on Reconsideration is the final disposition of this matter and agrees not to seek judicial review.

We have approved the parties' agreement, thereby fully and finally resolving this matter. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
WENDI S. BRIGGS, Claimant
WCB Case No. 88-13176
ORDER ON REMAND
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerbands.

This matter is before the Board on remand from the Court of Appeals. Kaiser Health Plan v. Briggs, 108 Or App 338 (1991). The court has reversed our prior order, which found claimant's claim for a neck and low back condition compensable because claimant had established that her work was a material contributing cause of her disability or need for treatment. The court remanded for reconsideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991), and Liberty Northwest Insurance Corporation v. Damm, 107 Or App 764 (1991), which held that a claimant must establish that her employment was the major contributing cause of a condition or its worsening in order to prove an occupational disease under former ORS 656.802(1)(c). We proceed with our reconsideration.

FINDINGS OF FACT

We adopt the Referee's "Findings."

ULTIMATE FINDINGS OF FACT

Claimant's work exposure constituted a series of traumatic events or occurrences that required medical services and resulted in physical disability. Claimant's neck and low back strain/sprain and overuse syndrome were the major contributing cause of her disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

The self-insured employer contends that we must address whether claimant's work exposure worsened any underlying back condition(s) which claimant may have. It argues that claimant's idiopathic scoliosis and/or a prior back injury claim constitute preexisting conditions. We disagree.

To begin, we are not convinced that Exhibit 10, and the testimony of the claims examiner concerning the indexing system that generated the exhibit, establishes that claimant had a prior back injury claim. Claimant testified that she had no recollection of a prior back injury. Secondly, on this record, we find no evidence that claimant treated for a back injury prior to March 1987, when she first saw Kaiser physician Dr. Gloekler for work related back problems. Finally, all of the medical treatment which claimant sought prior to her July 5, 1988 claim related her back complaints to her work activities for the employer.

Claimant was employed in the dental offices of Kaiser Health Plan as a dental assistant. A large part of her job involved bending over patients while assisting the dentist. She first sought treatment at Kaiser Urgent Care for neck and low back symptoms on March 3, 1987. Dr. Gloekler's chart note indicated that claimant's back and neck pains resulted from work as a dental assistant, leaning over much of the day. (Ex. A).

Claimant next saw Kaiser physician Dr. Olson, M.D., who also stated that claimant's back pain resulted from bending over at work. (Ex. B). On March 11, 1987, Olson referred claimant to physical therapy for "back tenderness related to job back stress." (Ex. C). Claimant continued physical therapy for

approximately a month then discontinued going because, although her back had improved somewhat, she did not feel the physical therapy was helping.

In June 1988, claimant saw Dr. Owen, D.C., who diagnosed lumbosacral and cervical sprain/strain and took claimant off work for approximately one week. Owen stated that claimant's "injury and pain [were] due to chair and positioning required at work." (Ex. 5).

In July 1988, Dr. Utterback, an orthopedist, performed an independent medical examination. He diagnosed an overuse syndrome and stated that claimant's back and neck condition would probably remain symptomatic until claimant found "some type of work for which her body is more ideally suited." (Ex. 7-2).

Subsequent to his initial examination, Dr. Utterback responded in a cursory fashion to questions submitted to him by the employer's counsel. Utterback stated that claimant's work was "most likely not" the major contributing cause of her problems, and that it was "possible" that her work activities contributed in a material way to the overuse syndrome. (Ex. 9-2). Because Dr. Utterback's second "report" is conclusory and somewhat contradictory to his initial conclusion that related claimant's work to her symptoms, we do not consider it to be persuasive. Somers v. SAIF, 77 Or App 259 (1986).

Each physician who examined claimant, including Dr. Utterback after his initial examination, related claimant's back problems to her work exposure, although none quantified the magnitude of the causation in terms of the "major contributing cause." However, "magic words" are not required. See Liberty Northwest Insurance Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986); Leo R. Cox, 43 Van Natta 2354 (1991).

Accordingly, for the reasons expressed above, we agree with the Referee that claimant's work activities involved a series of traumatic events which were the major contributing cause of her neck and low back strain/sprain and overuse syndrome. Consequently, we hold that claimant's occupational disease claim is compensable.

The Referee previously concluded that the employer's denial was not unreasonable. On remand, claimant again contends that the denial was unreasonable. However, claimant did not raise the issue at the time of Board review or before the Court of Appeals. Therefore, we decline to address the issue at this late date.

Claimant also contends that she is entitled to an assessed attorney fee for her counsel's efforts before the Court of Appeals. We agree. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or Board, the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1).

Here, claimant has finally prevailed before the Board with respect to a claim or award for compensation after remand from the Court of Appeals. Therefore, she is entitled to a reasonable attorney fee for services before every prior forum. See ORS 656.388(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services in every prior forum concerning the issue of compensability of her back injury claim is \$4,500, to be paid by the employer. This fee is in lieu of, and not in addition to, claimant's prior attorney fee awards. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, the Referee's order dated November 14, 1988 is affirmed.

IT IS SO ORDERED.

November 7, 1991

Cite as 43 Van Natta 2482 (1991)

In the Matter of the Compensation of

SANDRA L. DEEL, Claimant

WCB Case No. 90-10592

ORDER ON REVIEW

Merrill Schneider, Claimant Attorney

Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Podnar's order that: (1) upheld the insurer's denial of claimant's neck injury claim; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable denial. On review, claimant preserves a constitutional argument that the statutes in effect prior to the 1990 amendments should apply to this case. The issues on review are compensability, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following exceptions and supplementation. We do not adopt the next-to-the-last paragraph. Muscle areas different from those previously treated were injured when claimant scraped ice off of a bus at work on February 14, 1990. Claimant's work activities were a material contributing cause of this new injury.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

On review, claimant alleges that she will be denied due process through the application of the statutes as amended in 1990 rather than those in effect at the date of injury. However, she preserves this constitutional argument rather than addressing it at this level of review. In other words, claimant does not seriously wish the Board to address this issue, but raises it merely to forestall any argument that she has failed to exhaust administrative remedies. While we have the authority to decide constitutional questions, Cooper v. Eugene School District No 4J, 303 Or 358, 364-5 (1986), we decline to do so where the challenging party gives us no argument as to why the statute's application to her is unconstitutional. Herman M. Carlson, 43 Van Natta 963 (1991).

Compensability

Based on his finding that claimant had a longstanding problem with her neck and mid-back, the Referee found that claimant had not proved by a preponderance of the evidence that work activities were the major contributing cause of claimant's need to seek medical treatment. We disagree.

Citing ORS 656.005(7)(a)(B), the insurer argues that claimant had a pre-existing condition and, therefore, must prove that her work activities are the major contributing cause of her need for medical treatment. Because we find that claimant suffered a new injury to different muscle areas than those previously treated, we conclude that ORS 656.005(7)(a)(B) is not applicable.

Therefore, in order to establish a compensable injury, claimant must show an accidental injury arising out of and in the course of employment. ORS 656.005(7)(a). The injury must be established by medical evidence supported by objective findings. Suzanne Robertson, 43 Van Natta 1505 (1991). Claimant's disability or need for treatment is compensable if the industrial injury is a material contributing factor. Julie K. Gasperino, 43 Van Natta 1151 (1991); Mark Wiedle, 43 Van Natta 855 (1991).

Because claimant was treated in the past for pain in her neck, upper back and between her shoulders, the issue of whether the work incident caused a new injury is a complex medical question. Thus, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

On March 22, 1990, claimant was examined by the Independent Chiropractic Consultants. (Ex. 3). The Consultants did not discuss: (1) whether claimant sustained a new injury; or (2) whether the work injury or any preexisting condition caused the need for treatment, although they were aware of claimant's pre-existing problems. They merely concluded that claimant was medically stationary in regard to the February 14, 1990 work injury and required no continuing chiropractic care as a result of that injury. (Ex. 3-4).

On July 10, 1990, claimant was examined by Dr. Stigler, D.O., on referral from Dr. Davison, treating chiropractor. (Ex. 6). Dr. Stigler gave no opinion as to whether claimant sustained a new injury. In any event, Stigler had an incomplete history in that he was unaware that claimant had previously received treatment for neck and upper back pain.

Dr. Davison is the only physician to address the question of whether the work activity caused a new injury. Davison had treated claimant before the February 14, 1990 work incident. When he examined claimant on February 15, 1990, he noted objective findings including muscle tenderness, muscle spasm and reduced range of motion. (Ex. 5). Furthermore, in a well-reasoned opinion, Davison explained how the work activity caused claimant's problems. (Ex. 5-3). Davison also opined that the work activity caused a new injury to different muscles and that this injury materially worsened her condition and independently contributed to her need for medical treatment. (Ex. 8-2). This opinion is un rebutted.

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, there are no persuasive reasons not to defer to Dr. Davison's opinion.

Under these circumstances, we conclude that claimant has established that the February 14, 1990 incident was a material contributing cause of her cervical condition and need for medical treatment. We further conclude that Dr. Davison's opinion establishes claimant's injury by objective findings. Accordingly, claimant has established a compensable injury.

For prevailing against the insurer's denial, claimant's counsel is entitled to an assessed fee under ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the compensability issue, is \$2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Unreasonable Denial

The Referee found that the insurer's denial was not unreasonable. Although we find the claim compensable, we agree that the denial was not unreasonable. On review, claimant gives no reasoning to support her assertion that the denial was unreasonable.

The standard for determining an unreasonable denial is whether the carrier has a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available at the time of the denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977); see also Carol J. Knapp, 41 Van Natta 851, 854 (1989).

Medical records available at the time of the denial show that claimant was receiving chiropractic treatment to her neck, mid-and upper back prior to the injury. On this basis, given the 1990 amendments to ORS 656.005(7)(a)(B), we find that the insurer had a legitimate doubt as to its liability. Accordingly, we find that the denial was not unreasonable.

ORDER

The Referee's order dated August 23, 1990 is reversed in part and affirmed in part. The insurer's denial is set aside and the claim is remanded to it for processing according to law. The remainder of the order is affirmed. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of \$2,000, payable by the insurer.

November 7, 1991

Cite as 43 Van Natta 2484 (1991)

In the Matter of the Compensation of
PEGGY L. PROCTOR, Claimant

WCB Case No. 90-17092

ORDER ON REVIEW

Karen M. Werner, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee McWilliams' order that upheld the SAIF Corporation's denial of claimant's urinary incontinence and hypothyroidism conditions. On review, the issue is compensability.

We affirm and adopt the order of the Referee with the following supplementation.

Citing amended ORS 656.005(7)(a)(A), the Referee concluded that claimant had failed to prove that the work injury and the accepted mental condition were the major contributing cause of the consequential conditions of urinary incontinence and hypothyroidism. We agree.

Subsequent to the Referee's order, we issued Julie K. Gasperino, 43 Van Natta 1151 (1991), in which we construed the phrase "consequential condition" to include only problems that arise from conditions previously deemed compensable, i.e. "secondarily consequential conditions," as opposed to conditions that arise directly from the injurious event, i.e. "primarily consequential conditions." Accordingly, we held that the 1990 amendments to the definition of compensable injury did not affect the standard of compensability for conditions intrinsically related to the underlying compensable event.

Here, claimant contends that antidepressants caused her urinary incontinence and hypothyroidism conditions. Those antidepressants were prescribed for her mental condition which was accepted in 1988 as a consequence of the 1983 work injury. We do not find the prescribed antidepressants to be intrinsically related to the work injury. Therefore, any condition caused by the antidepressants would be a "secondarily consequential condition" and must be established by the major contributing cause standard. We agree with the Referee that claimant has failed to meet that standard.

Claimant also argues that the diagnostic tests which identified her urinary incontinence and hypothyroidism conditions should be found compensable, even if the Board finds the actual conditions not compensable.

ORS 656.245 extends to payment for diagnostic procedures performed as a result of an industrial injury 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. Kenneth M. Simons, 41 Van Natta 378, recon 41 Van Natta 646 (1989); Clifford D. Howerton, 38 Van Natta 1425 (1986).

However, claimant has failed to carry her burden to establish what, if any, diagnostic tests for the urinary and hypothyroidism conditions were reasonable and necessary to determine any causal relationship between those conditions and claimant's treatment for her compensable psychiatric condition. Therefore, any diagnostic services regarding the urinary and hypothyroidism conditions are not compensable medical services.

ORDER

The Referee's order dated February 6, 1991 is affirmed.

In the Matter of the Compensation of
GREGORY A. WEIGEL, Claimant
WCB Case No. 91-09058
ORDER DENYING MOTION TO DISMISS
Gatti, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

The insurer has moved for dismissal of claimant's request for review on the ground that the request does not contain a statement of the reason review is requested. In the alternative, the insurer seeks acknowledgment of its cross-request for review. We deny the motion to dismiss and acknowledge the cross-request for review.

FINDINGS OF FACT

The Referee's Opinion and Order issued October 9, 1991. On October 28, 1991, claimant mailed a request for Board review of the Referee's Opinion and Order. The request included a certificate of personal service upon the employer, the insurer and its counsel. In his request, claimant stated that he was requesting Board review of the Referee's October 9, 1991 Opinion and Order.

On October 30, 1991, the Board received the insurer's motion to dismiss claimant's request for review. In the event that the motion was denied, the insurer "conditionally" filed a cross-request for review. On October 30, 1991, the Board mailed a computer-generated letter to the parties acknowledging claimant's request for review.

CONCLUSIONS OF LAW AND OPINION

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

We have previously held that, considering the clear directive of ORS 656.295, we are not authorized to limit our jurisdiction to less than that provided by the statute. Kimberly L. Murphy, 41 Van Natta 847 (1989). Consequently, we have concluded that the aforementioned portion of OAR 438-11-005(3) is not jurisdictional. Id. Instead, we have reasoned that it is implemented as an informational aid, designed to assist the parties and the Board in identifying the specific case and the matters at issue. Id.

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

Finally, by this order, the insurer's cross-request for review of the Referee's order is acknowledged. A hearing transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule implemented. Thereafter, this matter will be docketed for review.

IT IS SO ORDERED.

November 8, 1991

Cite as 43 Van Natta 2487 (1991)

In the Matter of the Compensation of
JUDY J. MCPHERSON, Claimant
WCB Case No. 90-16094
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Mongrain's order that upheld the insurer's denial of claimant's right shoulder injury claim. On review, the issue is compensability.

We affirm and adopt the order of the Referee with the following supplementation.

As the Referee correctly stated, in order for a claimant to prove that her injury claim is compensable, she must show that the claim "is established by medical evidence supported by objective findings[.]" ORS 656.005(7)(a). A claimant may satisfy this statutory requirement if she offers evidence that a physician has examined her and determined that she suffers from a disability or a physical condition that requires medical services. Suzanne Robertson, 43 Van Natta 1505 (1991). That determination need not be based solely on purely objective factors, such as an x-ray that verifies the existence of a fracture. Instead, we have construed the "objective findings" requirement to be satisfied if the physician's evaluation of the physical condition is based only on the worker's description of the pain that she is experiencing. Id. The report, however, cannot merely recite the claimant's complaints of pain, but rather must indicate that the claimant does, in fact, experience symptoms. Id.

In this case, claimant relies on a medical report submitted by Dr. Brown, claimant's first treating physician, as proof of "medical evidence supported by objective findings." In that report, Dr. Brown diagnoses claimant as suffering from acute rotator cuff tendonitis. Dr. Brown also put claimant's arm in a sling and prescribed medication.

Dr. Brown's report, standing alone, may constitute sufficient medical evidence supported by objective findings to carry claimant's burden of proof. We conclude, however, that it is overcome by contrary evidence, including the report by the Orthopaedic Consultants. That report, although noting a "rather diffuse tenderness" and reduced motion in claimant's shoulder, indicated that shoulder motion increased when she was distracted and found that claimant had "strong elements of embellishment and functional components" during the examination. (Ex. 14). Significantly, both Dr. Brown and Dr. Peterson, claimant's present treating physician, agreed with the report. Furthermore, results from an arthrogram and CT scan were normal. In short, viewing all the evidence together, we are not persuaded that claimant's right shoulder injury claim "is established by medical evidence supported by objective findings," as required by

ORS 656.005(7)(a). We conclude that claimant failed to prove that she sustained a compensable injury to her shoulder.

ORDER

The Referee's order dated February 6, 1991 is affirmed.

November 8, 1991

Cite as 43 Van Natta 2488 (1991)

In the Matter of the Compensation of

KENNETH RETTIG, Claimant

WCB Case No. 90-19577

ORDER ON REVIEW

Vick & Gutzler, Claimant Attorneys

James Dodge (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Podnar's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for lead poisoning; and (2) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable claims processing. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant failed to establish by a preponderance of evidence that he has a compensable occupational disease. We adopt his conclusions and add the following supplementation.

Claimant contends that the Referee erred by concluding that his lead poisoning claim was not compensable on the grounds that no treatment was prescribed and claimant was never disabled as a result of his work for the employer. Claimant argues that he underwent diagnostic testing to determine the level of lead within his blood. Claimant contends that, if diagnostic services were performed, it is not relevant whether he received medical services or was disabled from work. See William E. Willingham, 40 Van Natta 1925 (1988).

We do not agree with claimant's interpretation of the Referee's decision. Although the Referee found that no treatment had been prescribed for claimant and there was no disability, his conclusion was based upon the rationale that claimant had not proven that he suffers from occupation-related lead poisoning.

In Finch v. Stayton Canning Co., 93 Or App 168 (1988), the court held that it was error for the Board to uphold the employer's denial of a claimant's occupational disease claim on the grounds that claimant had not yet lost time from work or required medical treatment other than diagnostic services. The court concluded that, because the Board found medical evidence to support compensability of claimant's carpal tunnel syndrome, it followed that diagnostic medical services performed to determine what was wrong with claimant were also compensable, even though no treatment was required. Finch, supra.

In the present case, the Referee noted that Dr. Bayer found no evidence of lead poisoning or nerve damage. The Referee also concluded that the persuasive medical evidence established that, if claimant did have nerve damage, it was potentially due to factors which were not work-related. Accordingly, the Referee found that claimant had not established a compensable occupational disease. We agree with the Referee that claimant has not established by a preponderance of the evidence that he has a compensable occupational disease.

When there is a dispute between medical experts, we rely on those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

For the following reasons, we agree with the Referee that Dr. Bayer's opinion is more persuasive. In June 1990, six months after claimant's last exposure at SAIF's insured, Dr. Morton, M.D., initially examined claimant and diagnosed occupational lead poisoning, symptoms of peripheral neuropathy due to lead, borderline symptoms of cognitive impairment, persistent symptoms compatible with early asthma and post-traumatic left hand limitation. However, a June 6, 1990 blood test indicated that claimant's blood lead level was normal. A nerve conduction study performed June 11, 1990 was also normal. Finally, a pulmonary function report dated June 13, 1990 found that claimant's lungs were normal.

Dr. Morton acknowledged that claimant's blood lead level was normal in June 1990. However, he opined that, because claimant's level was at 30 in May 1990 (with 25 ug/dl indicating excessive absorption of lead), his blood lead level several months earlier must have been at least twice as high.

Dr. Bayer, M.D., a toxicologist, did not agree that claimant's blood lead level had ever been abnormal and he reported that lead levels less than 40 mcg/dl were considered normal in adult workers. Dr. Bayer also did not agree with Dr. Morton that claimant's fall in blood lead must have been preceded by blood lead levels at least twice as high as 30, several months earlier. Dr. Bayer explained that the excretion of lead was not easily predictable, as variables such as concentration, duration of exposure and prior absorption of lead must be considered.

Finally, Dr. Bayer reported that, in the three months preceding the May 1990 blood test, claimant had worked at an auto body shop which could have exposed him to leaded gasoline fumes as well as fumes from the heating of metals. Dr. Bayer also noted that, although claimant complained of symptoms of chest congestion, headaches and numbness and tingling in his hands during his work with the employer, claimant's substance abuse could have contributed to his symptoms.

We are persuaded by the complete and well-reasoned opinion of Dr. Bayer. In addition, we do not find that Dr. Morton's opinion addresses the possible contributions to claimant's symptoms by the subsequent employment or substance abuse. We are also persuaded by Dr. Bayer's opinion that, because such variables affect the blood lead level, it cannot be predicted with certainty that claimant's prior blood level was abnormally high during his three months of work for the employer.

Because we have concluded that claimant has failed to establish an occupational disease, we also conclude that the diagnostic testing which claimant has undergone is not compensable. Accordingly, we affirm the Referee on the issue of compensability.

Penalties and Attorney Fees

We adopt the Referee's conclusions on this issue.

ORDER

The Referee's order dated January 18, 1991 is affirmed.

November 8, 1991

Cite as 43 Van Natta 2490 (1991)

In the Matter of the Compensation of

ELSIE D. RIOS, Claimant

WCB Case No. 90-07612

ORDER ON REVIEW

Craine & Love, Claimant Attorneys

C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Fink's order that granted claimant permanent total disability, whereas a Determination Order awarded 21 percent (67.2 degrees) unscheduled permanent disability for her rheumatoid arthritis condition. On review, the issue is extent of permanent disability, up to and including permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion and Conclusions of Law," with the following supplementation.

On review, SAIF contends that the Referee should not have rated claimant's impairment at hearing, as she was not medically stationary at the time. We disagree.

An injured worker is 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). Here, Dr. Kappes testified that he did not think that claimant's condition was "static," or "stationary" at the time of his September 1990 examination. However, Dr. Kappes also testified that the drugs claimant was taking were not a cure, and once she stopped taking them, the effectiveness would wear off. He was unable to state with any probability whether claimant would improve or worsen in the experimental program.

Finally, Dr. Kappes believed that, over time, claimant would continue to experience flare-ups of her arthritis condition, and based upon the fact that he had treated her for several years and realizing that she was in a relapse, Dr. Kappes was uncertain when claimant would ever be stable enough to return to work. Dr. Kappes also felt that claimant's current condition was a permanent one.

We conclude that Dr. Kappes' testimony, when taken as a whole, indicates that no further material improvement of claimant's rheumatoid arthritis condition would reasonably be expected from medical treatment or the passage of time.

Accordingly, we agree that the Referee properly rated claimant's impairment at the time of hearing.

SAIF also contends that there are jobs claimant is capable of performing. SAIF argues that vocational experts Lageman and Moses reported that claimant could work as an interpreter because the job could be structured to her medical limitations. Mr. Moses also testified that claimant could return to past employment, as long as she had an understanding employer who would permit her to take time off for flare-ups of her condition.

We conclude that the fact that a sympathetic employer might hire claimant does not establish that she is currently employable or able to sell her services on a regular basis in a competitive labor market. See Harris v. SAIF, 292 Or 683, 695 (1982). We also conclude that claimant's room and board plus a \$30 per month stipend is not regular gainful employment, as claimant and Father Albano testified that she worked only when she was capable of doing so, and even if claimant could not care for herself, the Society would take care of her.

Finally, SAIF contends that claimant has not shown that she is motivated to seek employment. We disagree.

The record shows that claimant was forced to leave several jobs because of her medical condition. Claimant also attempted to retrain herself through a data entry program. Claimant has contacted several legal organizations to offer her services as an interpreter but she has not been able to obtain work. Finally, claimant has worked for the Society teaching children's classes and visiting farm workers when her condition allows. Claimant also testified that she was willing to work. Under the circumstances, we agree with the Referee that, but for her compensable condition, claimant would have been willing to seek regular gainful employment.

Because SAIF requested review and we have affirmed the Referee on the issue of permanent total disability, claimant's counsel is entitled to an assessed fee. After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that \$2,000 is a reasonable assessed attorney fee for claimant's counsel's services concerning the issue of permanent total disability. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue presented, and the value of the interest involved.

ORDER

The Referee's order dated January 9, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$2,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
ROBERT P. ROTH, Claimant
WCB Case No. 90-07949
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of Referee Galton's order that: (1) granted claimant permanent total disability, whereas a prior Determination Order had awarded him 22 percent (70.4 degrees) unscheduled permanent partial disability for his cervical and psychological conditions; (2) declined to authorize an offset for permanent disability payments made prior to October 1, 1990; and (3) directed the employer to offset its overpayment of temporary disability benefits paid subsequent to October 1, 1990, against 25 percent of each permanent total disability payment due. On review, the issues are permanent total disability, offset, and percentage of offset. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant was 63 years old at the time of hearing. He has a GED and one-half year of college. Claimant's work experience includes jobs in the fields of automotive equipment and scientific instrument technology, business machine repair, building maintenance and plant engineering, and locksmith.

Claimant sustained a compensable injury on October 30, 1984, when he received an electric shock while working on wiring. A June 10, 1988 Determination Order awarded claimant 20 percent unscheduled permanent partial disability for his chronic cervical strain and occipital headaches which resulted from the injury.

On March 27, 1987, claimant exhibited threatening behavior and was subsequently admitted to a hospital. He began to treat with Dr. Harrison, M.D., a psychiatrist. Claimant was readmitted to the hospital in May 1987, at which time his mental condition was diagnosed as bipolar disorder.

The employer's denial of claimant's psychological condition was set aside by a January 13, 1989 Opinion and Order. A May 14, 1990 Order on Review affirmed the Referee's order and the employer did not appeal.

Claimant is limited to sedentary work with restrictions on crouching, kneeling, carrying or regular lifting. He has not returned to work.

FINDINGS OF ULTIMATE FACT

Claimant is incapacitated from regularly performing work at a gainful and suitable occupation.

Efforts to obtain work would be futile.

But for the compensable injury, claimant would be willing to seek regular gainful employment.

CONCLUSIONS OF LAW AND OPINION

Permanent total disability

The Referee concluded that claimant was permanently totally disabled. We agree.

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as the condition of the labor market." Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977).

Unless claimant's physical incapacity, in conjunction with his nonmedical disabilities, renders a work search futile, he must also establish that he has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3); SAIF v. Scholl, 92 Or App 594, 597 (1988). Moreover, even if a work search would be futile, he must further establish that, but for the compensable injury, he would have returned to work. SAIF v. Stephen, 308 Or 41, 47-48 (1989).

In the present case, the employer argues, in effect, that claimant's psychological condition should not be considered in determining whether claimant is permanently totally disabled. The employer contends that claimant's treating psychiatrist, Dr. Harrison, M.D., does not attribute claimant's current symptoms and disability to the October 30, 1984 injury. The employer also asserts that claimant does not exhibit the symptoms of a Class 3 psychosis, and therefore, Dr. Harrison's opinion is not persuasive. Finally, the employer contends that the other psychiatrists (Drs. Smith, Turco and Sturges) who examined claimant have concluded that claimant's psychological condition is attributable to a pre-existing condition, rather than to his compensable injury.

We conclude that, under the law of the case, claimant has established a compensable psychological condition. A prior referee relied upon the opinion of Dr. Harrison, the treating psychiatrist, in concluding that claimant's psychological condition was compensable. A subsequent Order on Review affirmed the Referee's order. The Board agreed that Dr. Harrison's opinion was persuasive and further agreed that Dr. Smith's opinion that the injury did not cause or contribute to claimant's condition should be rejected. The Board's order was not appealed.

We conclude that the present case is similar to a court case in which the court concluded that, although a carrier's doctor was entitled to reiterate his original conclusion that claimant's condition was unrelated to her injury, his opinion conflicted with the law of the case, which was that permanent disability resulted from the injury. Kuhn v. SAIF, 73 Or App 768, 772 (1985). In Kuhn, a prior referee rejected the opinion of the carrier's doctor who related claimant's condition to a congenital abnormality. The Referee relied, instead, upon the opinion of claimant's treating doctor. The carrier did not request Board review. At a subsequent hearing on the issue of aggravation, the Referee again relied upon the opinion of the treating doctor and discounted the opinion of the carrier's doctor, who continued to assume that the injury had caused no permanent disability.

The court in Kuhn agreed with the Referee and found that the opinion of the carrier's doctor conflicted with the law of the case. Accordingly, the court concluded that, as a legal matter, the carrier's doctor was wrong and his opinion must be discounted. Kuhn, supra. Also see Edgar L. Kinnett, 43 Van Natta 1240 (1991); Donna J. Wilson, 42 Van Natta 1026, 1028 (1990).

We conclude that, under the law of the case, claimant's psychological condition is related to his compensable injury. Under the circumstances, the employer may not argue that claimant's condition is attributable to a preexisting disorder. Moreover, we do not rely upon the opinions of Drs. Smith, Turco and

Sturges, whose opinions are based upon conclusions contrary to the law of the case. Therefore, in determining claimant's permanent disability, we take into account his compensable psychological condition.

In September 1989, Dr. Harrison reiterated that claimant suffered from a bipolar disorder that had "both manic and depressive expressions." Dr. Harrison reported that claimant's manic episodes had responded well to treatment with lithium, but he had not had much success in treating claimant's chronic depression. Finally, Dr. Harrison reported that claimant was completely disabled from any employment. (Ex. 101).

In March 1990, Dr. Olmscheid, claimant's treating neurologist, reported that claimant had neck pain which was present most of the time, in addition to chronic pain in the cervical region. In September 1990, Dr. Olmscheid reported that claimant had frequent, almost daily headaches "proportional to the degree of neck pain...." Dr. Olmscheid found that claimant's physical capacity was limited to sedentary work with additional restrictions on crouching, kneeling or lifting with any regularity. Additionally, Dr. Olmscheid noted that claimant also had an "element of chronic depression which requires on-going treatment." (Ex. 110A).

At hearing, Dr. Harrison testified that he prescribes numerous medications for claimant's psychiatric disorder. Dr. Harrison also testified that claimant was depressed and his psychological condition affected his ability to maintain social relationships, to deal with the public, to carry out complex instructions, to complete tasks, and to deal with the everyday stresses of a work environment. Finally, Dr. Harrison testified that claimant would not be capable of regular attendance at either a part-time or full-time job.

Under the circumstances, we conclude that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation, due to his 1984 compensable injury and its psychological sequelae. In reaching this conclusion, we rely upon the opinions of claimant's treating doctors, Drs. Olmscheid and Harrison, who have treated claimant over a four-year period. We conclude that, as claimant's treating neurologist and psychiatrist, Drs. Olmscheid and Harrison are in the best position to comment on the effect of claimant's physical and mental impairment. See Givens v. SAIF, 61 Or App 490 (1983).

Assuming arguendo that claimant is not permanently and totally disabled from a medical standpoint, we would nevertheless conclude that he is permanently and totally disabled under the "odd-lot" doctrine. See Wilson v. Weyerhaeuser, 30 Or App 403 (1988). Claimant is 63 years old and his employment history has involved work primarily in the fields of maintenance, repair and locksmith work. Because of his condition and his reaction to medication, claimant was unable to complete vocational rehabilitation services which began in July 1987. At hearing, claimant testified that he was unable to return to work due to chronic pain. He also attempted to return to locksmith work which he was unable to perform due to unsteadiness of his hands.

Finally, we are persuaded that, but for his compensable injury, claimant would be willing to work. Claimant attempted to return to his regular job and locksmith work. Vocational counselors noted claimant's statements that he was motivated to return to work. At hearing, claimant testified that he would return to work if he could and he had sent out resumes to employers.

We conclude that the opinions of Dr. Olmscheid and Dr. Harrison, in addition to claimant's testimony, establish that claimant is not capable of performing work at a gainful and suitable occupation. Under the circumstances,

claimant's age, aptitude and lack of training, combined with his physical and psychological conditions, render him permanently totally disabled under the "odd-lot" doctrine.

Offset: permanent partial disability against permanent total disability

The Referee concluded that the employer had not proven that it was entitled to offset permanent partial disability paid pursuant to the April 1990 Determination Order against claimant's permanent total disability award.

We agree that the employer is not entitled to an offset of permanent partial disability benefits which were paid prior to the effective date of the permanent total disability award. See e.g. Rinaldo F. Sinclair, 42 Van Natta 174 (1990). Moreover, although claimant would not be entitled to receive simultaneous permanent partial disability payments and permanent total disability payments, see Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983), the employer has not asserted that it is continuing to pay partial disability payments awarded under the 1990 Determination Order. Accordingly, we affirm the Referee on the issue of offset of permanent total disability benefits against permanent partial disability benefits.

Percentage of offset

The Referee concluded that the employer could recover its overpayment of temporary disability benefits by taking an offset against 25 percent of each permanent total disability payment due to claimant. The employer contends that it should be permitted to an offset against 100 percent of each permanent total disability payment due, until the overpayment has been recouped. We agree.

We acknowledge claimant's argument that, if an offset is permitted against the entire amount of the incremental permanent total disability payment, it could result in hardship to workers who are permanently totally disabled. However, we are unable to find authority in the statute or rules pertaining to offset that would allow us to impose a method of collection of overpayment upon the employer. Under the circumstances, we conclude that the employer is permitted to offset the \$2,371.95 overpayment of temporary disability benefits against claimant's permanent total disability award, until the overpayment has been recovered.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$1,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated November 28, 1990, as reconsidered by the February 8, 1991 order, is reversed in part and affirmed in part. That portion of the Referee's order that directed the employer to offset its \$2,371.95 overpayment of temporary disability benefits against 25 percent of claimant's permanent total disability payments is reversed. The employer is authorized to offset the stated amount of temporary disability benefits against claimant's permanent total disability award. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of \$1,500, payable by the employer.

In the Matter of the Compensation of
AUDREY L. YAKES, Claimant
WCB Case No. 89-01405
ORDER ON REMAND
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. The court has reversed our prior order, which reversed a Referee's order that awarded a carrier-paid attorney fee when the insurer rescinded its "de facto" denial of claimant's medical service claim prior to hearing. The court has reversed and remanded for reconsideration in light of Jones v. OSCI, 108 Or App 230 (1991). The insurer has submitted a "Memorandum on Remand" reiterating its prior argument that claimant did not appeal from an order or decision denying a claim for compensation.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation. Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

In light of our finding that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of the insurer's "de facto" denial prior to the scheduled hearing, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1). Jones v. OSCI, supra. Consequently, as supplemented herein, we adopt that portion of the Referee's "Opinion," which concluded that claimant is entitled to an attorney fee for the services rendered in this matter.

Nevertheless, we modify the Referee's \$1,800 attorney fee award. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee concerning the rescission of the insurer's "de facto" denial prior to hearing is \$1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the issue (as represented by the record and claimant's attorney's statement of service), and the value of the interest involved. On this latter point, we note that we have generally held that results obtained in the form of medical services are generally considered to be "rather modest." Dwight E. Fillmore, 40 Van Natta 794 (1988), aff'd 98 Or App 567 (1989); Clifford D. Howerton, 38 Van Natta 1425 (1986); Derry D. Blouin, 35 Van Natta 570 (1983).

Accordingly, on reconsideration, the Referee's order dated August 29, 1989 is modified. In lieu of the Referee's attorney fee award, claimant's attorney is awarded \$1,200, to be paid by the insurer.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT L. BEDWELL, Claimant
WCB Case No. 89-08167
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The SAIF Corporation requests review of Referee Holtan's order that set aside its denial of claimant's claim for a current low back condition. On review, the issues are claims processing and aggravation. We reverse.

FINDINGS OF FACT

Sometime prior to 1980, claimant injured his low back in a motorcycle accident. His back problems resolved thereafter, to the extent that he was able to perform heavy labor, chop wood and practice martial arts.

Claimant began working for the employer in 1987. His job involved repetitive bending and lifting, but not regular heavy lifting. He began experiencing low back pain again in February 1987 and filed a claim against SAIF. SAIF denied the claim on the grounds that it did not provide coverage for the employer. During the next year, claimant experienced numerous exacerbations and sought treatment from various physicians. His symptoms included paraspinal muscle spasms and extreme pain behavior.

Eventually, SAIF, as processing agent for the noncomplying employer, agreed to accept claimant's occupational disease claim for a low back condition, by stipulation effective February 12, 1988. SAIF accepted the claim on May 2, 1988.

Dr. Blosser diagnosed claimant's condition as joint dysfunction, noting a pattern of response to symptoms called "back spasm syndrome." He declared claimant medically stationary, without permanent impairment, on April 4, 1988 and released him for work. Claimant returned to full-time work.

A July 27, 1988 Determination Order closed the claim with no award of permanent impairment. Claimant did not appeal the Determination Order.

During the summer and fall of 1988, claimant worked as a landscaper. He taught martial arts, sparred with his son, hunted and fished and enjoyed playing with his pitbull.

On December 27, 1988, claimant was involved in a motor vehicle accident (MVA). He treated for neck, upper back and low back pain which began immediately after the MVA. Dr. McIntyre released him from work.

On March 13, 1989, SAIF denied claimant's aggravation claim, on the grounds that claimant's then current condition, diagnosed as a back strain, was unrelated to his February 13, 1987 industrial "injury."

Claimant did not seek medical treatment for his back between the first week in April 1988 and the December 27, 1988 MVA. He has not worked since the MVA.

CONCLUSIONS OF LAW AND OPINION

At the outset, we address claimant's contention that SAIF's acceptance encompassed claimant's current condition.

Claimant points out that his low back symptoms are the same now as they were when his occupational disease claim was accepted. He argues that SAIF accepted the condition causing the symptoms, citing SAIF v. Abbott, 103 Or App 49 (1990) (Having accepted a condition involving upper extremity swelling, aching and hand numbness, SAIF could not avoid responsibility for claimant's carpal tunnel syndrome condition, because the acceptance encompassed the disease causing the symptoms).

Here, claimant filed a claim for "acute cervical and lumbar strain with associated segmental dysfunction, myospasm complicated by grade 1 retrolesthesia [sic] cervical hypolordosis, and hyposthesia [sic] of left upper extremity C3-T1 permatomes." (Ex. 2). By stipulation, the parties agreed that the claim is properly analyzed as an occupational disease and SAIF agreed to accept the claim. (Ex. 11-2). On May 2, 1988, SAIF formally accepted claimant's claim for "acute cervical and lumbar strain." (Ex. 12).

Considering these facts, particularly the notice of claim acceptance, we conclude that the scope of SAIF's acceptance was specifically limited to the cervical and lumbar strain which it formally accepted. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). In reaching this conclusion, we note that there is some medical evidence which suggests that claimant's current problems may be due in part to psychological factors which were not identified as such prior to the 1988 MVA. However, no psychological condition has been diagnosed by a psychologist or psychiatrist. Therefore, claimant has not established that any psychological condition which he may have is compensable. Under these circumstances, we are unwilling to conclude that SAIF accepted anything other than the cervical and lumbar strain listed in its formal acceptance. See Johnson v. Spectra Physics, 303 Or 49, 52 (1987). Moreover, in view of our finding below that claimant's MVA was a superceding cause of his current problems, SAIF is not procedurally precluded from denying claimant's claim for a condition which is not the same as the condition it accepted. See Bauman v. SAIF, 295 Or 788, 794 (1983). We turn to the merits.

Because claimant requested a hearing before May 1, 1990, and the hearing was convened before July 1, 1990, we apply the law in effect before July 1, 1990. See Or Laws 1990 (Special Session), ch 2, 54(2)

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the industrial injury. See former ORS 656.273(1); Perry v. SAIF, 307 Or 654, on rem 99 Or App 52 (1989). He must show that there is a material relationship between the compensable condition and the alleged worsening. Grable v. Weyerhaeuser Co., 291 Or 387 (1981). The causal connection between the compensable condition and the current condition must be "substantial," but the compensable condition need not be the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

Here, although claimant's low back symptoms are the same now as they were when his occupational disease claim was accepted, his disability and need for treatment for his low back have not been continuous since the onset of the disease. In fact, claimant sought no treatment for his low back between the first week in April 1988 and the December 1988 MVA. Dr. Blosser, who treated claimant at the onset of his low back problems and again after the MVA, reported that claimant was "fine," when he released him to return to work in April 1988. (Ex. 23-1). We also note that claimant's wife and son recalled at hearing that claimant was doing well before the MVA. (Tr. 128-9, 159). In the interval, moreover, claimant performed heavy work as a landscaper, taught martial arts, sparred with his son, hunted and fished and rough-housed with his pitbull. (Tr. 14-118).

The medical evidence concerning causation is divided. Due to the gap in low back treatment and claimant's ability to engage in physical activities involving his low back prior to the MVA, the causation issue is a complex medical question. Resolution of the issue requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). In this case, we are unpersuaded by the medical evidence supporting a continuing causal relationship between claimant's 1987 occupational disease and his current problems for the following reasons.

Dr. Blosser, who treated claimant in 1987 and again following the MVA, initially opined that claimant's problems following the MVA were related to that accident, rather than to his preexisting work-related condition. (Ex. 17). Later, he changed his opinion, indicating that claimant's current problems are related to his occupational disease, via claimant's psychological response to pain, known as "back spasm syndrome." Blosser admitted that he had changed his opinion regarding the causation of claimant's current problems. He explained that, because claimant's response to low back pain is the same now as it was before the MVA, and because claimant's symptoms began at the onset of his occupational disease, Blosser related the current problems to the initial work-related cause. Inasmuch as Blosser described claimant as "fine" prior to the MVA, his reasoning concerning the temporal relationship between claimant's symptoms and onset of his occupational disease is not persuasive as to claimant's current condition. Since Blosser did not offer a reasonable explanation for changing his opinion, we attach little probative value to it. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also Kelso v. City of Salem, 87 Or 630 (1987) (physician had reasonable explanation for change in his opinion).

Dr. Waldman, chiropractor, examined claimant and opined: "Due to the fact that this patient did not complain of back trouble prior to his original industrial injury, it would be sensible to conclude that the initial industrial injury which occurred on 2/13/87 has to some degree contributed to this patient's current condition." (Ex. 38-3). In reaching that conclusion, Waldman apparently relied on claimant's history that the December 1988 MVA caused no material worsening. (See Ex. 38-2). However, that history is contradicted by claimant's sudden need for low back treatment following the MVA. Consequently, we do not rely on Waldman's opinion, which is not based on an accurate history. We are similarly unpersuaded by the opinion of Dr. Sirounian, as it is conclusory. (Ex. 36A). See Somers v. SAIF, 77 Or App 259 (1986).

Under these circumstance, particularly in the absence of persuasive medical evidence supporting a causal relationship between claimant's compensable condition and his current problems, we conclude that claimant has not carried his burden of proof.

ORDER

The Referee's order dated November 14, 1990 is reversed. The SAIF Corporation's March 13, 1989 denial is reinstated, and upheld. The Referee's assessed fee award is reversed.

In the Matter of the Compensation of

ASHWANI K. GROVER, Claimant

WCB Case No. 87-15229

ORDER ON REVIEW

Hollander & Lebenbaum, Claimant Attorneys

Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of those portions of Referee Schultz' Opinion and Order on Remand that: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability award for a low back injury from 20 percent (64 degrees), as awarded by Determination Order, to 58 percent (185.6 degrees); and (3) upheld the insurer's denial of claimant's impotency condition. The insurer cross-requests review of that portion of the Referee's order which set aside its partial denial of claimant's middle and upper back condition. On review, the issues are extent of unscheduled permanent disability, including permanent total disability, and compensability. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except that the August 27, 1987 Determination Order terminated time loss on July 15, 1987, not September 15, 1987.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinions," except those concerning claimant's middle and upper back and neck complaints, with the following supplementation.

The Referee set aside the insurer's March 2, 1989 partial denial, which denied the compensability of the above mentioned conditions as well as claimant's psychological condition. (See Ex. 96A). We agree with the Referee's conclusion that claimant has carried his burden regarding his psychological condition. However, we disagree with his conclusions concerning claimant's middle and upper back and neck complaints.

The Referee found claimant's thoracic and cervical complaints compensable, based on claimant's credible testimony regarding the onset of symptoms, his injury-related functional overlay, and evidence supporting a finding that physical therapy contributed to claimant's thoracic, cervical and left shoulder symptoms. The Referee discarded the opinion of Dr. Tilson, former treating physician, which concluded that these complaints are not related to the 1986 injury. (See Ex. 93A). In so doing, the Referee reasoned that Tilson overlooked the mechanism of the 1986 injury and claimant's reporting of relevant symptoms soon after that injury.

Claimant has the burden of proving that his 1986 injury was a material contributing cause of his thoracic and cervical disability and/or need for treatment. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). In this case, there is no evidence that claimant had upper back problems prior to the 1986 low back injury and he did begin reporting upper back symptoms within two months of his compensable injury. However, causation is not inferred from temporal proximity alone. See Allie v. SAIF, 79 Or App 284, 288 (1986); Edwards v. SAIF, 30 Or App 21 (1977), rev den, 279 Or 301 (1977). In fact, due to the passage of time since the injury and the number of potential causes, the causation issue in this case is a complex medical question which must be resolved by expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 426

(1967): Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

Numerous physicians recorded claimant's upper back complaints. However, the only expert who arguably related these symptoms to the 1986 injury is Dr. Pomerleau, chiropractor, who first treated claimant over a year after his injury. Pomerleau noted that a 1987 MRI, (see Ex. 30), revealed claimant's thoracic and cervical degenerative disc disease and that claimant has "dermatome losses at C6, 7 & 8 levels and L5 and S1 levels." (Ex. 91A). She opined: "With coexistent [sic] acute disc disease and radiculopathy, a combination of upper and lower motor neuron involvement should be expected." (Id.) Inasmuch as the preponderance of the medical evidence indicates that claimant's disc disease is minimal or mild, rather than acute, and that claimant does not have nerve root involvement, (see Ex. 85), we conclude that Pomerleau's opinion is not persuasive as it is not based on an accurate history. See Somers v. SAIF, 77 Or App 259 (1986).

Instead, we are persuaded by the opinion of Dr. Tilson, who recorded claimant's upper back complaints during the time he treated claimant for his back problems in 1986 and 1987. (See Exs. 10, 19, 21, 22, 24, 25). Tilson diagnosed degenerative joint disease in claimant's thoracic spine, "superimposed strain by history," (Ex. 22, emphasis added) and "arthritis degenerative thoracic spine minimal, superimposed industrial strain cervical thoracic & lumbar spine by hx" (Ex. 24, emphasis added). Although claimant has consistently maintained that all of his back problems are related to his 1986 injury, claimant's opinion regarding causation is not sufficient to carry his burden in this case. See Uris v. Compensation Department supra; Kassahn v. Publishers Paper Co., supra.

In 1989, Tilson opined there was no relationship between claimant's 1986 injury and his neck and upper back pain. (Ex. 93A). We acknowledge that, in his 1989 report, Tilson apparently overlooked his own earlier recording of claimant's upper back complaints. Nevertheless, we note that Tilson's opinion concerning causation was based on the undisputed x-ray findings as well as claimant's reporting. Inasmuch as claimant's x-ray changes are not trauma-related and of questionable clinical significance, Tilson's opinion is persuasive, regardless of the timing of claimant's reporting.

Moreover, Tilson's conclusions are consistent with the opinions of Drs. Howell and Berselli. Dr. Howell, osteopath, noted claimant's upper back complaints, (Ex. 26-3), but diagnosed somatic dysfunction and found no evidence of unresolved neck or low back strains. (Ex. 26-7). Dr. Berselli, orthopedic surgeon, noted claimant's complaints, contrasted with normal objective findings, (Ex. 27), and concluded that claimant's problems were mainly psychological. (Ex. 59a).

In the absence of persuasive medical evidence relating claimant's upper back symptoms to his compensable injury, we conclude that claimant has not carried his burden in this regard. In reaching this conclusion, we are mindful of the Referee's unappealed finding that claimant's low back complaints are a compensable component of his injury-related psychological condition. However, inasmuch as there is no persuasive evidence indicating that claimant's 1986 injury involved his middle or upper back or his neck, we are unwilling to conclude that his symptoms in those areas are causally related to his compensable condition. Given our approval of the Referee's impairment rating, no additional impairment would be awarded for the upper back, had we found that condition to be compensable.

We have determined herein that the portion of the insurer's March 2, 1989 partial denial concerning claimant's middle and upper back claim should be reinstated. However, that portion of the Referee's order that set aside the insurer's partial denial of claimant's psychological claim is not disturbed. Inasmuch as the Referee awarded a \$4,500 assessed attorney fee for prevailing on both partially denied claims, that fee is modified, so that claimant's counsel is compensated for his services concerning the claim for a psychological condition only. See ORS 656.386(1).

Accordingly, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing concerning the psychological claim is \$2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value to claimant of the interest involved.

Finally, we note that claimant seeks impairment ratings for lost range of motion in his hips. However, there is no evidence connecting claimant's hip impairment to his compensable injury. Therefore, that impairment is not ratable under the "standards." See Thomas C. Moore, 43 Van Natta 1002, 1003 (1991); Dennis L. Greger, 43 Van Natta 1445, 1446 (1991).

ORDER

The Referee's order dated June 5, 1989, as amended on June 20, 1989 and corrected on June 30, 1989, is affirmed in part, modified in part and reversed in part. That portion of the order that set aside the portion of the March 2, 1989 denial that denied claimant's middle and upper back conditions is reversed. That portion of the denial is reinstated and upheld. In lieu of the Referee's award of an assessed fee, claimant's counsel is awarded a total assessed fee of \$2,500, for his services at the hearing level concerning claimant's claim for a psychological condition. The remainder of the order is affirmed.

November 13, 1991

Cite as 43 Van Natta 2502 (1991)

In the Matter of the Compensation of
RONALD T. SMITH, Claimant

WCB Case No. 90-15868

ORDER ON REVIEW

Ackerman, et al., Claimant Attorneys

John M. Pitcher, Defense Attorney

Reviewed by Board Members Westerband and Moller.

Claimant requests review of Referee McWilliams' order that upheld the self-insured employer's denial of claimant's low back and right hip injury claim. On review, the issue is course and scope of employment.

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

Addressing the factor of whether the activity was an ordinary risk of, and incidental to, the employment, claimant argues that, where the activity occurred within time and place constraints of employment, the dispositive factor is whether the employer expressly or impliedly allowed the conduct. Claimant cites Clark v. U.S. Plywood, 288 Or 255 (1980), in support of this argument. However, we note that the Court in Clark also held that "the other prerequisite to recovery must be shown, that is, that the injury arises out of the course of

employment." Clark, supra at 267. Here, we agree with the Referee that claimant's injury did not arise out of the course of employment. Furthermore, we find Clark distinguishable in that it dealt with activities for the personal comfort of the employee. The personal comfort doctrine is not involved in the present case.

Finally, we note that, although the activity need not be similar to the worker's work duties to be an ordinary risk of employment, it must be a risk the worker is exposed to because of the nature of his working conditions. Fred H. Jacobson, 43 Van Natta 1420 (1991). Here, there is nothing in the nature of claimant's working conditions as a dryer feeder that exposed him to a risk of injury while loading particle board into his personal vehicle.

ORDER

The Referee's order dated January 30, 1991 is affirmed.

November 14, 1991

Cite as 43 Van Natta 2503 (1991)

In the Matter of the Compensation of
FRANK M. DECLEVE, Claimant
WCB Case Nos. 89-04495 & 89-04496
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Emerson's order that: (1) declined to award temporary total disability upon finding a compensable aggravation claim; and (2) finding claimant's bilateral shoulder condition medically stationary, determined the extent of permanent disability. The self-insured employer cross-requests review of the Referee's order that: (1) set aside its denial of claimant's aggravation claim for a bilateral shoulder condition; (2) set aside its partial denial of claimant's medical services claim for chiropractic treatment for the bilateral shoulder condition, as well as the low back condition; and (3) increased claimant's unscheduled permanent disability award for a bilateral shoulder condition from 15 percent (48 degrees), as awarded by a Determination Order, to 35 percent (112 degrees). On review, the issues are temporary disability, premature closure, aggravation, medical services and extent of unscheduled permanent partial disability.

The Board affirms and adopts the order of the Referee as supplemented.

Medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of an injury. When palliative care reduces pain and enables a claimant to work, such treatment is considered reasonable and necessary. See former ORS 656.245; West v. SAIF, 74 Or App 317, 320-321 (1985); Jose Ybarra, 40 Van Natta 5 (1988).

Here, claimant testified, and the medical record supports, that palliative care relieved severe pain, and enabled claimant to engage in his daily regime. Claimant sought this treatment on an "as needed" basis. In addition, we find that claimant's return to "light" duty work is circumstantial evidence of the effectiveness of these treatments in permitting claimant to work.

Inasmuch as claimant did not submit a reply brief concerning the insurer's cross-request, no attorney fee shall be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated September 12, 1991 is affirmed.

November 14, 1991

Cite as 43 Van Natta 2504 (1991)

In the Matter of the Compensation of
SOLEDAD FLORES, Claimant
WCB Case No. 90-10779
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of those portions of Referee Spangler's order that: (1) found claimant medically stationary as of May 23, 1990; and (2) declined to authorize the insurer to offset temporary disability benefits paid after May 7, 1990. Claimant cross-requests review of those portions of the Referee's order that: (1) awarded claimant 18 percent (57.6 degrees) unscheduled permanent disability, whereas a Determination Order awarded no permanent disability; (2) upheld the insurer's denial of claimant's current chiropractic treatment; and (3) declined to assess a penalty and related attorney fees for the insurer's allegedly unreasonable denial of chiropractic services. On review, the issues are medically stationary date, offset, medical services, extent of permanent disability and penalty and attorney fees. We affirm in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant's pseudoarthrosis at L4-5 is a congenital problem which preexists the compensable injury since at least 1982. (Exs. 6, 65-6).

Claimant sought treatment for a "sore back" in 1982 when she had painful low back symptoms that lasted one week. (Ex. 12-1).

Claimant's treating physician, Dr. Waldman, found claimant medically stationary on May 23, 1990. (Exs. 70-2, 71-2, & 78-1).

Claimant has not returned to regular or modified work. Claimant has not been given a written release to return to regular employment by her attending physician. Claimant has not been given a written offer of modified employment.

Claimant is not credible.

ULTIMATE FINDINGS OF FACT

We adopt the Referee's "Ultimate Findings of Fact" with the exception of the last sentence. We replace the last sentence with the following:

There was an overpayment of temporary total disability from May 23, 1990 to June 19, 1990.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Senate Bill 1197. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Senate Bill 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.¹

Medically Stationary Date

The Referee found that claimant was medically stationary on May 23, 1990. The insurer argues that claimant was medically stationary on May 7, 1990, the date the Orthopaedic Consultants examined claimant. We agree with the Referee.

"Medically stationary" means that no further improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). We may properly consider post-closure medical evidence, which does not pertain to a subsequent change in the worker's condition. Scheuning v. J. R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987). Claimant's treating physician, Dr. Waldman, found claimant medically stationary on May 23, 1990. Dr. Waldman has had a greater opportunity to observe and evaluate claimant's condition than the Orthopaedic Consultants who examined claimant only once. Therefore, we find the opinion of Dr. Waldman more persuasive than that of the Consultants. Accordingly, we conclude that May 23, 1990 is claimant's correct medically stationary date.

Offset

The Referee found that claimant had not returned to regular or modified employment, nor had she been given a written release to return to regular or modified work. Relying on ORS 656.268(3), he concluded that there was no overpayment of temporary disability entitling the insurer to an offset. The insurer argues that it is entitled to an offset of temporary disability benefits paid after the date claimant became medically stationary against future awards, if any, of permanent disability.

In amending ORS 656.268, the 1990 Legislature modified subsection (1), deleted paragraph (2)(c), and added subsection (3). The new statute provides as follows [brackets indicate portions which have been deleted by the 1990 amendments]:

"(1)...Claims shall not be closed [nor temporary disability compensation terminated] if the worker's condition has not become medically stationary....

1. In reaching this conclusion, we recognize that, when determining claimant's entitlement to continued temporary disability payments, former ORS 656.268(3) was in effect, and the insurer was required to conform its conduct to that statute. However, we find nothing anomalous in a decision by the legislative to apply amended ORS 656.268(3) retroactively to all existing claims, thereby requiring the insurer's entitlement to an offset to be determined by the amended statute.

"[(2)(c) 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 Department of Insurance and Finance under this section.]

"(3) Temporary total disability benefits shall continue until whichever of the following events first occurs:

"(a) The worker returns to regular or modified employment;

"(b) The attending physician gives the worker a written release to return to regular employment; or

"(c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

We interpret these changes to ORS 656.268 to indicate the Legislature's intent to change claimants' procedural entitlement to temporary disability. Specifically, we conclude that it was the intent of the legislature to eliminate the requirement that claimants must be medically stationary before carriers may unilaterally terminate temporary total disability payments. We reach this conclusion based upon statutory construction and legislative history.

The function of ORS 656.268 is to provide for the orderly processing of claims, i.e., the carrier's procedural obligations. See Fazzolari v. United Beer Distributors, 91 Or App 592, 595, on recon 93 Or App 103, rev den 309 Or 236 (1988); Vip's Restaurant v. Krause, 89 Or App 214 (1988). The statute does not establish substantive entitlement to temporary disability benefits. Substantive entitlement to temporary disability benefits, which is codified by ORS 656.210 and developed by case law, provides that temporary disability benefits are due only for those periods until a claimant is restored to a condition of self support and maintenance as an able-bodied worker. See ORS 656.268; Fazzolari v. United Beer Distributors, supra at 595-596; Austin v. SAIF, 48 Or App 7 (1980) (citing Dimitroff v. State Ind. Acc. Com., 209 Or 316 (1957)). We note that ORS 656.210 was left unchanged by the legislature.

We find the plain meaning of the amended subsection (1), "Claims shall not be closed [nor temporary disability compensation terminated] if the worker's condition has not become medically stationary..." to accomplish two important functions: (1) it allows for the closing of claims based on claimant's medically stationary date, and thus, establishes claimant's substantive entitlement, per the Determination Order or Notice of Closure, to temporary disability; and (2) it eliminates the requirement that claimant be medically stationary as a necessary predicate for unilateral termination of temporary disability benefits by the carrier.

In reviewing the legislative history, we must interpret the statute in keeping with the legislative intent. Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). We find some guidance from the legislative history relating to passage of amended ORS 656.268. There is no express legislative discussion regarding the deletion of the "nor temporary disability compensation terminated" clause in former ORS 656.268(1), nor a discussion of the deletion of former ORS 656.268(2)(c). However, in floor debates of the House, Representative Shiprack stated that the amendments to ORS 656.268 was to overturn Fazzolari v.

United Beer Distributors, supra. See House Floor Proceedings, p. 36, lines 22-25; p. 37, line 1.

Therefore, we turn to the legal significance of the Fazzolari decision for the purpose of ascertaining legislative intent. Prior to Fazzolari, ORS 656.268 had been interpreted to allow a carrier to unilaterally terminate temporary total disability when claimant returned to regular work, was released by his physician to return to regular work, or there had been a determination that the claimant's condition was medically stationary. Under this prior case law interpreting former ORS 656.268, claimant was not required to be medically stationary to terminate temporary disability benefits. See e.g. Jackson v. SAIF, 7 Or App 109, 115 (1971). This interpretation remained undisturbed until the Fazzolari decision.

In Fazzolari, the court held that former ORS 656.268 provided, as a procedural matter, that the carrier could not unilaterally terminate claimant's temporary total disability until claimant was either released to regular work or returned to regular work and was medically stationary. Id. at 595. Accordingly, the fundamental impact of the Fazzolari decision was to limit the carrier's ability to unilaterally terminate temporary disability benefits.

As noted previously, one of the changes made by the legislature was to delete the language in ORS 656.268(1) which stated "nor temporary disability compensation terminated." We note that this language was quoted in italics by the Fazzolari court in reaching its conclusion concerning procedural entitlement to temporary disability benefits. Although there is no discussion of this issue in the court's opinion, it is clear from the court's citation and highlighting of this language that it formed the basis for the court's conclusion that a claimant must be medically stationary before temporary disability benefits could be unilaterally terminated. See Fazzolari v. United Beer Distributors, supra at 594.

Therefore, we find that when the legislature stated that it was overturning the court's decision in Fazzolari it was an implicit statement that the legislature desired to return to the state of the law prior to the Fazzolari decision, when a carrier could procedurally terminate temporary disability upon a return to regular work or a release to regular work without claimant also being medically stationary. Thereafter, upon claim closure, a claimant's substantive entitlement to temporary disability benefits would be determined.

In conclusion, it is our view that a claimant's substantive entitlement to temporary total disability remains unchanged by the modifications to ORS 656.268. Substantive entitlement to temporary disability compensation is determined on claim closure, at which time a claimant is entitled to temporary disability for that period of time, prior to becoming medically stationary, when he is unable to work. Moreover, a carrier is entitled to offset any temporary disability benefits paid in excess of a claimant's substantive entitlement against permanent disability awards.

In so holding, we recognize that an argument can be made that the amendments to ORS 656.268 eliminate the distinction between procedural and substantive entitlement to temporary total disability benefits. We presume that, under this theory, a claimant would remain substantively entitled to temporary disability benefits until one of the requirements of 656.268(3) was established. However, there is no legislative history supporting such a substantial change in the long-established principles applicable to substantive entitlement to temporary disability benefits. To the contrary, the existing legislative history supports our conclusion that only a carrier's ability to unilaterally terminate benefits was intended to be affected:

"[T]his section covers a portion that currently the law sharply restricts how an employer can stop time-loss benefits. Now, the cumbersome process of applying for permission to stop time loss often creates overpayments of benefits that are never recovered, or complicate future developments on the claim. Under this new law, an insurer can simply stop such payments without first getting approval under several conditions." 1990 Special Session, May 7, 1990, Senate Floor Proceedings, Senator Brenneman, p. 130-31.

Accordingly, we conclude that the legislative intent behind the 1990 amendments to ORS 656.268 was to limit procedural payments of temporary disability benefits, and thereby to limit overpayments which might never be recovered. There is no indication in the legislative record that the Legislature intended to extend claimant's substantive entitlement to temporary disability compensation.

We turn to the case at hand. Claimant's claim was closed by Determination Order dated July 3, 1990. The order found claimant to be medically stationary on May 15, 1990, and awarded temporary partial disability from September 27, 1988 through May 31, 1989, and temporary total disability from June 1, 1989 through May 15, 1990. By stipulation, the parties have agreed that the insurer has paid temporary disability benefits from May 16, 1990 through June 19, 1990.

Previously, we have concluded that claimant's medically stationary date is May 23, 1990. Therefore, claimant's substantive entitlement to temporary total disability ended May 23, 1990. Accordingly, the insurer is entitled to take an offset for those payments made after May 23, 1990 against any future awards of permanent disability.

Extent of Permanent Unscheduled Disability

The Referee awarded claimant 18 percent (57.6 degrees) unscheduled permanent disability, whereas the July 3, 1990 Determination Order had awarded no permanent disability. Claimant requests that we increase her unscheduled permanent disability award.

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. Former OAR 438-10-010.

Because claimant's condition became medically stationary in May, 1990, and her claim was closed by Determination Order on July 3, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant unscheduled permanent disability.

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age and Education

The appropriate value for claimant's age of 31 years is 0. Former OAR 436-35-290.

The appropriate value for claimant's seven years of formal education is 1. Former OAR 436-35-300(3).

We agree with the Referee that the appropriate value for claimant's skills is 3 and adopt that portion of the Referee's "Conclusions of Law." See former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

The Referee found that claimant did not have competence in a specific vocational pursuit. We disagree. Claimant has demonstrated competence in a specific vocational pursuit, that of a cabinet assembler. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

Adaptability

We adopt that portion of the Referee's "Conclusions of Law," with regard to claimant's adaptability to perform her regular work and concur that the appropriate adaptability value is 1. Former OAR 436-35-310(4).

Impairment

Claimant argues that she has chronic conditions limiting repetitive use of her neck and back so that she should receive a value of 5 percent for each. We agree with the Referee that claimant has sustained a compensable chronic condition limiting her ability to repetitively use her back and assign a value of 5. Former OAR 436-35-320(4). We also agree with the Referee that claimant has failed to prove that she has a chronic neck condition due to her compensable injury, and assign no value for a chronic neck condition.

We agree with the Referee that the evidence is insufficient to prove that claimant has sustained compensable spinal nerve plexus damage. Accordingly, we assign no value pursuant to former OAR 436-35-350(4).

The Referee found claimant's minimal disc bulge at L4-5 compensable. We disagree. The evidence is inconsistent that claimant has a disc bulge at L4-5. Dr. Purnell, radiologist, compared x-rays of claimant's lumbar spine taken on October 5, 1988, a few weeks after the compensable injury, to 1982 x-rays. The comparison indicates that "there has been very little interval change in the appearance of the lumbar spine." (Ex. 6). Dr. Purnell does not describe a disc bulge. On July 14, 1989, Dr. Harris, radiologist, reported that "no evidence of herniated disc is seen." (Ex. 21). Although there are references in some medical reports that claimant has a minimal disc bulge at L4-5, there is no evidence that this minimal disc bulge is due to the compensable injury. Additionally, Dr. Fuller, orthopedic surgeon, who authored a report which refers to a "sacralization of L5 on the left," stated that this sacralization is "not productive of any symptoms." (Ex. 23-5). Accordingly, we assign no value. ORS 656.214(5).

The Referee found that claimant's transverse process at L5 was indicative of pseudoarthrosis. He concluded that this condition was a compensable disc derangement under former OAR 436-35-350(2). We disagree. There is no medical evidence indicating that claimant's pseudoarthrosis is due to the compensable injury. Rather, this condition preexists claimant's compensable injury. Claimant's pseudoarthrosis was first noted in an x-ray study made in 1982. (Ex. 6). X-rays taken on October 5, 1988, a few weeks after the compensable injury, were compared to the 1982 x-rays. The comparison indicates that "there has been very little interval change in the appearance of the lumbar spine." (Ex. 6). Additionally, there is no evidence that claimant's preexisting pseudoarthrosis contributes to claimant's symptoms. Claimant's treating chiropractor, Dr. Waldman, merely notes the existence of lumbar disc degeneration. Particularly noteworthy, Dr. Brown, neurologist, and Dr. Thompson, orthopaedic surgeon, taking into consideration claimant's preexisting pseudoarthrosis, opine that claimant has sustained no permanent impairment due to the compensable injury. (Ex. 65-6). Accordingly, we assign no value. ORS 656.214(5).

Claimant argues that she has sustained loss range of motion due to the compensable injury. We agree with the Referee that claimant's noted exaggerations of the extent of her physical limitations is not sufficient evidence of a loss of range of motion and that there is no persuasive objective medical evidence that claimant has sustained any loss of range of motion due to the compensable injury.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to her education value, 4, the sum is 4. When that value is multiplied by claimant's adaptability value, 1, the product is 4. When that value is added to claimant's impairment value, 5, the result is 9 percent unscheduled permanent disability. Former OAR 436-35-280(7). However, because the insurer does not challenge the Referee's increased award, we affirm the Referee's award.

Compensability of Chiropractic Services

With the exclusion of his first paragraph under "Medical Services," p. 4, we adopt the Referee's "Conclusions of Law" with regard to the compensability of claimant's current chiropractic treatments.

Penalties and Related Attorney Fees

Claimant argues on review that the insurer's July 20, 1990 denial, denying claimant's current chiropractic treatments, is unreasonable because the July 20, 1990 denial letter gave incorrect information and that the July 26, 1990 denial letter, which amended the earlier denial, is unreasonable because it did not provide claimant with required information. Additionally, claimant argues that the insurer did not comply with the Director's Bulletin #215.

Upon our de novo review, we conclude that the July 26, 1990 denial letter, which states that its purpose is to amend the July 20, 1990 denial, does give claimant adequate information regarding the new statutory limitations on palliative chiropractic treatment. Furthermore, the insurer's failure to comply with a Director's bulletin has not caused a delay in the payment of compensation, nor is it a refusal to pay compensation.

We concur with the Referee that none of the insurer's denials are unreasonable.

Claimant is entitled to an assessed fee if her compensation has not been reduced or disallowed. See ORS 656.382(2). Although the insurer requested review of the claimant's medically stationary date, and we have affirmed that aspect of the Referee's order, that finding was germane only to issue of the amount of the insurer's offset. The Board has previously concluded that an offset does not reduce compensation within the meaning of ORS 656.382(2). See Christine L. Davis, 42 Van Natta 397, 398 (1990); see also Strazi v. SAIF, 109 Or App 105 (1991). Accordingly, claimant is not entitled to an assessed fee in this matter.

ORDER

The Referee's order dated September 14, 1990 is affirmed in part and reversed in part. That portion of the Referee's order which declined to award an offset is reversed. The insurer is allowed an offset of temporary total disability benefits paid from May 23, 1990 to June 19, 1990 against future awards, if any, of permanent disability. The remainder of the Referee's order is affirmed.

November 14, 1991

Cite as 43 Van Natta 2511 (1991)

In the Matter of the Compensation of
RONALD T. HOFMANN, Claimant
WCB Case No. 91-02122
ORDER DENYING MOTION TO DISMISS
Michael B. Dye, Claimant Attorneys
Cooney, et al., Defense Attorneys

The insurer has moved the Board for an order dismissing claimant's request for review of the Referee's August 30, 1991 order. Contending that notice of claimant's request was not timely provided to the other parties to this proceeding, the insurer seeks the dismissal of claimant's request for Board review. We deny the motion.

FINDINGS OF FACT

On August 30, 1991, the Referee issued an Opinion and Order. On Monday, September 30, 1991, the Board received claimant's request for Board review of the Referee's order. The request included a certificate of personal service by mail, certifying that copies of the request had been mailed to the employer, its insurer, and the insurer's counsel on September 30, 1991.

CONCLUSIONS OF LAW AND OPINION

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 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). 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, supra.

Here, the 30th day after the Referee's August 30, 1991 order was September 29, 1991, a Sunday. Therefore, the final day to timely request review was Monday, September 30, 1991. ORCP 10A; ORS 174.120. Claimant's request for review was received by the Board and copies were mailed to the other parties to the proceeding on September 30, 1991. Inasmuch as such submissions were made on the

final day to timely comply with ORS 656.289(3) and 656.295(2), we have jurisdiction to consider this case.

The insurer seeks dismissal of claimant's request, asserting that it, as well as its counsel and the employer, did not receive notice of the appeal until after the 30th day. We decline to dismiss.

Claimant's request for review included claimant's attorney's Certificate of Mailing, which certified that copies of the request had been mailed on September 30, 1991 (the final day in which to perfect an appeal of the Referee's order), to the employer, the insurer and the insurer's counsel. This proof of service by mail is in compliance with OAR 438-05-046(2)(a). Thus, this service by mail was complete upon mailing. OAR 438-05-046(2)(a); Franklin Jefferson, 42 Van Natta 509 (1990). The fact that the employer and its representatives did not receive copies of claimant's request for Board review prior to expiration of the 30 day appeal period does not establish that copies were not timely mailed to the employer, the insurer and its counsel as previously certified. Franklin Jefferson, supra.

Finally, Gail E. Collins, 42 Van Natta 2343 (1990), the case upon which the insurer relies, is not inconsistent with this decision. In Collins, a carrier's motion to dismiss the claimant's request for review was granted because the record failed to establish that all parties to the proceeding were either provided with a copy, or received actual knowledge, of the claimant's request for review within the statutory 30-day period. However, unlike claimant's request for review in this case, the request for review in Collins did not indicate that copies of the request had been provided to the other parties. Here, as previously noted, claimant's request for review included claimant's attorney's certification that copies of the request had been mailed to the other parties and their representatives on September 30, 1991, which was the final day before the expiration of the statutory appeal period.

Accordingly, the insurer's motion is denied. In light of this order, the following revised briefing schedule will be implemented. Claimant's appellant's brief shall be due 21 days from the date of this order. The insurer's respondent's brief shall be due 21 days from the date of the mailing of claimant's appellant's brief. Claimant's reply brief, if any, shall be due 14 days from the date of mailing of the insurer's respondent's brief. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
SCOTT D. HUBERT, Claimant
WCB Case No. C1-02258
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Whitehead & Klosterman, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

On October 25, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Here, the proposed agreement purports to release claimant's rights and the employer's obligations under claimant's accepted thoracic strain/sprain claim. In addition, the agreement notes the insurer denied claimant's aggravation claim on March 7, 1990, and claim for treatment for a right sacroiliac condition on April 19, 1990. The agreement then recites that as part of this settlement, and "in lieu of a hearing," the parties agree these denials will "be affirmed in all respects and remain in full force and effect." (CDA page 4, lines 21-25).

ORS 656.236(1) permits parties, by agreement, to make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 436-60-005(9) (Emphasis supplied). See also OAR 438-09-001(1).

The above language appears to dispose of claim(s) in which there is a dispute over the compensability of the claim(s), resolving the dispute against compensability. The denied conditions cannot be disposed of by CDA. The purpose of the CDA is to dispose of an "accepted claim," with the exception of medical services, as the claim existed at the time the Board received the CDA. See ORS 656.236(1). It is not the function of a claim disposition agreement to resolve compensability issues. By agreeing that the denied claims shall be affirmed, the parties have essentially entered into a disputed claim settlement. See OAR 438-09-001(2).

Inasmuch as the disputed claim settlement is in the same document as a claim disposition agreement, it impermissibly exceeds the bounds of OAR 438-09-020(1)(b). Therefore, we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a); see Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Accordingly, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
SAMUEL LUCONTRO, Claimant
Own Motion No. 90-0657M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Emmons, et al., Claimant Attorneys

Claimant requests review of the self-insured employer's April 10, 1991 Notice of Closure that closed his March 20, 1985 claim for upper back and neck strain and bilateral carpal tunnel syndrome with an award of temporary disability compensation from December 27, 1990 through March 3, 1991. This open period was approved by our Own Motion Order of December 28, 1990 for temporary total disability benefits in relation to left carpal tunnel syndrome surgery. Claimant now contends that his left carpal tunnel syndrome was not related to the 1985 injury, but rather, represents a new injury.

Because a "new injury" claim is not subject to our own motion jurisdiction, see Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988), the issue of whether claimant's condition represents a new industrial injury is not a proper matter for this forum. It is a matter for which a hearing may be requested. See ORS 656.283(1); James Swindler, 41 Van Natta 2360 (1989). Had there been a pending request for hearing on a new injury claim, we would have postponed action on this own motion matter until the pending litigation had been resolved. However, inasmuch as there is no indication that claimant has requested a hearing, we proceed to review the merits of the claim closure.

By chart note dated March 22, 1990, Dr. Warren, the treating physician, declared claimant medically stationary regarding his left carpal tunnel condition. Warren also noted right wrist problems and suggested that, if the problems persist, claimant should have a limited bone scan. However, there are no subsequent medical reports confirming the need for the scan. Thus, we find that Warren did not raise a reasonable expectation of further material improvement from treatment or the passage of time. See ORS 656.005(17). Therefore, we find that claimant became medically stationary on March 22, 1991. Accordingly, the employer's April 10, 1991 Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

November 14, 1991

Cite as 43 Van Natta 2514 (1991)

In the Matter of the Compensation of
VERNE WEHTJE, Claimant
Own Motion No. 66-0257M
OWN MOTION ORDER
SAIF Legal Department, Defense Attorney

The SAIF Corporation submitted to the Board claimant's claim for medical benefits relating to his April 29, 1953 industrial injury. SAIF recommends reopening of claimant's claim to provide reimbursement for prosthetic sheaths.

For conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b). Here, we find that the requested medical service is reasonable and necessary for the compensable injury and is required to maintain the status of a prosthetic device. Accordingly, claimant's claim is reopened to provide prosthetic sheaths in an amount not to exceed \$90.00. See OAR 438-12-037(1)(d). Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. By this order, the claim is again closed.

In addition to this request, SAIF notified us that the Napa Valley Pain Center is questioning the Oregon Fee Schedule and its application to an out-of-state provider. By a July 12, 1991 Own Motion Order we had allowed reimbursement for an office visit and injections by the Napa Valley Pain Center in the amount of \$221.82, the figure provided after application of the Oregon Fee Schedule. The total amount of the billing before auditing to the schedule was \$440.40. SAIF informs us that the provider would like to be reimbursed for the remaining portion of his billing in the amount of \$218.58.

When, as here, a dispute exists between an insurer and a medical service provider regarding the amount of a fee for medical services, only the director has the authority to resolve the dispute. See ORS 656.248(13). In the event of such a dispute, either party may request review by the Workers' Compensation Division of the Department of Insurance and Finance according to the provisions of OAR 436-10-110. In the event that review by the Division is requested and the provider prevails, the insurer may submit another request to reopen claimant's claim in order to provide reimbursement for such amounts as the director deems appropriate.

IT IS SO ORDERED.

November 15, 1991

Cite as 43 Van Natta 2515 (1991)

In the Matter of the Compensation of
FIDEL D. CHAVEZ, Claimant
WCB Case No. 89-21657
SECOND ORDER ON REMAND
Hollis Ransom, Claimant Attorney
Meyers & Radler, Defense Attorneys

The self-insured employer requests reconsideration of our October 25, 1991 Order on Remand that awarded claimant a \$1,200 carrier-paid attorney fee under amended ORS 656.386(1) when the employer rescinded its denial of claimant's low back injury claim prior to hearing. Contending that claimant's attorney's actions did not result in claimant obtaining compensation which he was not already receiving, the employer asserts that claimant's attorney is not entitled to an attorney fee under amended ORS 656.386(1).

As stated in our prior order, claimant requested a hearing objecting to the employer's acceptance of his aggravation claim for a 1986 compensable injury and the denial of his "new injury" claim for his current low back condition. While the hearing request was pending, claimant's attorney received a written response from claimant's attending physician concluding that claimant's current condition represented a new injury. Prior to the hearing, the employer rescinded its denial and accepted claimant's "new injury" claim.

Noting that we found that claimant's temporary disability rate was higher under the aggravation claim than the rate is under the "new injury" claim, the employer argues that claimant's attorney effectively "obtained" less compensation for claimant as a result of the pre-hearing rescission of the employer's "new injury" denial. Consequently, the employer contends that claimant is not entitled to an attorney fee award. We disagree.

The employer misinterprets amended ORS 656.386(1), which provides for the award of a reasonable attorney fee "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by a referee is not held." (Emphasis supplied). Amended ORS 656.386(1) is not conditioned upon increased or greater compensation. Rather, the allowance of an attorney fee is premised

on a finding that claimant's attorney has been instrumental in obtaining compensation without a hearing. "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8).

Here, as a result of claimant's attorney's efforts, the employer rescinded its denial of claimant's "new injury" claim prior to the hearing. The rescission of that denial and the acceptance of claimant's "new injury" claim establishes claimant's entitlement to all benefits, including medical services, as set forth in ORS Chapter 656 which result from the compensable injury. Such benefits constitute "compensation." ORS 656.005(8). Inasmuch as claimant's attorney was instrumental in obtaining this "compensation" for claimant without a hearing, claimant is entitled to an attorney fee award under amended ORS 656.386(1).

Accordingly, our October 25, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 25, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 15, 1991

Cite as 43 Van Natta 2516 (1991)

In the Matter of the Compensation of

RITA K. HINMAN, Claimant

WCB Case No. 90-04152

ORDER ON REVIEW

J.R. Perkins III, Claimant Attorney

Kennedy, Bowles, et al., Attorneys

Larry D. Schucht (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Fink's order that upheld the SAIF Corporation's denial, on behalf of the noncomplying employer, of her occupational disease claim for a bilateral foot condition. With her appellant's brief, claimant has also submitted further materials and requests that we remand the matter to the Referee for consideration of that evidence. On review, the issues are remand and compensability. We decline to remand and affirm.

FINDINGS OF FACT

In February 1990, the Department of Insurance and Finance ("Department") found that the employer was noncomplying. A hearing was held in March 1990 before Referee Fink. By interim order dated June 18, 1990, Referee Fink found that claimant was a subject worker, therefore he affirmed the Department's finding that the employer was noncomplying. Additionally, Referee Fink's order directed the SAIF Corporation, on behalf of the noncomplying employer, to consider claimant's claim on the merits and advise him when it either accepted or denied the claim. Thereafter, SAIF denied claimant's claim on the basis that her bilateral foot condition was not causally related to her work activities.

In 1987, claimant became employed by the employer as the manager of a bowling alley. Her duties included public relations, paying bills, doing bookwork and other office duties. Claimant performed the majority of these job duties sitting in a chair or on a stool. In December 1989, two counter employees were terminated. Following their termination, claimant's hours increased and she

worked at the counter and performed some janitorial work in addition to her other job duties. In early December 1989, claimant did not have access to an automobile, therefore she walked to work. The walk to work took approximately 15 minutes and was uphill. During December 1989, claimant continued to perform the majority of her job duties sitting down.

Claimant was terminated from her employment at the end of December 1989. In January 1990, claimant sought treatment from Dr. Peruzzo, M.D., for bilateral foot pain. She filed a workers' compensation claim attributing her foot pain to prolonged standing at work during December 1989. Claimant's condition was diagnosed as bilateral plantar fasciitis and chronic foot fatigue.

Claimant is 5' 5" and weighs over 300 pounds. She has bilateral flat feet and systemic arthritis.

CONCLUSIONS OF LAW AND OPINION

Remand

With her appellant brief, claimant has submitted additional evidence concerning the number of hours she worked and her work duties. She contends that this evidence is relevant to show that Dr. Fuller had an accurate history. Claimant requests that we remand this matter to the Referee for admission of this evidence.

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 the consideration of additional evidence, it must be clearly shown that the 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 (1985).

Claimant did not object to the admission of Dr. Fuller's report, or ask for a continuance to prepare further evidence concerning the history given to Dr. Fuller. Moreover, claimant's argument addresses the manner in which the Referee interpreted Dr. Fuller's report in relation to her credibility and does not address whether the record was incompletely or insufficiently developed. Finally, the evidence proffered by claimant was obtainable with due diligence at the time of hearing. Accordingly, we conclude that remand is not warranted in this instance and proceed to the merits.

Compensability

The Referee concluded that claimant had not established that her work activities were causally related to her bilateral foot condition. We agree.

Claimant's claim is for bilateral plantar fasciitis and chronic foot fatigue which she attributes to prolonged standing at work during December 1989. Therefore, her claim is properly analyzed as an occupational disease. Former 656.802(1)(c); Valtinson v. SAIF, 56 Or App 184, 187 (1982). In order to be compensable as an occupational disease, claimant must prove that her condition arose out of and in the course of her employment. Former 656.802(1)(c). To establish that her condition arose out of and in the course of her employment, claimant must prove that her work exposure was the major contributing cause of her condition. Id.; Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991).

At the outset, we note that the Referee found claimant's testimony not credible based on her demeanor at hearing. When a Referee's credibility finding

is made on the basis of demeanor deference is given to the Referee's determination. International Paper Co. v. McElroy, 101 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). In this instance, we do not find any reason not to defer to the Referee's finding. Further, we agree with the Referee that there are inconsistencies in claimant's testimony. Accordingly, we agree with the Referee that claimant is not a credible witness. We now turn to the medical evidence.

On a questionnaire provided by claimant's counsel, Dr. Peruzzo indicated that the time that claimant spent on her feet was the major contributing cause of her bilateral foot condition. In answering this question, Dr. Peruzzo assumed that claimant spent 1/2 hour to 1 hour walking to work and 9 to 10 hours on her feet while at work. Dr. Fuller opined that the time that claimant spent on her feet materially contributed to her bilateral foot condition. Dr. Fuller based his opinion on the assumption that claimant was on her feet 16 hours per day. Dr. Fuller also noted that claimant's weight and flat feet contributed to her condition. Finally, Dr. Schwarz was unable to state whether claimant's work exposure contributed to her bilateral foot condition.

Dr. Peruzzo's opinion is premised on the assumption that claimant was on her feet 9 to 10 hours a day. This is not consistent with our finding that claimant spent the majority of her time at work sitting down. Similarly, Dr. Fuller's opinion is premised on the faulty assumption that claimant spent 16 hours on her feet at work. Moreover, Dr. Fuller opined that the time claimant spent on her feet at work was a material contributing cause rather than the major contributing cause. Both Dr. Peruzzo's and Dr. Fuller's opinions are based on an inaccurate history, therefore we do not find their opinions persuasive. Miller v. Granite Construction Co., 77 Or App 473, 476 (1977).

Accordingly, we conclude that claimant has not established that her work activities were the major contributing cause of her bilateral foot condition. Therefore, the condition is not compensable.

ORDER

The Referee's order dated November 5, 1990 is affirmed.

November 15, 1991

Cite as 43 Van Natta 2518 (1991)

In the Matter of the Compensation of
DALE E. HOLDEN, Claimant
WCB Case No. 90-11918
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Harri's order which set aside its denial of claimant's claim for a right knee injury. On review, the issue is compensability.

We affirm and adopt with the following supplementation.

The employer argues that this case falls under the standard set forth in Phil A. Livesley Company v. Russ, 296 Or 25 (1983). Under that standard, a truly unexplained fall that occurs on the employer's premises while the worker is performing required duties is compensable if the worker can eliminate all

idiopathic causes. That analysis is only applicable when a worker falls for unknown reasons and an injury results from the fall. Folkenberg v. SAIF, 69 Or App 159 (1984).

Here, claimant did not fall and the cause of claimant's worsened knee condition is known. The medical evidence links claimant's condition to the activity of pushing a cart weighing 100 pounds at work. Inasmuch as claimant's knee injury does not arise from an unexplained fall, the standard of analyzing compensability as articulated in Phil A. Livesley V. Russ is not applicable. See Roxie A. Lingle, 43 Van Natta 1742 (1991).

The employer also argues that there are no objective findings to support compensability as required by ORS 656.005(7)(a). We disagree. Dr. James noted claimant's subjective complaints of sharp pain, catching and increased crepitus and concluded that claimant had sustained an injury to his knee at work. A physician's evaluation of a worker's subjective complaints satisfies the definition of "objective findings." Suzanne Robertson, 43 Van Natta 1505 (1991).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$500 is a reasonable assessed fee for claimant's attorney's efforts concerning the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated March 4, 1991 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$500, to be paid by the self-insured employer.

November 15, 1991

Cite as 43 Van Natta 2519 (1991)

In the Matter of the Compensation of
ROBERT F. HOLLING, Claimant
WCB Case Nos. 90-08517 & 90-08518
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Livesley's order which upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral hand/wrist condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the claim was not compensable based on a lack of objective findings to support the claim pursuant to amended ORS 656.007(a). Oregon Laws 1990 (Special Session), Ch. 2, 3. We agree, but base our decision on the following reasoning.

An occupational disease is defined as, inter alia, any disease arising out

of and in the course of employment caused by any series of traumatic events or occurrences which requires medical services or results in physical disability or death caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment. ORS 656.802(1)(c). In order to prove a compensable occupational disease, claimant must prove that employment conditions were the major contributing cause of his bilateral wrist/hand condition. ORS 656.802(2). Existence of the disease must be established by medical evidence supported by objective findings. Id.

The Referee found insufficient objective findings to support compensability. Although we conclude the record contains objective findings, we nonetheless agree with the Referee's ultimate conclusion. On examination, Dr. Jones noted claimant had hypesthesia in the index and middle fingers of the left hand. We have held that such evidence meets the definition of objective findings under ORS 656.005(7)(a). Suzanne Robertson, 43 Van Natta 1505 (1991).

We generally give greater weight to the opinion of the treating physician absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). Dr. Jones, claimant's treating physician, who is an orthopedic and hand surgeon, diagnosed cumulative trauma disorder, which he related to claimant's work.

We are not persuaded that Dr. Jones' opinion establishes that claimant's work activities were the major contributing cause of his hand and wrist condition. He opined that cumulative trauma disorder was the "greatest probability." Dr. Jones reached his diagnosis of cumulative trauma disorder by excluding several other explanations for claimant's symptoms. Claimant cannot carry his burden of proof merely by disproving other possible explanations for his condition. ORS 656.266; William L. Guthridge, 42 Van Natta 1039 (1990). Accordingly, we find Dr. Jones' opinion unpersuasive.

Examining neurologist, Dr. Rosenbaum, could not attribute claimant's symptoms to work-related cumulative trauma disorder. He opined that Dr. Jones' initial assumption that the left hand symptoms were a response to the sliver was the most likely diagnosis. He also opined that the right hand symptoms were more problematic. He stated that the work claimant was doing, picking up "2 by 4s" with the right hand for one week, was not particularly likely to cause seven months of recurrent swelling.

Examining hand surgeon, Dr. Jewell, opined that he did not believe to a reasonable medical probability that claimant's work activities contributed to the advancement of a disease process. Dr. Jewell questioned the relationship between claimant's upper extremity symptomatology and his employment activities given the fact that these continued even though claimant had not worked for the employer for several months. Dr. Jones acknowledged that symptoms due to overuse syndrome should diminish. However, claimant testified the symptoms have not decreased since he left work.

We defer to the opinions of Drs. Jewell and Rosenbaum because we consider their opinions well reasoned. Somers v. SAIF, 64 Or App 259 (1986). Moreover, unlike Dr. Jones' opinion, their evaluations were not based on a determination of causation by exclusion. Accordingly, we find that claimant has failed to prove that his employment activities constituted the major contributing cause of his bilateral hand and wrist condition.

ORDER

The Referee's order dated February 7, 1991 is affirmed.

In the Matter of the Compensation of
SHARON K. MARVIN, Claimant
WCB Case No. 90-19280
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Crumme's order which: (1) found that claimant had failed to timely notify the insurer of her injury; (2) upheld the insurer's denial of her claim for a right knee condition; and (3) declined to assess a penalty for an alleged unreasonable denial. On review, the issues are timeliness, compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following supplementation. Claimant's twist injury to her right knee in February 1990 was not a material contributing cause of her disability and need for medical treatment commencing September 20, 1990.

CONCLUSIONS OF LAW

Timeliness/Compensability

We affirm and adopt that part of the Referee's order which upheld the insurer's denial on the ground that claimant had failed, without good cause, to give the employer timely notice of the injury, and that the employer was substantially prejudiced by the delay. Assuming arguendo that claimant's notice of injury was timely, we would still uphold the insurer's denial.

The Referee found (at least implicitly) that claimant's disability and need for treatment in September 1990, resulted from a combination of the February 1990 knee twist and claimant's preexisting condition. Finding the case governed by ORS 656.005(7)(a)(B), the Referee concluded that claimant was not entitled to disability compensation or treatment because claimant failed to establish that the February 1990 knee twist was the major contributing cause of her disability and need for treatment. We agree that the case is governed by ORS 656.005(7)(a) and that claimant failed to meet her burden of proof.

The Board has recently held that, under ORS 656.005(7)(a), a determination of compensability is a two-part test if there is a preexisting condition. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, it must be determined whether there was a "compensable injury" under ORS 656.005(7)(a), i.e., an accidental injury arising out of and in the course of employment. Thus, claimant must first prove by a preponderance of the evidence that the February 1990 incident at work was a material contributing cause of her disability or need for medical services.

The extent of the relationship, if any, between the February 1990 knee twist and the onset of claimant's disability in September 1990 is a complex medical question that we cannot decide without expert opinion. Kassahn v. Publishers Co., 76 Or App 105, 109 (1985).

It is undisputed that following the February 1990 incident, claimant neither sought medical treatment nor became disabled until September 20, 1990, after she twisted her knee at home. Dr. Ahbel, who operated on claimant's right knee in November 1990, diagnosed degenerative joint disease and a medial

meniscus tear which he found "degenerative in nature." (Ex. 15-1). Claimant relies solely on the opinion of Dr. Corrigan, claimant's treating physician, who opined that:

"If the history as provided ... by Mrs. Marvin is correct, it is my opinion that the meniscus tear in her right knee which necessitated further treatment and ultimately arthroscopic partial medial meniscectomy was due to her described injury that occurred in early February of 1990." (Emphasis Added).

The Referee found, and we agree (for the reasons stated in detail by the Referee, whose reasoning we adopt as our own), that the history Dr. Corrigan relied on was not correct, and consequently, his opinion on the question of causation was not reliable. There is no other medical evidence in the record on the question of causation. Therefore, claimant failed to meet her burden of proving by a preponderance of the evidence that she sustained a compensable right knee injury in February 1990. Furthermore, assuming arguendo, that claimant proved a compensable right knee injury in February 1990, we affirm and adopt the reasoning and conclusion of the Referee that claimant failed to establish that her compensable injury is and remains the major contributing cause of her disability and needs for medical treatment commencing September 20, 1990.

Penalties

We affirm and adopt the Referee's order as it pertains to penalties.

ORDER

The Referee's order dated March 8, 1991 is affirmed.

November 15, 1991

Cite as 43 Van Natta 2522 (1991)

In the Matter of the Compensation of
GORDON K. WARE, Claimant
WCB Case Nos. 90-13954 & 90-19112
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Darrell E. Bewley, Defense Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Westerland and Gunn.

Liberty Northwest Insurance Corporation requests review of Referee Davis' order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

FINDINGS OF ULTIMATE FACT

Claimant did not suffer a new compensable injury while working for SAIF's insured.

CONCLUSIONS OF LAW AND OPINION

Relying on Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986), and Linda L. Wise, 42 Van Natta 115 (1990), the Referee found that Liberty had not established that claimant's work activities at SAIF's insured contributed to a pathological worsening of claimant's compensable condition. Therefore, he concluded that Liberty remained responsible for claimant's current condition. Although we agree with the Referee's ultimate conclusion that Liberty remains the responsible carrier, we do so for different reasons.

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g.

54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The current version of Chapter 656 states that when a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. Or Laws, Special Session, Ch. 2 49. Thus, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991).

Therefore, under the new analysis, Liberty, as the last carrier against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, it now has the burden of establishing that claimant sustained a new compensable injury while working for SAIF's insured. Accordingly, in order to establish a new compensable injury, Liberty must establish, by medical evidence supported by objective findings, that claimant sustained a subsequent disability or need for medical services, a material contributing cause of which were his work activities with SAIF's insured. Mark N. Wiedle, 43 Van Natta 855 (1991).

Considering claimant's prior injury to his back and his history of symptomatic waxing with increased activity, we conclude that the cause of his condition is a complex medical question. Thus, while claimant's testimony is probative, the resolution of that question primarily turns on an analysis of medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 259 (1985). Here, the record contains no medical evidence that claimant suffered a new injury in 1990.

Dr. Leistikow has continued to treat claimant since the original September 1985 injury at Liberty's insured and provides the only medical evidence relating to the causation of claimant's current condition. Leistikow repeatedly opined that claimant's current condition resulted from an aggravation of the September 1985 injury. (Exs. 31-1, 33-1, 35, 46, 54, 64). Furthermore, the record shows that, after the original September 1985 injury, claimant continued to experience exacerbations with physical exertion. (Ex. 25, 26).

Thus, because no medical evidence establishes that claimant suffered a new compensable injury at SAIF's insured, Liberty remains the responsible carrier

and shall process claimant's claim as such. See Or Laws 1990 (Special Session), ch. 2, section 49.

Attorney Fees

Because the Referee's order addressed both compensability and responsibility, compensability remained at risk on review. Tanya L. Baker, 42 Van Natta 2818 (1990). 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 Liberty, the insurer that initiated Board review. See Tanya L. Baker, supra; Joel D. Turpin, 42 Van Natta 1736 (1989).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$400 is a reasonable assessed fee for claimant's counsel's efforts on review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue presented and the value of the interest involved.

ORDER

The Referee's order dated February 14, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable fee of \$400, payable by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
JIMMY L. GERMAN, Claimant
WCB Case No. 90-15892
ORDER DENYING RECONSIDERATION
Francesconi & Associates, Claimant Attorneys
Hallock & Bennett, Defense Attorneys

On October 7, 1991, we reversed a Referee's order that had declined to award an assessed attorney fee for claimant's counsel's services in obtaining rescission of the insurer's denial of his low back injury claim prior to hearing. Relying on amended ORS 656.386(1), we awarded \$750 as a reasonable insurer-paid attorney fee.

We have received a proposed "Stipulation and Order" from the parties which is designed to resolve the issue concerning the amount of a reasonable attorney fee. We treat such a submission as a motion for reconsideration of our October 7, 1991 order. The motion is denied for lack of jurisdiction.

In accordance with 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 is abated, stayed, republished or withdrawn within 30 days of its issuance. International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Here, our order issued on October 7, 1991 and copies of the order were mailed to all parties to the proceeding on that date. Consequently, the final day before expiration of the 30-day period was November 6, 1991. The parties' stipulation, submitted with a November 4, 1991 cover letter, was received by the Board's Portland office on November 5, 1991. (The letter was misaddressed in that it was directed to the Referee who had initially heard the case, rather than to the Board to which review of the Referee's order had been requested and from which the October 7, 1991 order had issued). The stipulation was routed from the Board's Portland office to its office in Salem and received on November 8, 1991. Unfortunately, by the time we received the stipulation, the 30-day statutory period had elapsed, thereby preventing us from reconsidering our October 7, 1991 order. ORS 656.295(8); International Paper Co. v. Wright, supra.

In conclusion, every attempt is made to respond to motions for reconsideration as expeditiously as we possibly can. Parties can provide immeasurable assistance in these efforts by directing their submissions to the appropriate forum. In any event, despite the best of intentions in responding to post-order submissions, the ultimate responsibility for preserving parties' rights under a final, appealable order rests with those parties.

Accordingly, because our October 7, 1991 order has become final by operation of law, we lack jurisdiction to consider the parties' stipulation. Therefore, the request for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
DORIS A. PACE, Claimant
WCB Case No. 90-08372
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Black's order which: (1) declined to assess a penalty-related attorney fee for an allegedly unreasonable failure to process her aggravation claim; and (2) reduced claimant's award of unscheduled permanent disability from 17 percent (54.4 degrees), as awarded by Determination Order, to 3 percent (9.6 degrees). The self-insured employer cross-requests review of those portions of the Referee's order which: (1) found that claimant was entitled to interim compensation from January 18, 1990 through April 16, 1990; (2) assessed a penalty for an allegedly unreasonable failure to process claimant's aggravation claim; and (3) awarded claimant 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm whereas a Determination Order had not awarded any scheduled permanent disability. On review, the issues are entitlement to interim compensation, penalties and attorney fees, and extent of scheduled and unscheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

In November 1988, claimant sustained a compensable injury to her left knee and back when she slipped and fell. In February 1989, claimant sustained a second compensable injury to her back, right shoulder and right elbow when she fell down some stairs. Both claims were processed under the same claim number by the employer.

Claimant became medically stationary with respect to all accepted conditions in November 1989. A December 5, 1989 Determination Order closed her claim and awarded 17 percent unscheduled permanent disability. The Determination Order did not award any scheduled permanent disability for claimant's right arm.

On January 10, 1990, claimant was examined by Dr. Clibborn. Dr. Clibborn wrote the employer indicating that claimant's condition had deteriorated and that she was unable to work as a security guard. Dr. Clibborn reported that claimant was experiencing headaches, dizziness and increased pain and numbness in her right arm. He also reported that claimant was unable to use her right hand due to right arm pain. The employer received Dr. Clibborn's report on January 18, 1990. The employer did not respond to Dr. Clibborn's report.

Claimant continued to experience right arm and shoulder pain throughout the winter and spring of 1990. Claimant returned to her regular work as a security guard on July 11, 1990.

Claimant has sustained losses of ranges of motion in her cervical and thoracolumbar spine. With regard to her cervical spine the range of motion findings are: flexion to 40 degrees; extension to 40 degrees; rotation to 60 degrees; and, lateral bending to 40 degrees. With regard to her thoracolumbar spine, the range of motion findings are: (sitting) flexion to 90 degrees; extension to 25 degrees; rotation to 30 degrees; and, lateral bending to 30 degrees.

Claimant experiences right shoulder pain and referred pain into the right arm with activity.

CONCLUSIONS OF LAW AND OPINIONInterim Compensation

The Referee concluded that claimant was entitled to interim compensation from January 18, 1990 through April 16, 1990. We agree that claimant is entitled to interim compensation, but we find she is entitled to interim compensation from January 18, 1990 through July 11, 1990.

Claimant requested a hearing prior to May 1, 1990, but the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Oregon Laws 1990, Chapter 2, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Oregon Laws 1990, Chapter 2, Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Brian L. Dunn, 43 Van Natta 1673 (1991); Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The employer contends that under amended ORS 656.273(6), claimant was not entitled to interim compensation despite Dr. Clibborn's January 1990 report that her compensable right arm condition had worsened. Noting that claimant failed to prove her aggravation claim,¹ the employer relies on the legislature's insertion of "compensable" in amended subsection (6) which now states:

"(b) A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first instalment of compensation due under ORS 656.262 shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from a compensable worsening under subsection (1) or (8) of this section." (Emphasis added).

As amended ORS 656.273(6) is interpreted by the employer, there is no longer any such thing as "interim compensation" where the claim is for an aggravation. We disagree.

Interim compensation is a term coined by the court in Jones v. Emanuel Hospital, 280 Or 147 (1977) to refer to temporary disability benefits which ORS 656.262 requires the carrier to pay to a claimant who is off work on an initial injury or aggravation claim until the carrier accepts or denies the claim. Nix v. SAIF, 80 Or App 656, 658, n. 2 (1986). The employer must begin paying interim compensation on an aggravation claim no later than the 14th day after it receives notice or knowledge of a medically verified inability to work due to a worsened condition. Avalos v. Bowyer, 89 Or App 546 (1988). The notification is not intended to establish a substantive right to compensation, but is intended to ensure prompt payment of interim support to the worker who has filed the claim. See Silsby v. SAIF, 39 Or App 555, 562 (1979).

ORS 656.273(2) still requires the claimant to file a claim for an aggravation with the carrier in order to obtain additional compensation for a worsened compensable condition. We have held that to constitute an aggravation claim under ORS 656.273(3) as amended, the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that

¹ Claimant did not request review of that portion of the Referee's order which upheld the employer's denial of claimant's aggravation claim.

claimant's compensable condition has worsened from a medical standpoint. Herman M. Carlson, 43 Van Natta 963 (1991). We interpret the minor language change at issue here as having a similar purpose, i.e., to require the medical report to constitute prima facie evidence of all applicable elements provided in ORS 656.273(1) or (8) for establishing a compensable worsening.

We do not believe the legislation intended, by the addition of a single word, to leave injured workers without any maintenance or support pending the carrier's acceptance or denial of the aggravation claim. The employer has not provided, and we are not aware of, any legislative history which would suggest that, after notice of an initial injury claim, the employer is required to pay claimant interim compensation, but in the case of an aggravation claim, the employer is required to give the worker no support until the claim is accepted or proven compensable at hearing. Absent plain and unambiguous statutory direction for such a fundamental change of legislative policy, we conclude that ORS 656.273(6) required the employer to pay claimant interim compensation no later than the 14th day after it received medical verification of an inability to work as documented in a medical report which constitutes prima facie evidence of a compensable worsening.

The employer also contends that Dr. Clibborn's January 1990 report did not constitute a claim for aggravation triggering the duty to pay interim compensation because it did not include any objective findings as required by amended ORS 656.273(3). Dr. Clibborn's report states:

"On January 10, 1989 [sic] we discussed with the [claimant] her present condition and I have found out that this [claimant] has been removed from a time loss status. I want you to know that this [claimant's] condition has deteriorated markedly since her IME of November 7, 1989. Since that examination, the [claimant] has experienced increases in her headaches, she also has increased pain in her right arm with numbness in her right fingers and increased pain in her right shoulder. She is still having [sic] headaches and dizziness and I feel that this [claimant] is unable to return to her previous job as a security guard.

[Claimant] cannot use her right hand at this time, as her right hand is not only painful, but her right forearm is in a splint at this time to minimize her pain."

Dr. Clibborn's report indicates that claimant's condition had worsened and that claimant was unable to perform her work as a security guard. The report also indicates that claimant was experiencing increased pain in her right arm and shoulder and other symptoms to the extent that she was unable to use her right hand. Thus, Dr. Clibborn has clearly diagnosed a worsening of the compensable condition based on expert analysis of his examination findings and claimant's reported symptoms. We have held that such evidence meets the definition of "objective findings." See Suzanne Robertson, 43 Van Natta 1505 (1991); Robert E. Leatherman, 43 Van Natta 1678 (1991). Such findings may be based on a physically verifiable impairment, but may also be based on a physician's evaluation of the worker's description of the pain that she is experiencing. Jacquelyn L. Hetrick, 43 Van Natta 2357 (1991).

Inasmuch as we have concluded that Dr. Clibborn's report triggered the employer's duty to pay interim compensation, we must now decide through what date the employer was obligated to pay interim compensation. The Referee concluded that claimant was entitled to interim compensation through April 16, 1990, the date of her request for hearing. We disagree.

A carrier is obligated to pay interim compensation on an aggravation claim beginning no later than 14 days after the carrier receives medical verification of an inability to work due to the compensable condition, and continuing until a formal denial of the claim is issued. ORS 656.262(4); Bono v. SAIF, 298 Or 405 (1984); Roger G. Prusak, 40 Van Natta 2037 (1988). If a carrier does not issue a formal denial, its obligation to pay interim compensation continues through the date of hearing unless claimant has returned to regular work. James S. Espinoza, 43 Van Natta 908, 910 (1991); Valerie D. Barry, 41 Van Natta 199, 206 (1989).

Here, the employer received Dr. Clibborn's report on January 18, 1990. Therefore, the duty to pay began 14 days after the date of receipt of Dr. Clibborn's report. Claimant returned to regular work on July 11, 1990, which extinguished the employer's duty to pay interim compensation. Accordingly, we modify the Referee's order and find that the employer was obligated to pay interim compensation from January 18, 1990 through July 11, 1990.

Penalties

The Referee found the employer's failure to process the claim unreasonable and awarded claimant a penalty with one-half of the penalty payable to claimant's counsel under ORS 656.262(10). We agree that the employer's failure to process the claim unreasonable. However, we modify the amount of the penalty.

We have herein found that Dr. Clibborn's report was an aggravation claim which triggered the employer's duty to process the claim. The employer did not pay interim compensation, nor did it deny the claim. The employer offers no persuasive explanation for its failure to process claimant's aggravation claim. Therefore, we agree with the Referee that the employer's failure to process the claim was unreasonable.

The Referee awarded claimant a 25 percent penalty based on interim compensation payable from January 18, 1990 through April 16, 1990. Inasmuch as we have concluded that claimant was entitled to interim compensation from January 18, 1990 through July 11, 1991, we modify the Referee's order and assess a penalty equal to 25 percent of the interim compensation due from January 18, 1990 through July 11, 1991. Pursuant to ORS 656.262(10)(a) claimant's counsel is awarded one-half of the penalty, in lieu of an attorney fee.

Attorney Fees

Claimant contends that she is also entitled to an attorney fee pursuant to ORS 656.382(1) for the employer's unreasonable failure to process her aggravation claim. We disagree.

Former ORS 656.262(10) authorized the assessment of an attorney fee under ORS 656.382(1) if a carrier unreasonably refuses to pay compensation. However, the legislature amended ORS 656.262(10) during its 1990 Special Session. See Or Laws 1990 (Special Session), Ch. 2, 15. In place of the language authorizing the assessment of an attorney fee under ORS 656.382(1), ORS 656.262(10)(a) provides that, if the worker is represented by an attorney, the attorney shall receive one-half the penalty "in lieu of an attorney fee."

Here, the factual basis asserted in support of the ORS 656.382(1) fee -- the employer's unreasonable failure to process the aggravation claim -- is identical to the factual basis for which the Referee assessed a penalty under ORS 656.262(10)(a). Under such circumstances, the simultaneous assessment of an attorney fee under ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the

penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991). Accordingly, claimant is not entitled to an attorney fee under ORS 656.382(1).

Extent of Unscheduled Permanent Disability

We adopt the conclusions and reasoning concerning the extent of unscheduled permanent disability as set forth in the Referee's order.

Extent of Scheduled Permanent Disability

We adopt the conclusions and reasoning concerning the extent of scheduled permanent disability as set forth in the Referee's order.

Attorney Fees/Board Review

Because we have not disallowed or reduced interim or permanent disability compensation payable to claimant, she is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the entitlement to interim compensation and extent of scheduled permanent disability issues is \$500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 9, 1990, is modified in part and affirmed in part. That portion of the order which awarded claimant interim compensation from January 18, 1990 through April 16, 1990 is modified. Claimant is awarded interim compensation January 18, 1990 through July 11, 1990. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, however, the total attorney fee awarded by the Referee and the Board from this compensation shall not exceed \$3,800. That portion of the Referee's order which assessed a penalty equal to 25 percent of the interim compensation payable from January 18, 1990 through April 16, 1990 is modified. Claimant is awarded a penalty equal to 25 percent of the interim compensation payable from January 18, 1990 through July 11, 1990. This fee shall be paid in equal shares to claimant and her attorney. The remainder of the order is affirmed. For services on review concerning the entitlement to interim compensation and extent of scheduled permanent disability issues, claimant's counsel is awarded an assessed attorney fee of \$500, payable by the self-insured employer.

November 19, 1991

Cite as 43 Van Natta 2530 (1991)

In the Matter of the Compensation of
SHERRIE L. BROCK-TREMAIN, Claimant
WCB Case No. 90-17584 & 86-10198
ORDER ON REVIEW
Allen, et al., Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of those portions of Referee Garaventa's order that: (1) affirmed a Determination Order that awarded no unscheduled permanent partial disability; and (2) upheld the SAIF Corporation's denial of her injury

claim for a myofibrositis condition. On review, the issues are extent of unscheduled permanent disability and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last sentence in the next to last paragraph.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Partial Disability

We adopt the conclusions and reasoning concerning claimant's entitlement to permanent partial disability as set forth in the Referee's order with the following supplementation.

In concluding that claimant had failed to establish a permanent impairment as a result of her compensable injury, the Referee relied in part on the opinion of Dr. Weiner, an orthopedic surgeon whom the Referee considered claimant's "most recent attending physician." (O & O at 5). Weiner opined that claimant's soft tissue injury had totally resolved with no permanent residual. On review, claimant contends that the Referee's reliance was misplaced because Weiner was, in fact, an evaluating physician who examined her on one occasion. She contends that the most recent attending physician was Dr. Jacob, an orthopedic surgeon, who reported that she had limited range of motion in her cervical spine.

After our review of the record, we agree with claimant that Weiner was not claimant's most recent treating physician. Nonetheless, we find his opinion well-reasoned and based on complete information. Consequently, we find it persuasive. Somers v. SAIF, 77 Or App 259 (1986). Moreover, while the opinion of the treating physician is generally given more weight because of that doctor's greater opportunity to see and treat the claimant, that is not the case here. The record reveals that, like Weiner, Jacob examined claimant on only one occasion and did not have any better opportunity to evaluate claimant's condition.

Compensability

The Referee concluded that claimant's myofibrositis condition, which the Referee evidently characterized as a "consequence of a compensable injury," was not compensable because claimant had failed to show that her compensable injury was the major contributing cause of the alleged condition. See amended ORS 656.005(7)(a)(A). Subsequent to the Referee's order, we construed the phrase "consequential conditions" to include only problems that arise from conditions previously deemed compensable, as opposed to conditions that arise directly from the injurious event. Julie K. Gasperino, 43 Van Natta 1151 (1991). Accordingly, the 1990 Amendments to the definition of a compensable injury do not affect the standard of compensability for conditions intrinsically related to the underlying compensable event.

In this case, neither party challenges the Referee's apparent characterization of claimant's condition as a "consequential condition." Nonetheless, we conclude that, even if that characterization is incorrect, the condition is not compensable because claimant has failed to prove that her compensable injury was a material contributing cause of her disability or need for treatment. Of all the medical opinions submitted in this matter, only Dr. Whitmire attributed the condition to claimant's compensable injury. We give little weight to his opinion, however, in light of the substantial contrary evidence questioning whether claimant does, in fact, have myofibrositis and numerous medical opinions suggesting psychogenic overlay.

ORDER

The Referee's order dated October 31, 1990 is affirmed.

November 19, 1991

Cite as 43 Van Natta 2532 (1991)

In the Matter of the Compensation of
JIMMIE G. CLARK, Claimant
WCB Case No. 90-00705
ORDER ON REVIEW (REMANDING)
Vick & Gutzler, Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of those portions of Referee Michael Johnson's order that: (1) set aside its denial to the extent it denied claimant's claim for a low back injury; and (2) assessed a penalty and related attorney fee for an allegedly unreasonable denial. Alternatively, the employer requests that this matter be remanded for the admission of additional evidence. Claimant cross-requests review of those portions of the Referee's order which: (1) upheld the employer's denial to the extent it denied degenerative disc disease; and (2) upheld the employer's denial to the extent it denied a right inguinal hernia. On review, the issues are remand, compensability and penalties and attorney fees. We remand.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

At the hearing, the employer's counsel indicated that White Oaks Treatment Center would not provide claimant's records without a signed release from claimant. Claimant's counsel indicated that claimant would sign a release necessary to obtain the records from White Oaks Treatment Center. (Tr. 24). The Referee left the record open for submission of the records from White Oaks Treatment Center. Claimant did not provide the employer's counsel with the necessary release form. The records from White Oaks Treatment Center were not obtained and thereafter the Referee closed the record.

FINDINGS OF ULTIMATE FACT

The record is incompletely developed.

CONCLUSIONS OF LAW AND OPINION

The employer contends that the Referee erred in closing the record without receipt of the records from White Oaks Treatment Center. The employer asks that we remand this matter to the Referee for the purpose of obtaining and submitting these records into the record.

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 the consideration of additional evidence, it must be clearly shown that the 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 (1985).

Here, claimant agreed at hearing to provide the employer's counsel with the release forms necessary to obtain the records from White Oaks Treatment Center. The records have potential relevance to the issues and the Referee properly left the record open for submission of these records. However, claimant did not provide the employer's counsel with the necessary release forms and the record was closed without the treatment records.

Under these circumstances, we conclude that the record has been incompletely developed. Moreover, we find that the employer's counsel exercised due diligence in trying to obtain the treatment records. Therefore, we conclude that remand is appropriate in this instance.

Accordingly, we remand this matter to the Referee to open the record for additional evidence regarding claimant's treatment at White Oaks Treatment Center. The Referee is instructed to proceed in any manner that will achieve substantial justice. ORS 656.283(7). The Referee then shall issue a final appealable order reconsidering those issues raised at hearing.

ORDER

The Referee's order dated February 20, 1991 is vacated. This matter is remanded to Referee Michael Johnson for further proceedings consistent with this order.

November 19, 1991

Cite as 43 Van Natta 2533 (1991)

In the Matter of the Compensation of
DARLINE H. DAVIS, Claimant
WCB Case No. 90-20167
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of that portion of Referee Livesley's order that declined to authorize an offset of temporary disability benefits paid from March 20, 1990 to October 12, 1990. Claimant cross-requests review of those portions of the Referee's order that: (1) declined to award unscheduled permanent disability for her upper back/cervical condition; (2) declined to award temporary total disability from March 19, 1990 through August 8, 1990; and (3) declined to award claimant's counsel an attorney fee for her counsel's services concerning the offset issue. In its brief, the employer moves to strike that portion of claimant's cross-reply brief that submitted argument on the offset issue not previously raised in her respondent/cross-appellant's brief. On review, the issues are offset, extent of unscheduled permanent disability, temporary total disability and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Offset

At the outset, we address the employer's motion to strike additional argument on the offset issue. The employer appealed on the issue of offset and claimant cross-appealed on other issues. Claimant responded to the employer's

offset issue in her respondent's/cross-appellant's brief. Claimant subsequently submitted further argument on the offset issue in her cross-reply brief. On review, the employer moves to strike the additional argument on the offset issue.

We agree that the portion of claimant's cross-reply brief submitted to rebut the employer's argument on the offset issue should be stricken. See Jerry D. Mann, 41 Van Natta 1712 (1989); OAR 438-11-0020(2). Accordingly, we do not consider that portion of claimant's brief in our review.

The Referee concluded that the employer had not proven its entitlement to an offset, because, although the employer established that it had paid claimant temporary disability payments through October 12, 1990, there was no evidence that the checks were mailed or cashed. We conclude that the employer has established its entitlement to an offset.

Exhibits 27 through 29 include a calculation of the employer's overpayment, a ledger of the dates and amounts of temporary disability payments, and copies of the checks issued to claimant. Claimant has not alleged that the payments were not received or that the stated amount of the overpayment is incorrect. See Eldon E. Hunt, 42 Van Natta 2751, 2753 (1990). Under the circumstances, we agree that the employer has proven its entitlement to an overpayment and we authorize an overpayment of the amount stated.

Attorney fees

Because we have reversed the Referee on the offset issue, the issue of attorney fees is moot.

Extent of unscheduled permanent disability

Claimant contends that she is entitled to an award of unscheduled permanent disability, as her upper back/cervical condition has permanently worsened since the March 1989 stipulation, which was the last arrangement of compensation. We adopt the Referee's conclusions and opinion on the issue of unscheduled permanent disability.

Medically stationary date/temporary total disability

The Referee concluded that claimant was medically stationary on March 19, 1990. He based his opinion upon the report of Dr. Schachner, who treated claimant for her thumb condition. We agree that claimant has failed to prove that she was not medically stationary on the date of closure. We, therefore, affirm the Referee on the issue of the medically stationary date and entitlement to additional temporary total disability.

ORDER

The Referee's order dated February 28, 1991 is reversed in part and affirmed in part. That portion of the Referee's order that declined to authorize an offset is reversed. The employer is authorized to offset the stated amount of the overpayment of temporary disability against future awards of permanent disability. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
PEGGY A. DAWES, Claimant
WCB Case Nos. 90-16743 & 90-15303
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Brazeau's order that upheld the insurer's denial of her medical services claim for low back surgery. In her brief, claimant contends that, if her medical services claim is found to be compensable, her claim was prematurely closed by the August 13, 1990 Determination Order. On review, the issues are medical services and premature closure. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion," with the following supplementation.

We agree with the insurer's contention that, whether claimant seeks to prove that her medical services claim is compensable as a consequence of her accepted right knee injury or as an injury which has combined with a preexisting condition, she is required to prove her claim under the "major contributing cause" standard. See Julie K. Gasperino, 43 Van Natta 1151 (1991); ORS 656.005(7)(A)(a); and Bahman A. Nazari, 43 Van Natta 2368 (1991); ORS 656.005(7)(a)(B). In addition, we agree with the Referee's conclusion that claimant has not met her burden of proof and, accordingly, her medical services claim for low back surgery is not compensable.

ORDER

The Referee's order dated December 21, 1990 is affirmed.

In the Matter of the Compensation of
BRUCE L. HIRSCHKORN, Claimant
WCB Case No. 90-20179
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee T. Laverre Johnson's order that set aside its denial of claimant's claim for a right knee injury and resulting condition. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant has a preexisting right knee arthritic condition.

SAIF's September 25, 1990 denial denied that claimant had sustained a compensable injury on July 13, 1990, and denied that claimant's employment was the major contributing cause of the development or worsening of his right knee condition. (Ex. 6).

At hearing, SAIF explained that it had denied claimant's right knee condition that resulted from claimant's activities on July 13, 1990, whether or not claimant's condition is considered to stem from an injury or occupational disease claim. (Tr. 4). Claimant conceded that the denial denied "whatever condition arose from his employment exposure." (Tr. 5).

ULTIMATE FINDINGS OF FACT

The July 13, 1990 compensable injury is not the major contributing cause of claimant's resulting right knee condition and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proven, by medical evidence supported by objective findings, that he had sustained a compensable injury to his right knee on July 13, 1990 which was a material contributing cause of his need for medical treatment. We agree that, insofar as SAIF denied the occurrence of a compensable injury on July 13, 1990, that denial should be set aside. However, claimant has a preexisting knee condition. SAIF's September 25, 1990 denial, as clarified and litigated at hearing, also denied that claimant's employment on July 13, 1990 was the major contributing cause of his resulting right knee condition. In this regard, claimant conceded that the denial denied "whatever condition arose from his employment exposure."

Under ORS 656.007(a)(B), where a claimant has a preexisting condition which combines with a compensable injury to cause or prolong disability or need for treatment, the claimant must establish that the compensable injury is the major contributing cause of the disability or need for medical services. Therefore, although claimant has proven that there was a compensable injurious incident on July 13, 1990, claimant must, under ORS 656.005(7)(a)(B), also prove by a preponderance of the evidence, that the compensable July 13, 1990 injury is the major contributing cause of his disability or need for medical services. Bahman M. Nazari, 43 Van Natta 2368 (1991). We find that the causation of claimant's resulting right knee condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant's treating physician, Dr. Gripekoven, orthopedist, reported on August 28, 1991, that claimant's:

"preexisting condition was the major contributing factor for his present problem. In other words, he should not have had a problem doing his usual employment if his knee was normal. I feel this represents a temporary symptomatic flare-up of the pre-existing arthritic condition and it would be difficult to quantitate any material worsening based on this episode." (Ex. 5).

Because there is no evidence to the contrary, we conclude that claimant's compensable July 13, 1990 injury is not the major contributing cause of his disability and/or need for medical services. Accordingly, although claimant has

established the occurrence of a compensable injury on July 13, 1990, his resulting condition is not compensable.

The Referee assessed a \$1,500 attorney fee for claimant's counsel's services at hearing. Because we are reinstating and upholding a portion of SAIF's denial, we conclude that the attorney fee at hearing should be adjusted accordingly. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing in setting aside SAIF's denial of the July 13, 1990 compensable injury is \$750. Additionally, we find that a reasonable fee for claimant's counsel's services on review for successfully defending on the issue of the compensability of the July 13, 1990 injury is \$750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 28, 1991 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the SAIF Corporation's denial insofar as it denied compensation for claimant's resulting right knee condition is reversed and that portion of SAIF's denial is reinstated and upheld. In lieu of the Referee's assessed attorney fee award, claimant is awarded a reasonable assessed fee for services at hearing and on review in the amount of \$1,500. The remainder of the order is affirmed.

November 19, 1991

Cite as 43 Van Natta 2537 (1991)

In the Matter of the Compensation of
JOSEPH L. MacISAAC, Claimant
WCB Case No. 90-19056
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Stoel, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee Kinsley's order that set aside its denial of claimant's occupational disease claim for a right arm condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on the medical opinions of Drs. Hogan and Burr, found that claimant had proven by a preponderance of evidence that work activity was the major contributing cause of his right arm strain. We disagree.

We agree with the Referee that, because claimant's right arm strain developed over a period of time, his condition is most appropriately described as an occupational disease. In order to prove a compensable claim for an occupational disease, claimant must prove that "employment conditions were the major contributing cause of the disease or its worsening." ORS 656.802(2).

Claimant was examined by three physicians. Claimant was first seen by Dr. Hogan. Although Hogan diagnosed claimant as suffering from overuse tendinitis, a review of Hogan's notes do not reveal that Hogan had an opinion as to the cause of claimant's condition. At most, Hogan's notes merely describe claimant's work activities; they do not, however, indicate any connection between those work activities and the condition of claimant's right arm. We therefore find that Hogan provides no assistance in our determination as to whether claimant's employment conditions were the major contributing cause of his right arm strain.

Claimant's other treating physician was Dr. Burr. Like Dr. Hogan's notes, Burr's notes contain little discussion as to the cause of claimant's condition. The sole occasion when Burr directly addresses the issue of causation is in a December 28, 1990 letter to claimant's attorney, where he states that

"[Claimant] just did not have the overall physique to be doing heavy work regardless of how much he had to lift, [even] a little bit repeatedly. He was just a very asthenic young individual with poor muscular development. * * *

"I do believe that work entailing any type of heavy lifting would be provocative of muscular ligamentous, tendinitis, myositis and symptoms related to overwork, so indeed any of these factors could be a materially contributing cause in his symptomatology." (Ex. 23) (Emphasis added).

Although Burr's opinion is probative of the causation issue, we find that it does not meet claimant's burden of proof. Burr supports the possibility that claimant's work activity produced his right arm complaints, but only as a "materially contributing cause." We are mindful that "magic words" are not necessary to establish the compensability of a claim. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). However, we do not consider Burr's opinion sufficient to satisfy claimant's burden of establishing compensability, particularly when Burr qualifies his statement with the word "could." A claimant must prove more than just a possibility of the requisite causal connection. Lenox v. SAIF, 54 Or App 551 (1981); Gormley v. SAIF, 52 Or App 1055 (1981). Burr's medical opinion simply falls short of proving that work activity was the major contributing cause of claimant's condition.

Moreover, any reliance on Dr. Burr's opinion as proving a causal relationship between claimant's work activities and his condition is further reduced by Burr's responses to Dr. Button's findings. Button found that claimant's symptoms were caused by personal factors rather than employment conditions. In responding to this finding, Burr first stated, "I am not sure. He relates the symptoms to heavy work." We find that this statement referred to claimant since the only other logical person Burr could have been referring to would be Button and Button clearly did not relate claimant's complaints to his work. Therefore, although Burr's response does not indicate complete agreement with Button, neither does it provide persuasive evidence that Burr believed that work activity caused claimant's symptoms. Furthermore, when asked a second time whether he concurred with Button's opinion, Burr answered, "Basically, yes."

In short, we find that the evidence is insufficient to support the conclusion that employment conditions were the major contributing cause of claimant's right arm condition.

ORDER

The Referee's order dated March 13, 1991 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
KAREN J. MAROON, Claimant
WCB Case No. 89-13721
ORDER ON REMAND (Remanding)
Lauren Paulson, Claimant Attorney
Norman Cole (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Maroon v. Great Western Construction, 107 Or App 510 (1991). The court has reversed our prior order which affirmed a Referee's order that found claimant was not a subject worker because she was a sole proprietor of Great Western and had not elected coverage for herself under ORS 656.128. The court concluded that substantial evidence did not support a finding that claimant was the sole proprietor of Great Western. Furthermore, the court reasoned that the evidence weighed so heavily against such a finding that we could not reasonably have so found. Because claimant was not the sole proprietor of Great Western and was not insured as such, the court held that she could be covered as a subject worker of Great Western. Although the Referee had found that claimant was not a subject worker because she was not paid for her services, our order declined to resolve the issue because we held that claimant could not be a subject worker. Consequently, the court has remanded for consideration of that issue and we have received supplemental briefs from the parties on the matter. Inasmuch as we find the record insufficiently developed to resolve the issue of whether claimant was a subject worker, we remand to the Referee.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation.

At hearing, claimant testified that she was paying herself out of Great Western's account and such wages would be shown on the company's ledger sheet. Although the Referee determined that the ledger sheets were obtainable, she declined to leave the record open following the hearing.

CONCLUSIONS OF LAW AND OPINION

We may remand to the Referee should we find that the record has been "improperly, incompletely, or otherwise insufficiently developed." Former ORS 656.295(5).

Here, the Referee concluded that, although claimant was working as a roofer at the time of her injury, there was no record that she was ever paid for her services. Accordingly, the Referee found that, because claimant was not selling services for remuneration or pay, she could not be a subject worker pursuant to former ORS 656.005(27) (now ORS 656.005(26)).

Benefits under the Workers' Compensation Act are available only when a worker-employer relationship exists. ORS 656.018(1); ORS 656.018(2). The two elements necessary to create the relationship, i.e., to make claimant a "subject worker" of the employer, are whether the employer had contracted to pay "a remuneration for and secure the right to direct and control the services" of claimant. Martelli v. R.A. Chambers and Associates, 99 Or App 524 (1989); ORS 656.005(13); former ORS 656.005(27) (now ORS 656.005(26)).

We conclude that the record has not been completely developed on the issue of whether Great Western contracted to pay claimant for her work for the company. Claimant's husband testified that she was hired as a bookkeeper in 1986 and she continued to do the books following their marriage in June 1987.

Claimant's husband also testified that she was paid approximately \$200 per week for her bookkeeping work. In addition, he testified that, as husband and wife, he and claimant shared in both the losses and profits of the business.

Although claimant testified that she received wages for a while, she could not remember whether she was paid at the time of her injury. Claimant also testified that she would have been paying herself out of Great Western's account and the payment should be noted on the ledger sheet. Claimant further testified that she provided the ledger sheets to SAIF's auditor. Claimant believed that the ledger sheets could be found at Great Western's office, and her counsel offered to leave the record open for submission of the ledger.

The Referee declined to leave the record open to admit the additional records, although she had determined that the records could be procured within approximately 90 minutes. SAIF's counsel agreed to let the record stand as it was, and claimant's counsel conceded that he had no objection to the accuracy of the auditor's worksheets.

Under the circumstances, we conclude that the record on the issue of whether claimant was a subject worker of Great Western has been insufficiently developed. Accordingly, we remand on the issue of whether claimant was a subject worker of Great Western.

SAIF argues that it did not provide coverage for claimant at the time of her injury, regardless of whether claimant was a sole proprietor or a worker. Specifically, SAIF contends that, since Great Western is an assumed business name of claimant's husband and because SAIF never contracted with claimant's husband, it provided no insurance for the entity known as Great Western.

Inasmuch as this case is being returned to the Referee for further proceedings, SAIF's argument can be considered by the Referee on remand. In conducting those further proceedings, the Referee is directed to consider the effect, if any, SAIF's acceptance of premiums from Great Western has upon this issue. See e.g. Quadel Industries v. Luckman, 95 Or App 612 (1989) (No basis for carrier to refuse coverage where, although the employer had not elected coverage for the claimant, who was a corporate officer, carrier nonetheless had knowledge of the claimant's status and had accepted premiums on his behalf).

Finally, we note that SAIF did not appear at hearing as processing agent for a noncomplying employer. See James L. Guyton, 41 Van Natta 1277 (1989). Thus, any potential issue of noncompliance concerning any entity's status as an employer would not be properly before the Referee.

Accordingly, on remand, the Referee's order dated November 15, 1989 is vacated and this matter is remanded to Referee Quillinan for further proceedings consistent with this order. Those proceedings may be conducted in any manner that will achieve substantial justice.

IT IS SO ORDERED.

In the Matter of the Compensation of
CASEY M. MORELAND, Claimant
WCB Case No. 90-18002
ORDER ON REVIEW
Robert L. Philmon, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of that portion of Referee Schultz' order which set aside its denial of claimant's left foot injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion" with the following supplementation.

Claimant has the burden of proving that he suffered an injury on April 25, 1990 while performing his work activity which was a material contributing cause of his left foot disability or need for medical care and services. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Claimant's injury must also be established by medical evidence supported by objective findings. ORS 656.005(7)(a).

"Objective findings" in support of medical evidence are defined to include, but are not limited to, "ranges of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence substantiated by clinical findings." Amended ORS 656.005(19). In Suzanne Robertson, 43 Van Natta 1505 (1991), we held that a physician's report established medical evidence supported by objective findings where:

" . . . [The doctor] did not report that claimant merely complained of a pulling sensation or tenderness. He determined, evidently based on his physical exam, that [claimant] did, in fact, suffer from those conditions. After his evaluation of claimant, he concluded that claimant had an acute thoracic strain and related the injury to [claimant's] activities at work." Robertson, 43 Van Natta at 1507.

Here, the only physician who examined claimant while he was suffering from the effects of his foot strain was Dr. Anderson. The other doctors in the record did not have the opportunity to examine claimant until after his foot strain had resolved. Accordingly, we find Dr. Anderson's opinion to be the more persuasive and we accord it the greater weight. John A. Calder, 42 Van Natta 977, 979 (1990).

Dr. Anderson noted claimant's acute foot pain and tenderness, and he also viewed claimant limping. Based upon his evaluation of claimant, he concluded claimant had sustained a foot strain on April 25, 1990. (Exs. 3, 4, 5). Based upon the history given by claimant concerning the amount of walking he does on his job, the type of work he performs and the onset of the pain, Dr. Anderson expressly reported this as an occupational job injury. (Ex. 4). Therefore, Dr. Anderson's report rules out claimant's condition as being idiopathic. Hubble v. SAIF, 56 Or App 154 (1982); also see Roxie A. Lingle, 43 Van Natta 1742 (1991).

We find that Dr. Anderson determined, based on his training and objective analysis of what he found and heard, that claimant's complaints amounted to objective findings of a work-related injury on April 25, 1990. Robertson, supra, at 1507. Therefore, we conclude that claimant has established a compensable injury. Accordingly, we affirm the Referee's order setting aside the employer's denial.

Inasmuch as the employer has requested review, and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel services on review is \$750, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case, (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 4, 1991 is affirmed. For services on review, claimant's attorney is awarded \$750, to be paid by the self-insured employer.

November 19, 1991

Cite as 43 Van Natta 2542 (1991)

In the Matter of the Compensation of
RONALD D. ROBINSON, Claimant
WCB Case No. 91-08084
ORDER DENYING MOTION TO DISMISS
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Claimant has moved the Board for an order dismissing the insurer's request for review of a Referee's October 16, 1991 order, which dismissed claimant's request for hearing. We conclude that we have jurisdiction to consider the insurer's request for review and deny the motion to dismiss.

FINDINGS OF FACT

In June 1991, claimant filed a request for hearing. Contending that the insurer had failed to pay interim compensation from May 30, 1991 to the time of the request for hearing, claimant sought interim compensation, penalties and attorney fees.

On October 16, 1991, stating that claimant had withdrawn his hearing request, the Referee issued an Order of Dismissal. On October 30, 1991, the insurer mailed a request for review of the Referee's order to the Board. The request included a certificate of personal service by mail upon all parties to the proceeding and their representatives.

CONCLUSIONS OF LAW AND OPINION

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 656.298(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 16, 1991 order was November 15, 1991. The insurer's request for review was mailed to the Board and copies were mailed to the other parties to the proceeding on October 30, 1991. Inasmuch as such submissions were made within 30 days of the issuance of the Referee's October 16, 1991 order, we have jurisdiction to consider this case. See ORS 656.289(3); 656.295(2).

Claimant contends that because he "withdrew his Request for Hearing, there is no issue for Board Review." We disagree.

As a result of the Referee's order, claimant's request for hearing concerning the interim compensation, penalty and attorney fee issues were dismissed. Thus, certainly insofar as claimant's entitlement to interim compensation was concerned, the order had the potential of impacting claimant's right to compensation. See Donald L. Lowe, 41 Van Natta 1873 (1989). In that respect, it is an appealable final order. See Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974); Donald L. Lowe, supra.

In conclusion, because the insurer timely requested Board review, the Referee's order had not become final. ORS 656.289(3). Furthermore, after conducting our review, we are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(6). Thus, the issues of claimant's entitlement to interim compensation, penalties and attorney fees remain viable.

Accordingly, the motion to dismiss is denied. As a result of this order, it will be necessary to revise the briefing schedule. The insurer's appellant's brief shall be due 21 days from the date of this order. Claimant's respondent's brief shall be due 21 days from the date of the mailing of the insurer's appellant's brief. The insurer's reply brief, if any, shall be due 14 days from the date of mailing of claimant's respondent's brief. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

November 19, 1991

Cite as 43 Van Natta 2543 (1991)

In the Matter of the Compensation of
JEFFREY M. RUBIN, Claimant
WCB Case Nos. 90-16854 & 89-15470
ORDER ON REVIEW
Philip Schuster II, Claimant Attorney
Nelson, et al., Defense Attorneys

Reviewed by Board Members Moller and Tenenbaum.

The insurer requests review of that portion of Referee Bethlahmy's order that set aside its partial denial of claimant's medical services claim for detoxification treatment. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established the compensability of his medical services claim for drug detoxification treatment. We adopt the conclusions and reasoning as set forth in the Referee's order, and we add the following supplementation.

To establish compensability of his medical services claim for detoxification treatment, claimant must prove that the original injury was the major contributing cause of his consequential drug dependency and subsequent need for detoxification treatment. See ORS 656.005(7)(a)(A); Julie K. Gasperino, 43 Van Natta 1151 (1991).

Here, the Referee found that, following surgeries for his compensable condition, numerous drugs were prescribed for claimant, including Vicodin, Tylenol #3, Flexeril, and Valium. A May 15, 1990 intake summary described claimant's "presenting problem" as prescription "painkillers reactivated opiate addiction."

In October 1990, the Orthopaedic Consultants examined claimant and reported that, following his second surgery, because he became addicted to Codeine, taking up to 20 Tylenol #3 per day as well as using some Xanax and Skelaxin, claimant was "admitted for detox for four or five days and then has been treated as an outpatient." The Consultants also reported that "there is no doubt that he has been given narcotic medication by his treating physicians and did get into an addiction problem with Codeine...."

In December 1990, claimant was examined by Dr. Sonntag, M.D. Dr. Sonntag reported that, following his surgery, claimant began having increasing problems with neck and right upper extremity pain. Dr. Sonntag further reported that claimant was "frankly addicted to Percodan because of the severe pain...."

Under the circumstances, we conclude that claimant has established that his compensable injury was the major contributing cause of the consequential addiction to prescription drugs. Moreover, claimant's addiction to prescription drugs was the major contributing cause of his hospitalization and need for drug detoxification treatment. Accordingly, the detoxification program is a compensable medical service. See e.g. Joseph M. Ell, 43 Van Natta 78 (1991).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 13, 1991 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of \$750, payable by the insurer.

In the Matter of the Compensation of
MEL L. EVENHUS, Claimant
WCB Case No. 90-13860
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the insurer's denial of claimant's injury claim on the basis that the claim was not timely filed. On review, the issues are timeliness of the claim and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's injury claim for a cervical condition was barred by his failure to give the employer written notice within 30 days of the accident and that his untimeliness was not excused under ORS 656.265. We agree and adopt the Referee's conclusions and reasoning with the following supplementation.

Even assuming the claim was timely filed, we conclude that claimant has failed to establish a compensable injury. A compensable injury is an accidental injury "arising out of and in the course of employment." ORS 656.005(7)(a). As a general rule, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). The question is whether the relationship between the injury and employment is sufficient to allow compensation. Rogers v. SAIF, 289 Or 633 (1980).

In this case, claimant was injured in a motor vehicle accident during the time between his split shifts and off the employer's premises. The "in-between" time is considered claimant's own time for which he receives no compensation, notwithstanding the split-shift pay differential. Many employees, including claimant, use the time to retrieve their personal vehicles from the district parking lot. Nonetheless, the employer exercised no direction or control over the employees in the period between the split shifts. Moreover, the option and convenience of claimant returning to the parking lot was a benefit to claimant, not the employer, and was not a substantial part of the service he performed for employer as a bus driver.

Under those circumstances, we conclude that claimant has failed to establish a sufficient work relationship between the motor vehicle accident and his employment as a bus driver to justify compensation. Accordingly, for that reason, and those relied upon by the Referee, we uphold the insurer's denial of claimant's injury claim for a cervical condition.

ORDER

The Referee's order dated March 12, 1991 is affirmed.

In the Matter of the Compensation of
TRACY JOHNSON, Claimant
WCB Case No. 90-05539
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Janice Pilkenton, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Hoguet's order that: (1) upheld the insurer's "partial denial" of claimant's request for authorization for a third change of attending physician; and (2) affirmed an order of the Medical Director denying claimant's request for a third change of attending physician. We conclude that the Hearings Division lacks jurisdiction over this issue and vacate the Referee's order.

FINDINGS OF FACT

Claimant compensably injured his low back while working for the insured on October 26, 1987. He initially treated with Dr. Daack, D.O., but, in May 1988, switched to the care of Dr. Gabrielson, D.C.

In June 1989, claimant began treating with Dr. Thompson, M.D., at the Oregon Spine Center. Dr. Thompson recommended pain center treatment, which claimant undertook in December 1989. Upon discharge from the pain center, claimant tried to return to Dr. Gabrielson for care and treatment, but discovered that Dr. Gabrielson no longer practiced chiropractic medicine in Oregon.

In March 1990, claimant began treating with Dr. Nichols, D.C., and requested a change of attending physician. In a letter dated March 6, 1990, the insurer refused the request pursuant to former OAR 436-10-060(4). It explained that claimant had already had three attending physicians and that he needed to seek the Director's approval for any additional change. Claimant then requested the Director to approve the change of attending physician; however, a representative of the Director refused to authorize the requested change in a letter dated June 8, 1990.

Thereafter, claimant supplemented an earlier request for hearing and raised the issue of the propriety of the Director's decision. A hearing was convened on July 13, 1990. The Referee issued an order that upheld what he characterized as "the carrier's partial denial of March 6, 1990 and the Medical Director's affirmance thereof on June 8, 1990." (O & O at 3).

CONCLUSIONS OF LAW AND OPINION

On May 7, 1990, the Oregon Legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Law. Or Laws 1990 (Special Session), ch. 2. Because a hearing was convened after July 1, 1990, this matter is properly analyzed under those revisions. Or Laws 1990 (Special Session), ch. 2, 54; Ida M. Walker, 43 Van Natta 1402 (1991).

A threshold issue not raised by either party is whether the Referee had jurisdiction to review the Director's refusal to authorize claimant's request for an additional change of attending physician. Prior to the 1990 amendments, review of the Director's decision would have been within the Hearings Division's jurisdiction under former ORS 656.704(3), which provided:

"For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under ORS 656.001 to 656.794, and for determining

the procedure for conduct and review thereof, matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation of 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 1990 Legislature, however, amended that provision to refashion the jurisdictional authority of the Hearings Division. The last sentence of ORS 656.704(3) now provides:

"However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter." Or Laws 1990 (Special Session), ch. 2, 37. (Emphasis supplied.)

The question, therefore, is whether ORS 656.245(3), which provides that a carrier may request the Director's approval for a third change of attending physician, is a "proceeding for resolving a dispute regarding medical treatment." We conclude that it is and, accordingly, vacate the Referee's order for lack of subject-matter jurisdiction.

ORS 656.245(3) provides that an injured worker may choose the initial attending physician and change attending physicians two times without approval from the Director. If the worker thereafter selects another attending physician, the carrier may require the Director to approve the new selection. If requested, the Director shall determine, with the advice of one or more physicians, whether the selection shall be approved.

The statute does not provide or require the Director to conduct a formal quasi-judicial proceeding to make the determination. To the contrary, the legislature essentially left the resolution to the discretion of the Director, subject only to the condition that it act on the advice of one or more physicians. However, despite the lack of formal requirements, ORS 656.245(3) does provide a process for resolving a dispute between an injured worker and a carrier that refuses to voluntarily recognize a subsequent medical provider as an attending physician. Viewed in that light, the statute provides a "proceeding for resolving a dispute regarding medical treatment," within the meaning of ORS 656.704(3).

Accordingly, we conclude that a dispute involving a claimant's request for a third change of attending physician is, by definition, not a "matter concerning a claim" over which the Hearings Division has jurisdiction. Rather, such disputes are solely within the province of the Director and must be resolved under the applicable procedures for administrative review set forth in former OAR 436-10-008(2).

ORDER

The Referee's order dated July 25, 1990 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

Board Members Gunn and Kinsley dissenting.

The majority concludes that the Board no longer has jurisdiction to hold a hearing regarding a worker's third change of attending physician under ORS 656.245(3)(a). We respectfully dissent because we believe this conclusion is contrary to our scope of jurisdiction set forth in ORS 656.704(3).

In 1990, the legislature restricted workers' and employers' right to a hearing by eliminating the Board's jurisdiction over matters "regarding medical treatment or fees for which a procedure is otherwise provided in this chapter." ORS 656.704(3). Where the parties' access to a hearing procedure is being reduced or eliminated, we believe the prudent approach is to strictly read this language at face value as applying only to medical treatment or fees and to avoid interpreting this language as covering other matters not specifically stated, such as the workers' choice of physician. Further, a search through the scant legislative history from the public hearings covering the amendment of ORS 656.704(3) reveals no discussion that the parties' right to hearing about the workers' choice of physician was to be reduced or eliminated.

We believe that the new language in ORS 656.704(3) refers to ORS 656.327 and 656.248. The 1990 Legislature made substantial amendments to these statutes which specifically deal with medical treatment and fees. ORS 656.327 deals with the Director's procedures to resolve matters regarding "medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." ORS 656.327(1)(a) (Emphasis added). ORS 656.248 deals with the Director's procedures to resolve disputes over "the amount of a fee for medical services." ORS 656.248(13) (Emphasis added).

The Legislature did not amend the language in ORS 656.245(3)(a) regarding a worker's choice of physician. This language was in effect long before the amendments to ORS 656.704(3). ORS 656.245(3)(a) provides that an insurer may require the Director's approval of a worker's third change of the attending physician. Up to the time of the majority's opinion in this case, the parties have always had the right to request a hearing regarding the change of physician issue whether or not the insurer had exercised its option to use the Director's procedure for approval. We believe it is error to extinguish this right without specific direction to do so by the Legislature.

Finally, we observe that the workers' choice of an attending physician significantly impacts the course and outcome of workers' claims for compensation. With limited exceptions, only this physician may authorize medical services, ORS 656.245(3)(b)(A); only this physician may authorize payment of benefits for disability from work while the worker is recovering from the injury or disease, ORS 656.245(3)(b)(B); only this physician may make findings regarding the worker's permanent impairment for the purpose of determining the appropriate award for permanent disability, ORS 656.245(3)(b)(B).¹ When so much depends on the choice of physician, we are reluctant to conclude that the Legislature left the resolution of this matter to the discretion of the Director, subject only to the advice of one or more physicians, and without the parties' right to a hearing.

To summarize, we conclude that the parties continue to have the right to hearing under ORS 656.704(3) regarding the third change of attending physician because: (1) neither the plain language of the statute nor the legislative history support an opposite conclusion; (2) the statute can logically be read to apply to other statutes that specifically address the issues of treatment and fees; and (3) we are reluctant to read ORS 656.704(3) more broadly so that it operates to reduce or eliminate the parties' right to a hearing for resolving a dispute regarding this significant issue.

1. We recognize the broad exceptions to these requirements for managed care organizations.

In the Matter of the Compensation of
JAMES D. YERBY JR., Claimant
WCB Case No. 89-18528
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Davis' order that upheld the self-insured employer's denial of his aggravation claim for a back and neck injury. Claimant has also submitted a motion asking that we remand this matter for transcription of closing arguments. In the alternative, claimant asks that we take judicial notice of California statutes concerning workers' compensation. On review, the issues are remand, administrative notice and aggravation. We decline to remand and affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order.

FINDINGS OF ULTIMATE FACT

We adopt the "Findings of Ultimate Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant requests that we remand this matter for transcription of closing arguments. He alleges that in closing argument, the parties stipulated that the State of California apportions workers' compensation benefits when a non-California compensable injury is aggravated in California. Alternatively, he asks that we take administrative notice of California statutes concerning apportionment of workers' compensation benefits. We decline to remand. A remand for the purpose indicated is neither necessary nor appropriate, since as claimant recognizes, this Board may take administrative notice of the laws of California which may be relevant to this case.

Administrative Notice/Aggravation

We adopt the conclusions and reasoning of the Referee concerning the aggravation issue with the following supplementation.

Claimant asks that we take administrative notice of California's statutes concerning apportionment of workers' compensation benefits. He contends that it was not necessary to file a claim in California as he would not receive the same amount of compensation under California's workers' compensation law as he would be entitled to under Oregon law. The Court of Appeals has recently addressed this issue in a manner which renders immaterial California's laws on apportionment of workers' compensation benefits.

In Wootton v. Stadeli Pump & Construction, 108 Or App 548 (1991), the claimant had a back injury which was accepted by an Oregon employer. Subsequently, the claimant sustained another injury to his back while working for a California employer. The court applied Milville v. SAIF, 76 Or App 603 (1985) and found that the claimant's back condition was the responsibility of the California employer. The claimant had contended that under California law, his disability would be apportioned, and therefore he would not be receiving full

compensation for his injury. Wootton, supra at 550. He argued that responsibility should not shift to an employer in another state unless, under the laws of that state, the claimant would be fully compensated for his disability. Id. at 551. The court rejected this argument and stated:

"There is no requirement that a claimant must be compensated by an out-of-state employer to the same extent that he would be in Oregon in order for responsibility to shift under the last injurious exposure rule to the out-of-state employer." Id. at 553.

Under that rule, the Oregon employer is not responsible for the claimant's condition, where the claimant's work for the out-of-state employer independently contributed to the worsening of the compensable condition, and the claimant has not filed a claim in the other state. Miville v. SAIF, supra, at 607.

Here, we have adopted the Referee's conclusion that claimant's employment in California independently contributed to a worsening of his underlying back condition. Since claimant did not file a claim with his California employer, the self-insured employer is no longer responsible for claimant's low back condition. Miville, supra at 607. Therefore, the self-insured employer's denial should be upheld.

ORDER

The Referee's order dated November 14, 1990, as reconsidered January 14, 1991, is affirmed.

November 21, 1991

Cite as 43 Van Natta 2549 (1991)

In the Matter of the Compensation of

AMANUEL A. GEZAHAGNE, Claimant

WCB Case No. 90-21620

ORDER ON REVIEW

Parker & Bush, Claimant Attorneys

Acker, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of that portion of Referee Galton's order which set aside its denial of claimant's aggravation claim for an asthma condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation.

The May 18, 1989 Opinion and Order, which awarded claimant 34 percent unscheduled permanent disability, is the last award of compensation.

Claimant was not working at the time of the last award of compensation. Claimant is currently more limited in his ability to find employment than he was at the time of the last award of compensation.

ULTIMATE FINDINGS OF FACT

Claimant experienced a worsening of his reactive airway disease since the last award of compensation. His symptomatic worsening has resulted in diminished earning capacity to a level below that fixed at the time of the last award

of compensation. At the time of the last award of compensation, future periods of increased symptoms were anticipated. Claimant's symptomatic worsening is more than the waxing and waning of symptoms contemplated by the last award of compensation.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had experienced a worsening of his reactive airway disease since the last award of compensation and that the worsening was more than the waxing and waning of symptoms contemplated by the last award of compensation. We agree and adopt the Referee's "Conclusions and Opinion" with the following supplementation.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled reactive airway disease condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the medical worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Claimant also has the burden to prove that he has sustained a worsening of his compensable condition that is more than a waxing and waning of symptoms as contemplated by the last award or arrangement of compensation. ORS 656.273(8). If there was medical evidence prior to the last award of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, *supra*; see also International Paper Co. v. Turner, 91 Or App 91, rev den 307 Or 101 (1988).

Claimant's asthma condition claim was closed by Determination Order on January 4, 1989, and a May 18, 1989 Opinion and Order increased his unscheduled permanent disability award to 34 percent. Claimant returned to his treating pulmonologist, Dr. Keppel, in March 1990, and complained that his asthma was not getting better. In July 1990, Dr. Keppel reported that claimant was having problems, both at work and at home, with his asthma condition. In September 1990, Dr. Keppel reported that claimant's underlying reactive airway disease had "become more sensitive in the last year, greatly limiting his ability to find employment."

An October 7, 1990 pulmonary function study showed claimant's forced vital capacity (FVC) was 105% of predicted, his forced expiratory volume (FEV1) was 98% of the predicted value and his FEV1/FVC percentage was 76%. (A prior study conducted in September 1988 showed an FVC of 110%, FEV1 of 104%, and FEV1/FVC percentage of 77%.)

We conclude that Dr. Keppel's 1990 report constitutes a claim for aggravation. We are also persuaded that claimant has established that his reactive airway condition has worsened. Although Dr. Bardana, an independent medical examiner, concluded that there was no evidence that claimant's condition has worsened, he also reported that:

"As indicated in the past, I never felt there was any consistent or convincing evidence that (claimant) had developed western red cedar asthma...I continue to believe that (claimant) does not have any evidence for occupational bronchial asthma."

We agree with the Referee that, because claimant's asthma condition has previously been found compensable, Dr. Bardana's opinion is contrary to the law of the case. Accordingly, his opinion, which is based upon a conclusion contrary to the law of the case, is not persuasive. See Kuhn v. SAIF, 73 Or App 768 (1985).

The insurer also contends that claimant has not established that the compensable condition is the major contributing cause of his worsening, as Dr. Keppel reported that other factors could have contributed to the worsened condition. We disagree. Under amended ORS 656.273, a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition, provided that no off-the-job injury is the major contributing cause of the condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991); ORS 656.273.

Here, although Dr. Keppel noted that "environmental precipitants may be playing a role" in claimant's worsened condition, we do not agree that his statement may be construed to mean that off-work conditions are the major contributing cause of claimant's worsened condition. Moreover, when read as a whole, we conclude that Dr. Keppel's report establishes that the compensable condition is a material contributing cause of claimant's worsened reactive airways disease.

Under the circumstances, we conclude that claimant has established a worsening of his compensable reactive airway disease condition, which is supported by objective findings in the report of Dr. Keppel and the pulmonary function studies. See Suzanne Robertson, 43 Van Natta 1505 (1991).

Although claimant has established a worsening of his condition, he must also establish that this worsening has resulted in diminished earning capacity. Smith v. SAIF, supra. Prior to his last claim closure, Dr. Keppel opined that claimant should avoid strong odors, irritants or changes in temperatures.

In July 1990, however, Dr. Keppel reported that claimant found that his asthma became problematic during his work as a dishwasher and in several office settings. In September 1990, Dr. Keppel reported that claimant's asthma proved to be so sensitive that it was difficult for him to work around strong irritants or fumes. Dr. Keppel suggested that claimant should be re-trained, and he further reported that claimant's underlying reactive airway disease had become more sensitive in the last year, "greatly limiting his ability to find employment." Finally, following an asthmatic episode in November 1990, Dr. Keppel reported that Dr. Patterson prescribed prednisone for claimant and he had been advised that he should live in another part of the country.

We rely upon the opinion of Dr. Keppel, and conclude that claimant has established diminished earning capacity as a result of his worsened condition, as his report indicates that there are fewer jobs claimant can now perform and claimant would need to be re-trained for those jobs.

Finally, as claimant has previously been awarded unscheduled permanent disability, he must also show that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

Here, claimant's last award of compensation was the May 18, 1989 Opinion and Order which increased his permanent unscheduled disability award to 34 percent. At that time, the prior Referee agreed with Dr. Keppel's opinion that claimant had permanent residuals as a result of his condition and, due to the

possibility of future ongoing and persistent asthma, he should be removed completely from any exposures to wood dust.

In 1990, however, Dr. Keppel believed that claimant had become more sensitive, which greatly limited his ability to find employment. Claimant's doctors recommend that he be re-trained to avoid certain work environments and it was suggested that claimant move to another part of the country. Under the circumstances, we conclude that claimant's worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. Accordingly, we conclude that claimant has established a compensable aggravation.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the issue of aggravation is \$750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 19, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$750, payable by the insurer.

November 21, 1991

Cite as 43 Van Natta 2553 (1991)

In the Matter of the Compensation of
WILLIAM HOAG, Claimant
WCB Case No. 90-17644
ORDER ON REVIEW
Doblie, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Brown's order that upheld the insurer's denial of his aggravation claim for his low back injury. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant was not working at the time of his last award of compensation. Medical evidence prior to the last award of compensation indicated continuing pseudoarthrosis at L5. (Ex. 2-4). At that time, claimant reported an inability to perform any type of activity. (Ex. 2-2). His symptoms included a constant dull ache originating in the low back with sharp pain radiating to the hips bilaterally and down the thighs to the knees. (Ex. 3C). He reported essentially the same symptoms at his hearing before Referee Brown.

CONCLUSIONS OF LAW AND OPINION

The issue is whether claimant has established a compensable aggravation of his low back condition. Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is properly analyzed under the 1990 amendments to the Workers' Compensation Law. See Oregon Laws 1990 (Special Session), chapter 2, 54(2); Ida Walker, 43 Van Natta 1402 (1991).

Under the current version of ORS 656.273, an injured worker is still entitled to compensation for a "worsened condition" resulting from the compensable injury since the last arrangement or award of compensation. Furthermore, the traditional definition of a "worsened condition," *i.e.*, an increase in symptoms or a pathological change resulting in diminished earning capacity, remains intact. See Leroy Frank, 43 Van Natta 1950 (1991). The worsened condition, however, must be established by medical evidence supported by objective findings. ORS 656.273(1).

The Referee found that claimant's claim lacks a physician's report of an objective worsening of his compensable condition. Claimant argues, in part, that Dr. Webb's report of motion at the L5-S1 level of approximately 3-4 mm establishes an objective worsening of his condition. (Ex. 15). However, Dr. Webb opined no more than that "an element of his pain may be due to presumed pseudoarthrosis with evidence of some gross motion present." Not only does Dr. Webb phrase his report in terms of possibility rather than probability, but the record persuades us that claimant's pseudoarthrosis existed at the time of the last award of compensation. (Ex. 2).

Moreover, even if we were to agree that claimant's condition has worsened, we are not persuaded that the worsening has rendered claimant less able to work. See Smith v. SAIF, 302 Or 396 (1986); Leroy Frank, *supra*. Claimant was not working at the time of his last award of compensation. Similarly, he is not working at the present time. He rates his pain level now as approximately the same as it was at the time of his last award. (Compare Tr. 21 with Ex. 3-5). While Dr. Misko reported that claimant was disabled due to pain (Ex. 6-2), nothing in his report supports the conclusion that claimant is less able to work now than he was at the time of his last award. Further, although Dr. Misko initially believed that claimant would benefit from further surgery (Ex. 9), he subsequently agreed with the Orthopaedic Consultant's report, wherein they noted the "entirely subjective" nature of claimant's complaints and opined that surgery would not be appropriate. (Exs. 11-5, 12).

In sum, claimant continues to experience disabling symptoms due to his compensable injury and resulting surgeries. However, we are not persuaded that claimant is any less able to work now than he was at the time of his last award of compensation. Accordingly, he has failed to establish a compensable worsening of his condition.

ORDER

The Referee's order dated February 22, 1991 is affirmed.

November 21, 1991

Cite as 43 Van Natta 2554 (1991)

In the Matter of the Compensation of
NANCY C. HOOVER, Claimant
WCB Case No. 90-20131
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Miller, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Otto's order that upheld the self-insured employer's partial denial of her claim for a dorsal-lumbar spine condition. On review, the issues are claims processing and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Ultimate Findings of Fact," with the following modification.

The last sentence on page one and the first sentence on page two are replaced with:

"In mid-July 1988, claimant first reported low back pain."

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law," with the following supplementation and modification.

Claimant argues that the employer was precluded from issuing its partial denial, because it accepted her low back injury claim. We disagree.

On the 827 form describing her injury, claimant reported that the muscles in her neck, shoulders and back were injured. (Ex. 1). On the same 827 form, Dr. Panzer, treating chiropractor, described the nature and location of the injury as: "Moderate hypertonicity right cervicothoracic musculature. Active trigger points in right paracervical and right/levator scapulae muscles. Palpable cervical intervertebral motion restriction." (Id.) Panzer diagnosed "Acute post-traumatic cervicothoracic sprain/strain; Associated myofascial pain syndrome with attendant cephalgia; [and] Cervicothoracic joint dysfunction." (Id.)

The employer accepted claimant's injury claim on June 20, 1988, by checking the appropriate box on claimant's 801 form. (Ex. 2). On that form, claimant listed the body parts affected as her left and right neck, shoulders and back. She explained that she had "injured muscles in neck and shoulders." (Id.)

There is no medical evidence of low back problems until mid-July 1988, after claim acceptance. (See Exs. 3A & 4-1). Based on the information contained in the 827 and 801 forms and the timing of claimant's reporting of symptoms, we conclude that the scope of the employer's acceptance did not include claimant's subsequent low back problems. Moreover, inasmuch as the employer did not "specifically" or "officially" accept a low back condition, its partial denial was permissible. See ORS 656.262(6); Johnson v. Spectra Physics, 303 Or 49, 52 (1987).

Finally, concerning the merits, we replace the last sentence in the "Conclusions of Law" section with:

"Based on the lack of low back symptoms contemporaneous with the motor vehicle accident, and the lack of persuasive medical evidence relating claimant's low back problems to that accident, we conclude that claimant has failed to carry her burden of proof by a preponderance of the evidence."

ORDER

The Referee's order dated February 6, 1991 is affirmed.

In the Matter of the Compensation of
VIRGIL R. HUTSON, Claimant
WCB Case No. 90-15307
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Otto's order which: (1) set aside its partial denial of claimant's psoriasis condition; and (2) set aside a Determination Order dated August 22, 1990. On review, the issues are compensability, premature closure and extent of unscheduled permanent disability. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact" with the following supplementation.

Claimant has 10.5 years of formal schooling and a GED. The highest specific vocational pursuit level demonstrated by claimant during the ten years preceding the hearing was 7, as a blaster working for Harding and Daughters, Inc.

Claimant's back condition became medically stationary on June 1, 1990.

Claimant's psoriasis condition was medically stationary in mid-June 1990.

Claimant's residual physical capacity is in the light category.

Claimant has an unoperated disc bulge at L3-4. (Ex. 37-2, 48). He also has an unoperated disc bulge at L5-S1 from a previous low back injury in 1986.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. We agree that the amended statute applies to the issue of compensability because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the compensability issue is not subject to a special exception to the Act's general applicability provision. Moreover, application of the 1990 amendments to the compensability issue will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991).

Additionally, the amendments to ORS 656.268 (4), (5), (6), (7), and (8), requiring that disputes about premature claim closure and extent of disability first be reviewed by the Appellate Unit apply only to claims which become medically stationary after July 1, 1990. Here, claimant's back was stationary on June 1, 1990. On October 5, 1990, Dr. Key, claimant's treating physician, stated that claimant's psoriasis was stationary as of mid-June, although the doctor acknowledged an exacerbation in August, after the Determination Order. Accordingly, the law as amended by Oregon Laws 1990 does not apply to the issues of premature closure and extent of permanent disability.

Compensability of Psoriasis

We adopt the Referee's "Conclusions of Law" with respect to this issue.

Premature Closure

The Referee set aside the August 22, 1990 Determination Order reasoning that, because it closed claimant's claim without considering the compensable psoriasis condition, it was issued in error. We disagree.

At the time the Determination Order issued, claimant's psoriasis claim had been denied. A condition that is denied at the time the Determination Order issues is not considered when rating permanent partial disability. Here, it was not until after the Determination Order issued that the Referee found the condition compensable. Nevertheless, a claim is not prematurely closed simply because a compensable condition was in a denied status at the time of the Determination Order. To prevail, claimant must prove that the denied condition was not medically stationary at that time.

We conclude that claimant's psoriasis claim was medically stationary when the claim was closed. In July 1990, Dr. Key stated that he could not say that claimant was medically stationary. However, in October 1990, Dr. Key stated that claimant was medically stationary with respect to his psoriasis condition in mid-June 1990. (Ex. 61). He noted that in June claimant had discontinued using medication for the psoriasis and was stable with very little involvement. (Ex. 56). It was not until after the Determination Order dated August 22, 1990 closed his claim that claimant again had an outbreak of psoriasis. Accordingly, we conclude that claimant's claim was not prematurely closed because of his psoriasis condition.

Extent of Permanent Disability

Because we find that claimant's claim was not prematurely closed and that his compensable condition was medically stationary, we rate claimant's unscheduled permanent disability as of the date of hearing.

Because claimant's low back condition became medically stationary on June 1, 1990, and his claim was closed by Determination Order on August 22, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Those standards were effective January 1, 1990. (WCD Admin. Order 1-1989). Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Age and Education

The appropriate value for claimant's age of 39 years is 0. Former OAR 436-35-290.

The appropriate value for claimant's GED is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was a Blaster (DOT # 859.261-010), SVP 7. Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Adaptability

The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Here, claimant is not working as a result of his compensable injury and no offer of employment has been made. Claimant's physical capacity is in the light category. Therefore, the appropriate adaptability value is 4. Former OAR 436-35-310(4)(c).

Impairment

Low Back

As a result of his injury on June 22, 1989, claimant has an unoperated disc bulge at L3-4. The disc bulge at L5-S1 was caused by his previous injury in 1986. For the unoperated disc condition at L3-L4, claimant is entitled to an impairment value of 4. Former OAR 436-35-350(2).

It is apparent from the record that claimant has decreased range of motion in his lumbar spine, and Dr. Gray states that claimant has a chronic back problem. Nevertheless, we find no evidence that relates claimant's loss of range of motion in his lumbar spine to his current injury, as opposed to his injury in 1986. Accordingly, claimant has not met his burden of proving that his loss of range of motion is due to his current compensable injury and, thus, he is not entitled to an impairment value for such loss.

Psoriasis

Because we have found that claimant's psoriasis condition was medically stationary when the claim was closed on August 22, 1990, we must also rate impairment due to the psoriasis.

Claimant would have us rely on a report from Dr. Stanulis, Ph.D., who writes that claimant has a Class 3 permanent personality disorder (psychophysiological reactions) in the mild range (66 to 80 percent). OAR 436-35-400(4)(c)(D). (Ex. 65-7). Dr. Stanulis implies that claimant's psoriasis is caused by psychophysiological reactions. We are not persuaded by Dr. Stanulis for the following reasons. First, claimant admits that Dr. Stanulis is not treating him, (Tr. 7), and it is not clear whether he ever personally examined claimant or simply reviewed the medical record. Second, in his report (Ex. 65), Dr. Stanulis does not relate claimant's alleged permanent personality disorder to his compensable back injury. Accordingly, we conclude that claimant's psoriasis is not ratable pursuant to OAR 436-35-400.

Alternatively, claimant's psoriasis condition could be rated pursuant to OAR 436-35-440 which provides for impairments of the skin or integumentary system. Specifically, Class 1 impairments are characterized by present signs or symptoms of skin disorder, but with treatment there is no limitation, or minimal limitation, in the performance of the activities of daily living. Claimant's treating dermatologist, Dr. Key, has indicated that claimant's psoriasis does not limit his ability to work as long as the psoriasis is treated by medication. See e.g., Exs. 61, 62, 63. Accordingly, we conclude that claimant has 5 percent impairment of the integumentary system. OAR 436-35-440, Class 1.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 1, the sum is 1. When that value is multiplied by claimant's adaptability value, 4, the product is 4. When that value is added to claimant's combined impairment value, 8.8 (OAR 436-35-320(2)), the result is 12.8 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 13 percent.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987).

Here, we find no evidence that claimant has more or less unscheduled permanent disability than that allowed by the "standards."

Attorney Fees: Hearing/Review

Because we reinstate the Determination Order, we modify that portion of the Referee's order that awarded claimant's attorney \$1,900 in fees for setting aside the partial denial and the Determination Order. Parenthetically, we note that even if we had agreed with the Referee's decision to set aside the Determination Order, claimant's attorney would not be entitled to a carrier-paid fee. Rather, any attorney fee would come from the increased compensation created by the Referee's order. ORS 656.386(2); Dianne M. Bacon, 43 Van Natta 1930 (1991).

In any event, after considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services at hearing concerning the issue of compensability of claimant's psoriasis condition is \$1,600.

The insurer requested review and we have found that claimant's compensation should not be disallowed or reduced. Therefore, claimant's attorney is entitled to an assessed fee. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the issue of compensability of claimant's psoriasis is \$900, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 27, 1990 is reversed in part, modified in part, and affirmed in part. That portion which set aside the August 22, 1990 Determination Order is reversed. The Determination Order is reinstated. However, that portion of the Determination Order which awarded 4 percent (12.8 degrees) unscheduled permanent disability is modified. In addition to the Determination Order award, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability giving him a total award to date of 13 percent (41.6 degrees) unscheduled permanent disability for a low back injury and related psoriasis condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800, payable directly to claimant's attorney. That portion of the Referee's order which awarded an assessed attorney fee is modified. In lieu of the \$1,900 attorney fee for services at hearing, claimant's attorney is awarded a reasonable attorney fee of \$1,600 for setting aside the partial denial of claimant's psoriasis condition. The remainder of the Referee's order is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed attorney fee of \$900, payable by the insurer.

November 21, 1991

Cite as 43 Van Natta 2560 (1991)

In the Matter of the Compensation of
FREDERICK W. IMMONEN, Claimant
WCB Case Nos. 90-15706 & 90-20226
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Black's order that upheld the SAIF Corporation's denial of his claim for his current right ankle condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Reasoning," with the following supplementation.

Claimant contends that his current right ankle condition is compensable as an occupational disease. We agree with the Referee that this matter is properly analyzed under the Workers' Compensation Act as amended, effective July 1, 1990. Accordingly, claimant must prove that his employment conditions, in the form of a series of traumatic events or occurrences, were the major contributing cause of the worsening of his preexisting degenerative arthritis disease. Additionally, claimant must prove the worsening of his preexisting ankle condition by medical evidence supported by objective findings. ORS 656.802(2).

At the outset, we agree with the Referee's conclusion that claimant's failure to contest SAIF's March 4, 1988 denial of his preexisting degenerative condition bars litigation of compensability of his preexisting condition as it existed at the time of the March 1988 denial. See Anna M. Turner, 41 Van Natta 1956 (1989). However, claimant is not precluded from proving any contribution

his employment may have had to the worsening or development of his right ankle condition following the March 4, 1988 denial.

Here, a February 16, 1988 Form 827 completed by claimant's treating doctor, Dr. Jones, M.D., lists claimant's diagnosis as "mild medial swelling and has a palpable loose body anterolaterally." Dr. Jones noted that x-rays had been taken and claimant had a loose body anterolaterally, "but has absolutely no joint space."

On March 22, 1988, Dr. Jones informed claimant's wife that there were several causes of osteoarthritis, including genetics and trauma. Dr. Jones also reported that claimant would need an ankle fusion.

In May 1990, Dr. Jones saw claimant for a follow-up visit regarding his right ankle. He reported that claimant had intermittent discomfort in his ankle for a number of years prior to his January 1988 visit. Dr. Jones stated that, when he saw claimant on January 18, 1988, he was surprised to find "absolute absence of the ankle joint space with a large anterior loose body." During the May 1990 examination, Dr. Jones noted "marked crepitation with an interior (sic) loose body...(which) appears to have increased in size." Dr. Jones again recommended an ankle fusion.

On August 15, 1990, Dr. Jones reported that claimant's "degenerative disease of the ankle can be related either to his multiple ankle injuries i.e. sprains, or to primary osteoarthritis." He concluded that he had "no way of determining this at this point." Dr. Jones believed that anyone who had osteoarthritic change within a joint would have worsening of that condition with increased activity. He also stated that he understood that claimant's work was quite heavy and if he had had a more sedentary job, the rate of progression of his current disease would not have been as rapid.

Under the circumstances, we agree with the Referee that claimant has failed to prove that his work activities since March 4, 1988 were the major contributing cause of the worsening of his preexisting osteoarthritis condition. Moreover, although the medical evidence indicates objective findings of a worsening since January 18, 1988, there is no evidence, in the form of objective findings, that the worsening occurred after March 4, 1988, the date of the partial denial from which claimant failed to appeal. We, therefore, affirm the Referee on the issue of compensability.

ORDER

The Referee's order dated January 29, 1991 is affirmed.

November 21, 1991

Cite as 43 Van Natta 2561 (1991)

In the Matter of the Compensation of
HENRY MARTIN, Claimant

WCB Case Nos. 90-00997 & 90-15834

ORDER ON REVIEW

Peter O. Hansen, Claimant Attorney

Davis & Bostwick, Defense Attorneys

Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of Referee Quillinan's order that: (1) found that claimant's condition was medically stationary as of March 28, 1990 and that

his claim was not prematurely closed; and (2) upheld the SAIF Corporation's partial denials of claimant's cervical condition. On review, the issues are premature closure and the propriety of SAIF's partial denials. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee concluded that claimant's bilateral carpal tunnel syndrome condition was medically stationary as of March 28, 1990 and that his claim was not prematurely closed. We agree.

A claim for compensation shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). The test for determining whether a worker is medically stationary is whether "further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

In this case, there is no explicit statement that claimant was medically stationary prior to March 1990. Nonetheless, "magic words" are not necessary to establish a medically stationary date and circumstantial medical evidence is as effective as a direct statement. See Austin v. SAIF, 48 Or App 7 (1980); Paul E. Voeller, 42 Van Natta 1775 (1990). After our review of the record, we agree with the Referee that the preponderance of the medical evidence indicates that claimant's carpal tunnel syndrome condition was medically stationary prior to closure. Claimant was released to work in January 1990 with no restrictions on the use of his hands. The medical evidence indicates that, although claimant had some persisting symptoms stemming from his noncompensable extensor tenosynovitis, his carpal tunnel syndrome condition had resolved at that time and, in fact, had not required treatment since September 1989.

In a March 26, 1990 chart note, Dr. Struckman reported that claimant was not medically stationary because claimant "was not yet back to full activity, and [I] do not feel that we should close his claim until such time as he is doing full work load." (Ex. 25B). However, as noted by the Referee, claimant had returned to work in February 1990; in fact, Struckman had released claimant to work in January 1990. Moreover, a conclusion that a worker is not medically stationary is properly based on medical facts regarding whether "further material improvement would reasonably be expected from treatment or the passage of time," not solely on whether or not the worker has returned to work. Accordingly, we do not find Struckman's note persuasive.

In short, the preponderance of the evidence indicates that claimant's bilateral carpal tunnel syndrome condition was medically stationary as of March 28, 1990. Accordingly, claimant has failed to establish that his claim was prematurely closed.

Partial Denials

The Referee upheld SAIF's partial denials of claimant's cervical condition, concluding that such denials were permissive "precautionary" denials.

Claimant contends that the denials are premature because he had not filed a claim for his cervical condition at the time they were issued.

SAIF issued the denials after receiving information from claimant's treating physician, Dr. Struckman, that x-rays had revealed degenerative spurring in claimant's cervical spine that might possibly be the cause of his ongoing symptoms. Struckman did not suggest any specific treatment; however, he did indicate that claimant would continue with physical therapy while he further investigated the condition. (Ex. 1-9). We have previously held that a "precautionary" denial is proper under some circumstances. See Robert L. Mowry, 43 Van Natta 1007 (1991); Sidney M. Brooks, 38 Van Natta 925 (1986). After our review of this record, we agree with the Referee that Struckman's chart note put SAIF on notice of a possible claim for the cervical condition and, consequently, that it was proper for SAIF to partially deny that condition. See Jack Allen, 43 Van Natta 190 (1991).

ORDER

The Referee's order dated January 30, 1991 is affirmed.

November 21, 1991

Cite as 43 Van Natta 2563 (1991)

In the Matter of the Compensation of
JAMES A. MORGAN, Claimant
WCB Case No. 88-22211
ORDER ON RECONSIDERATION
Stebbins & Coffey, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Claimant requests reconsideration of our October 31, 1991 Order on Review that upheld the SAIF Corporation's denial of his occupational disease claim for his psychological condition.

Claimant first contends that our order is inconsistent, as we adopted the Referee's "findings," but we further concluded that the evidence did not clearly and convincingly show that claimant's work-related stressors were the major cause of his psychological condition. We note that the "findings" referred to by claimant were included in the "Findings of Ultimate Fact" section of the Referee's opinion and order. Our order, however, adopted only the Referee's "Findings of Fact." Our order did not adopt the Referee's ultimate findings or conclusions of law and opinion.

Claimant also contends that the Referee found that he was inadequately trained for his position. Claimant argues that, because we adopted the Referee's "findings," it is inconsistent for us to have concluded that claimant had not proven that his training was insufficient. Again, we note that we adopted only the Referee's "Findings of Fact." The Referee concluded, in his "Conclusions of Law and Opinion" that claimant was inadequately trained. In our order on review, however, we did not adopt the Referee's conclusions.

Claimant also contends that we inappropriately applied ORS 656.802(2)(d), i.e., the portion of the statute providing that claimant must prove his case by clear and convincing evidence, to the other elements of the statute. We do not agree with claimant's interpretation of our order. We concluded that the evidence did not "clearly and convincingly show that the remaining stressors were the major cause of (claimant's) psychological condition...." In other words, because claimant has not established that the major cause of his condition is due to his work, he has not met his burden of proof requiring that he establish,

by clear and convincing evidence, that his condition arose out of and in the course of employment.

Next, claimant contends that the employer's corrective actions were unreasonable. Claimant agrees that generally it is not unreasonable for an employer to criticize a worker for numerous errors nor for a work plan to be implemented. However, claimant contends that it was unreasonable to criticize him when his work conditions included an excessive case load, difficulty with co-workers and a high turn-over of supervisors. Claimant also contends that job criticism should not be singled out as a sole stressor, when other stressors existed at work.

We continue to conclude that the record does not establish that the stressors (other than criticism) were the major cause of claimant's psychological condition. We also note that Dr. Colbach opined that criticism of claimant was the primary work-related stressor causing his condition.

Finally, claimant contends that the record shows he was inadequately trained for his job, which resulted in a stressor contributing to his condition. Claimant agrees that he received the same training as his co-workers, however, he also contends that, because his background and experience were different from other workers, such training was inadequate. We continue to conclude that the only evidence in the record on the issue of sufficiency of training is claimant's statements that he believed the training was inadequate, and the reports of the doctors who relied upon his statements in that regard. Our order noted that claimant had satisfactorily performed his job through the time of his first performance rating. Under the circumstances, we do not agree that claimant has proven by a preponderance of the evidence that his training as a jobs worker was inadequate.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, subject to the foregoing supplementation, we adhere to and republish our October 31, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 21, 1991

Cite as 43 Van Natta 2564 (1991)

In the Matter of the Compensation of
STEPHEN A. SCARRATT, Claimant
WCB Case No. 88-12306
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Scarratt v. H. A. Anderson Construction Co., 108 Or App 554 (1991). In our prior order, Stephen A. Scarratt, 42 Van Natta 607 (1990), we found claimant's industrial injury had caused a temporary increase in his wrist symptoms without worsening his underlying arthritic condition. Consequently, we held that claimant's symptoms due to the injury, but not his underlying arthritis, were compensable. The court has remanded this matter to us for clarification.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except those contained in paragraph five of her "Findings of Fact" section, as our own, and supplement them

with the following additional findings of fact. Claimant's use of a jackhammer materially contributed to a temporary increase in his wrist symptoms, resulting in his need for treatment. However, claimant's underlying arthritic condition was neither caused nor worsened by his use of the jackhammer.

The increased symptoms caused by claimant's industrial injury consist of severe effusion and pain in both wrists. (Ex 2). The increased symptoms began on August 19, 1987, when claimant operated the jackhammer. (Ex 1). These symptoms began lessening when claimant obtained other employment which involved handling mail. (Ex 5-1). On September 23, 1988, claimant's symptoms had returned to their pre-August 19, 1987 status. (Ex 5-3).

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the insurer's denial of claimant's bilateral wrist condition in its entirety. We modified the Referee's order, holding that when a compensable injury makes an underlying condition temporarily symptomatic without causing or worsening that condition, the carrier's liability is limited to the effects of the temporary symptomatic increase. Stephen A. Scarratt, supra. Consequently, we upheld the insurer's denial insofar as it denied claimant's underlying wrist condition and set aside the denial to the extent that it denied claimant's temporary symptomatic increase.

The court concluded that an employer is not responsible for conditions that are not related to an occupational injury or for conditions that existed before the injury occurred and were not worsened by the injury. See Barrett v. D & H Drywall, 300 Or 325 (1986); clarified 300 Or 553, 555 (1986). Therefore, the court found that we did not err in considering whether claimant's underlying arthritis had been worsened by the injury.

The court further concluded that our determination that claimant's underlying condition was not worsened was relevant to our decision concerning the nature of claimant's compensable condition. Nevertheless, reasoning that it was unclear from our order, which, if any, of claimant's ongoing symptoms are "due to" his compensable injury, the court remanded this matter to us for clarification.

After reconsidering this matter, we find that claimant's symptoms of pain and effusion in both wrists, which Dr. Struckman noted in his chart note of February 1, 1988, are due to claimant's industrial injury on August 19, 1987. In February of 1988 claimant became employed as a mail handler. Since that time he has not experienced significant wrist or hand complaints while performing his duties. On September 23, 1988, Dr. Button, the examining hand surgeon, opined that claimant was medically stationary in regard to his work exposure with the employer, and that no permanent impairment of function had occurred. Instead, Dr. Button attributed any permanent impairment of function to claimant's pre-existing arthritic process. Dr. Button noted that claimant had changed jobs and become a mail handler. As a result of this change in jobs, Dr. Button reported, claimant was functioning satisfactorily with no permanent restrictions.

A review of the medical evidence and claimant's employment history persuades us that, as of Dr. Button's September 23, 1988 examination, claimant was no longer experiencing ongoing symptoms due to his compensable injury. Accordingly, we hold that the carrier is responsible for medical treatment and disability caused by claimant's increased symptoms from August 19, 1987 until September 23, 1988, when the symptoms due to the injury had resolved.

On reconsideration, as supplemented herein, we adhere to and republish our March 26, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 22, 1991

Cite as 43 Van Natta 2566 (1991)

In the Matter of the Compensation of
STEVEN W. BASTING, Claimant
WCB Case No. 90-16606
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Moller.

The SAIF Corporation requests review of Referee Otto's order which set aside a Director's Review and Order denying redetermination of claimant's eligibility for vocational assistance. On review, the issue is vocational assistance. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact," except the last full paragraph under the latter heading, and also under that heading, the reference in the first and second paragraphs to March 3, 1990. The appropriate reference date in both paragraphs is March 3, 1989.

CONCLUSIONS OF LAW

Where a worker is dissatisfied with the actions of the insurer regarding vocational assistance, the worker must apply to the Director for review of the matter before requesting a hearing. ORS 656.283(2). Argonaut Insurance Company v. Workers' Compensation Department, 89 Or App 591, rev den 305 Or 671 (1988). The Director's decision may be modified only if the decision: (a) violates a statute or rule; (b) exceeds the statutory authority of the agency; c) was made upon unlawful procedure; or (d) was characterized by abuse of discretion or clearly unwarranted exercise of discretion. A finding of one of those circumstances is mandatory before a Director's order may be changed by a Referee. Lonnie H. Stout, 42 Van Natta 2548 (1990).

The Referee found that the Director violated a rule by concluding in his August 13, 1990 order that claimant was not entitled to a redetermination of his eligibility for vocational assistance. We conclude that, under the rules in force, claimant was not entitled to redetermination of eligibility, and the Director's order must be upheld even though the Director cited the wrong rule.

At all times material, OAR 436-120-050 authorized insurers to end a worker's eligibility for vocational assistance when:

"(9) The worker has stopped attending training without notifying either the vocational assistance provider or the insurer."

Pursuant to this rule, SAIF ended claimant's eligibility for vocational assistance effective October 28, 1988, because he had stopped attending training without notifying either his counselor or the insurer. The Director, upon

review of the matter, upheld SAIF's decision by order dated March 3, 1989. Claimant did not appeal.

In March 1990, while his claim was still open, claimant claimed entitlement to a redetermination of his eligibility for vocational assistance under OAR 436-120-055(2)(e), which requires the insurer to redetermine eligibility where "the worker's physical condition has substantially worsened, if the worker was medically stationary at the time of the latest eligibility determination" (as was claimant). SAIF refused. On review, the Director agreed with SAIF's position that claimant was not entitled to a redetermination during the current opening of the claim. Although the Director cited the wrong authority for that proposition (ORS 656.273), his decision was nonetheless correct under the rules which did apply.

OAR 436-120-055 provides, in relevant part:

"(2) The insurer shall redetermine eligibility for a worker previously determined ineligible only under the following conditions:

"* * * *

"(e) The worker's physical condition has substantially worsened, if the worker was medically stationary at the time of the latest eligibility determination. ..."

"(3) Except as provided in section (1) of this rule, a worker will not again become eligible, under the current opening of a claim, after eligibility has once ended under OAR 436-120-050."

As previously discussed, SAIF ended claimant's eligibility for vocational assistance effective October 28, 1988, pursuant to OAR 436-120-050 because claimant stopped attending training without notifying his counselor or the insurer. Claimant's claim remained opened at all times after that determination. The Referee found however, that OAR 436-120-055(3) was inapplicable because OAR 436-120-050(9) had been repealed by the Director effective January 1, 1986. We disagree.

By order of adoption dated December 12, 1985 (of which official notice is taken), the Director did purport to repeal a rule identified as OAR 436-120-050 effective January 1, 1986. However, by the same order, all of the Director's rules on "end of eligibility for vocational assistance" including the same subsection at issue in this case, were found in OAR 436-120-090, (not in subsection 050, as at the present time). Thus, whatever the Director repealed effective January 1, 1986, it was not the rule at issue in the present case. More importantly, however, by order dated December 16, 1987, OAR 436-120-050 was adopted in its present form, effective January 1, 1988, and has existed since its adoption, without change. Thus, regardless of whether it had ever been repealed, OAR 436-120-050 existed at all times material to the present case. Therefore, OAR 436-120-055(3) applied so as to disallow claimant's March 1990 request for redetermination of eligibility.¹

ORDER

The Referee's order dated January 16, 1991 is reversed, and the Director's Review and Order dated August 13, 1990 is reinstated and affirmed.

¹ In its brief, SAIF asserts that by bulletin dated June 1, 1988, the Director corrected a clerical error in his rules by advising that all references to OAR 436-120-050 were supposed to be to 045. Whether or not the Director can effectively renumber his rules by bulletin and whether this Board could take official notice of such a bulletin are matters which we need not decide in this case. It is irrelevant to our determination whether all references in Division 120 are to 050 or 045. Furthermore, it is the substance of the rules which controls.

In the Matter of the Compensation of
REYNALDO MAYORAL, Claimant
WCB Case No. 91-00258
SECOND ORDER OF DISMISSAL
Michael Dye, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our November 8, 1991 order that dismissed its request for review of a Referee's order that: (1) awarded temporary total disability; and (2) assessed a penalty for unreasonable claim processing based on the aforementioned award. We took such an action because we had approved the parties' Claim Disposition Agreement (CDA), in which claimant had agreed to fully release his rights to future workers' compensation benefits (including temporary disability), except medical services, for his compensable injury. WCB Case No. C1-02011. Reasoning that the issues pending review "pertained" to temporary disability and concluding that claimant had released his rights to such future benefits, we dismissed the request for Board review.

Noting that penalties and attorney fees were also issues on review, SAIF objects to our statement that all issues on review "pertained" to temporary disability. Furthermore, SAIF asks that our order be modified to expressly reverse the Referee's award of temporary disability and the assessment of penalties and attorney fees. Claimant has filed a response to SAIF's request.

SAIF has misinterpreted our intentions in dismissing its request for Board review. In the hopes of clarifying this matter, we offer the following supplementation.

Because claimant released his right to temporary disability benefits in accordance with the CDA, he is not entitled to any temporary disability granted under the Referee's order. Moreover, since any penalty and penalty-associated fee under ORS 656.262(10) is dependent on the payment of temporary disability, it follows that claimant is no longer entitled to the penalty and fee assessed by the Referee's order. Thus, by virtue of our dismissal order acknowledging the approval of the parties' CDA, the Referee's order has been effectively reversed.

Accordingly, our November 8, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 8, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 22, 1991

Cite as 43 Van Natta 2568 (1991)

In the Matter of the Compensation of
JOHN M. SMITH, Claimant
WCB Case No. 88-09368
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
David Horne, Defense Attorney.

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Brown's order that declined to grant permanent total disability. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in April 1976. He subsequently underwent a laminectomy at L4-5. His claim was initially closed by a December 1977 Determination Order which awarded 35 percent unscheduled permanent partial disability (PPD) for his low back condition. Claimant requested a hearing and, on April 5, 1978, a Referee awarded 100 percent unscheduled permanent disability for the same condition. That order was not appealed.

The claim was reopened for vocational rehabilitation in 1979. Claimant undertook coursework directed toward becoming a certified real estate appraiser. Claimant's "attentions and tenacities" were rated at the time by his vocational counselor as "marginally adequate." (Ex. 54). During the course of his training, it was discovered that claimant would require considerably more coursework and training than initially anticipated, in order to be eligible for job placement. On July 10, 1980, claimant's vocational counselor reported that claimant was "becoming increasingly squirrly [sic]" and, when confronted about "getting his act together," claimant "generally responded with a series of domestic excuses to ameliorate his sometimes lack of follow through, and occasionally has cited subjective symptomatology as reasons he has not been as reliable as he should be." (Ex. 57).

Claimant's claim was reclosed by a September 1980 Determination Order which purported to award 15 percent unscheduled PPD, in lieu of the prior awards. However, at the November 1990 hearing, the parties agreed that the Evaluation Division's reduced award was invalid, because the 1978 award of 100 percent unscheduled permanent disability became final when it was not appealed.

Claimant requested a hearing from the 1980 Determination Order, seeking PTD status. In February 1981, he filed a claim for a cervical injury, contending that his compensable low back condition caused his leg to buckle resulting in a fall which, in turn, caused cervical injury. The insurer denied the claim and claimant requested a hearing. The hearing requests from the September 1980 Determination Order and the February 1981 denial were consolidated.

On March 1, 1981, claimant's vocational counselor opined that further training would be to no avail, unless claimant changed his attitude dramatically. He noted that claimant "has not and does not intend to do anything aggressively toward returning himself to work. He seems quite content to stay at home and purport an increased physical disability. He seems to have taken a passive 'honorable' disability retirement. . . ." (Ex. 69).

Claimant was evaluated for pain center treatment on January 28, 1982. Dr. Cramer, a member of the examining panel of physicians, commented that claimant "very much sees himself as totally and permanently disabled." (Ex. 88-3). Dr. Yospe, psychologist and member of the panel, concluded that claimant "does not seem to be very motivated toward vocational rehabilitation." (Ex. 90-4). The panel opined that claimant's "basic problem at this point is that he really wants a total disability settlement. He really is not interested in vocational rehabilitation and makes this reasonably clear in our discussions with him. He has many excuses to describe why he is unable to be trained or be made capable of doing any type of work." (Ex. 89-2). The panel concluded that further vocational or pain rehabilitation was not appropriate.

At a June 1982 hearing, the referee set aside the insurer's partial denial of the cervical condition and ordered the claim reopened. He did not reach the PTD issue. The Board affirmed the Referee's Opinion and Order on April 21, 1983.

Claimant's physicians released him to sedentary work and a new vocational rehabilitation program was initiated in October 1984. Numerous potential employers were contacted in 1985 and claimant made occasional contacts with his vocational counselor. By the end of April 1986, claimant had had only two interviews and no offers of work.

After reviewing claimant's history through October 1986, Dr. Voiss opined that claimant's "refusal to return to employment is a consequence of developmental, psychological and personal factors which are not related to the variously described industrial injuries and that such injuries, if they did in fact occur on the job, were symptomatic of the subject's underlying emotional disturbance. The intransigent nature of this man's presentation indicates that for psychological reasons, unrelated to the described injuries, he will actively obstruct all efforts at vocational rehabilitation, or other efforts to return him to active employment." (Ex. 127-23). Dr. Mauer, then treating physician, agreed with the essence of Voiss' report. (Ex. 128).

In early 1987, claimant participated in a pain center program. The center's vocational counselor noted that claimant would like to be considered permanently and total disabled, and recommended sheltered employment. (Ex. 134-5). In his report, following completion of the pain center program, Dr. Wheeler stated that he was "cautiously optimistic of the vocational plans of returning [claimant] to work. As these become more finalized, I suspect it will become more apparent whether he is, indeed motivated to do so as he reports." (Ex. 138-1).

The claim was again closed by a February 20, 1987 Determination Order, which awarded temporary total disability benefits for the period from February 13, 1981 through January 12, 1987 and 30 percent unscheduled PPD for claimant's cervical condition. However, the parties agreed to set that Determination Order aside as premature.

Thomas Stipek, psychologist, evaluated claimant in September 1987 and in February 1988. He opined that vocational rehabilitation efforts, following the real estate appraisal training, had been misdirected, largely because claimant lacked experience in the fields identified for potential employment. (Ex. 149-14-15). Due to claimant's psychological makeup, physical problems and lack of adequate training, Stipek concluded that claimant is "totally permanently disabled from performing any work in the competitive work economy. . . ." (*Id.* at 15).

A June 22, 1987 Determination Order awarded temporary disability through May 4, 1987 and 30 percent unscheduled PPD for the cervical condition. Claimant requested a hearing, again contending that he was permanently and totally disabled. A March 1988 Stipulation and Order of Dismissal without Prejudice was subsequently issued. In June 1988, claimant again requested a hearing. On August 22, 1988, the day of hearing, the insurer offered to continue vocational rehabilitation efforts for claimant and the Presiding Referee deferred the hearing. Although the claim was apparently not formally reopened, the insurer paid temporary disability benefits through November 12, 1990, the date of the hearing here.

In September 1988, claimant agreed to participate in an electro mechanical technician training program. However, the program ended in January 1989, due to claimant's failure to comply with his responsibilities in the Return-To-Work plan. (Ex. 160). His vocational counselor observed: "Although [claimant] has very consistently verbalized high levels of motivation . . . [his] actions are totally and completely contradictory to all of his verbalizations." (Ex. 159-4).

Claimant was 58 years of age at hearing. He completed the eleventh grade in school and obtained a GED. Prior to the 1976 compensable injury, claimant worked as an unskilled laborer and served ten years as a Marine. He qualified for Social Security disability in 1981 and remains qualified. Claimant has not worked since the 1976 injury, except for a one-week trial period. He participated in vocational rehabilitation programs intermittently between 1979 and 1990.

Claimant is physically capable of performing sedentary work. He is not permanently precluded from regularly performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, claimant must establish that he has suffered a permanent worsening of his underlying condition to prove entitlement to greater disability than awarded by the last arrangement of compensation, the April 5, 1978 Opinion and Order. See Stepp v. SAIF, 78 Or App 438 (1986).

In this case, claimant received 30 percent PPD in 1987 for his cervical condition. Inasmuch as the Board affirmed a Referee's order which determined that claimant's cervical condition is a compensable consequence of the 1976 industrial injury (and the Board's order became final when it was not appealed), claimant has established a permanent worsening of his compensable condition. See Stepp v. SAIF, supra at 441 n. 1. Therefore, claimant was not precluded from litigating the PTD issue at the hearing here. Accordingly, we proceed to the merits.

The Referee concluded that claimant was not permanently and totally disabled. We agree.

To establish permanent total disability, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1). Claimant may prove permanent total disability status by a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders a work search futile, he must also establish that he has made reasonable efforts to obtain such employment. ORS 656.206(3); SAIF v. Scholl, 92 Or App 594 (1988). Even if a work search would be futile, claimant must nevertheless prove that, but for the compensable injury, he is willing to work. SAIF v. Stephen, 308 Or 41 (1989).

The first step in determining whether claimant is permanently and totally disabled requires an evaluation of his physical condition.

Claimant contends that the fact that Dr. Woolpert, his former treating doctor, never released him to work is persuasive evidence that he is unable to work based on physical factors alone. The most recent opinion by Woolpert is dated February 1984. (Ex. 100). Moreover, inasmuch as Woolpert's predictions regarding claimant's ability to work are apparently based on nonmedical factors (particularly claimant's background skills and abilities) as well as physical factors, his opinion does not support claimant's contention. (See Exs. 85 & 100).

We next turn to the nonmedical factors. Claimant is 58 years of age, has completed the eleventh grade and obtained a GED. His occupational experience consists of unskilled labor, mostly millwork. As a result of his compensable injury, he can no longer perform such work. Claimant has enrolled in 3

vocational rehabilitation programs since 1979. None of his training led to job placement. Most recently, claimant enrolled in a community college electro mechanical program. However, his vocational assistance file was closed in January 1989 due to inadequate participation. In his closing report, Steven Cardinal, vocational rehabilitation counselor, opined that claimant's rehabilitation efforts had been unsuccessful because no labor market had been found for claimant's knowledge, skills and abilities. (Ex. 159-1). However, Cardinal also opined that claimant "is substantially more motivated to return to a permanent relationship with the Workers' Compensation system than he is to make any effort to develop new bodies of knowledge and/or skills which he could use in a potentially satisfying and rewarding vocational setting." (Ex. 159-5).

Claimant argues that his lack of motivation is essentially a compensable consequence of his industrial injury. He reasons that inappropriate vocational programs caused him to be discouraged about his vocational future and that his diminished motivation is, therefore, due to his compensable injury. We are not so persuaded.

Inasmuch as claimant's demonstrated interest in returning to work was marginal, at best, before his first vocational training disappointment, we are not persuaded that his current lack of motivation is due to discouragement with inappropriate vocational programs. Although claimant occasionally verbalized interest in his training programs, his actions generally belied his words. Refusal to accept vocational rehabilitation is strong evidence of lack of motivation to reenter the work force. Marvin v. SAIF, 67 Or App 40, 43 (1984).

We reiterate that claimant must establish his willingness to work, even if it would be futile for him to look for work. SAIF v. Orr, 101 Or App 612 (1990); SAIF v. Stephen, *supra*. In the instant case, claimant's vocational training participation has not been adequate and his expressed interest in training and working is not supported by his actions. Therefore, we conclude that claimant has not proven that he is willing to work or would be, but for his compensable conditions. Consequently, claimant is not entitled to PTD benefits.

ORDER

The Referee's order dated December 12, 1990 is affirmed.

In the Matter of the Compensation of
MARIE M. LIBBETT, Claimant
WCB Case No. 90-01127
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

The self-insured employer requests review of Referee Harri's order which: (1) set aside the employer's denial of an aggravation claim; and (2) assessed a penalty and attorney fee for an unreasonable denial. On review, the issues are propriety of the denial and penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Propriety of Denial

The Referee found the employer's denial improper under the holdings in Roller v. Weyerhaeuser, 68 Or App 743 (1984) and Safstrom v. Riedel International, Inc., 65 Or App 728 (1983). We disagree.

The court in Roller and Safstrom held that partial denials which have the effect of denying future responsibility and, in effect, closing the claim without following statutory procedures are improper. Here, the denial was not a partial denial but, rather, a denial of an aggravation of claimant's compensable injury. The denial did not purport to deny future liability but denied claimant's right to reopening of his claim for additional benefits under ORS 656.273. Finally, the denial did not affect claim closure but denied reopening under ORS 656.273 or denied keeping the claim open under ORS 656.273 when closure would otherwise be authorized by ORS 656.268(5). Because we find no reason that the employer's denial was improper, we proceed to address the merits of the aggravation claim.

Aggravation

The Referee initially found that claimant had suffered a compensable aggravation. We agree.

To establish a compensable aggravation, claimant must prove a worsened condition, materially related to the compensable injury, since the last award or arrangement of compensation, ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). In this case, the last award or arrangement of compensation was the Opinion and Order dated May 3, 1988. For every aggravation of an unscheduled condition, claimant must show that the worsened condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986).

In late September and early October 1989, claimant began having increased pain in her back and legs. At that time she was participating in an authorized training program (ATP). On October 5, 1989, claimant experienced severe pain in her back and right leg. Dr. Jones, her treating physician, noted a very markedly positive right straight leg raise for radiation of pain down her leg and his immediate impression was rerupture of her L5-S1 disc or perhaps a rupture of L4-5. (Ex. 41). Claimant was immediately taken off her ATP, which was subsequently terminated for medical reasons.

The uncontroverted evidence shows, and we conclude, that claimant had experienced a symptomatic exacerbation of her compensable back condition in

October 1989. Further, at her last arrangement of compensation, claimant was capable of light work. (Ex. 29). Following the October 5, 1989 symptomatic exacerbation, Drs. Counts and Casey released claimant from her authorized training program (ATP). At the time of hearing, she was not able to return to training or to work. We rely on Dr. Casey's opinion and, therefore, conclude that as a result of her symptomatic exacerbation, claimant sustained diminished earning capacity.

Under these circumstances, we conclude that claimant has established a compensable aggravation.

Penalty and Attorney Fee

The Board adopts the Referee's conclusions and reasoning with regard to this issue.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the aggravation issue is \$800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 30, 1990, is affirmed. For services on review concerning the aggravation issue, claimant's counsel is awarded an assessed attorney fee of \$800, payable by the self-insured employer.

November 25, 1991

Cite as 43 Van Natta 2574 (1991)

In the Matter of the Compensation of
CHARLES S. KARAM, Claimant

Own Motion No. 89-0421M

OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Suzanne Ritter, Claimant Attorney

Claimant requests reconsideration of our October 9, 1991 Own Motion Order Reviewing Carrier Closure in the above-captioned case. Under Board rules, a motion for reconsideration shall be denied if not submitted to the Board in a timely manner. See OAR 438-12-065(2). In order to be timely, the motion for reconsideration must be submitted within 30 days of the date of mailing of the Board's order unless the party requesting reconsideration establishes to the Board's satisfaction that there was good cause for the failure to file the request within 30 days of the mailing date. Id.

Claimant contends that he requested reconsideration on November 6, 1991. However, the first indication that a request for reconsideration had been filed was contained in a November 12, 1991 letter received by the Appellate Unit of the Workers' Compensation Division on November 15, 1991. This request had been misaddressed to them. The Appellate Unit forwarded the letter to us on November 18, 1991. Here, we do not deem a misaddressed letter referring to an earlier request for reconsideration, without more, to be good cause for failure to file within 30 days. Inasmuch as claimant's request for reconsideration was received untimely, we deny his request for reconsideration.

We note parenthetically that the additional medical evidence provided by claimant was dated September 23, 1991 and was thus available with due diligence within the time allotted for the provision of evidence prior to our October 9, 1991 order. See OAR 438-12-060(3). Thus, the additional evidence would not have been considered had we granted reconsideration. OAR 438-12-065(3).

IT IS SO ORDERED.

November 25, 1991

Cite as 43 Van Natta 2575 (1991)

In the Matter of the Compensation of
RICHARD E. LYON, Claimant
WCB Case No. C1-00262
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Guy B. Greco, Claimant Attorney

Reviewed by Board Members Neidig and Moller.

On November 8, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

ORS 656.236(1) permits parties, by agreement, to make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" [CDA] as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 436-60-005(9); see also OAR 438-09-001(1).

Here, the CDA recites that claimant agrees to release his rights and the insurer's obligations as they relate to claimant's accepted neck and lumbar strains. The proposed disposition agreement then provides that "By and through this document," claimant requests a hearing (although we are unable to ascertain what action of the insurer claimant is challenging). Moreover, the parties have inserted language into the Board's Order clause so that it now also declares: "It is further ordered that the Request for Hearing filed herein by claimant is hereby dismissed with prejudice. . . ."

The function of a claim disposition agreement is to dispose of accepted claims, with the exception of medical services, as those claims exist at the time the Board receives the CDA. See ORS 656.236(1). It is not within the province of a claim disposition agreement to accomplish claim processing functions under ORS 656.268 through ORS 656.283. See, e.g., Randi E. Morris, 43 Van Natta 2265 (1991); Frederick M. Peterson, 43 Van Natta 1067 (1991). Inasmuch as claimant seeks to file a request for hearing within the claim disposition agreement, it impermissibly exceeds the bounds of OAR 438-09-020(1)(b). Therefore, we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a); see Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Moreover, the agreement was not accompanied by a summary sheet and the corresponding data regarding claimant's case as required pursuant to OAR 436-60-145(3). As this agreement was submitted to the Board on or after June 1, 1991, this information must be in the summary form and format prescribed by the

Director in Bulletin 217 (Revised) (WCD Admin. Order 3-1991), which issued March 16, 1991.

Finally, OAR 436-60-145(4)(g) requires that claimant be provided with a specified notice in prominent or bold-face type, and that the specified notice be contained in the proposed agreement as opposed to merely reciting that claimant "has been provided" such notice.

Here, although the agreement purports to incorporate by reference the required notice, a copy of that notice was not forwarded with the proposed agreement. Thus, there is no evidence that claimant was provided with the notice prescribed by OAR 436-60-145(4)(g).

Consequently, for all of the above-noted reasons, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

November 25, 1991

Cite as 43 Van Natta 2576 (1991)

In the Matter of the Compensation of
JEFFREY L. STRUCK, Claimant

WCB Case Nos. 90-14592 & 90-16092

ORDER ON REVIEW

Bischoff & Strooband, Claimant Attorneys

Schwabe, et al., Defense Attorneys

Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of those portions of Referee Mongrain's order which: (1) set aside the insurer's denial insofar as it denied claimant's medical services claim for his current low back condition; and (2) awarded a \$2,200 attorney fee. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's March 1987 compensable low back injury materially contributed to his current low back condition. We disagree.

Claimant received treatment for his March 1987 compensable low back strain until December 1987. He was eventually awarded 7-1/2 percent unscheduled permanent disability for his March 1987 injury pursuant to a June 1988 stipulation. Although claimant experienced occasional complaints and flareups, he did not seek further medical treatment from December 1987 until February 20, 1990.

During that interval, he worked approximately 13 months and 21 months for two other employers.

The day after claimant left the employ of his most recent employer, he filed a "new injury" claim. His injury was described in the following manner: "stocking shelves and suddenly got sharp pain in [his] lower back." (Ex. 12). That same day, claimant sought emergency room treatment. The chart notes of that examination reveal that claimant complained of a gradual onset over the last week of low back pain with constant aching. (Ex. 11). Claimant also was experiencing right hip aching with his right leg "falling asleep."

Claimant began treating with Dr. Streitz, orthopedist, in March 1990. Based on a history of low back pain since March 1987 and a sudden onset of pain while shelf loading for claimant's most recent employer, Streitz diagnosed chronic and recurrent lumbosacral strain. Streitz did not relate claimant's complaints to his employment in general or to any employer in particular.

On March 29, 1990, claimant began treating with Dr. Peterson, orthopedist. Peterson, who had previously treated claimant following his 1987 injury, diagnosed "recurrent sprain of the lower back." Other than reciting claimant's statement of the cause of his complaints ("aggravation of previous injury worked [sic] freight and checking back started hurting."), Dr. Peterson did not offer an opinion concerning the relationship between claimant's current complaints and his March 1987 injury. Furthermore, there is no indication that Peterson was aware of the description in claimant's "new injury" claim of February 14, 1990 of sudden onset of sharp pain while working for his recent employer.

In July 1990, Dr. Peterson referred claimant to Dr. Maukonen, neurologist. (Ex. 25). Maukonen reported a history in which claimant had experienced no further back problem from December 1987 until his sudden onset of pain in February 1990 while working for his recent employer. Based on that history and the examination, Maukonen diagnosed chronic lumbar strain and attributed claimant's current back complaints to the February 1990 incident with the recent employer. (Ex. 25-4).

To establish the compensability of his current low back condition, claimant must prove that his March 1987 compensable injury is a material contributing cause of his low back disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). Considering the length of time between claimant's 1987 injury and his current complaints, as well as his intervening periods of employment with other employers and the reference to a February 1990 work incident with a more recent employer, we conclude that the causation issue is a complex medical question. Thus, the resolution of this issue requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the medical evidence does not satisfy claimant's burden of establishing the compensability of his medical services claim. To begin, neither Dr. Streitz nor Dr. Peterson expressly related claimant's current low back complaints to his March 1987 compensable injury. Each physician diagnosed recurrent low back strain. Such references could suggest a causal relationship between claimant's present disability and his compensable injury. Furthermore, we recognize that "magic words" are not necessarily required to establish the requisite causal relationship. McClendon v. Nabisco Brands, 77 Or App 412 (1986). Nevertheless, in light of the reference in claimant's "new injury" claim to a sudden onset of low back pain while working for his most recent employer, we consider the opinions offered by Drs. Streitz and Peterson to be unpersuasive on the critical issue of causation because each of the physicians fails to discuss

the impact that claimant's February 1990 work incident had upon his current condition.

Dr. Maukonen is the only physician who expressly addressed the causation question. Specifically, Maukonen concluded that claimant had suffered a "chronic lumbar strain 2/14/90 while working at [claimant's recent employer]." Thus, Dr. Maukonen does not attribute claimant's current low back disability or need for medical treatment to claimant's March 1987 compensable injury.

In conclusion, we are not persuaded that claimant's March 1987 compensable injury is a material contributing cause of his current disability or need for medical treatment for his low back. Consequently, we conclude that claimant's medical services claim is not compensable. In light of our decision, the attorney fee issue has become moot.

ORDER

The Referee's order dated December 31, 1990, as reconsidered February 21, 1991, is reversed in part. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award is also reversed. The remainder of the Referee's order is affirmed.

November 26, 1991

Cite as 43 Van Natta 2578 (1991)

In the Matter of the Compensation of
ELIZABETH A. BONAR-HANSON, Claimant

WCB Case Nos. 90-11630 & 90-10935

ORDER ON REVIEW

Gatti, Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by the Board Members Moller, Westerland, Kinsley, Neidig, and Gunn.

The insurer requests review of that portion of Referee Tenenbaum's order which set aside its denial of claimant's aggravation claim for a right shoulder injury to the extent it denied medical treatment. Claimant cross-requests review of that portion of the Referee's order which upheld the insurer's aggravation denial to the extent it denied disability benefits. On review, the issues are aggravation and medical services. We reverse that portion of the Referee's order that set aside the insurer's denial insofar as it denied medical treatment.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

In April 1990, Dr. Berkeley reported that claimant had tenderness and decreased range of motion in her right shoulder. He further reported that a "click" developed when claimant's shoulder was elevated.

FINDINGS OF ULTIMATE FACT

The February 1990 incident at claimant's home was the major contributing cause of claimant's worsened right shoulder condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the major contributing cause of claimant's worsened condition was an injury not occurring within the course and scope of employment and, therefore, upheld the insurer's denial insofar as it denied disability benefits. However, the Referee found that claimant remained entitled to medical benefits on the basis that the compensable injury was a material contributing cause of claimant's worsened condition. We agree that the February 1990 incident was the major cause of claimant's worsened condition. We disagree that claimant is entitled to medical services for the worsened condition.

The sole issue in this case is whether claimant has established a compensable aggravation. Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, her claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Dr. Switlyk opined that claimant's right shoulder condition had symptomatically worsened following the February 1990 incident. This symptomatic worsening is supported by Dr. Berkeley's objective findings of tenderness, decreased range of motion and an audible click when claimant's shoulder was elevated. Finally, claimant was unable to work following the February 1990 incident. Accordingly, we find that claimant sustained a symptomatic worsening of her right shoulder condition that is supported by objective findings and resulted in diminished earning capacity. Consequently, claimant has established a worsened condition.

Inasmuch as the February 1990 incident, which did not occur in the course and scope of her employment, contributed to her worsened condition, she must also prove legal causation.

Generally, a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if there is an off-work injury which is the major contributing cause of the worsened condition, the worsening is not compensable. ORS 656.273(1).

The only opinion regarding causation of claimant's right shoulder condition comes from Dr. Switlyk, who began treating claimant in June 1990. Dr. Switlyk stated that:

"[t]he major factor in [claimant's] ongoing condition is still her original injury in 1987. Her aggravation of January [sic] 1990 changed her status but I think the major proportional cause of her condition is her original injury and ongoing symptoms before the aggravation. This is based primarily on the history that she has always had pain with activities before the most recent aggravation and that her old prior symptoms have just been made worse by this aggravation." (Emphasis supplied).

Thus, although Dr. Switlyk opines that the major cause of claimant's "ongoing" right shoulder condition is the industrial injury, he also opined that the

February 1990 aggravation changed her status. Furthermore, Dr. Switlyk described the February 1990 incident as a worsening of claimant's prior symptoms. We interpret Dr. Switlyk's opinion to mean that, at the time he examined claimant in June 1990, the industrial injury was the major cause of her right shoulder condition. However, we also interpret his opinion to mean that the major cause of claimant's symptomatic worsening in February 1990 was the at-home incident.

Under these circumstances, we conclude that the February 1990 incident was the major contributing cause of the worsened condition. Accordingly, claimant's worsened right shoulder condition is not compensable.

Although the Referee found that the February 1990 incident was the major contributing cause of claimant's worsened right shoulder condition, she concluded that claimant remained entitled to medical services for the worsened condition. We disagree.

As amended, ORS 656.273(1) provides:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

We interpret this provision to mean that if an injury, not occurring in the course and scope of employment, is the major contributing cause of a worsened condition, then claimant is not entitled to additional compensation, including medical services, for the worsened condition. ORS 656.273(1) makes no distinction between medical services and other forms of compensation. Rather, it specifically includes medical services as additional compensation claimant may be entitled to if she establishes a compensable aggravation. Inasmuch as we have concluded that the February 1990 incident was the major contributing cause of claimant's worsened right shoulder condition, it follows that she is not entitled to medical services for the worsened condition.

In reaching this conclusion, we wish to make clear that in finding claimant's worsened right shoulder condition not compensable, we are only addressing the symptomatic worsening following the February 1990 incident. Should the symptomatic worsening resolve, her underlying right shoulder condition would remain compensable provided that the industrial injury was a material contributing cause of the condition. We also note that claimant may be entitled to continuing medical services provided that such services are related to the compensable condition rather than the noncompensable worsened condition.

ORDER

The Referee's order dated November 26, 1990 is reversed in part and affirmed in part. That portion of the Referee's order that set aside the insurer's aggravation denial to the extent it pertained to medical services is reversed. The insurer's denial is reinstated and upheld in its entirety. The Referee's award of a \$1,700 assessed attorney fee is reversed. The remainder of the order is affirmed.

Board member Gunn dissenting.

I must dissent in this case for three reasons. First, I do not find the evidence supports that the February 1990 incident was a separate "injury not occurring within the course and scope of employment." Second, I do not agree with the majority's interpretation of Dr. Switlyk's report. Finally, I believe the majority erred in placing the burden of proof on claimant to establish that an off-work injury was not the major contributing cause of her worsened condition.

First, the majority treats the February 1990 incident as an "injury not occurring within the course and scope of employment." Claimant had previous to this February incident restricted (due to pain) voluntary use of her right shoulder and arm, (i.e., carrying her purse on her left shoulder or while driving and turning the steering wheel of her car). The sudden involuntary, unrestricted use of the arm and shoulder in February brought pain and symptoms almost exactly the same as her original 1987 injury. The February incident was not an "injury," but a pathological consequence directly attributable to her 1987 injury. That it happened at her home does not or should not alter the causation of the worsening which was the 1987 injury.

Second, the majority interprets Dr. Switlyk's report as establishing that the February 1990 incident was the major contributing cause of claimant's worsened condition. The majority's interpretation of this document to provide "proof" that the February incident was the major factor in the worsening is incorrect and not supported by the actual words or meaning of Dr. Switlyk's report.

Dr. Switlyk's report clearly states "the major factor in [claimant's] ongoing condition is still her original injury in 1987." See (Ex. 22). Rather than relying on Dr. Switlyk's expert opinion, the majority substitutes its own opinion and makes an unwarranted medical conclusion that is not supported by the clear language of Dr. Switlyk's report. This interpretation places the majority in the untenable position of being a medical expert.

The Referee originally described this evidence as "weak." Clearly, she did not anticipate the majority's interpretive skills. I understand the majority's interpretation and like "Reaganomics," it's plausible but just does not work. The majority's interpretation would only be correct if they could rewrite the second half of the document and eliminate the first sentence or two which clearly assigns the 1987 injury as the major factor of causation.

Assuming, arguendo, that my reading of Dr. Switlyk's report is not correct, the next logical interpretation would be that the report supports both the majority's conclusion and my conclusion. Such an interpretation would place the medical evidence in equipoise which leads to my final disagreement with the majority's opinion.

If the evidence is in equipoise, then a resolution of the issue is decided by determining which party has the burden of proof. The general rule is that the burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side. See Oregon Evidence Code Rules 305-307; Harris v. SAIF, 292 Or 683 (1982). I submit that the majority erred in placing the burden of proof on claimant in this instance.

As amended, ORS 656.273(1) provides:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medi

cal services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable." (Emphasis supplied).

The majority's reading of the emphasized portion of this provision implies claimant must provide a "negative" proof. That is, claimant must prove that an injury that did not occur within the course and scope of employment is not the major contributing cause of the worsened condition.

ORS 656.266 places the burden on claimant to affirmatively establish that an injury or occupational disease is compensable and of proving the nature and extent of disability. However, the courts have generally resisted imposing a negative burden of proof in other provisions of Chapter 656. See Satterfield v. Compensation Dept., 1 Or App 524, 528 (1970). (The burden of proving that the employer was prejudiced by an untimely notice of injury is on the employer). Absent language that clearly places a negative burden of proof on claimant, I would find that the burden of proving that an off-work injury is the major cause of the worsened condition is on the carrier.

Under my analysis, the initial burden of proving an aggravation remains with claimant. That is, claimant must establish a worsened condition which is materially related to the compensable injury. Perry v. SAIF, 307 Or App 654 (1989). This is consistent with ORS 656.266. However, if there is an injury not occurring within the course and scope of employment that also contributes to the worsened condition, then it is incumbent upon the carrier to establish that this injury is the major contributing cause of the worsened condition. This interpretation would eliminate the negative burden of proof. Therefore, I conclude that the only appropriate interpretation of the statute is to assign that burden to the carrier.

In the instant case, the only evidence (and that only by the majority's strained interpretation) is in equipoise. Therefore, claimant prevails.

For the above-stated reasons, I dissent.

November 26, 1991

Cite as 43 Van Natta 2582 (1991)

In the Matter of the Compensation of
GENE A. CURRY, Claimant
WCB Case No. 90-09401
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The self-insured employer requests review of that portion of Referee Thye's order that awarded claimant permanent total disability. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee determined that claimant's chronic depression, combined with his knee disability, permanently incapacitates him from employment and,

therefore, concluded that claimant is permanently and totally disabled. We agree with the Referee's ultimate conclusion, but offer the following analysis.

In order to establish permanent and total disability, claimant must prove 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). Permanent total disability may be established through medical evidence of physical incapacity or under the "odd-lot doctrine." Under that doctrine, claimant may establish permanent total disability, even though not completely physically disabled, if non-medical factors, such as age, education, adaptability to perform nonphysical labor, mental capacity and emotional condition foreclose him from gainful employment. Harris v. SAIF, 282 Or 683 (1982). Claimant has the burden of proving that he is willing to seek regular work and has made reasonable efforts to obtain such employment, unless such efforts would be futile. SAIF v. Stephen, 308 Or 41 (1989). Moreover, in determining whether claimant is permanently and totally disabled, we consider only disability that preexisted or was caused by his compensable injury. See ORS 656.206(1)(a). Subsequent, noncompensable conditions are not considered. Emmons v. SAIF, 34 Or App 603 (1978).

The Referee evidently concluded that claimant is totally disabled based on medical evidence alone. We disagree. Both Dr. Matarazzo and Dr. Parvaresh concluded that claimant is currently unemployable. Both doctors, however, did not base their opinions solely on claimant's compensable disabilities. Matarazzo expressly indicated that, in reaching his opinion, he relied on claimant's age and work history. (Ex. 102-4). Parvaresh based his opinion solely on medical evidence, but specifically considered claimant's subsequent noncompensable organic brain disorder. (Ex. 104-4). Accordingly, we do not find their opinions persuasive evidence that claimant's chronic depression and knee disability alone permanently incapacitate him from employment.

Nonetheless, we conclude that claimant is permanently and totally disabled under the "odd-lot doctrine." Claimant, who was 65 years old at hearing, has an eighth grade education. His previous occupations include heavy construction work and furniture manufacturing. His knee disability prevents him from not only performing his prior occupations, but also many sedentary and light jobs because of his restrictions with sitting, standing and walking. Claimant also suffers from chronic depression, which, when combined with his underlying rigid personality, severely limits his adaptability to nonphysical labor.

Adele Hetfeld, claimant's vocational expert, testified that claimant has limited transferable skills and, after considering his physical restrictions, age, lack of formal education and narrow work experience, concluded that claimant was not employable. Norman Alverson, the employer's vocational expert, testified that, in his opinion, claimant was employable. As noted by the Referee, however, Alverson's opinion assumes that claimant is able to adapt to non-physical labor. That assumption is not supported by the medical record. Claimant's two attempts to return to work were thwarted by the interaction of his chronic depression and knee condition, resulting in both his treating orthopedist and treating psychiatrist preventing him from further work or seeking vocational services. Although those attempts occurred prior to the onset of his noncompensable memory problems that further decreased his employability, we are not persuaded that claimant's depression subsequently resolved to the extent that claimant was otherwise employable.

Considering the above-mentioned medical and vocational evidence, we conclude that claimant is no longer able to perform any work at a gainful and suitable occupation. Moreover, any efforts to obtain employment would have been futile. Finally, we conclude that claimant has established that, but for his compensable injury, he is willing to work and would probably still be working in

the construction business. In reaching this latter conclusion, we rely on claimant's testimony that, prior to his injury, he did not intend to retire immediately upon the funding of his union pension. We also rely on the facts that, after his injury, claimant continued to work until his surgery, that he made several attempts thereafter to return to work and cooperated in vocational assistance until his treating physicians terminated such activities.

Because the employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the extent of claimant's permanent disability is \$1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 21, 1991 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable attorney fee of \$1,000, to be paid by the self-insured employer.

November 26, 1991

Cite as 43 Van Natta 2584 (1991)

In the Matter of the Compensation of
LAURIE FRICK, Claimant
WCB Case No. 90-15265
ORDER ON REVIEW (REMANDING)
David O. Horne, Defense Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant, pro se, requests review of Referee Leahy's order that dismissed her request for hearing for failure to appear. In her appellant's brief, claimant requests remand. On review, the issues are the propriety of the dismissal and remand. We vacate and remand.

FINDINGS OF FACT

A Notice of Hearing set this case for hearing on December 4, 1990 at 9:00 a.m. When the unrepresented claimant did not appear, the Referee dismissed the request for hearing at 10:45 a.m.

After the Referee's order issued, claimant requested Board review, contending that extraordinary circumstances prevented her from appearing at the hearing and from timely requesting a postponement under OAR 438-06-081.

CONCLUSIONS OF LAW AND OPINION

OAR 438-06-071 provides, in relevant part:

"(1) A request for hearing may be dismissed if a referee finds that the party that requested the hearing has abandoned the request for hearing. . . ."

"(2) Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the referee shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

OAR 438-06-081 provides, in relevant part:

"A scheduled hearing shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties requesting postponement. * * * *"

We have interpreted the above-quoted rules to allow a claimant alleging extraordinary circumstances the opportunity to establish such circumstances for the purpose of justifying his or her nonappearance at a scheduled hearing. In a case where a claimant's attorney asked the Referee to reschedule the matter after issuance of an Order of Dismissal (due to claimant's failure to appear in person or by his representative), we held that a similar version of the rule required the Referee to consider a motion for postponement, even after an order of dismissal issued, so long as the Referee retained jurisdiction. Mark R. Luthy, 41 Van Natta 2132 (1989).

In Wonder Windom-Hall, 43 Van Natta 1886 (1991) (on reconsideration) (citing Luthy, supra), we held that the Referee properly dismissed the claimant's request for hearing for her failure to appear at hearing. However, in both Luthy and Windom-Hall, we concluded that the record was insufficiently developed to determine whether circumstances existed to justify postponement. Therefore, the Referees' orders were vacated and the cases were remanded with instructions to proceed with hearings, if the claimants established extraordinary circumstances for their failure to appear at hearing.

In the present case, claimant requested review rather than reconsideration. Nevertheless, considering her assertions about the circumstances which allegedly prevented her appearance at the hearing, we treat her request as a request for reconsideration. Moreover, as in Luthy and Windom-Hall, the record is insufficiently developed to determine whether postponement or continuance would have been justified when the hearing was dismissed. Consequently, we vacate and remand.

ORDER

The Referee's order dated December 11, 1990 is vacated and the case is remanded to the Presiding Referee with instructions to assign a referee to determine whether a postponement or continuance of the December 4, 1990 hearing should be granted. If so, the Referee shall proceed with a hearing concerning the merits of the claim. If not, the Referee shall issue a final appealable dismissal order.

November 26, 1991

Cite as 43 Van Natta 2585 (1991)

In the Matter of the Compensation of
GERALD D. MEEKER, Claimant
WCB Case No. 90-22347
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

The self-insured employer requests review of Referee Crumme's order that directed it to pay claimant's scheduled permanent disability awards at the rate of \$305 per degree. On review, the issue is the rate of scheduled permanent disability.

We affirm and adopt the Referee's order with the following supplementation.

The Referee concluded that claimant's June 8, 1990 and November 1990 awards of scheduled permanent disability should be paid at the rate of \$305 per degree. We agree.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the 1990 amendment to ORS 656.214(2), which increased the value per degree of scheduled permanent disability from \$145 to \$305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury. See Or Laws 1990 (Special Session), ch. 2, 7 and 54. Because claimant's awards of scheduled permanent disability were made after May 7, 1990, the Referee correctly concluded that the awards should be paid at the rate of \$305 per degree.

Noting that the SAIF Corporation has filed a petition for review of our decision in Herron with the Court of Appeals, the employer requests that we stay our decision in this case until the court has rendered an opinion in Herron. Were we to grant the employer's motion, resolution of this matter would be delayed for an indeterminate time. We decline to take an action which would result in such a delay, particularly where alternative measures exist to resolve such disputes. Shirley A. Roth, 43 Van Natta 1802 (1991). Consequently after considering the matter, we deny the motion.

Because the employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the rate of permanent disability issue is \$800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated April 24, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$800, to be paid by the self-insured employer.

November 26, 1991

Cite as 43 Van Natta 2586 (1991)

In the Matter of the Compensation of
STEVEN K. MILES, Claimant
WCB Case No. 88-17001
ORDER ON REMAND
Galton, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Multnomah County v. Miles, 108 Or App 496 (1991). The court reversed our prior order, which found that claimant had established that his work activity was a material contributing cause of his bilateral carpal tunnel syndrome and

therefore had proved a compensable occupational disease claim. The court remanded for reconsideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991), which held that a claimant must establish that his employment was the major contributing cause of a claimed condition or its worsening in order to prove a claim for occupational disease under former ORS 656.802(1)(c).

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant did not establish that his work activities were the major contributing cause of either the onset or worsening of his carpal tunnel syndrome and that, therefore, claimant did not prove a compensable occupational disease claim. We reversed the Referee's order in reliance of our order in Donna E. Aschbacher, 41 Van Natta 1242 (1989), which held that, under the 1987 amendments to former ORS 656.802(1), a claimant could prove a compensable claim under former ORS 656.802(1)(c) by merely showing that work was a material contributing cause of a claimed condition or a worsening of the symptoms of a preexisting disease. We found that claimant had established the exacerbation of symptoms in his wrists and hands and so set aside the denial of the claim.

The Court of Appeals subsequently reversed our order in Aschbacher, holding that the legislature had not intended to change the standard of proof necessary to prove a claim under former ORS 656.802(1)(c) and that a claimant was still required to show that the work activity was the major contributing cause of a claimed condition or worsening of an underlying disease. Aetna Casualty Co. v. Aschbacher, supra. The court therefore reversed and remanded the order in this case for reconsideration.

The date of injury for an occupational disease claim is the date upon which the claimant was last exposed to the employment conditions which caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Here, claimant's last work exposure which could have caused his disease occurred in 1988, bringing his claim under the 1987 amendments to former ORS 656.802(1)(c). We thus look to the Court of Appeals' decision in Aschbacher for the standard of proof necessary to prove a claim under former ORS 656.802(1)(c) and determine whether claimant showed that his work activity was the major contributing cause of a claimed condition or its worsening.

Claimant was examined by three physicians, Dr. Azhar, his family physician, Dr. Berkeley, a neurosurgeon, and Dr. Nathan, a hand specialist. All three physicians diagnosed claimant as suffering from carpal tunnel syndrome. Additionally, Nathan diagnosed "severe median entrapment neuropathy."

Azhar and Berkeley expressed opinions that claimant's work caused claimant's condition. Nathan testified that claimant's work activities did not contribute to his median entrapment neuropathy condition, based on the severity of his condition and the absence of nerve lesions on claimant's hands where he gripped a shovel and tar wand. Nathan also testified, however, that a person with claimant's condition becomes symptomatic when there is a decrease in oxygen to the nerve and that shoveling causes such a decrease and could result in symptoms similar to those experienced by claimant.

We believe that the resolution of this claim depends on the characterization of the condition for which claimant seeks compensation. In Georgia-Pacific v. Warren, 103 Or App 275 (1990), the Court of Appeals considered whether a

claimant's carpal tunnel syndrome was a compensable occupational disease when the evidence showed that claimant also suffered from an underlying condition of "entrapment neuropathy." The court explained that "sometimes the medical evidence will support the conclusion that the symptoms for which compensation is sought are the disease," id. at 278, and concluded that, because claimant sought compensation for the syndrome and the syndrome was caused by work activity, she had proved a compensable claim.

We are persuaded that the Warren rule applies to this claim. We agree with the Referee that Dr. Nathan convincingly proved that claimant suffers from "entrapment neuropathy" and that this underlying condition was not caused by claimant's work activities. All of the physicians, however, agreed that claimant also has carpal tunnel syndrome. This is the condition for which claimant seeks treatment and compensation; it therefore, under Warren, qualifies as the "occupational disease" at issue in this case.

We thus address, as Aschbacher requires, whether claimant proved that employment conditions were the major contributing cause of his carpal tunnel syndrome. Both Drs. Azhar and Berkeley concluded that claimant's condition was caused by work activities. Dr. Nathan, although not explicitly stating the same opinion, testified that claimant's act of shoveling would decrease oxygen to the median nerve, which could result in his symptoms. We conclude this evidence is sufficient for claimant to carry his burden of proof.

When a claimant finally prevails with respect to a claim for compensation after remand from the court, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1). We therefore award claimant's counsel a reasonable attorney fee for services provided at hearing, on Board review, and before the court.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing, on review before the Board, and on appeal before the court concerning the compensability issue is \$4,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts may go uncompensated.

Accordingly, on reconsideration, the Referee's order dated January 27, 1989 is reversed. The self-insured employer's denial is set aside, and the claim is remanded to the employer for processing according to law. For services at hearing, on review before the Board, and on appeal before the court, claimant's attorney is awarded an attorney fee of \$4,000, to be paid by the self-insured employer.

IT IS SO ORDERED.

November 27, 1991

Cite as 43 Van Natta 2588 (1991)

In the Matter of the Compensation of

KENNETH CARRELS, Claimant

WCB Case No. 90-18148

ORDER ON REVIEW

Robert G. Dolton, Claimant Attorney

Nelson, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Leahy's order that: (1) set aside its denial of claimant's current low back condition; and

(2) assessed a penalty for an unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

In January 1990, claimant sustained a compensable injury to his left chest and low back when he fell from a scaffold. Following emergency room care, claimant treated with Dr. Mutch, M.D., for this injury. The insurer accepted a contusion/strain of the chest wall and a lumbosacral sprain. Claimant had experienced no prior back pain.

In early February 1990, Dr. Mutch reported that claimant's left chest pain had resolved. Dr. Mutch further reported that claimant continued to experience low back pain and tenderness. On February 14, 1991, Dr. Mutch released claimant for regular work. However, claimant did not return to his regular work as the job had ended and his position was not available. In March 1990, Dr. Mutch reported that claimant experienced low back pain after playing the drums in a band.

In late March 1990, claimant began treating with Dr. Kehr, chiropractor. Claimant continued to experience low back pain with any protracted activity. In June 1990, claimant returned to Dr. Mutch. At that time, Dr. Mutch recommended a CT scan of the lumbar spine. The CT scan revealed severe foraminal stenosis at right L5-S1 and an asymmetric bulge of the annulus at right L5-S1.

At the time of the injury, claimant weighed between 275 and 280 pounds. At the time of the CT scan, claimant weighed approximately 334 pounds.

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury remains the major contributing cause of his low back condition.

The insurer's denial was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's current low back condition was compensable. We agree.

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990. Ida M. Walker, 43 Van Natta 1402 (1991).

No medical evidence exists that claimant's foraminal stenosis condition preexisted his injury. However, claimant has a preexisting obesity condition. (Ex. 26). Therefore, to obtain compensation for his resulting low back condition claimant must, under ORS 656.005(7)(a)(B), also prove by a preponderance of the evidence, that the compensable January 4, 1990 injury is the major contributing cause of his disability or need for medical services. Bahman M. Nazari, 43 Van Natta 2368 (1991).

Initially, Dr. Mutch stated that he was unable to say that claimant's foraminal stenosis was secondary to the work injury. However, Dr. Mutch did indicate that the annulus bulge may be related to the compensable injury. Later, Dr. Mutch reported that claimant's symptomatology was related to the compensable injury. Dr. Hendricks reported that claimant's obesity did not cause claimant's

back problem, but did retard recovery. Dr. Hendricks then opined that claimant's current low back condition was secondary to the compensable injury. There is no contrary medical evidence.

We conclude that claimant has established that his compensable injury remains the major contributing cause of his low back condition. In reaching this conclusion, we rely mainly on the opinion of Dr. Hendricks and to a lesser degree on the opinion of Dr. Mutch. Dr. Hendricks acknowledges claimant's obesity, but unequivocally relates claimant's low back symptoms to the compensable injury. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic Words" not required). Although Dr. Mutch initially was unable to relate the stenosis to the industrial injury, he later opined that claimant's symptoms were related to the industrial injury. Under these circumstances, we find that claimant's current low back condition is compensable.

Penalties

The Referee found that the insurer's denial was unreasonable. We agree and adopt his discussion of this issue.

Attorney Fee/Board Review

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled an attorney fee on review for defending the Referee's award of a penalty. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 15, 1991 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of \$750, payable by the insurer.

November 27, 1991

Cite as 43 Van Natta 2590 (1991)

In the Matter of the Compensation of
RICHARD H. CHURCH, Claimant
WCB Case No. 90-19562
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Harri's order which set aside its denial of claimant's aggravation claim for his neck and left shoulder condition. Claimant, in his respondent's brief, argues that the Referee erred in declining to assess a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are aggravation and penalties and attorney fees.

We affirm and adopt the order of the Referee with the following supplementation.

In order to prove a claim for aggravation, a claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity since the last award or arrangement of compensation. See Leroy Frank, 43 Van Natta 1950 (1991). The worsening must be more than a waxing and waning of symptoms contemplated by the previous award of permanent disability. ORS 656.273(8). In addition, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1).

The Referee found that claimant experienced a symptomatic exacerbation of his neck and left shoulder condition and the exacerbation resulted in diminished earning capacity. Furthermore, the Referee found that the exacerbation was more than the degree of waxing and waning of symptoms contemplated at the time of the settlement of the claim. The Referee therefore concluded that claimant's condition had worsened.

The insurer asserts that claimant's aggravation claim was not established by medical evidence supported by objective findings. The insurer notes that only Dr. Knox states that claimant's condition has worsened. It argues that, because there is no indication that Knox reviewed claimant's prior medical records, Knox is "not in the position to judge whether or not claimant has worsened since that time." The insurer further contends that neither Dr. Knox nor Dr. Bailey, claimant's treating physician, provide any evidence of an exacerbation of symptoms or worsened neurological condition.

For the reasons given by the Referee, we are persuaded that the record, as a whole, is sufficient to prove the aggravation claim. Dr. Knox's report documenting muscle spasms and very definite limitation of motion in claimant's neck and left shoulder provides support of claimant's subjective complaints of increased pain and weakness. Such a report constitutes medical evidence of a worsening supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991). Claimant's worsened condition also resulted in diminished earning capacity to a level below that fixed at the time of the previous award; at the time of settlement, claimant was expected to be capable of light to medium work whereas Dr. Knox took claimant off work. Finally, claimant's worsened condition is greater than the waxing and waning of symptoms contemplated by the settlement. The reports at that time from Dr. Fitchett, claimant's treating physician, and the Orthopaedic Consultants provide no evidence that claimant's symptoms would render him totally disabled but rather state that claimant was capable of light to medium work.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the issue of aggravation of claimant's neck and left shoulder condition is \$500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 29, 1991 is affirmed. Claimant's attorney is awarded \$500 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
ROBERT E. HORNE, Claimant
WCB Case No. 90-21335
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of those portions of Referee Bethlahmy's order which: (1) increased claimant's scheduled permanent disability award for loss of use or function of the left foot (ankle) from 19 percent (25.65 degrees), as granted by an Order on Reconsideration, to 24 percent (32.4 degrees); and (2) directed SAIF to pay claimant's scheduled permanent disability award at a rate of \$305 per degree. Claimant cross-requests review, contending that the Referee's award of scheduled permanent disability should be increased. On review, the issues are scheduled permanent disability and claims processing.

We affirm and adopt the order of the Referee with the following supplementation.

SAIF contends the Referee exceeded her statutory authority in reviewing the Department of Insurance and Finance's (DIF) Order on Reconsideration because, in amending ORS 656.283(7), the legislature allegedly intended to narrow the Referee's scope of review. To support its contention, SAIF relies on the standard provided in ORS 656.283(1)(a) for review of DIF orders regarding vocational assistance. In such cases, the decision of the Director may only be modified if it: (1) violates a rule or statute; (2) exceeds the statutory authority of the agency; (3) was made upon unlawful procedures; or (4) was characterized by abuse of discretion or clearly unwarranted exercise of discretion. We reject SAIF's contention for the following reasons.

Review of Reconsideration Orders issued under ORS 656.268 is governed by ORS 656.283(7). As amended, ORS 656.283(7) expressly provides that "nothing in this section shall be construed to prevent or limit the right of the injured worker . . . to present evidence at hearing and to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268."

After conducting our review, we conclude, as did the Referee, that claimant's impairment exceeded that found by the Evaluation Section, according to a preponderance of the evidence presented at hearing. Consequently, we find that the Director's standards were incorrectly applied in the reconsideration order. Id. We further agree with the Referee that according to the correct application of those standards, claimant's scheduled permanent disability award for loss of use or function of the left foot (ankle) is 24 percent.

Inasmuch as SAIF has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on review concerning SAIF's request for review is \$500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 7, 1991 is affirmed. For services on Board review, claimant's attorney is awarded \$500, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
FRANK J. MILBY, Jr., Claimant
WCB Case No. 90-17174
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The SAIF Corporation requests review of Referee Livesley's order that: (1) set aside its denial of claimant's neck injury claim; and (2) assessed a penalty for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

Claimant was employed as an auto mechanic for SAIF's insured. In June 1990, he consulted Dr. Larson, an osteopath, for pain in his left shoulder and medical scapular area. Claimant attributed the pain to working underneath a vehicle with his head tilted backward for an extended period of time. Larson diagnosed a cervical strain and possible disc herniation and prescribed medication. An MRI, taken on July 24, 1990, revealed a left disc herniation at C4-5.

Claimant had previously consulted Larson for left shoulder and arm pain in November 1989. X-rays taken at that time showed normal cervical and thoracic spine with no fractures, degenerative changes or other significant abnormalities.

On August 3, 1990, claimant filed an 801 form, asserting that he had suffered a compensable injury. On August 16, 1990, SAIF denied the claim, relying on reports that claimant was remodeling his home and working on automobiles off-the-job as well. It believed that the off-the-job exposures were a possible cause of claimant's condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found all witnesses credible based on demeanor. We defer to that finding, because of the Referee's opportunity to observe the witnesses. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Relying on their testimony and the medical evidence, the Referee concluded that claimant has established a compensable injury. We agree.

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[.]" ORS 656.005(7)(a). To establish a compensable injury, claimant must show that: (1) he injured himself in performing his job; and (2) the injury was a material contributing cause of the resultant disability or need for medical treatment. The first is a question of legal causation; the second concerns medical causation. Harris v. Farmers' Co-op Creamery, 53 Or App 618 (1981). Claimant carries the burden of proving both legal and medical causation by a preponderance of the evidence. Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981).

SAIF first contends that claimant failed to establish legal causation. It argues that, despite the Referee's express finding, claimant is not credible because his statements and testimony are inconsistent and contain numerous discrepancies. It suggests that claimant actually injured himself during off-the-job activities, such as installing sheet rock in his home or working on automobiles during nonwork hours.

After an objective evaluation of claimant's statements and testimony, we find nothing that casts doubt on his credibility. According to his examining physicians, claimant reported that:

"[F]or the last three or four years he had been remodeling his house. Since last summer he has been doing just electrical work. He states that the walls in the house are bare and that he has done no sheet rocking." (Ex. 7-3).

SAIF contends that that history is inconsistent with claimant's testimony at hearing that he did, in fact, install some sheet rock in his home. However, the above-quoted history relates only to the period of time after summer. Claimant has not denied the fact that he hung sheet rock earlier in the year.

During the independent medical exam, claimant also denied doing outside automotive work or automotive work at home. SAIF contends that that statement conflicts with claimant's testimony that he had worked on his personal car at home. We disagree. When asked whether he told the physicians that he wasn't doing any outside automotive work during the summer, claimant testified as follows:

"CLAIMANT: That is correct. I do not scab at home."

"REFEREE: What does that mean?"

"CLAIMANT: That means if you came to me and said, 'I want you to work on my car, could you work on it at home?' I don't do that. You would have to take it to a dealership or to a regular garage to have it done[.]" (Tr. at 78).

When his statements and testimony are viewed as a whole, we are persuaded that, in denying outside and home automotive work, claimant simply was stating that he did not work on cars for others outside his work with the insured. He did not deny the fact that he worked on his own vehicles at home. In any event, there is no evidence that claimant was injured doing any of these off-work activities.

Based on claimant's credible testimony that he experienced an immediate onset of left arm numbness and blurred vision after he walked out from under a vehicle and raised his head, and in the absence of any evidence that claimant's off-the-job activities were a causative factor in claimant's condition, we conclude that claimant has met his burden of proving legal causation.

SAIF next contends that, even if claimant established that he injured himself at work, claimant has failed to establish medical causation. It maintains that claimant has a preexisting cervical condition and that, therefore, he must establish that the work-related incident was the major contributing cause of his disability or need for medical services under ORS 656.005(7)(a)(B). We disagree. Although claimant did receive some treatment for neck and shoulder pain in 1989, and Dr. Kitchel, M.D., commented that claimant had extensive underlying degenerative disease, we are not persuaded that claimant had a cervical condition that preexisted the June 26, 1990 injury. Aside from Dr. Kitchel's unexplained comment, there is no evidence of any degenerative disease. In fact, x-rays taken in 1989 showed a normal cervical spine with no fractures, degenerative changes or other significant abnormalities. Accordingly, we conclude that ORS 656.005(7)(a)(B) is not applicable.

Therefore, in order to establish medical causation, claimant must show that the industrial injury is a material contributing cause of his disability or need

for treatment. Mark Wiedle, 43 Van Natta 855 (1991). The primary medical evidence in this case comes from Dr. Brooks, a neurologist, and Dr. Baker, an orthopedic physician, who examined claimant at the office of the Medical Consultants Northwest. Although they were unable to exactly determine how claimant's disc herniation occurred, they found claimant's work activities consistent with his symptoms and findings.

Based on that report, as well as the reasons relied upon by the Referee, we find that claimant's work activity was a material contributing cause of his current condition. Accordingly, we conclude that claimant has also established medical causation and affirm the Referee's determination that the claim is compensable.

Penalties

We adopt the conclusions and reasoning concerning the unreasonableness of SAIF's denial as set forth in the Referee's order.

Attorney Fee on Board Review

Because SAIF initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved. We note that claimant is not entitled to an attorney fee for defending against the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 20, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable attorney fee of \$1,000, to be paid by the SAIF Corporation.

November 27, 1991

Cite as 43 Van Natta 2595 (1991)

In the Matter of the Compensation of
DONALD C. MOON, Claimant
WCB Case Nos. 90-14189 & 90-09730
ORDER ON REVIEW
Max Rae, Claimant Attorney
Pamela Schultz, Defense Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by the Board en banc.

Claimant requests and Liberty Northwest Insurance Corporation cross-requests review of that portion of Referee Garaventa's order which: (1) upheld Aetna Casualty Company's denial of compensability and responsibility for claimant's back injury claim; and (2) set aside Liberty Northwest's denial of compensability and responsibility for the same condition. On review, the issues are compensability and responsibility. We reverse in part, affirm in part, and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

FINDINGS OF ULTIMATE FACT

Claimant's work activities in March 1990 while working for Liberty Northwest's insured, caused a flareup of the symptoms of the original injury claimant sustained while working for Aetna's insured in January 1990.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found claimant's claim compensable as an occupational disease, and assigned responsibility for the claim to Liberty Northwest. We agree that the claim is compensable. However, we conclude that the claim is compensable as an injury and that Aetna is responsible for the claim. There is no question but that claimant twice injured his back while working for Aetna's insured in January 1990. First, he tripped and twisted his back. Later that same day, he slipped in some mud and fell, injuring the same area. Aetna contends that claimant did not sustain a compensable injury while working for its insured because claimant did not seek medical treatment until March 1990, when he was working for Liberty Northwest's insured. We disagree. It is true that no claim was processed until March 1990, because until that time, claimant did not seek medical treatment for the injury. The issue, however, is not when the claim was processed, but whether claimant suffered a compensable injury. The evidence clearly shows that claimant compensably injured his back in January while working for Aetna's insured. Daniel Powers, 42 Van Natta 1221 (1990). Furthermore, the evidence establishes that his need for medical treatment was related to the injuries sustained while working for Aetna's insured. His work activities for Liberty Northwest's insured only caused a flareup of the symptomatology of the original injury.

Responsibility

We analyze this matter under the Workers' Compensation Act as amended by Senate Bill 1197, effective July 1, 1990. Ida M. Walker, 43 Van Natta 1402 (1991). We have held that under Section 49 of Senate Bill 1197, an insurer that is responsible for a compensable injury remains responsible for continued or increased disability during employment with a later carrier, unless the claimant sustains a new injury or occupational disease¹ during the subsequent employment

¹ We conclude that the term "new compensable injury" as used in Section 49(1) of Senate Bill 1197 includes and applies equally to a new occupational disease. ORS 656.804 provides that an "occupational disease, as defined in ORS 656.802, is considered an injury for employees of employers who have come under ORS 656.001 to 656.794, except as otherwise provided in ORS 656.802 to 656.807." Nothing in Section 49 or elsewhere in ORS Chapter 656 provides otherwise. Furthermore, we can identify no policy reason why the legislature would draw a distinction between an injury and an occupational disease for the purpose of shifting responsibility for the worker's condition to the subsequent employer. To be compensable, both conditions must arise out of an in the course of employment and the level of contribution of the work activities required to prove an occupational disease (major contributing cause) is greater than the level of contribution required to prove an injury (material contributing cause). Thus it would be anomalous to shift responsibility to the subsequent employer because of a new injury, but not in the case of a new occupational disease. For these reasons, we conclude that a "new compensable injury" as used in Section 49 includes a new occupational disease.

See Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, in order to shift responsibility to Liberty Northwest in the present case, Aetna had to establish that claimant sustained a new compensable injury or occupational disease while working for Liberty Northwest's insured. ORS 656.005(7)(a) and 656.802.

The evidence shows that claimant's condition did not result from a discrete period of work activity with the subsequent employer. Thus, claimant did not sustain a new injury. Hall v. Home Insurance Co., 59 Or App 526, 529 (1982); Valtinson v. SAIF, 56 Or App 184 (1982). Nor did claimant sustain a new compensable occupational disease. Claimant's regular work activity caused a gradual worsening of the symptoms of the initial injury, but no pathological worsening. ORS 656.802(2). Therefore, responsibility remains with Aetna.

At hearing, the Referee awarded claimant's counsel an attorney fee of \$1,800, payable by Liberty Northwest. Inasmuch as we have determined that responsibility for the claim lies with Aetna, the Referee's order shall be modified to require payment of the attorney fees by Aetna.

ORDER

The Referee's order dated November 21, 1990 is reversed in part, affirmed in part, and modified in part. Those portions of the order which upheld Aetna Casualty Company's denial and set aside Liberty Northwest Insurance Corporation's denial are reversed. Liberty Northwest's denial is reinstated and upheld. Aetna's denial is set aside, and the claim is remanded to Aetna for processing pursuant to law. The attorney fee awarded to claimant's counsel by the Referee in the amount of \$1,800 is modified to the extent that the fee shall be paid to claimant's counsel by Aetna. The remainder of the Referee's order is affirmed.

Board Member Kinsley Specially Concurring.

Although I concur in the result reached by the majority of the Board members, I disagree that Section 49 of Oregon Laws 1990, Chapter 2, is applicable to this case.

Section 49(1) states:

"When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."
(Emphasis added.)

By its terms, this new statute addresses only those cases involving successive injuries. The majority applies this statute to cases involving occupational diseases by using ORS 656.804. My review of case law reveals a tangled web of legal tests for determining responsibility in cases involving successive injuries, successive exposures causing diseases, and mixed cases where there are distinct injuries with prior or subsequent disease exposures. However, I found no instance where ORS 656.804 was used to make a specific test dealing with one category of cases generally applicable to other categories of cases. I believe different legal tests have developed because the nature and definition of injuries and diseases is very different, as well as the burden of proof required to

prove each. O'Neal v. Sisters of Providence, 22 Or App 9 (1975). An often quoted observation by the Supreme Court is the following:

"One who claims that he is afflicted with an occupational disease has undergone experiences substantially different from those of another workman who is the victim of an industrial accident. An occupational disease is stealthy and steals upon its victim when he is unaware of its presence and approach. Accordingly, he can not later tell the day, month or possibly even the year when the insidious disease made its intrusion into his body. Although his weakened condition may manifest ill health its cause may be uncertain and puzzle even the most skillful of physicians. Upon the other hand, the victim of an industrial accident virtually always can tell the day and even the hour when the purported injury befell him. He does not attribute his present condition to something that crept in upon him unobserved but to an accident which he and possible others observed. * * *" White v. State Ind. Acc. Com., 227 Or 306, 322, 362 P2d 302 (1961).

Because of these differences, assignment of responsibility when diseases are involved requires different considerations. In particular, although we can usually determine when a new injury occurs in order to assign liability to a specific employer, how can we tell when a "new" disease occurs?

In the legislative hearings, there is no statement from the presenters of SB 1197 that Section 49 was intended to apply to occupational diseases. On the contrary, Representative Kevin Mannix, who has experience in workers' compensation law as a referee and legal practitioner, and who attempted to pass legislation clarifying responsibility law in a past session, recognized that Section 49 was "inadequate" to address all responsibility law questions, but that this "complex issue" would be addressed by future action. See Transcript, Interim Special Committee on Workers' Compensation, May 4, 1990, Tape 18, Side A.

I also rely upon the following statement by Representative Mannix to conclude that Section 49 was to be applied only to injury cases:

"Although I don't think 49 goes far enough, let's state for the record that it says here, first of all, this will do away with the current court's interpretations of what is a new injury for responsibility purposes. Do you hear that judges on the Court of Appeals, members of the Board, when you read the transcript of this hearing? . . . This says there's going to have to be a new compensable injury and this bill defines compensable injury and so if there isn't a new compensable injury under the definition of the law, then responsibility remains with the first employer." Id. (Emphasis added.)

The definition of a compensable injury is set out in ORS 656.005(7)(a) and is distinct from the definition of a compensable disease, which is set out at ORS 656.802.

In conclusion, although I understand the majority's desire to have a clear statutory test to cover all responsibility law questions, I believe Section 49 was only a beginning by the legislature toward that end. By its terms, Section 49 only applies to successive injury cases. Therefore, the result in this case is governed by Boise Cascade v. Starbuck, 296 Or 238 (1984). Example (4) in that case describes a situation, similar to this case, where there was an injury at one employment which contributed to a disability occurring during a later employment involving work conditions capable of causing the disability (i.e., occupational disease exposure), but which did not contribute to the disability. In Starbuck, as here, the first employer is liable. Id. at 244.

In the Matter of the Compensation of
DOLORES N. PETERS, Claimant
WCB Case Nos. 89-25315 & 89-14076
ORDER ON RECONSIDERATION
Vick & Gutzler, Claimant Attorneys
Cummins, et al., Defense Attorneys

Claimant requests reconsideration of that portion of our October 30, 1991 Order on Review that modified the Referee's award of a \$4,500 assessed fee to \$2,500 for services rendered at hearing after successfully prevailing against the insurer's back-up denial pursuant to ORS 656.386(1). Claimant seeks reinstatement of the \$4,500 assessed fee awarded by the Referee.

After review of the applicable portions of OAR 438-15-010(4), we conclude that reconsideration of our reduction of the Referee's award of \$4,500 is appropriate. Claimant's counsel previously submitted a valid statement of services in an amount greater than that awarded by the Referee. Furthermore, we recognize that the Referee had a better opportunity than ourselves to interact with counsel and to determine the effectiveness of counsel. Accordingly, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we decline to modify the Referee's award and conclude that \$4,500 adequately and reasonably compensates claimant's counsel for his services at hearing regarding the backup denial issue.

Accordingly, our October 30, 1991 order is withdrawn. On reconsideration, as amended herein, we adhere to and republish our October 30, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

November 27, 1991

Cite as 43 Van Natta 2599 (1991)

In the Matter of the Compensation of
THOMAS PORTER, Claimant
WCB Case No. 90-07645
ORDER ON REVIEW
Westmoreland, et al., Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of those portions of Referee Crumme's order that: (1) upheld the SAIF Corporation's denial of claimant's low back injury claim; and (2) declined to award additional temporary total disability. On review, the issues are compensability and temporary total disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Although claimant requested a hearing before May 1, 1990, the hearing was convened after July 1, 1990. Therefore, the "savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue is not subject to a special exception to the Act's general

applicability provision. See, e.g., 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Turning to the merits of the claim, the Referee found that claimant's current low back condition was caused by a combination of his underlying back condition and the July 29, 1988 on-the-job injury. The Referee concluded, however, that the condition was not compensable under ORS 656.005(7)(a)(B), because the July 29, 1988 injury was not the major contributing cause of claimant's need for medical treatment. Accordingly, he upheld SAIF's denial. We modify.

As amended by the 1990 Legislature, ORS 656.005(7)(a) provides, in pertinent part:

"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; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

" * * * * *

"(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." Or Laws 1990 (Special Session), ch. 2, 3. (Emphasis supplied.)

In amending that statute, the legislature did not change the elements necessary to establish an initial compensable injury. As in the past, an injury is compensable if it arises out of and in the course of employment and results in disability or the need for medical services. Accordingly, an injured worker establishes a compensable claim if he proves that the accident is a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). By adding subsection (B), however, the legislature limited the compensation to which a worker may be entitled in a compensable injury claim. Under that provision, a worker who suffers a compensable injury, yet who also suffers from a preexisting condition or disease that combines with the injury to cause or prolong disability, will be compensated for disability and treatment only if the compensable injury is the major contributing cause of particular periods of disability or need for particular treatment. See Bahman M. Nazari, 43 Van Natta 2368 (1991).

On this record, we first conclude that claimant has established the compensability of his July 29, 1988 injury. There is no dispute that, while in the course and scope of his employment, claimant was struck in the low back by a fallen tree, a portion of which punctured his skin producing a small wound. Although claimant did not immediately seek medical treatment from a physician, he did administer self-medication and ultimately sought medical treatment for low back pain, and a strain was diagnosed. Furthermore, the medical evidence establishes that the July 29, 1988 injury was a material contributing cause of that need for medical services. Accordingly, we conclude that claimant has established a compensable injury.

Assuming that the denial also raises the question of whether claimant is entitled to compensation for the particular medical services at issue--lumbar spondylosis surgery, we address that question as well.¹ Of all the expert opinions on medical causation submitted in this matter, only Dr. Nash, claimant's attending physician, related claimant's need for surgery directly to the July 29, 1988 injury. (Ex. 15A). Dr. Nash, however, based his opinion on the mistaken belief that claimant had no prior history of back pain. As claimant himself testified, he has had intermittent low back pain and treatment for 20 to 30 years. Accordingly, we do not find Dr. Nash's opinion to be based on complete information and give it little weight. Somers v. SAIF, 77 Or App 259 (1986).

Other medical experts attribute claimant's need for surgery to a combination of the July 29, 1988 injury and his preexisting degenerative disc disease. Dr. Berkeley, a neurosurgeon, noted that claimant had lumbar spondylosis predating the July 29, 1988 accident, but believed that the injury was a "significant contributing factor" in precipitating claimant's symptomatology and forcing claimant to seek further medical advice. (Ex. 15B). Dr. Stanford, an orthopedic surgeon, also attributed claimant's need for surgery in part to the July 29, 1988 injury, but believed that the preexisting problems were the major factor. He explained:

"The degenerative disc disease in his cervical and lumbar spines were present at the time of his injury. * * * It is not appropriate to say that this man would not have had problems had it not been for the accident. First of all, he was having some problems; second of all, the degenerative change in his cervical and lumbar spines is a progressive thing and almost for sure would have begun to give him significant problems. It is inappropriate, at best, to state that his problems with his spine now are related significantly to his accidents." (Ex. 13-2).

Based on those opinions, we conclude that claimant has failed to prove by a preponderance of the evidence that the compensable injury was the major contributing cause of the condition for which he seeks medical services. Accordingly, pursuant to ORS 656.005(7)(a)(B), SAIF's denial is upheld to the extent that it denied compensation for the proposed lumbar surgery.

Temporary Total Disability

At hearing, claimant's attorney conceded that, if claimant's low back condition is not the compensable result of the work-related accident, SAIF's reduction in payment of temporary total disability benefits was proper. Although we have determined that claimant has established a compensable claim, we concluded that his current condition is not compensable because the July 29, 1988 injury was not the major contributing cause of his need for medical treatment. Accordingly, no additional temporary total disability is due.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing against a denial of compensation. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a

¹Because the denial was issued prior to the 1990 amendments, the denial did not treat this issue separately. We infer from the arguments of counsel that this issue is raised pursuant to ORS 656.005(7)(a)(B).

reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 21, 1990 is affirmed in part and modified in part. The SAIF Corporation's March 29, 1990 denial is set aside in part and upheld in part. That portion which denied that claimant sustained a compensable injury on July 29, 1988 is set aside. That portion of the denial that denied payment of claimant's low back surgery is upheld. For services at hearing and on Board review concerning the compensability issue, claimant's counsel is awarded an assessed fee of \$1,500, payable by SAIF. The injury claim is remanded to SAIF for further processing according to law. The remainder of the order is affirmed.

November 27, 1991

Cite as 43 Van Natta 2602 (1991)

In the Matter of the Compensation of

JAMES D. REYNOLDS, Claimant

WCB Case No. 90-20391

ORDER ON REVIEW

Brownstein, Rask, et al., Claimant Attorneys

Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Neal's order that upheld the SAIF Corporation's denial, on behalf of a noncomplying employer, of his left ankle injury claim. On review, the issue is whether the injury arose out of the course and scope of employment. We reverse.

FINDINGS OF FACT

Claimant worked as a laborer and carpenter for All Phase Contractor beginning on January 1, 1990. (Tr. 4). He worked six days a week and was paid for eight and a half hours a day, from 8:30 a.m. to 5:30 p.m. with a half hour for lunch. (Tr. 5). On June 23, 1990, he stepped off a platform and broke his ankle. (Tr. 15). He filed a workers' compensation claim on July 23, 1990 (Ex. 7), and the Department of Insurance and Finance subsequently found All Phase Contractors to be a noncomplying employer. (Ex. 10). The owner, Mathew English, is the former brother-in-law of claimant and Bob Standring and Andy Argeris, the other two workers on the regular crew. (Tr. 22). They were all friends. (Tr. 33).

The office building, where claimant was injured, was part of a five-building mini-storage construction site. (Tr. 6). The employer was hired as a subcontractor by the general contractor to do the insulation and sheetrock in the office building and the sheeting in the other four buildings, which were storage buildings. (Tr. 48-49). The employer subcontracted out the finishing work on the sheetrock in the office building. (Tr. 12-13). After claimant finished his work in the office building, he occasionally delivered supplies to the finishing subcontractors and went there to pick up nails that were stored in the office building. (Tr. 18).

On the day claimant was injured, claimant, Standring and Argeris finished their day's sheeting work in the storage buildings at approximately 4:40 p.m. and loaded the tools into the employer's truck. (Tr. 17). The employer was not

at the construction site. (Tr. 11). Standring wanted to inspect the finishing work in the office building before they left the site. (Tr. 15, 32, 39). Claimant and Argeris followed him into the office building. (Tr. 32). Standring did not object. (Tr. 40).

Standring was the oldest and the most experienced of the three workers. (Tr. 9). Claimant and Argeris were trainees. (Tr. 9). Standring was not the official supervisor, but, because he was the most knowledgeable, he was often the lead worker on the crew. (Tr. 47). Claimant considered Standring his supervisor when the employer was not at the work site. (Tr. 9).

While the employer had not instructed them to inspect the subcontractors' work (Tr. 46), Standring wanted to check the finishing work in the office building to make sure that the subcontractors had done a good job. If the work was substandard, Standring intended to report it to the employer so he could talk to the subcontractors. (Tr. 32 and 39).

Claimant was injured at approximately 4:55 p.m. (Tr. 17). Standring, Argeris and claimant were checking the office building. Claimant came down the stairs and stepped off a three foot platform, twisting his ankle inward and breaking it. (Tr. 15-17).

Although claimant had finished his sheeting work in the storage buildings for the day, his paid shift was not over until 5:30 p.m. (Tr. 5). He was still responsible for transporting the employer's tools and driving the other two workers in the employer's truck back to the employer's home. (Tr. 27).

After claimant was injured, Standring drove claimant to the employer's house and then Argeris drove him to the emergency room. (Tr. 37). Claimant required surgery on his ankle. (Ex. 6).

Standring did not think they were doing anything wrong in checking the finishing work in the office building. (Tr. 38). It was Standring's idea, and not claimant's, to tell the employer that claimant had been injured falling off a spool while nailing sheeting in the storage building. (Tr. 37). Claimant just went along with the story. (Tr. 23). Later, Standring told the employer the truth. (Tr. 38).

Later, the employer told claimant that he was not covered by workers' compensation insurance. He suggested that claimant file for welfare benefits and asked claimant to say that he was not injured on the job so that the employer would not "get in trouble with SAIF." The employer promised to help claimant out with some money on the side. (Tr. 20). The employer never did, so claimant contacted an attorney and filed a claim. (Tr. 21). SAIF denied his claim on October 26, 1990. (Ex. 15).

ULTIMATE FINDINGS OF FACT

Claimant's June 23, 1990 injury arose out of and in the course of his employment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's injury was not work-related and, therefore, not compensable. We disagree.

In determining whether the claim is compensable, the question is whether claimant's injury arose out of and in the course of employment. ORS 656.005(7)(a). In Rogers v. SAIF, 289 Or 633 (1980), the Supreme Court adopted

a unitary "work connection" test, which requires claimant to prove that the relationship between his injury and his employment is sufficient that the injury should be deemed compensable. In applying this approach, it is first necessary to determine whether the injury occurred while claimant was at work or engaged in work-related activity, taking into consideration time, place and circumstances surrounding the injury.

In our de novo review, we rely on the seven factors first identified by the Court of Appeals in Jordan v. Western Electric Co., 1 Or App 441 (1970) in determining whether an injury is work related: (1) whether claimant's activity at the time of the injury was for the benefit of the employer; (2) whether the activity was contemplated by the employer and the employee; (3) whether the activity was an ordinary risk of, and incidental to, the particular employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed or acquiesced in by the employer; and (7) whether the employee was on a personal mission. Timberline Lodge v. Kyle, 97 Or App 239 (1989); Preston v. SAIF, 88 Or App 327 (1987); Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571 (1985). All of these factors are considered and no one factor is dispositive. Id.

Benefit to the Employer

Claimant's injury occurred while he and the two other workers inspected the finishing subcontractors' work in the office building. On review, SAIF argues that the workers went to the office building only to satisfy their own curiosity. However, we are persuaded that Standring, with claimant and Argeris following, went to the building to check the quality of the subcontractors' finishing work so he could report back to the employer. We base this conclusion upon the testimony of all three workers, who stated that the reason they were in the office building was to inspect the finishing work and report to the employer. Even though the employer testified that he had not asked them to perform that task, we find that he was the only one who would have benefited from the inspection, especially if the quality had been substandard.

Activity Contemplated by the Parties

Here, the Referee concluded that the employer did not contemplate that claimant would return to the office building to inspect the finishing work because the sheeting had been completed in that building. We do not agree because we find that claimant's work was not completed since he continued to deliver and pick up supplies in the office building. Additionally, SAIF argues that the fact that the workers fabricated a story about claimant's injury shows that the activity was not contemplated. We do not find this persuasive based upon Standring's testimony that he did not think there was anything wrong with inspecting the office building and he did not know why he made up the story. (Tr. 37). Even assuming arguendo that the inspection activity was not contemplated by the employer, we do not find this factor dispositive.

Ordinary Risk of and Incidental to Employment

SAIF claims that the injury was not an ordinary risk of claimant's employment because he had completed his work in the office building. As we stated above, claimant testified that, even after he finished the sheetrock, he continued to deliver supplies to the finishing subcontractor and to pick up nails at the office building and had done so on the day of the injury. The employer stated that he did not "remember that happening" on "that particular day." We find claimant's testimony more persuasive. Moreover, we agree with claimant's assertion that being injured while walking through a job site is an ordinary risk of and incidental to construction employment.

Payment for the Activity

SAIF contends that claimant had completed his work for the day and that claimant's visit to the office building was a personal deviation on claimant's way home. There is no dispute that, when claimant was injured at 4:55 p.m., he was not on his way home. He had not completed his responsibilities or his shift. He still was required to drive Standring and Argeris back to the employer's house in the employer's truck, which would take until 5:30 p.m. We, therefore, conclude that claimant was paid for the activity.

Activity on Premises

SAIF appears to argue on review that the injury did not occur on the employer's premises because, as a subcontractor at the construction site, the employer's control over the office building ended when claimant finished his sheetrock work in that building. We disagree. While the employer's testimony characterized the office building, where claimant was injured, as a former work site (Tr. 45), we find that the office building was an ongoing work site because claimant continued to enter that building to deliver and pick up supplies and the building was also part of a larger five-building construction site where the employer's crew continued to work on storage buildings. (Tr. 6 and 48-49).

Employer Direction and Acquiescence

Here, we conclude that Standring was claimant's supervisor in fact, if not in title. While the employer testified that Standring was not claimant's supervisor, he acknowledged that Standring was the oldest, the most experienced and the crew's leader. (Tr. 47). Claimant testified that he and Argeris were just trainees and that he considered Standring his supervisor when the employer was not at the work site. (Tr. 9). The day claimant was injured, the employer was not at the work site. (Tr. 11). Standring announced that he was going to inspect the office building because he wanted to report to the employer about the quality of the finishing work. (Tr. 36, 39-40). Argeris testified that he and claimant followed him into the building. (Tr. 32). Standring did not object (Tr. 40) and therefore, as the workers' "de facto" supervisor, he acquiesced to their presence.

Personal Mission

Because we find that the inspection of the finishing work in the office building was for the benefit of the employer, we find as to this factor that claimant was not on a personal mission.

Conclusion

Although no one factor is dispositive here, our conclusions concerning each factor, when taken as a whole, persuade us that there is a significant work-connection between claimant's injury on June 23, 1990 and claimant's employment. Consequently, we hold that claimant's injuries arose out of and in the course of claimant's employment. Accordingly, SAIF's denial shall be set aside.

Claimant is entitled to an assessed attorney fee for finally prevailing against SAIF's denial of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of claimant's injury is \$3,800, to be paid by the SAIF Corporation on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time

devoted to the case (as represented by the record and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 6, 1991 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded \$3,800, to be paid by SAIF on behalf of the noncomplying employer.

November 27, 1991

Cite as 43 Van Natta 2606 (1991)

In the Matter of the Compensation of
ROSEMARY E. SZABO-BERRY, Claimant
WCB Case No. 89-08806
ORDER ON REVIEW (REMANDING)
Royce, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Tenenbaum and Moller.

Claimant requests review of Referee Mills' order that upheld the insurer's partial denial of her bilateral inner ear condition, including her claim for perilymph fistulas. In her brief, claimant objects to the Referee's exclusion of Dr. Black's reports and requests remand to allow the insurer to cross-examine Dr. Black and for admission of Dr. Black's reports. On review, the issues are evidence, remand and compensability. We vacate and remand.

FINDINGS OF FACT

The insurer accepted claimant's claim for a concussion on March 20, 1987. On November 2, 1989, it issued a partial denial, described by the parties as a denial of the conditions diagnosed and treated by Dr. Black, including perilymph fistulas, endolymphatic hydrops and benign paroxysmal positional nystagmus. (See Ex. 11-1).

Claimant requested a hearing on the written partial denial and an alleged "de facto" denial of the perilymph fistulas. The hearing convened on November 20, 1989. At the outset, the Referee received the exhibits submitted by claimant. He left the record open for a master exhibit list (to be prepared by the insurer), the depositions of Doctors Black and Brown, "and potentially, depending on what is developed in the master list, for further rebuttal evidence from claimant." (Tr. 2-3). The Referee admitted no exhibits at the time of hearing.

After the hearing, claimant's counsel attempted to schedule Black's deposition, as requested by the insurer. In February 1990, claimant's counsel informed the insurer and the Referee that Black would be unavailable for the deposition which had been scheduled for March 1990. The insurer moved that Black's reports be excluded, due to the doctor's failure to submit to cross-examination. In May 1990, claimant's attorney requested more time and opined that a subpoena would be necessary to compel Black to attend a deposition. The insurer renewed its motion that Black's reports be excluded. On June 12, 1990, the Referee advised that the reports would be excluded. In July 1990, the insurer requested that closing arguments be received. In September 1990, claimant contended that the reports should not be excluded absent the insurer's subpoena of Dr. Black. The Referee again advised the parties that Black's reports would be excluded and requested submission of closing arguments. The record was closed on November 26, 1990, when the last closing argument was received. The disputed medical

reports were never admitted. After the record was closed and the Referee issued his order, the insurer submitted a master exhibit list and a number of documents including the November 2, 1989 partial denial.

CONCLUSIONS OF LAW AND OPINION

A referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7). The Board and the courts have long encouraged the exercise of discretion in evidentiary matters in favor of admission so long as the fundamental fairness of the proceeding is not compromised. See Lucke v. Compensation Department, 254 Or 439, 442-43 (1969); Cristofano v. SAIF, 19 Or App 272, 273, 275 (1974); Cherry Walker, 40 Van Natta 1973 (1988).

In this case, the Referee's decision to continue the hearing for the depositions of Drs. Black and Brown (and, potentially, for claimant's rebuttal evidence) and to allow the insurer to submit a master exhibit list was within his discretion, as well as appropriate, considering the situation. However, the Referee ultimately excluded Dr. Black's reports, based on his finding that the doctor refused to submit to cross-examination. Because the insurer did not request a subpoena compelling Dr. Black's appearance, we conclude that it has not established that Black "refused" to submit to cross-examination. We also conclude that, under the circumstances of this case, Black's reports should not have been excluded unless he did refuse to be cross-examined. We reach these conclusions based on the following statute and rule.

ORS 656.310(2) provides, in relevant part:

"The contents of medical, surgical and hospital reports presented by claimant for compensation shall constitute prima facie evidence as to the matter contained therein; so also shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination. * * * *"

The statute addresses the evidentiary value of medical reports presented by claimants separately from such reports presented by insurers or employers. The two clauses of the sentence are divided by a semicolon. The first clause simply states that reports from claimant's experts "shall constitute prima facie evidence." The second clause states that "so also shall such reports presented by the insurer or self-insured employer, provided the doctor rendering such reports consents to cross-examination." The second clause contains conditional language which is absent from the first clause. Given the semicolon separating the clauses, as well as the "so also * * * provided" construction of the second clause, we conclude that the statute places a burden on the insurer to ensure that its experts consent to cross-examination, whereas such a burden is not placed on the claimant. This conclusion is supported by the Board's rule, which is patterned after the statute.

OAR 438-07-005(3) provides:

"The insurer may subpoena the claimant's attending or consulting physician(s) or vocational expert for cross-examination. Medical, surgical, hospital and vocational reports offered by the insurer will also be accepted as prima facie evidence provided the insurer agrees to produce the medical or vocational expert for cross-examination upon request of the claimant. The reports of any medical or vocational expert who has refused to make herself or himself

available for cross-examination shall be excluded from the record unless good cause is shown why such evidence should be received. The cost of cross-examination of any medical or vocational expert under this section shall be paid by the insurer." (Emphasis added).

The first phrase of the rule expressly provides: "The insurer may subpoena the claimant's attending or consulting physician(s) or vocational expert for cross-examination." (Emphasis added). The second phrase requires the insurer to produce its experts for cross-examination. In the rule, as in the statute, we read the differential treatment to place a burden on the insurer which it does not place on the claimant. By implication then, claimant is not required to produce her witness for the insurer's ease of cross-examination.

The third sentence of the rule deals with situations where the author of a report "refuses" to make himself available for cross-examination. The question in the present case is whether Black has "refused", within the meaning of the statute and rule. If so, his reported opinion should be excluded. However, we now hold that claimant's expert has not "refused," unless and until the insurer has subpoenaed him and he fails to comply with the subpoena.

In this regard, we note that the Board's representatives are empowered to issue and serve subpoenas for the attendance of witnesses and the production of papers, contracts, books, accounts, documents and testimony before any hearing under ORS 654.001 to 654.295, 654.750 to 654.780 and 656.001 to 656.794.¹ ORS 656.726(2)(c). Concerning enforcement, ORS 656.732 provides that the circuit court, on application of the Referee, shall compel obedience to subpoenas issued and served pursuant to ORS 656.726.

In this case, because claimant advised the insurer in February 1990 that Black had cancelled a scheduled deposition, and the record was not closed until November 1990, the insurer had ample time to subpoena Dr. Black. There is no indication that the insurer made an effort to do so.

Moreover, this is not a case where the insurer has made all reasonable attempts to compel cross-examination, but is deprived of its right to do so. See Marie C. Walsh, 42 Van Natta 2372 (1990) (Board upheld exclusion of exhibits where insurer attempted to subpoena physician, but physician's office refused to disclose his address or location); see also William V. Bellamy, 42 Van Natta 651 (1990) (Exhibits excluded where insurer would be required to invoke extra-territorial process to exercise its right to cross-examine out-of-state physicians). Because the insurer made no attempt to compel the witness' cooperation, substantial justice is not served by allowing it to benefit from the exclusionary rule.

The insurer argues that a subpoena would be of no value in compelling Black's testimony, because Black has already demonstrated that he is not willing to cooperate. This argument lacks persuasive force because, in the absence of a subpoena, it is speculative. Moreover, Black's compliance or noncompliance with a hypothetical subpoena is not material to our decision in this case. Rather, our holding is that, in the interest of substantial justice, Dr. Black's reports should only be excluded under the rule if Dr. Black's refusal to make himself available for cross-examination is demonstrated by his refusal to cooperate after service of a lawfully issued subpoena.

1. Practically speaking, the attorneys act as the Board's representatives in preparing and serving the subpoenas.

We note that although there is a statutory provision for compelling adherence to a subpoena through Circuit Court intervention, a witness' refusal to be cross-examined for purposes of seeking the exclusion of his or her testimony or reports under OAR 438-07-005(3) is sufficiently demonstrated by a refusal to respond to a subpoena issued by this forum, and we do not require proof of further lack of cooperation at the Circuit Court level to establish that refusal.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Because the record does not establish whether Dr. Black would continue to be unavailable for cross-examination if subpoenaed, the record is not sufficiently developed on the evidentiary issue. Moreover, we have not previously interpreted our rule to require a carrier to subpoena a witness prior to moving for exclusion of reports. Therefore, in the further interest of substantial justice, we remand to the Referee to afford the insurer an opportunity to fully exercise its right to cross-examine Dr. Black, or waive its right to do so. The Referee shall then determine which exhibits, including those submitted after the prior closure of the record, should be admitted in the interest of substantial justice. When the record has been fully developed, the Referee shall issue a final, appealable order on the merits.

ORDER

The Referee's order dated November 29, 1990 is vacated. This matter is remanded to Referee Mills for further proceedings consistent with this order.

November 27, 1991

Cite as 43 Van Natta 2609 (1991)

In the Matter of the Compensation of
ALICE A. TAUG, Claimant
WCB Case No. 90-16849
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of Referee Knapp's order that denied her request for additional temporary total disability benefits. On review, the issue is entitlement to temporary total disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On May 7, 1990, the Governor signed into law Senate Bill 1197, an extensive revision of the workers' compensation statutes. See Or Laws 1990 (Special Session), ch. 2. Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, we analyze this matter under

amended ORS 656.268, which provides, in part:¹

"(3) Temporary total disability benefits shall continue until whichever of the following events first occurs:

"(a) The worker returns to regular or modified employment;

"(b) The attending physician gives the worker a written release to return to regular employment; or

"(c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

In this case, claimant was released, and in fact returned, to regular work on October 9, 1989. Although her attending physician later changed the release to modified work, the insurer was authorized to terminate payment of temporary total disability under amended ORS 656.268(3)(a).

The question remains, however, whether the insurer was obligated to recommence payment of temporary total disability benefits on March 15, 1990, the date claimant left work. Claimant contends that she is entitled to a resumption of such benefits because she left work as a direct result of her compensable injury. We disagree.

An injured worker whose temporary total disability benefits have been properly terminated becomes entitled to resumption of temporary total disability if, prior to claim closure, the attending physician again authorizes time loss. OAR 436-60-030(4)(a). In this case, Dr. Wayson reported that, as of January 29, 1990, claimant "was not able to return to full duty because of exacerbation of her symptoms." (Ex. 41). However, claimant was, in fact, performing regular work at that time and continued to do so for more than one month thereafter. Moreover, in a note dated January 8, 1991, Dr. Wayson candidly acknowledged that at no time did he authorize claimant to quit her job. (Ex. 42). Accordingly, we conclude that claimant did not leave her job with the necessary medical authorization.

Claimant relies on Judith L. Keeler, 42 Van Natta 154 (1990). However, as recognized by the insurer, Keeler was decided under former ORS 656.268, which required payment of temporary total disability until the claim was closed, or claimant was both medically stationary and released to return to regular work. See Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). Moreover, the claimant in Keeler did not return to work after her injury but, rather, left work "as a direct result of the disabling effects of her compensable injury." 42 Van Natta at 154. In this case, claimant performed her regular job from October 8, 1989 to March 15, 1990, at which time she decided to quit. Her

¹In reaching this conclusion, we recognize that, when determining claimant's entitlement to temporary total disability payments, former ORS 656.268(3) was in effect, and the insurer was required to conform its conduct to that statute. However, we have previously concluded that there is nothing anomalous in a decision by the legislature to apply amended ORS 656.268(3) retroactively to all existing claims, thereby requiring the claimant's entitlement to temporary total disability benefits to be determined by the amended statute. See Rocky L. Coble, 43 Van Natta 1907 (1991).

reasons for quitting may have included the expectation that her symptoms would reduce; however, she also wanted to return to school and finish her communications degree.

In short, the insurer was authorized to terminate payment of temporary total disability benefits upon claimant's return to work. Because there was no material change in claimant's condition from the time she returned to work, and because there was no authorization from her treating physician to either miss work or quit her job, claimant's volitional act of leaving her employment does not entitle her to a resumption of temporary total disability benefits.

ORDER

The Referee's order dated February 6, 1991 is affirmed.

November 27, 1991

Cite as 43 Van Natta 2611 (1991)

In the Matter of the Compensation of

BENNIE J. TIBBETS, Claimant

WCB Case No. 89-25859

ORDER ON REVIEW

Flaxel, et al., Claimant Attorneys

Foss, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The insurer requests review of that portion of Referee McWilliams' order that set aside its partial denial of claimant's claim for a hiatal hernia. On review, the issues are compensability, and, if the hernia is not compensable, premature closure, extent of permanent disability and offset. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," but not her "Findings of Ultimate Fact," with the following supplementation.

As of June 27, 1989, no material improvement in claimant's compensable condition was reasonably expected.

The only ongoing treatment for claimant's neck, back, left shoulder and left arm problems is pain medication.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant bears the burden of proving that her work injury is a material cause of her current disability or need for treatment for a hiatal hernia. Harris v. Albertson's Inc., 65 Or App 254, 257 (1983). Due to the passage of time since claimant's compensable injury and the number of potential causal factors, causation is a complex medical issue which must be resolved by expert medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). Resolution of the causation dispute in this case requires expert analysis rather than expert observation. Allie v. SAIF, 79 Or App 284 (1986).

The Referee decided that claimant carried her burden of proving that the October 1987 work injury was a material cause of her current disability or need for treatment for a hiatal hernia. In reaching this conclusion, the Referee

relied on the opinion of Dr. Liebold, who first treated claimant in 1989 and apparently detected and diagnosed the hernia by October of that year. (See Exs. 34, 39-3). The Referee found Liebold's opinion regarding causation to be persuasive, even though it is based in part on claimant's reporting and claimant is not a reliable historian. The Referee reasoned that, because there is no dispute concerning the mechanism of the accepted muscle strain and claimant's initial symptoms were arguably consistent with the existence of a hernia soon after the injury, Liebold's history was accurate.

The insurer contends that the mechanism of the accepted injury is disputed and Liebold's opinion is not persuasive, because his history concerning the 1987 lifting incident differs from claimant's testimony regarding her injury. We agree.

Claimant stated that she did not tell Liebold that she and another woman lifted a very heavy container of fish 1-2 feet off the ground and moved it 20 feet. (Tr. 49-51). However, Liebold relied on that history in forming his opinion regarding causation. (See Exs. 51, 61, 62). Inasmuch as claimant denies the history upon which Liebold relied, we do not conclude that Liebold's opinion is based on an accurate history. Therefore, we do not find Liebold's opinion to be persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Moreover, we note that Liebold also stated that "it is not a hard matter to produce an [sic] hiatal hernia" and that claimant's weight and lack of muscle tone could easily result in a hiatal hernia. (Ex. 61).

Assuming, without deciding, that claimant's symptoms following the work injury were consistent with the hernia diagnosis which followed over a year later, we are not persuaded that the injury caused the hernia. First, as we explained above, Liebold's opinion regarding causation is not persuasive. Second, the remaining medical evidence supports the opposite conclusion. (See Exs. 39-2 & 45-1). Third, we note that, two months after the injury, claimant was asymptomatic and wanted to return to work. (Ex. 8). The latter evidence suggests that claimant did not have a hernia resulting from her 1987 injury. For these reasons, we conclude that claimant has not carried her burden of proving that her compensable injury was a material cause of her hiatal hernia.

Because the Referee found claimant's claim for a hiatal hernia to be compensable and remanded the claim for further processing, she did not address the premature closure, extent and offset issues. These issues were not briefed on review. However, inasmuch as they were properly raised at hearing and the record is sufficiently developed, we proceed to address them.

Premature closure

At hearing, claimant argued that she was not medically stationary, following her October 25, 1987 work injury, until June 1, 1990, the date of Dr. Liebold's last examination. We disagree.

An injured worker is 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). It is claimant's burden to establish that she was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

Here, claim closure on June 27, 1989 was apparently based on the findings reported and opinions expressed in the Orthopaedic Consultants' April 27, 1989 report. (See Ex. 33). The Consultants noted that claimant complained of pain in the left side of the neck, shoulder, rib cage, arm and the axillary line in the mid-thoracic region and that her headaches, which preexisted the 1987

injury, had worsened. The Consultants found no evidence of focal neurological deficit; opined that claimant was medically stationary and that any further treatment would be palliative only; and recommended that claimant return to a different job. (Id. at 4).

In evaluating the expectation of improvement at claim closure, we also consider post-closure medical reports, because claimant's condition did not change after closure and the only question is whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

In this case, the medical evidence indicates that claimant continued to seek treatment for a variety of complaints after claim closure. However, pain medication was the only treatment provided. Under the circumstances, we conclude that, as of June 27, 1989, the record does not show that material improvement could reasonably have been expected from medical treatment or the passage of time. Consequently, the claim was not prematurely closed and we proceed to address claimant's entitlement to permanent disability benefits.

Extent of permanent disability

Pursuant to the applicable rules, the evaluation of claimant's disability is based on the standards in effect at the time claimant's claim was closed by the June 27, 1989 Determination Order. Consequently, former OAR 436-35-001, et seq., apply to the rating of claimant's permanent disability. Former OAR 436-35-010 through 436-35-260 apply to a rating of scheduled permanent disability and former OAR 436-35-270 through 436-35-440 apply to a rating of unscheduled permanent disability.

Regarding scheduled disability, former ORS 656.214(2) provides in relevant part: "When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury." Regarding unscheduled disability, former ORS 656.214(5) provides in relevant part: "In all cases of injury resulting in permanent partial disability * * * the criteria for rating disability shall be the permanent loss of earning capacity due to the compensable injury." Only those losses which are due to the compensable injury are ratable.

In the present case, claimant's injury resulted in diagnosis of acute left intercostal muscle strain, acute left thoracic muscle strain and acute left upper abdominal muscle strain. (Ex. 1). Dr. Liebold, claimant's current treating physician, recently opined that the 1987 injury caused "cervical, [left] shoulder-scapular muscle strain-sprain, tendonitis, [left] dorsal myositis, an intercostal neuritis, tendonitis of [left] upper arm, postraumatic fibromyositis of these areas' structures, possible Rotator Cuff tear and secondary lower back dysfunction with Sacroiliitis and trochanter bursitis." (Ex. 62-1-2). In his physical capacities evaluation, Liebold stated that claimant has permanently restricted use of her neck, left shoulder and left arm and that "[she] will not be able to use her [left] arm reaching above the shoulder level and moving repetitively her head-neck and the [left] shoulder-arm and back." (Ex. 62-2). Liebold is the only medical expert who expressly related claimant's current upper body complaints to her 1987 sprain/strain injury.

On the other hand, the Orthopaedic Consultants concluded that claimant has no injury-related permanent impairment. (Ex. 33). Dr. Kho, neurologist, examined claimant on May 10, 1990, and noted her complaints of headaches, neck pain and "total back pain." (Ex. 58-1). Kho reported that claimant voluntarily restricted herself during range of motion testing. Based on her response to

palpation, Kho opined that claimant's neck, dorsal back and lower back pain is "non physiologic." (Ex. 58-4). He concluded that claimant suffers from:

"Severe psychogenic pain syndrome with: Depression. Chronic cervical, dorsal and lumbar myofascial pain syndrome with: Somatization disorder/conversion disorder. Suspect dependent/histrionic personality disorder. Muscle tension headaches. Chronic disuse syndrome of the back. Exogenous obesity moderate to severe. Interference and conversion signs noted during exam. Chemical dependency." (Ex. 58-4-5).

In this regard, we note that claimant does not have a ratable psychological condition, because no such condition has been diagnosed by a psychologist or psychiatrist, as required by former OAR 436-35-400(1). Moreover, no medical expert relates any psychological condition which claimant may have to her work injury.

Although we tend to give great weight to the opinions of a treating physician, see Weiland v. SAIF, 64 Or App 810, 814 (1983), we decline to do so here. We have previously found Dr. Liebold's opinion concerning the causation of claimant's hernia to be unpersuasive. We find his opinion regarding the relationship between claimant's other physical complaints and her 1987 injury to be similarly unpersuasive, for the following reasons.

First, inasmuch as claimant denied reporting the history of her injury which Liebold relied upon, we continue to find his opinion concerning causation to be generally unpersuasive. Second, numerous examining physicians recorded claimant's subjective neck, back, shoulder and arm complaints, noting the lack of objective findings explaining those complaints. Although claimant does have slightly bulging cervical discs, Liebold is the only physician who relates the bulges to claimant's injury. No physician relates claimant's complaints to her disc abnormalities. Examining doctors also reported that claimant exaggerates, voluntarily restricts her range of motion in these areas and that her ability to move increased when she was distracted. (Exs. 26-7, 27-2, 33-3, 58-4). Dr. Liebold did not explain why he believes that claimant's current complaints are related to the 1987 muscle strain, despite the absence of physical findings supporting his theory and the presence of reasoned medical opinions to the contrary. Neither do we find his range of motion measurements more reliable than those of examining physicians who noted claimant's exaggerations. Finally, although Liebold explained how claimant's injury could have caused her continuing complaints, he did not explain why he believes that did happen. See Gormley v. SAIF, 52 Or App 1055 (1981). In view of Liebold's apparently inaccurate history and his lack of reasoning, we find his opinion to be unpersuasive. And, in the absence of persuasive medical evidence associating claimant's chronic neck, back, left shoulder and left arm complaints with her 1987 injury, we conclude that claimant has not carried her burden of proving that she suffers ratable injury-related permanent residuals. Consequently, she is not entitled to permanent disability benefits and the Determination Order is upheld.

Offset

The insurer requests authorization to recover temporary total disability benefits paid for periods subsequent to claim closure on June 27, 1989. Inasmuch as the insurer has established an overpayment, (see Exs. 35-37), it is entitled to offset that overpayment against any future permanent disability award to which claimant may be entitled. See Robert E. Kubala, 43 Van Natta 1495 (1991).

ORDER

The Referee's order dated February 4, 1991 is reversed. The insurer's partial denial of the hiatal hernia claim is reinstated and upheld. The Referee's assessed attorney fee award is reversed. The June 27, 1989 Determination Order is affirmed. The insurer is allowed an offset for temporary disability paid for any period after June 27, 1989, against any future permanent disability award.

November 27, 1991

Cite as 43 Van Natta 2615 (1991)

In the Matter of the Compensation of
ANDREW L. WATKINS, Claimant
WCB Case No. 90-20276
ORDER ON REVIEW
Jackson & Vause, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Daron's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction and supplementation. We do not adopt the next to the last sentence of the sixth paragraph.

Dr. Grossman made a clinical finding of back pain and limitations on straight leg lifting.

The July 13, 1989 Determination Order award of 23 percent permanent partial disability for claimant's low back condition was the last arrangement of compensation for claimant's unscheduled condition. This unscheduled award was approved by an earlier referee's November 21, 1989 order.

The November 21, 1989 Stipulated order award of 10 percent loss of use or function of the left leg was the last arrangement of compensation for claimant's scheduled condition.

FINDINGS OF ULTIMATE FACT

Claimant experienced symptomatic worsening of his low back and left leg conditions, supported by objective medical findings, since his last arrangements of compensation (the July 13, 1989 Determination Order and the November 21, 1989 Opinion and Order).

Claimant's symptomatic worsening of his low back condition did not result in a diminished earning capacity below the level fixed at the time of the last arrangement of compensation.

Claimant's symptomatic worsening of his left leg condition did not result in increased loss of use or function of that member.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's condition had not worsened since his last arrangement of compensation. Therefore, the Referee concluded that claimant had

not established a compensable aggravation claim. Although we find that claimant has established a symptomatic worsening, we agree with the Referee's ultimate conclusion that claimant has not established a compensable aggravation claim.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Claimant is claiming an aggravation of both his unscheduled condition (low back) and his scheduled condition (left leg). We address these conditions separately.

Aggravation - Unscheduled Condition

To establish an aggravation claim for an unscheduled condition, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, he has suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991). See Larry L. Bowen, 43 Van Natta 1164 (1991).

Claimant argues that he experienced a symptomatic worsening of his low back condition supported by objective medical findings since his last arrangement of compensation. We agree.

On June 19, 1990, Dr. Grossman, claimant's then treating physician, opined that claimant's condition had worsened over the past four months. Dr. Grossman noted the following objective findings supporting a worsening of claimant's low back condition: (1) tenderness in the lumbar and lower dorsal spine; and (2) limitation of straight leg raising due to pain at zero degrees on the left and 20 to 25 degrees on the right. (Ex. 36). The record indicates that the first finding was present at the July 13, 1989 Determination Order; therefore, this finding does not represent a worsening of claimant's condition. (Ex. 23).

However, the last finding does represent a symptomatic worsening. Prior to the November 1989 order, pain limited claimant's straight leg raising to 30 degrees on the left and 40 degrees on the right. (Ex. 23). Thus, the June 1990 findings represent a symptomatic worsening supported by objective findings.

Notwithstanding our finding of a symptomatic worsening, we find that there is no persuasive evidence that claimant's symptomatic increase resulted in diminished earning capacity. Prior to the November 1989 order, claimant was unable to return to his regular job as a truck driver due to the work injury. As of April 4, 1988, claimant was released for light duty "with a limitation on the use of his back musculature." (Ex. 15). No physician has limited claimant's ability to work beyond the light duty limitation given in April 1988.

Claimant has not worked since his at-injury job. (Tr. 22). He testified that he is unable to work because his back pain limits his ability to sit. (Tr. 10). However, we do not find this testimony persuasive. Claimant's vocational assistance program was terminated because he declined or was unavailable for such assistance. (Ex. 28). Furthermore, the pain center noted that claimant stated that it would be difficult for him to attend the full program because of his involvement in his volunteer work. (Ex. 19-3). These items indicate that claimant's unemployment may be due to factors other than back pain. On this record, we do not find claimant's testimony that he cannot work because of back pain sufficient to carry his burden of proving that he has suffered diminished earning capacity.

In his June 19, 1990 report, Dr. Grossman noted that, up to six months ago, claimant was working almost 40 hours per week at a "desk job" and in the past three to four months he usually worked only one to three hours a day. (Ex. 36). Dr. Grossman seems to have an inaccurate history, given the fact that claimant has not worked since his at-injury job. However, even assuming that these hours of work refer to the volunteer work claimant testified that he was involved in, Dr. Grossman's report does not establish that claimant was not capable of doing light duty work. On this record, claimant has not established that his symptomatic worsening resulted in diminished earning capacity below the level fixed at the November 1989 order. Thus, claimant has not established a compensable aggravation of his low back condition.

Aggravation - Scheduled Condition

In order to establish a compensable aggravation of a scheduled condition, claimant must prove, by medical evidence supported by objective findings, a worsened condition resulting from the compensable condition. ORS 656.273(1) and (3); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of a scheduled body part, claimant must show that he is more disabled, i.e., has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988).

Dr. Grossman noted that claimant "has had more pain and episodes of falling down which he refers to as 'blackout spells.'" (Ex. 36). Claimant testified that his left leg gave out four times over the previous three to six months and that it had not done so before that period of time. (Tr. 15, 20). However, the November 1989 order noted that claimant's left leg "will occasionally give out." Furthermore, one of the bases for his previous scheduled award was this problem of his leg giving out. (Ex. 29-2, 29-6). Therefore, we do not find that his continuing problem with his left leg giving out establishes a worsening of his condition.

Dr. Grossman's June 19, 1990 report noted the following objective findings supporting a worsening of claimant's left leg condition: (1) atrophy of one-half inch in the left calf; and (2) "hypoesthesia [sic] of the entire left leg circumferentially." (Ex. 36). The record indicates that the first finding was present at the November 1989 order; therefore, that finding does not represent a worsening of claimant's condition. (Ex. 23, 29).

However, the last finding does represent a symptomatic worsening. Prior to the November 1989 order, sensation in claimant's left leg was decreased laterally to light touch. (Ex. 23). Thus, the June 1990 findings represent a symptomatic worsening supported by objective findings.

Nevertheless, the record does not establish that this loss in sensation resulted in an increased loss of use or function of claimant's left leg. There is

no evidence on this issue in the record. Accordingly, we conclude that claimant has not established an aggravation of his left leg condition.

ORDER

The Referee's order dated February 15, 1991 is affirmed.

November 27, 1991

Cite as 43 Van Natta 2618 (1991)

In the Matter of the Compensation of
MARY E. WEAVER, Claimant
WCB Case No. 91-00702
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Peterson's order that directed it to pay claimant's award of scheduled permanent disability at the rate of \$305 per degree. In her brief, claimant contends that she is entitled to penalties and attorney fees for an allegedly unreasonable failure to pay compensation at the correct rate. On review, the issues are rate of scheduled permanent disability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Rate of Scheduled Permanent Disability

We adopt the conclusions and reasoning concerning the rate of scheduled permanent disability issue with the following supplementation.

The Referee concluded that claimant's December 19, 1990 award of scheduled permanent disability should be paid at the rate of \$305 per degree. We agree.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the 1990 Oregon Laws, Chapter 2, section 7 amendment to ORS 656.214(2), which increased the value per degree of scheduled permanent disability from \$145 to \$305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Accordingly, because claimant's awards of scheduled permanent disability were made after May 7, 1990, the Referee correctly concluded that the awards should be paid at the rate of \$305 per degree.

Penalties and Attorney Fees

Claimant seeks penalties and attorney fees for an allegedly unreasonable failure to pay scheduled permanent disability at the correct rate. No hearing was held. Rather, the case was submitted to the Referee on stipulated facts. The Referee did not address the penalty and attorney fee issue. Although claimant's hearing request lists penalties and attorney fees as an issue, the issue was not raised by claimant's counsel in her trial memorandum. However, claimant has reasserted the request for penalty and attorney fees on Board

review, and SAIF, in its appellant's brief, does not rely on waiver of the request as its defense. Therefore, we address the issue.

The administrative rule SAIF relies on is contrary to the Board's holding in Herron, supra. As a general rule, we do not, in such circumstances, assess a penalty; for to do so would penalize the insurer for complying with a valid administrative rule. See e.g. John Keller, 38 Van Natta 1351, 1352 (1986). Although in Herron, the Board expressly gave no effect to the Director's rule, the Board did not declare the rule invalid. Therefore, we decline to assess a penalty in this case.

Attorney Fees on Board Review

Because we have not disallowed or reduced claimant's compensation, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the rate of scheduled permanent disability issue is \$700, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated April 16, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$700, to be paid by the SAIF Corporation.

November 29, 1991

Cite as 43 Van Natta 2619 (1991)

In the Matter of the Compensation of

CRAIG H. AYER, Claimant

WCB Case No. 90-21934

ORDER ON REVIEW

Karen M. Werner, Claimant Attorney

Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The SAIF Corporation requests review of Referee Quillinan's order setting aside its denial of claimant's low back injury claim. On review, the issue is compensability.

We affirm and adopt the order of the Referee with the following supplementation.

As the Referee correctly stated, in order for a claimant to prove that his injury claim is compensable, he must show that the claim "is established by medical evidence supported by objective findings." ORS 656.005(7)(a). As we stated in Suzanne Robertson, 43 Van Natta 1505 (1981), a claimant may satisfy this statutory requirement if he offers evidence that a physician has examined him and determined that he suffers from a disability or a physical condition that requires medical services. That determination need not be based solely on pure objective factors, such as an x-ray that verifies the existence of a fracture. Instead, we have construed the "objective findings" requirement to be satisfied if the physician's evaluation of the physical condition is based only on the worker's description of the pain he is experiencing. Id. The report,

however, cannot merely recite the claimant's complaints of pain, but rather must indicate that the claimant does, in fact, experience symptoms. Id.

Here, claimant relies on a medical report submitted by Dr. Kerr, claimant's sole treating physician, as proof of "medical evidence supported by objective findings." In that report, Dr. Kerr diagnoses claimant as suffering from low back pain syndrome. He indicated that claimant "exhibited some right sciatic nerve pain to the right mid-thigh." As the Referee indicated, Dr. Kerr recommended rest and prescribed medication, heat and massage. He also put claimant on light duty work.

We find this sufficient to constitute "objective findings" and to establish compensability of the claim. We are not persuaded by SAIF's argument that the claim is not compensable because this record does not contain any of the specific examples of "objective findings" listed in ORS 656.005(19). As indicated by the language of the provision, that list is not exclusive. Likewise, we do not consider Dr. Kerr's handwritten note indicating that there were no "objective findings" to be determinative. "Objective findings" is a legal term, not a medical term, and Dr. Kerr's original chart notes and subsequent letter to SAIF (Ex. 1 and 3) indicate that there were objective findings.

Because SAIF initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$650, to be paid by SAIF. In reaching this conclusion, we have particularly considered the complexity of the case, the time devoted to the issue (as represented by claimant's respondent's brief) and the value of the interest involved.

ORDER

The Referee's order dated March 1, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable attorney fee of \$650, to be paid by the SAIF Corporation.

November 29, 1991

Cite as 43 Van Natta 2620 (1991)

In the Matter of the Compensation of
KATHLEEN A. HOFF, Claimant
WCB Case No. 90-18230
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of those portions of Referee Knapp's order that: (1) increased her scheduled permanent partial disability award for a left leg injury from 8 percent (12 degrees), as awarded by a Determination Order, to 13 percent (19.5 degrees); and (2) affirmed the Determination Order award of no unscheduled permanent disability. The self-insured employer cross-requests review of that portion of the order that directed it to pay claimant's scheduled permanent disability award at the rate of \$305 per degree. On review, the issues are extent of permanent disability, scheduled and unscheduled, and the rate of scheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

Because claimant's condition became medically stationary on April 4, 1990, and her claim was closed by Determination Order on May 22, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Scheduled Disability

The Evaluation Section concluded, and the Referee agreed, that claimant is entitled to an award of 8 percent scheduled permanent disability for an 80 percent removal of the meniscus by surgery. Former OAR 436-35-230(4)(d). The Referee also concluded that claimant was entitled to an additional 5 percent scheduled permanent disability for atrophy of her left thigh. Former OAR 436-35-230(5)(b). Inasmuch as those values are not disputed, we agree with those conclusions and adopt them as our own.

In addition to those values, claimant contends that she is entitled to an award for a chronic condition limiting the repetitive use of her left leg. She relies solely on her testimony that she has knee pain while climbing, kneeling and bending.

Former OAR 436-35-010(7) allows for an award of 5 percent for chronic conditions that limit the repetitive use of a scheduled body part. However, claimant's testimony, while probative, does not by itself establish the existence of a chronic condition. See Ruben Carlos, 43 Van Natta 605 (1991). There must be medical evidence to support such a finding. In this case, Dr. Tacaks, claimant's treating physician, reported that claimant "has no limitations in bending, crawling, lifting, pushing or use of her lower extremities." (Ex. 22). Claimant's previous treating physician, Dr. Irvine, stated that claimant's knee pain was made worse by activities, but his report did not conclude that she has limitations on repetitive use of her left knee. (Ex. 17). Accordingly, based on this record, and in particular, Dr. Tacks' position contradicting claimant's, we agree with the Referee that, while claimant has some knee pain with certain activities, there is insufficient evidence to support an award based on a chronic limitation in repetitive use of her knee. Consequently, we decline to award claimant an impairment value for a chronic condition limiting repetitive use.

Unscheduled Disability

Claimant does not dispute that, because she had returned to regular work, factors of age, education and adaptability are not considered in determining the extent of unscheduled permanent disability. Former OAR 436-35-290(2); 436-35-

300(2); and 436-35-310(2). Rather, she contends that she is entitled to an impairment rating for a chronic condition limiting the repetitive use of her low back. Specifically, she contends that she is entitled to an award of 5 percent for her coccydynia, which causes tailbone pain and prevents her from sitting for prolonged periods of time.

Former OAR 436-35-320(4) allows for an award of 5 percent for chronic conditions that limit the repetitive use of an unscheduled body part, which we have defined as one of the areas of the body that is dealt with as a separate unit or system by the standards. See Larry L. McDougal, 42 Van Natta 1544 (1990). The only portions of the spine that are treated as a separate system by the standards are the thoracolumbar spine and the cervical spine. Former OAR 436-35-360; James H. Wiley, 43 Van Natta 153 (1991). Accordingly, claimant cannot receive a chronic condition award for the injury to her coccyx under the "standards."

Nonetheless, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987).

After our review of the record, we find clear and convincing evidence that claimant is entitled to an award of 5 percent unscheduled permanent disability. It is undisputed that, as a result of her compensable injury, claimant has difficulties with sitting over prolonged periods of time and experiences pain while rising from the sitting position. We find this to be clear and convincing evidence that claimant has sustained a loss of earning capacity in excess of that indicated by the "standards."

Rate of Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of \$305 per degree. We agree.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the 1990 amendment to ORS 656.214(2), which increased the value per degree of scheduled permanent disability from \$145 to \$305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury. See Or Laws 1990 (Special Session), ch. 2, 7 and 54. Because claimant's award of scheduled permanent disability was made after May 7, 1990, the Referee correctly concluded that the award should be paid at the rate of \$305 per degree.

Attorney Fee on Board Review

The employer initiated the request for review concerning the rate of permanent partial disability and we have not disallowed or reduced compensation awarded to claimant. Under those circumstances, claimant's attorney normally would be entitled to an assessed fee under ORS 656.382(2). Claimant's attorney, however, failed to file a brief in response to the employer's cross-request for review. Accordingly, no fee may be awarded. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated February 19, 1991 is affirmed in part and modified in part. Claimant is awarded 5 percent (16 degrees) unscheduled permanent

partial disability for her coccydynia. Claimant's attorney is awarded a reasonable approved fee of 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total amount of attorney fees awarded by the Referee and Board orders shall not exceed \$3,800. The remainder of the order is affirmed.

November 29, 1991

Cite as 43 Van Natta 2623 (1991)

In the Matter of the Compensation of
SARA L. WILSON, Claimant
WCB Case No. 90-17548
ORDER ON REVIEW
Leo & Horton, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The self-insured employer requests review of Referee Lipton's order that set aside its partial denial of claimant's low back condition. Claimant moves for dismissal of the employer's request for review on the basis that such review is mooted by the employer's rescission of its partial denial following issuance of the Referee's order. On review, the issues are dismissal and compensability.

We deny the motion to dismiss and, on the merits, affirm and adopt the Referee's order with the following supplementation.

FINDINGS OF FACT

The compensable injury was the major contributing cause of claimant's disability and need for low back treatment.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

Because the employer timely requested Board review, the Referee's order has not become final. See ORS 656.289(3). After conducting our review, we are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(6). Consequently, the compensability issue raised and addressed in the Referee's order remains viable.

The fact that subsequent actions have either been lawfully or erroneously taken in response to an appealed Referee's order does not resolve the question of whether the conclusions reached in that order were appropriate in the first instance. Vernon L. Cope, 43 Van Natta 641 (1991); Loren Callihan, 41 Van Natta 1449 (1989). Rather, that question remains subject to our jurisdiction. See ORS 656.289(3), 656.295(6). Accordingly, the motion to dismiss is denied.

Compensability

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van

Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The Referee concluded that claimant's low back condition, diagnosed as a lumbar syndrome, is compensable. The Referee evidently applied ORS 656.005(7)(a)(B): "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." Based on Dr. Hoppert's thorough and well-reasoned opinion (Ex. 49), the Referee found, and we agree, that the compensable back strain combined with a preexisting degenerative condition to cause disability and the need for treatment, and that the compensable injury was the major contributing cause of that disability and need for treatment.

The employer argues that the preexisting degenerative condition could not have worsened because an exact diagnosis of the condition was never made. That argument is without merit. An exact diagnosis of the preexisting condition is not required. It is sufficient that Dr. Hoppert diagnosed a degenerative condition that was rendered symptomatic by the compensable injury.

The employer also argues that there are insufficient objective findings of claimant's condition. We disagree. "Objective findings" in support of medical evidence include "diagnostic evidence substantiated by clinical findings." ORS 656.005(19). Here, Dr. Hoppert diagnosed a lumbar syndrome, which he described as a painful condition resulting from the combination of the compensable injury and degenerative changes. Because Dr. Hoppert has determined, based on his examinations, that claimant does, in fact, suffer from a lumbar syndrome, his reports constitute medical evidence supported by objective findings. See, e.g., Suzanne Robertson, 43 Van Natta 1505 (1991). Accordingly, the lumbar syndrome is compensable.

Because the employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is \$750, to be paid by the employer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case as represented by claimant's statement of services, and the value of the interest involved.

ORDER

The Referee's order dated January 29, 1991, is affirmed. For services on review, claimant's counsel is awarded an assessed fee of \$750, payable by the self-insured employer.

In the Matter of the Compensation of
MADELINE L. HENDRICKSON, Claimant
WCB Case No. 90-06454
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Neidig and Crider.

Claimant requests review of Referee Daron's order that upheld the insurer's denial of claimant's current chiropractic treatment. In her brief, claimant also seeks a penalty and related attorney fee for the insurer's allegedly unreasonable denial of such treatment. On review, the issues are medical services and penalties and attorney fees. We reverse on the medical services issue.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of the final sentence, and subject to the following supplementation.

Claimant's request for hearing was filed with the Board on March 23, 1990. Hearing in this matter was initially convened on June 25, 1990, and continued to July 9, 1990.

Claimant's compensable 1985 injury included her low back. Claimant subsequently received awards of permanent disability for her 1985 injury totalling 30 percent unscheduled permanent disability.

Referee Garaventa's February 6, 1990 order was affirmed and adopted by the Board on December 12, 1990. The Board's order has become final by operation of law.

FINDING OF ULTIMATE FACT

Claimant's current need for medical treatment is materially related to her compensable 1985 injury.

CONCLUSIONS OF LAW AND OPINION

Because claimant's request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, we apply the law in existence prior to its recent amendment. See Oregon Laws 1990 (Special Session), Chapter 2, Section 54(2).

Claimant bears the burden of proving by a preponderance of the evidence that her 1985 compensable injury materially contributes to her current need for medical treatment. Milburn v. Weyerhaeuser Co, 88 Or App 375, 378 (1987). The compensable injury need not be the sole cause or 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).

The Referee found that the denied chiropractic treatment was directed to claimant's low back, and that the low back condition had previously been found by Referee Garaventa not to be compensably related to the accepted injury. Claimant argues that her low back is a compensable component of her 1985 injury, and that Referee Garaventa concluded that her back condition had worsened but that the worsening was not related to claimant's compensable injury. Claimant contends that Referee Garaventa did not find that claimant's condition was no longer related to the compensable injury. We agree. Moreover, we conclude that

claimant's current condition requiring treatment remains materially related to the compensable 1985 injury.

Claimant's low back complaints have been an accepted aspect of her claim from the outset. (Ex. 2). The insurer does not dispute this fact. (Respondent's Br. p. 2). In addition, review of Referee Garaventa's February 6, 1990 order supports claimant's argument that the Referee found only that claimant had failed to establish that the worsening of her low back condition is materially related to the compensable injury. In this regard, Referee Garaventa expressly found that claimant's low back condition had worsened in the form of development of anterolithesis of L4-5. However, the Referee further concluded that claimant had failed to establish that this degenerative condition was causally related to the compensable injury. Therefore, Referee Garaventa did not conclude that claimant's low back condition itself was not materially related to the injury.

The question on which the parties properly focus is whether claimant's current need for chiropractic treatment is materially related to the compensable injury. The insurer argues that claimant has failed to establish that the treatment is materially related to the injury. Instead, the insurer argues, Dr. Gill's treatment is directed to the degenerative condition found not compensable by Referee Garaventa.

It is clear from Dr. Gill's reports that his treatments are, in part, related to claimant's noncompensable degenerative condition. However, Dr. Gill has also reported that his treatments are not directed solely to the L4-5 degenerative condition. (Ex. 43). Rather, he attributes the need for treatment to claimant's low back pain and instability, mid-back pain and stiffness, and ache across the shoulders and down the arms. Moreover, the existence of a causal relationship between claimant's current need for treatment and her compensable injury is further supported by the 30 percent unscheduled permanent disability award claimant has received on her claim.

The Western Medical Consultants opined in August 1989 that additional treatment would be considered palliative and directed toward claimant's degenerative condition. (Ex. 32). However, we do not find their opinion on this issue persuasive. First, their diagnoses included cervical and thoracolumbar strains, related to the compensable injury. In addition, while the Consultants opined that "the majority" of claimant's then-current complaints were related to the degenerative condition rather than the compensable injury, it is not necessary for claimant to establish that the compensable injury is the major cause of the need for treatment. Claimant need only establish that the injury remains a material contributing cause of the need for treatment. Van Blokland v. Oregon Health Sciences University, supra. We conclude that claimant has sustained her burden.

Penalties and Attorney Fees

In her brief, claimant alleges entitlement to penalties and related attorney fees for the insurer's allegedly unreasonable denial. We question whether this issue has been timely raised by claimant. See Mavis v. SAIF, 45 Or App 1059 (1980). At hearing, the Referee noted his understanding that the only issue before him was entitlement to medical services. (Tr. 2). Claimant's counsel agreed with that statement. Id. Therefore, it does not appear that penalties and attorney fees were litigated at hearing.

However, even if we were to conclude that the issue was timely raised, we would nevertheless find that the insurer's denial was not unreasonable. At the time of its denial, the insurer had the report of the Western Medical Consultants wherein they opined that claimant's need for treatment was solely related

to her noncompensable degenerative condition. Although we have concluded that the opinion is unpersuasive, we find it was sufficient to cause the insurer to have a legitimate doubt as to its liability. See Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

Claimant is entitled to a reasonable assessed attorney fee for her counsel's services regarding the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the denial is \$2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's briefs on review), the complexity of the issue, and the value of the interest involved to claimant.

ORDER

The Referee's order dated July 30, 1990 is reversed. The insurer's denial dated March 9, 1990 is set aside and the claim is remanded to the insurer for payment of the disputed medical bills. For services at hearing and on review concerning the denial, claimant's counsel is awarded a reasonable assessed attorney fee of \$2,000, to be paid by the insurer.

December 4, 1991

Cite as 43 Van Natta 2627 (1991)

In the Matter of the Compensation of
MANUEL ARGUELLO, Claimant
Own Motion No. 91-0588M
OWN MOTION ORDER

The insurer has submitted a claim for an alleged worsening of claimant's March 4, 1983 industrial injury. Claimant's aggravation rights have expired. Claimant was evaluated for a worsened low back condition in December 1990, which led to a request for refusion of his pseudoarthrosis at L3-4 in conjunction with neural element decompression. The insurer has denied claimant's request for surgery. In addition, the insurer opposes reopening claimant's claim for payment of temporary disability compensation, contending that claimant has removed himself from the work force.

We may exercise our own motion authority and reopen claimant's claim for additional temporary disability compensation if he has sustained a worsening of his compensable injury requiring either inpatient or outpatient surgery, or other treatment requiring hospitalization. ORS 656.278(1)(a). Here, the request for surgery has been denied as being neither reasonable nor necessary.

Further, in order to qualify for the payment of temporary disability compensation, claimant must have been in the work force at the time of the worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). The insurer contends that claimant had withdrawn from the work force. Claimant has not responded to the insurer's contention. However, claimant replied to the insurer's April 27, 1991 query about his current work status in a May 2, 1991 note, in which he stated that his last employer was Armour/Greyhound and his last date of work was March 4, 1983. In addition, a September 11, 1991 independent medical examiner's report provided by MedReview indicates that claimant was not currently working, although they report that claimant had returned to work as a maintenance worker at the employer in June 1987. Based on this record, we conclude that claimant was not in the work force at the time of the alleged worsening. Accordingly, we deny claimant's request for temporary disability compensation. See id.

Entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

December 4, 1991

Cite as 43 Van Natta 2628 (1991)

In the Matter of the Compensation of
ANNETTE M. COCHRAN, Claimant
WCB Case No. 90-10546
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Moller.

The insurer requests review of Referee Black's order which set aside its denial of claimant's aggravation claim for a left shoulder condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

In November 1987, claimant sustained a compensable injury to her left shoulder. The injury was eventually diagnosed as a brachial stretch injury and adhesive capsulitis in the shoulder joint. Following the injury, claimant periodically experienced shoulder pain and nerve damage symptoms including numbness in the fingers of the left hand. Claimant also experienced an eruption of herpes zoster at the injury site.

In December 1987, claimant was released to modified work. Although she remained symptomatic, she was able to perform the modified work through March 1990 with the exception of a two-day period in September 1989. That two-day period was attributable to an increase in claimant's left shoulder symptoms.

Claimant's claim was closed by an August 30, 1989 Determination Order which awarded her 7 percent unscheduled permanent disability. This award was increased to 9.5 percent by a March 22, 1990 Stipulation.

On March 26, 1990, claimant was involved in a motor vehicle accident while in Mexico. At the time of the collision, claimant braced herself against the dashboard of the car with both arms. She sustained contusions of the left leg, both knees and right side of the head. Following the accident, claimant experienced left shoulder, arm and hand numbness. Additionally, she suffered from a new outbreak of herpes zoster at approximately the same site as before.

As a result of her swollen knees and a general disruption in travel plans, claimant remained in Mexico until April 12, 1990. On April 16, 1990, claimant was examined by Dr. Rockey for continuing left shoulder pain and left hand numbness. Dr. Rockey released claimant from work until May 2, 1990. Electric studies were performed in July 1990 which indicated an ongoing nerve injury in the left shoulder.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Ch. 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in Section 54(2) does not apply. In addition,

the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Both Dr. Rockey and Dr. Nagel opined that claimant's left shoulder condition symptomatically worsened following the motor vehicle accident. Their opinions are supported by objective findings of nerve involvement and herpes zoster. Further, Dr. Rockey released claimant from work for approximately two weeks as a result of her left shoulder symptoms. There is no contrary medical evidence. Accordingly, we find that claimant sustained a symptomatic worsening of her left shoulder condition that is supported by objective findings and resulted in diminished earning capacity. The insurer does not argue otherwise. Consequently, claimant has established a worsened condition.

However, inasmuch as the motor vehicle accident, which did not occur in the course and scope of her employment, contributed to her worsened condition, she must also prove legal causation. The Referee found that the motor vehicle accident was not the major cause of claimant's symptomatic worsening and, therefore, concluded that claimant sustained a compensable aggravation. We disagree.

Generally, a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if there is an off-work injury which is the major contributing cause of the worsened condition, the worsening is not compensable. ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991).

Here, Dr. Rockey opined that the motor vehicle accident caused increased symptoms in her left shoulder where she had experienced previous job related complaints. He noted that the increased symptoms appeared to be related to the motor vehicle collision. Dr. Nagel, who treated claimant prior to the motor vehicle accident, testified that the motor vehicle accident caused claimant's increased symptoms. He believed that the accident aggravated claimant's prior left shoulder injury and, without the accident, claimant would not have had a new aggravation of old injuries.

Both Dr. Rockey and Dr. Nagel acknowledged claimant's compensable left shoulder injury. However, both physicians related her symptomatic increase to the motor vehicle accident. There is no evidence to the contrary. Under these circumstances, we conclude that the motor vehicle accident was the major contributing cause of claimant's worsened condition. Accordingly, claimant's worsened left shoulder condition is not compensable.

In reaching this conclusion, we wish to make clear that, in finding claimant's worsened left shoulder condition not compensable, we are only addressing the symptomatic worsening following the motor vehicle accident. Should the symptomatic worsening resolve, her underlying left shoulder condition would

remain compensable provided that the industrial injury was a material contributing cause of the condition. We also note that claimant may be entitled to continuing medical services provided that such services are related to the compensable condition rather than the noncompensable worsened condition. Elizabeth A. Bonar-Hanson, supra.

ORDER

The Referee's order dated January 30, 1991 is reversed. The insurer's denial is reinstated and upheld. The Referee's award of a \$2,250 assessed attorney fee is reversed.

December 4, 1991

Cite as 43 Van Natta 2630 (1991)

In the Matter of the Compensation of
JAMES A. CROSS, Claimant
WCB Case No. 89-18760
ORDER ON RECONSIDERATION
Quintin B. Estell, Claimant Attorney
Gail Gage (Saif), Defense Attorneys

The SAIF Corporation has requested reconsideration of our Order on Review dated November 6, 1991. In that order, we affirmed the Referee's determination that claimant was permanently and totally disabled.

In concluding that claimant was permanently and totally disabled, we were not persuaded by the opinion of Mr. Sakagawa, SAIF's vocational expert, because he concluded that claimant was employable based on the potential labor market in Oregon, whereas claimant lived in Troy, Montana. SAIF contends that our reasoning is not consistent with prior Board cases which hold that a hypothetically normal labor market is not necessarily limited to a finite geographical area. See, e.g., Clifford A. Bettin, 37 Van Natta 976 (1985), aff'd mem 79 Or App 545 (1986); Raymond Osborn, 34 Van Natta 576 (1982).

While we agree that claimant's "normal" labor market is not confined to Troy, Montana, we do not agree that Oregon is within that labor market. See Ronald R. Buddenberg, 43 Van Natta 434 (1991). Therefore, Mr. Sakagawa's analysis of jobs in Oregon does not persuasively reflect a hypothetically normal labor market for this particular worker.

Finally, claimant's counsel is entitled to an assessed attorney fee, in addition to the attorney fee assessed by our November 6, 1991 order, for prevailing over SAIF's request for reconsideration. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services in responding to SAIF's motion is \$400. In reaching this conclusion, we have particularly considered the time devoted to the issue and the value of the interest involved. Accordingly, claimant's counsel is awarded an assessed fee of \$400, to be paid by SAIF.

Accordingly, our November 6, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 6, 1991 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED

In the Matter of the Compensation of
GEORGE G. DANIELS, Claimant
WCB Case No. 90-02152
ORDER ON REMAND
Merrill Schneider, Claimant Attorney
C. Douglas Oliver (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. The court has reversed our prior order, which affirmed and adopted a Referee's order that declined to award a carrier-paid attorney fee when the SAIF Corporation rescinded its denial of claimant's low back injury claim prior to hearing. The court has reversed and remanded our order for further proceedings consistent with Jones v. OSCI, 108 Or App 230 (1991).

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation. Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

Considering that claimant's attorney filed a hearing request contesting SAIF's denial of claimant's low back injury claim and that SAIF rescinded its denial prior to hearing, we find that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. In light of our finding that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of SAIF's denial prior to the scheduled hearing, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1). Jones v. OSCI, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee concerning the rescission of SAIF's denial prior to hearing is \$900, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's statement of service), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, the Referee's order dated July 16, 1990 is reversed in part and affirmed in part. For services concerning the rescission of the denial, claimant's attorney is awarded \$900, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
CONCHITA M. HARE, Claimant
WCB Case No. 90-18916
ORDER ON REVIEW
Karen Werner, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee McCullough's order that upheld the insurer's denial of her aggravation claim for a low back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion and conclusions with the following supplementation. We agree with the Referee's application of the analysis used in Edward D. Lucas, 41 Van Natta 2272 (1989), reversed on other grounds, Lucas v. Clark, 106 Or App 687 (1991). See Leroy Frank, 43 Van Natta 1950 (1991).

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a compensable worsening of her low back condition claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, supra. Further, the medical worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Claimant also has the burden to prove that he has sustained a worsening of his compensable condition that is more than a waxing and waning of symptoms as contemplated by the last award or arrangement of compensation. ORS 656.273(8). If there was medical evidence prior to the last award of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, supra; see also International Paper Co. v. Turner, 91 Or App 91, rev den 307 Or 101 (1988).

We adopt the Referee's conclusion and reasoning that claimant has proven by objective findings that her low back condition had worsened since the June 1990 stipulation, the last arrangement of compensation. ORS 656.273(1). The stipulation increased claimant's unscheduled permanent disability award from 13 percent to 20 percent. The stipulation further provides that:

"Although claimant has returned to work with her employer, she now has a lighter job. She continues to have pain in her low back, which limits her ability to bend and to lift over 20 pounds. Claimant's symptoms are worse at some times than at other times. Because of claimant's continuing complaints of pain, an additional award of permanent partial disability is appropriate."

We now turn to the question of whether the stipulated order contemplated future periods of increased symptoms accompanied by diminished earning capacity. The June 1990 stipulation noted that claimant's symptoms are worse at some times than at others and granted an additional award for claimant's condition.

Considering such a provision, and Dr. Peterson's comments in December 1989 which refer to claimant's "chronic" low back condition, we conclude that the stipulation, which noted that claimant's symptoms were worse at some times than at other times, anticipated future periods of total disability. See Lucas v. Clark, supra.

The final relevant issue is whether the August 1990 exacerbation was more than a waxing and waning of symptoms contemplated by the stipulated order. For the reasons articulated by the Referee, we conclude that claimant has not established that the August 1990 flare-up was more than a waxing and waning of symptoms contemplated by the June 1990 stipulation.

ORDER

The Referee's order dated February 19, 1991 is affirmed.

December 4, 1991

Cite as 43 Van Natta 2633 (1991)

In the Matter of the Compensation of
MARK S. JONES

Own Motion No. 91-0577M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our November 5, 1991 Own Motion Order in the above captioned case. SAIF contends that claimant did not perfect a valid aggravation claim within the five years allotted by ORS 656.273. Claimant's aggravation rights expired September 9, 1991.

SAIF contends that it did not receive the August 26, 1991 chart note from Dr. Baker until September 12, 1991. However, after review of the file, we find that Dr. Baker's August 26, 1991 chart note was received by SAIF on September 3, 1991. See attachment A. SAIF received the same chart note again on September 12, 1991 with added information regarding claimant's office visit of September 9, 1991. We conclude that SAIF received Dr. Baker's chart note prior to the expiration of claimant's aggravation rights.

Accordingly, the request for reconsideration is denied.

December 4, 1991

Cite as 43 Van Natta 2633 (1991)

In the Matter of the Compensation of
MICHAEL K. QUINN, Claimant

Own Motion No. 91-09318M
OWN MOTION ORDER
Leeroy O. Ehlers, Claimant Attorney
Wallace & Klor, Defense Attorneys

On August 21, 1991, we postponed action concerning claimant's request to reopen his April 30, 1979 low back injury claim. We took this action to await the resolution of litigation concerning the compensability of claimant's current low back condition, which was pending before the Hearings Division. (WCB Case No. 91-09318).

On November 20, 1991, Referee Crumme approved a disputed claim settlement resolving the compensability of claimant's current low back condition. Pursuant

to the settlement, the parties agreed that the insurer's denial for that condition "shall be affirmed; and [claimant] shall take no Workers' Compensation benefits on account of the denied claims." The agreement further provided that all issues raised and raisable between the parties were resolved.

Inasmuch as claimant's request for Own Motion relief seeks the reopening of his 1979 injury claim and because claimant's hearing request concerning the causal relationship between his need for medical treatment and his 1979 injury has been dismissed, it follows that it has not been established that claimant's current condition is related to his 1979 injury. Accordingly, the request for Own Motion relief is denied. See ORS 656.278(1)(a).

IT IS SO ORDERED.

December 4, 1991

Cite as 43 Van Natta 2634 (1991)

In the Matter of the Compensation of
DEBRA L. SMITH-FINUCANE, Claimant
WCB Case No. C1-102409
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
James E. Bernstein, Claimant Attorney
David E. Wilson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

On November 14, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

ORS 656.236(1) permits parties, by agreement, to make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" [CDA] as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 436-60-005(9) (Emphasis added). See also OAR 438-09-001(1).

Here, the CDA recites that claimant agrees to release her rights and the insurer's obligations as they relate to claimant's accepted right knee injury condition. However, the proposed agreement also recites that the insurer "hereby accepts responsibility for claimant's left knee [claim filed on September 18, 1991, and agrees that her] left knee difficulties shall be encompassed under the December 2, 1985 claim."

The function of a claim disposition agreement is to dispose of accepted claims, with the exception of medical services, as those claims exist at the time the Board receives the CDA. See ORS 656.236(1). It is not within the province of a claim disposition agreement to accomplish claim processing functions under ORS 656.262. See, e.g., Randi E. Morris, 43 Van Natta 2265 (1991); Frederick M. Peterson, 43 Van Natta 1067 (1991).

In addition, the parties stipulate that the insurer denied an aggravation claim on September 26, 1991. The agreement then recites that in light of this claim disposition agreement, "claimant has agreed not to appeal from that denial." Although it is unclear whether the referenced denial concerns the left

knee condition purportedly being accepted by the proposed CDA or another denial, denied conditions cannot be disposed of by CDA.

Claim disposition agreements must be in separate documents from disputed claim settlement agreements. OAR 438-09-020(1)(b). It is not the function of a claim disposition agreement to resolve compensability issues or waive appeal rights. By agreeing that claimant shall not appeal the denied claim, the parties have essentially entered into a disputed claim settlement. See OAR 438-09-001(2).

Therefore, because the insurer seeks to accept responsibility for claimant's left knee problems within the claim disposition agreement, and because the disputed claim settlement is in the same document as a claim disposition agreement, the proposed agreement impermissibly exceeds the bounds of OAR 438-09-020(1)(b). Consequently, we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a); see Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Accordingly, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

December 5, 1991

Cite as 43 Van Natta 2635 (1991)

In the Matter of the Compensation of
THOMAS E. SINISCAL, Claimant
WCB Case No. 90-18136
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
David L. Lillig (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Podnar's order that affirmed the Notice of Closure award of 2 percent (6.4 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent partial disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his finding that claimant experienced a 2 percent loss of wage-earning capacity due to the compensable injury. Instead, we find that claimant sustained a 7 percent loss of earning capacity due to the injury.

CONCLUSIONS OF LAW AND OPINION

Claimant concedes that the standards for evaluating permanent disability allow an impairment value of only 2 percent for the decreased ranges of motion in his low back. He argues, however, that he is entitled to additional

permanent disability because of chronic disabling pain which allegedly limits repetitive use of the low back. We agree.

Claimant's testimony that he has disabling low back pain with certain activities, such as standing and stooping (Tr. 6), together with the opinion of Dr. Whitton, treating chiropractor, that these activities are limited (Exs. 3, 5, 12), are sufficient to establish that the pain prevents or limits repetitive use of his low back. Therefore, claimant is entitled to an additional value of 5 percent for impairment. See former OAR 436-35-320(4).

Pursuant to former OAR 436-35-360(11), the values of 2 and 5 are combined to yield a result of 7 percent impairment. Because claimant has returned to his usual and customary work, no values are assigned for the factors of age, education, and adaptability to perform a given job. See former OAR 436-35-290(2)(a), 436-35-300(2)(a), 436-35-310(2)(a). Thus, claimant is allowed 7 percent unscheduled permanent disability under the standards. See former OAR 436-35-280.

Claimant also contends that he has proven by clear and convincing evidence that the degree of his permanent disability is more than the entitlement allowed under the standards. See former ORS 656.283(7). The evidence is his testimony that he is a professional ballet dancer and that the injury is forcing him to quit dancing.

To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). Here, claimant testified that he had "hoped to dance for a couple of more years," but that he would have to quit later in the year due to the injury. His testimony implies that he is continuing to dance. Therefore, this disability is only speculative. Further, there is no evidence that claimant was paid regularly for dancing, and no evidence regarding the amount of such income or how often he danced. Under these circumstances, we do not find it "highly probable" that claimant's permanent loss of wage earning capacity exceeds the entitlement allowed under the standards. See, e.g., Darlene J. Byrd, 42 Van Natta 1029 (1990). Absent clear and convincing evidence, we conclude that claimant has been correctly compensated for his injury under the standards.

ORDER

The Referee's order dated February 8, 1991, is reversed. In addition to the Notice of Closure award of 2 percent (6.4 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, giving him a total unscheduled permanent disability award for the low back injury of 7 percent (22.4 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800.

In the Matter of the Compensation of
EDDIE BORREGO, Claimant
And, in the Matter of the Complying Status of
MORRIS SALTER, Employer
WCB Case Nos. 88-18220 & 88-18219
ORDER ON REMAND
Garrett, et al., Attorneys
David Ray Fowler (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Salter v. SAIF, 108 Or App 717 (1991). The court has reversed our prior order, Eddie Borrego, 42 Van Natta 2661 (1990), which had held that the Referee lacked jurisdiction to consider the compensability of claimant's injury claim because: (1) the noncomplying employer had not requested a hearing concerning the SAIF Corporation's acceptance of the claim on the employer's behalf; and (2) the employer had not placed compensability at issue by requesting a hearing from a Director's order finding the employer to be noncomplying. Reasoning that neither SAIF nor claimant had objected to the employer's orally raising the compensability issue at hearing, the court has concluded that we erred in holding that compensability was not properly before the Referee. Consequently, the court has remanded for our consideration of the compensability issue.

After conducting our de novo review of this record, we agree with the Referee that the preponderance of the persuasive medical and lay evidence does not establish that claimant's need for low back chiropractic treatment in October 1989 was materially related to a May 1989 work incident in which he moved a car off the employer's premises. Consequently, we adopt the Referee's order, which found that claimant's injury claim is not compensable.

Accordingly, on reconsideration, we affirm the Referee's order dated June 29, 1989.

IT IS SO ORDERED.

December 6, 1991

Cite as 43 Van Natta 2637 (1991)

In the Matter of the Compensation of
CAROL D. GOSS, Claimant
WCB Case No. 90-18146
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Tenenbaum's order that: (1) found that the employer could not stay payment of an award of unscheduled permanent partial disability; and (2) assessed a penalty and attorney fee for an allegedly unreasonable failure to timely pay an award of unscheduled permanent partial disability. On review, claimant contends that the adaptability value assigned by the Referee is incorrect. The issues on review are extent of unscheduled permanent disability, stay of compensation pending appeal, penalties, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant compensably injured her right ankle on October 6, 1987. The employer accepted the claim. This claim was closed by a Determination Order issued September 1988, allowing claimant 4 percent (6 degrees) scheduled permanent disability for loss of her right knee. In 1988, claimant filed a claim for back and hip conditions which allegedly were causally related to her accepted right knee condition. The employer denied the claim and claimant requested a hearing on the question of compensability.

By order dated March 5, 1990, a Referee found the claim compensable, set aside the employer's denial, and ordered the employer to accept the claim. On March 8, 1990, the employer filed a request for Board review of the Referee's March 5, 1990 order. On September 11, 1990, a Determination Order awarded claimant temporary total disability for designated periods, 23 percent (73.6 degrees) unscheduled permanent partial disability, and ordered the employer to pay claimant \$7,360. Without requesting reconsideration, the employer refused to pay the compensation awarded by the Determination Order. On April 3, 1991, the Board issued an Order on Review which reversed the Referee's March 5, 1990 order on the ground of claim preclusion. Carol D. Goss, 43 Van Natta 821 (1991); aff'd mem 110 Or App 151 (1991).

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

Claimant argues that she is entitled to an adaptability factor of 6 rather than the factor of 2.5 assigned by the Referee. Based on our April 3, 1991 Order on Review, which found that claimant is barred from litigating the compensability of her present low back and left hip condition, we find the issue of claimant's adaptability factor to be moot.

Stay of Compensation Pending Appeal

Prior to July 1, 1990, ORS 656.313 provided that "[f]iling by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant." The legislature amended ORS 656.313 effective July 1, 1990. Oregon Laws 1990 (Special session), Chapter 2, 23 (hereinafter, Senate Bill 1197 or "the Act"). As amended, ORS 656.313 provides:

"(1)(a) Filing by an employer or insurer of a request for hearing on a reconsideration order or a request for board review or court appeal stays payment of the compensation appealed, except for:

"(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs; and

"(B) Permanent total disability benefits that accrue from the date of order appealed from until the order appealed from is reversed." (Emphasis Added).

The employer contends that under amended ORS 656.313, the employer properly refused to comply with the terms of the September 11, 1990 Determination Order, because in March 1990, it filed a request for Board review of the Referee's March 5, 1990 Opinion and Order. We disagree.

ORS 656.313, as amended, provides that the filing by an employer of a

request for hearing on a reconsideration order¹ or a request for Board review or court appeal stays payment of the compensation appealed. Thus, the statute expressly applies only to an employer's appeal from the order which awards the compensation in dispute. Here, the order the employer had to appeal in order to stay payment of the compensation at issue, was the September 11, 1990 Determination Order which awarded claimant the temporary total and permanent partial disability benefits that the employer refused to pay. No appeal of that order was filed by the employer.

We reject the employer's contention, as did the Referee, that its request for Board review of a referee's March 5, 1990 Opinion and Order stayed payment of compensation awarded by the September 1990 Determination Order pursuant to amended ORS 656.313. The Referee did not decide the extent, if any, of the permanent or temporary disability benefits to which claimant was entitled. The issue before the referee concerned the compensability of claimant's physical condition (Ex. 51). The Determination Order which awarded claimant compensation was issued five months later and there was no appeal from that order. ORS 656.313, as amended, does not apply according to its terms.

Furthermore, we conclude that the legislature intended by amended ORS 656.313 to authorize insurers and employers to stay payment of compensation upon the filing of a qualifying appeal on or after July 1, 1990, the effective date of the Act. We disagree with the employer's argument that under Section 54(1) of the Act,² the legislature intended amended ORS 656.313 to apply retroactively to appeals which were filed before the Act's effective date. By conditioning the statute's application upon the filing of the insurer's appeal, ORS 656.313 operates by its own terms, to limit its application to an action taken by the insurer either on or after the statute's effective date. Prior to July 1, 1990, payment of compensation was not stayed upon filing of an employer's appeal. Had the legislature intended to discontinue, in midstream, the payment of compensation in all insurer's appeals pending at the various stages of administrative or court review on July 1, 1990, no matter when the appeal had been filed, the legislature would have said so in explicit language. In any event, the employer did not, at any time, appeal the compensation at issue. Its refusal to pay the compensation awarded by the September 11, 1990 Determination Order was unlawful.

¹ ORS 656.268 was also amended by Senate Bill 1197. As amended, ORS 656.268(5) provides that "[i]f the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." Under subsection (6)(b), any party objecting to the reconsideration order may request a hearing before a referee under ORS 656.283. Former ORS 656.268 permitted the objecting party to request a hearing under ORS 656.283 without first requesting reconsideration. Consistent with this legislative change, ORS 656.313 was amended to provide that the filing by an insurer or employer of a request for hearing "on a reconsideration order" stays payment of the compensation appealed. As previously stated, the employer did not request a hearing on a reconsideration order or request reconsideration of the September 11, 1990 Determination Order.

² Section 54(1) of Senate Bill 1197 provides:

"Except for amendments to ORS 656.027, 656.211, 656.214(2) and 656.790, this 1990 Act becomes operative July 1, 1990, and notwithstanding ORS 656.202, the 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of the date of injury, except as specifically provided in this section."

Penalties and Attorney Fees

The Referee found that the employer's failure to pay claimant's award of permanent partial disability was unreasonable. She therefore assessed a penalty and related attorney fee. We agree that a penalty is appropriate; however, we modify the attorney fee award.

The employer argues that its failure to pay was not unreasonable because it relied on amended ORS 656.313. It contends that evidence of its reliance on the 1990 amendments is shown by: (1) a letter from the Chief Staff Attorney of the Workers' Compensation Board which denied the employer's request for expedited review based on an appeal of a Referee's March 5, 1990 order; and (2) a letter from claimant's attorney stating that the employer's reliance on SB 1197 was unreasonable. (Exs. 53, 56).

We agree that these letters establish that the employer relied on amended ORS 656.313. However, ORS 656.313 clearly states that, in order to stay payment, the employer must request a hearing on a reconsideration order. Here, the employer requested neither a reconsideration of the Determination Order nor a hearing on a reconsideration order. Furthermore, the employer made no request for Board review of the temporary and permanent disability compensation. We find it unreasonable for the employer to rely on amended ORS 656.313 without following the clearly stated requirement for staying payment. Accordingly, we agree with the Referee that a penalty is appropriate in this instance.

The Referee awarded a penalty of 25 percent of the unpaid Determination Order award and assessed a \$500 attorney fee. We agree with the penalty award. However, ORS 656.262(10)(a) provides that if the insurer unreasonably delays or refuses to pay compensation, the insurer is liable for an additional amount up to 25 percent of the amounts then due. Furthermore, one-half of this additional amount is to be paid to claimant's attorney, in lieu of an attorney fee. ORS 656.262(10)(a); Nicolasa Martinez, 43 Van Natta 1638 (1991). Therefore, in lieu of the penalty and \$500 attorney fee awarded by the Referee, we award a 25 percent penalty with one-half of the penalty payable to claimant's attorney.

Because we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the stay of compensation is \$500, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 20, 1991, as reconsidered on February 28, 1991, is affirmed in part and modified in part. In lieu of the \$500 attorney fee and the 25 percent penalty for unreasonable delay or refusal to pay compensation, we assess a 25 percent penalty, with one-half of the penalty payable to claimant's attorney in lieu of an attorney fee. The remainder of the order is affirmed. For services on review concerning the stay of compensation issue, claimant's attorney is awarded an assessed fee of \$500, payable by the self-insured employer.

In the Matter of the Compensation of
ELVIS H. McMURRIAN, Claimant
WCB Case No. 90-18641
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Kinsley's order that: (1) upheld the insurer's denial of his aggravation claim for a low back condition; and (2) upheld the insurer's denial of his medical services claim for proposed low back surgery. On review, the issues are aggravation and medical services. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury in January 1986 when his lower body was struck by a log. He sought treatment for both knees and experienced low back pain. Claimant returned to work for approximately three months, but stopped working due to pain in both hips and both knees. At that time, claimant underwent left knee arthroscopic surgery for shaving of grade II to III chondromalacia. His claim was closed by a November 1986 Determination Order that awarded 10 percent scheduled permanent disability for the left knee. Thereafter, claimant's left knee award was increased to 30 percent by stipulation of the parties.

Following the injury, claimant continued to experience low back pain. Radiographs in 1987 revealed congenital anomalies in his lumbar spine including sacralization of L5, spina bifida occulta deformity at L5 and facet tropism at L4-5 and L5-S1. Later x-rays, taken in July 1989, revealed a mild diffusely bulging annulus at L3-4 and a mild asymmetric disc protrusion laterally and posteriorly on the right at L4-5.

Claimant was unable to return to his regular work as a log truck driver. He entered a vocational program and was trained in upholstery work. After completion of the vocational program, claimant's claim was closed by an August 1988 Determination Order that awarded temporary disability only. The Determination Order did not award any increased permanent disability. Claimant requested a hearing on the Determination Order contending he was entitled to unscheduled permanent disability.

In late 1989, a hearing was held before an earlier Referee. By a February 1990 Opinion and Order, the earlier Referee awarded claimant 19 percent unscheduled permanent disability for permanent low back symptoms. The Referee found that claimant's injury had not caused or worsened claimant's congenital low back anomalies. However, he further found that the compensable injury had caused a permanent symptomatic worsening of claimant's lumbar spine which resulted in unscheduled disability in the form of lost ranges of motion. The earlier Referee's order was not appealed and became final by operation of law.

On July 1, 1990, claimant was relaxing with his family at a park when he began experiencing severe low back and right leg pain. He sought treatment the following day from Dr. Newby, his treating physician. Dr. Newby reported that claimant had restricted lumbar ranges of motion and a marked worsening of low back symptoms. X-rays revealed a mild disc protrusion laterally on the right at the level of the L3-4 intervertebral foramina with mild compression of the exiting right L3 nerve root; minimal narrowing of the L4-5 right intervertebral foramina; and mild to moderate narrowing of the L5-S1 right intervertebral

foramina. A subsequent lumbar myelogram showed a lack of filling of the distal aspect of the right L3 nerve root sleeve.

On July 7, 1990, Dr. Newby opined that claimant had far lateral disc herniation at L3-4. Dr. Newby requested authorization to perform a discectomy at L3-4. In September 1990, the insurer denied reopening of claimant's claim on the basis that his current low back condition was not related to the compensable injury. The denial also denied the surgery proposed by Dr. Newby on the same basis.

In October 1990, Dr. Newby reported that a discectomy was not warranted and opined that the proposed surgery would not benefit claimant.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee found that claimant's low back condition was the same condition which the earlier Referee found not compensable. Therefore, she concluded that claimant had not established that his current condition was causally related to the compensable injury and she upheld the insurer's denial. We need not address the preclusive effect, if any, of the earlier Referee's order because we are not persuaded that claimant has suffered a compensable aggravation, regardless of the question of the preclusive effect of the prior order.

The issue is whether claimant has established a compensable aggravation. Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). The compensable injury must be a material contributing cause of the worsened condition. Robert E. Leatherman, 43 Van Natta 1677 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Inasmuch as claimant has congenital lumbar anomalies, the issue of whether the compensable injury is a material contributing cause of claimant's worsened condition is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Newby, claimant's treating physician, examined claimant following the July 1990 worsening. Following a lumbar myelogram, Dr. Newby reported an amputation of the L3 nerve root at right L3-4. Dr. Newby opined that this finding correlated with claimant's symptoms which lead him to recommend a L3-4 discectomy. Dr. Newby did not offer an opinion as to the casual relationship between the compensable injury and claimant's worsened symptoms.

Dr. Schachner reported that, at the time of the compensable injury, claimant had suffered some soft tissue damage superimposed on claimant's degenerating L4-5 intervertebral disc. Dr. Schachner opined that some of claimant's low back symptoms stemmed from the compensable injury. Dr. Schachner's opinion, however, addresses claimant's condition in April 1990, approximately 2 1/2 months prior to claimant's worsening. Therefore, Dr. Schachner's opinion does not establish a causal relationship between the compensable injury and claimant's July 1990 worsened symptoms.

Finally, the Western Medical Consultants, who examined claimant in August 1990, opined that it was unlikely that claimant's low back and right leg symptoms were related to the 1986 compensable injury.

Under these circumstances, we conclude that claimant has failed to establish that his compensable injury is a material contributing cause of his July 1990 worsened symptoms. Accordingly, claimant has not established a compensable aggravation.

Medical Services

Claimant contends that the Referee erred in upholding the insurer's denial to the extent that it denied the lumbar surgery proposed by Dr. Newby. We do not reach this question as we find the issue to be moot.

In addition to denying reopening of claimant's claim, the insurer's denial denied the L3-4 discectomy proposed by Dr. Newby. However, prior to the hearing, Dr. Newby had changed his opinion and reported that a discectomy was not warranted and that the proposed surgery would not benefit claimant. Inasmuch as Dr. Newby was no longer proposing surgery, the insurer's denial of the proposed surgery is moot. Therefore, we do not reach this issue.

ORDER

The Referee's order dated February 20, 1991 is affirmed to the extent that the Referee upheld the insurer's denial insofar as it denied claimant's aggravation claim for a low back condition. That portion of the denial which denied a surgery claim is moot.

December 6, 1991

Cite as 43 Van Natta 2643 (1991)

In the Matter of the Compensation of.

STANLEY MEYERS, Claimant

WCB Case No. 90-09863

ORDER ON REVIEW

Doblie & Associates, Claimant Attorneys

Nelson, et al., Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Referee McGeorge's order that: (1) set aside its denial of claimant's medical services claim on the grounds that the insurer had not submitted the matter to the Director pursuant to ORS 656.327; (2) set aside the insurer's denial of claimant's aggravation claim for a low back condition; and (3) assessed a penalty and related attorney fee for the insurer's allegedly unreasonable denial. On review, the issues are medical services, aggravation, penalties and attorney fees. We vacate in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May

1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue is not subject to a special exception to the Act's general applicability provision. See, e.g., 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Medical Services

Claimant initiated this proceeding pursuant to ORS 656.319, challenging, inter alia, the insurer's April 24, 1990 partial denial of chiropractic treatments in excess of two visits per month. Without addressing whether the treatments were reasonable and necessary, the Referee determined that the denial was procedurally improper under ORS 656.327 and set it aside. She concluded that, rather than issuing a denial, the insurer was required to request review of the allegedly excessive treatment by the Director. Although we agree, we must, nevertheless, vacate for lack of jurisdiction.

ORS 656.245 requires an insurer to provide "medical services for conditions resulting from the injury for such period as the nature of the injury or the process of recovery requires." ORS 656.327, as amended by the 1990 legislature, provides:

"(1)(a) If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer or self-insured employer shall so notify the parties and the director.

"(b) Unless the director issues an order finding that no bone fide medical services dispute exists, the director shall review the matter as provided in this section. * * *

"(c) The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section." Or Laws 1990 (Special Session), ch. 2, 26.

On review, the insurer maintains that the statutory procedure outlined in ORS 656.327 is permissive, not mandatory, and that it had a right to issue a formal denial under ORS 656.262, independently of its right to seek Director review. It explains:

"The provisions of ORS 656.327 are applicable only to those cases in which the party with a question about the efficacy or amount of treatment wishes review of the treatment. There is no mandatory review of all medical services cases by the Director of the Department of Insurance and Finance under ORS 656.327. If the employer wishes to have the Director review excessive treatment, as opposed to denying compensability and proceeding to a hearing * * * the employer must follow the statute either in the 1989 version or the 1990 version. The employer in this case did not wish to have the Director review the excessive medical treatment and did not request it." App. Reply Brief at 2.

We agree with the insurer that the provisions of the "1989 version" of the Workers' Compensation Act did not mandate Director review of medical services issues. In Lillie M. Willis, 42 Van Natta 1923 (1990), we reversed a Referee's conclusion that, under former ORS 656.327, the parties could not bring an issue of treatment frequency before the Hearings Division, but were limited solely to a review by the Director. We reasoned that the language of the former statute, when read in conjunction with former ORS 656.704(3), was discretionary upon the parties and that the Director had sole jurisdiction over the matter only if and when one of the parties requested review. Because neither party in that case had invoked the provisions of ORS 656.327, we concluded that the medical services dispute was appropriately before the Referee as a matter concerning a claim under ORS 656.283(1) and, therefore, nothing prohibited the carrier from issuing the frequency denial, or the claimant from requesting the hearing.

In reaching that decision, however, we noted that the legislature had subsequently amended ORS 656.704 in a manner that could impact the jurisdiction of the Director and this Board over medical services disputes. Id. at 1924. As amended, ORS 656.704(3), which applies to this case, provides:

"(3) For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under ORS 656.001 to 656.794, and for determining the procedure for the conduct and review thereof, matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter." Or Laws 1990 (Special Session), ch. 2, 37. (Emphasis supplied).

Under amended ORS 656.704(3), "matters concerning a claim" over which the Board, and thus the Hearings Division, has jurisdiction, do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." Accordingly, unlike the situation in Lillie M. Willis, supra, original jurisdiction over a dispute concerning the frequency of medical treatment is no longer shared by the Director and the Hearings Division. Rather, because such disputes are no longer matters concerning a claim, original jurisdiction lies exclusively with the Director.¹ Furthermore, until the Director issues an order after conducting his review, an insurer "shall not deny the claim for medical services nor shall the worker request a hearing." ORS 656.327(1)(c).

In the present case, the insurer did not request Director review, but instead issued a denial from which claimant requested a hearing. Clearly, by operation of ORS 656.704(3) and 656.327(1)(c), the insurer's denial is null and void as a matter of law, and the Referee was without authority to hold a hearing

¹ This conclusion is supported by the legislative history. The amendments to ORS 656.327 and 656.704 were proposed in Senate Bill 1197. In explaining the bill to the Special Committee of the legislature, a member of the Governor's Workers' Compensation Labor-Management Advisory Committee testified that the purpose of the amendments was to remove questions concerning the reasonableness and necessity of medical treatment from the litigation process and allow such decisions to be made by a physician rather than a referee. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 75.

concerning that null and void denial. The insurer had but two alternatives: either pay claimant's medical bills or initiate Director review of the dispute.² Its failure to initiate review procedures or pay the bills within 90 days of receipt will, by that fact alone, ordinarily constitute the unreasonable resistance to the payment of compensation, for which penalties or attorney fees will be assessed.³

We also conclude that an injured worker is entitled to request Director review where the insurer either expressly or impliedly denies treatment on grounds listed in ORS 656.327(1). The grounds stated in the statute for requesting Director review are receipt by an injured worker of medical treatment that is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." While an insurer, self-insured employer or the Director might object to treatment on such grounds, no apparent reason exists for a claimant to raise such a contention. And yet, the statute expressly includes "an injured worker" as one of the parties authorized to request review. We believe the legislature intended to authorize the injured worker to request review where the insurer denies treatment on grounds listed in ORS 656.327. An implied denial would arise when an insurer fails either to initiate Director review or to timely pay the medical bills. Such an interpretation not only gives meaning to the entire statutory provision, including the provision authorizing an injured worker to request review, but also furthers the legislative intent clearly expressed in ORS 656.704(3) to have disputes concerning the reasonableness and necessity of medical treatment decided by a physician rather than a Hearings Division referee.⁴

We vacate the Referee's decision insofar as it purports to set aside the denial, for the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division. We also vacate the Referee's attorney fee award for prevailing against the denial.

² We have concluded that the dispute between claimant and the insurer over the appropriateness of the medical treatment at issue is subject to the original jurisdiction of the Director and that therefore, under ORS 656.327(1)(c), the insurer could not deny the claim nor could claimant request a hearing concerning the denial. However, we do not decide here whether an insurer could deny a claim and the claimant request a hearing where the dispute concerns the extent of the causal relationship in fact and law, between the claimant's medical condition and the claimant's compensable injury or occupational disease.

³ Furthermore, by failing to timely request Director review, the insurer may waive its right to seek director review, and be held bound to pay the bills. See proposed OAR 436-10-046(4).

⁴ If ORS 656.327(1) were interpreted literally, the injured worker, whose medical bills were not paid, would not be able to request Director review of the insurer's refusal, or request a hearing before a Referee because of amended ORS 656.704(3). Thus, a literal interpretation of ORS 656.327(1) would effectively leave injured workers with a substantive right to reasonable and necessary medical treatment, but with no means to enforce that right. We have concluded that the legislature clearly intended, by amended ORS 656.704(3), to have disputes over the appropriateness of medical treatment be resolved by a physician rather than a Referee. On the other hand, it is also clear that the legislature did not intend to deprive the injured worker of all effective remedies, in the event of a dispute with an insurer over the appropriateness of medical treatment. Therefore, to effectuate the policy objectives of ORS 656.704(3) and 656.327, the latter statute must be liberally construed to authorize the insurer and the injured worker to request Director review of the insurer's refusal to pay medical bills.

Penalty and Attorney Fee

In addition to setting aside the April 24, 1990 denial, the Referee concluded that the insurer's failure to seek review from the Director was unreasonable and, therefore, the Referee assessed a penalty and related attorney fee. We conclude that penalties and/or attorney fees should not be assessed and reverse. We do so for two reasons.

ORS 656.262(10), as amended by the 1990 Legislature, authorizes the assessment of a penalty if a carrier "unreasonably delays or unreasonably refuses to pay compensation." If the worker is represented by an attorney, the worker's attorney shall receive one-half of the assessed penalty in lieu of an attorney fee. See Nicolosa Martinez, 43 Van Natta 1638 (1991). The reasonableness of a carrier's denial must be judged based upon the information available to the carrier at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

Senate Bill 1197 was not signed into law by the Governor until May 7, 1990, the Act's effective date. Thus, on April 24, 1990, when the insurer issued its partial denial, former ORS 656.327 did not mandate Director review or prohibit issuance of a denial, unless Director review had been requested, as previously discussed. In this case, the insurer did not request Director review. Therefore, the insurer did not act unreasonably simply by issuing a denial.

A reasonable argument could be made, however, that after the enactment of Senate Bill 1197, the insurer's adherence to its denial and failure or refusal to either pay claimant's medical bills or request Director review under ORS 656.327 became unreasonable resistance, for which penalties or fees should be assessed. If the jurisdictional issue here had been previously settled by the Board, we would conclude that the insurer did act unreasonably by failing or refusing to request Director review after enactment of the statutory amendments in question. However, although we disagree with and, in this order, reject the insurer's contention that original jurisdiction still lies concurrently with the Hearings Division and the Director notwithstanding the 1990 legislation, the insurer's contention is not frivolous for lacking of some plausible foundation in the law. For these reasons, we do not believe that the insurer's initial refusal to request Director review was unreasonable, or that its refusal became unreasonable after the effective date of the statutory amendments at issue. Accordingly, we reverse that portion of the Referee's order.

Aggravation

The Referee concluded that claimant established a compensable aggravation. We disagree.

To establish an aggravation claim, a claimant must show "worsened conditions resulting from the original injury." ORS 656.273(1). In a claim for increased compensation for an unscheduled condition, a claimant must prove that his symptoms have increased or that his condition has worsened so that he is less able to work in the broad field of general occupations, resulting in a loss of earning capacity. Smith v. SAIF, 302 Or 396 (1986).

In this case, claimant contends that he experienced a symptomatic worsening of his condition in early 1989. There is no evidence, however, that, as a result of the symptomatic flare-up, claimant was less able to work. Throughout the alleged aggravation period, claimant continued to work 50 to 55 hours per week without restrictions, doing repetitive bending, twisting, turning and lifting up to 40 pounds. Moreover, although Dr. Ho agreed that a less strenuous

position might be beneficial to claimant, he did not indicate that such a change was necessary and continued to authorize claimant to work without restrictions. There is no contrary medical evidence.

Based on the totality of the evidence, we are not persuaded that, as a result of the January 1990 symptomatic worsening, claimant's earning capacity was diminished below what it was at the time his claim was last closed. Accordingly, we conclude that claimant has not established a compensable aggravation of his back condition. The Referee's decision setting aside the aggravation denial is reversed. We also reverse the Referee's assessed fee award for prevailing on the aggravation issue.

ORDER

The Referee's order dated August 3, 1990 is vacated in part and reversed in part. Those portions of the Referee's order that set aside the insurer's April 24, 1990 partial denial of medical services and awarded an assessed fee for prevailing against that denial are vacated. The Referee's assessment of a penalty and related attorney fee for the insurer's allegedly unreasonable denial is reversed. Those portions of the Referee's order that set aside the insurer's June 1, 1990 denial of aggravation and awarded an assessed fee for prevailing against that denial are reversed. The aggravation denial is reinstated and upheld.

Board Member Gunn, specially concurring.

I agree that the amendments to ORS 656.327 and 656.704 mandate the result reached in the majority decision. I write only to express my opinions as to the liabilities that could be imposed if any party fails to follow the procedures established under ORS 656.327.

The majority holds that amended ORS 656.327 provides the Director with sole jurisdiction over disputes concerning medical fees and treatment. The majority also holds that ORS 656.327(1)(a) establishes a mandatory process for Director review of medical treatment that any party alleges is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

In addition to establishing a mandatory review process, ORS 656.327(1)(a) further mandates that any party seeking that review "shall so notify the parties and the director." In conjunction with this provision, ORS 656.327(1)(c) states: "The insurer or self-insured employer shall not deny the claim for medical services . . . that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section."

Pursuant to ORS 656.327, an insurer or self-insured employer has only two legal choices to follow in any medical treatment or fees dispute: pay for the medical treatment or seek review and notify the Director and worker. Failure to take either of these two actions within ninety (90) days⁵ would constitute a "de facto" denial of the medical services claim. If an insurer or self-insured employer failed to take either of these two actions, claimant could then request a hearing under ORS 656.283. Thereafter, a hearing would be held to decide the merits of the original issue and any attendant penalty issue concerning the failure to follow the clear statutory language in 656.327(1)(a) and (c). The

⁵ The Director has proposed an administrative rule which provides the insurer or self-insured employer with a 90-day time limit in which to initiate Director review or pay for medical treatment.

insurer or self-insured employer's exposure to imposition of penalties and related attorney fees would be significant.

The clear legislative purpose of the changes in ORS 656.327 and 656.704 was to reduce litigation and allow medical treatment and fees disputes to be resolved by the Director. Inaction by an insurer or self-insured employer on these matters will subject them to liability in the form of penalties and related attorney fees. Failure to pay for medical services or to proceed under the appropriate legal forum would certainly be viewed by this Board Member as a most unreasonable resistance to compensation. I further believe that a Referee (or the Board on de novo review) could find that if a worker was forced to request a hearing on this matter, it would be analagous to the employer requesting a hearing for the purpose of delay or other vexatious reason or without reasonable grounds, and could subject the employer to a penalty pursuant to ORS 656.382(3).

Board Members Kinsley and Tenenbaum dissenting.

The majority concludes that the Board no longer has original jurisdiction to consider a dispute regarding allegedly excessive medical treatment. Because we believe that conclusion is contrary to law, we respectfully dissent from that portion of their opinion.

The majority correctly reasons that, under the 1990 amendments to ORS 656.704(3), the issue of whether the Board has original jurisdiction of a medical treatment dispute turns on whether there is another procedure for resolving that dispute. If there is another procedure, the Board does not have jurisdiction of the dispute. However, the majority goes on to conclude that the Board does not have jurisdiction of any dispute regarding allegedly excessive treatment, because ORS 656.327 provides a procedure for resolving those disputes. The majority reasons that the Director's review procedure set forth in ORS 656.327 is the only procedure available to an insurer for challenging medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules." That reasoning is not supported by our reading of the law.

The Board has previously examined the medical review procedure under former ORS 656.327, before the 1990 amendments took effect.⁶ In Lillie M. Willis, 42 Van Natta 1923 (1990), the Board stated:

"The language of this former statute is discretionary upon the parties. It contains two requirements: first, there has to be one or more of the types of problems listed in the statute; and second, the parties have to want the Director to act. Once the matter has been submitted by one of the parties to the Director, then the provisions of ORS 656.327(2) take effect. At that point, the Director

⁶ Former ORS 656.327(1) provided, in pertinent part:

"If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by a medical panel, the injured worker, insurer, self-insured employer or director shall so notify the parties and the director. * * * The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section."

has sole jurisdiction over the matter and the insurer cannot deny the claim and the claimant cannot request a hearing. It is only at that point that the Hearings Division loses jurisdiction over the matter under ORS 656.283." (Emphases added.)

Because none of the parties in Willis submitted the matter to the Director pursuant to former ORS 656.327(1), the Board concluded that it had jurisdiction of the medical treatment dispute. The Board revisited the jurisdiction issue in Theron Stiehl, 43 Van Natta 686 (1991). In Stiehl the Board considered whether it had jurisdiction of a medical treatment dispute after the insurer had requested Director review of the dispute. Citing former ORS 656.327(1), the Board concluded that it had jurisdiction of the dispute because, although Director review was requested, there was no evidence that the Director had actually exercised his discretion to review the dispute.

Thus, the Board interpreted former ORS 656.327 to provide a discretionary procedure for challenging medical treatment that was alleged to be "excessive, inappropriate, ineffectual or in violation of rules." An insurer could either seek Director review or issue a denial of treatment under ORS 656.262(6). If the insurer sought Director review and the Director exercised his discretion to review, the Director had exclusive jurisdiction of the matter. If, on the other hand, the insurer issued a denial of treatment, claimant could request a hearing and the Board would have jurisdiction of the dispute. See ORS 656.319.

The 1990 amendments have not changed the discretionary nature of the medical review procedure. On the contrary, the language in former ORS 656.327(1), upon which the Board relied in Willis and Stiehl, has been retained without substantial changes in current ORS 656.327(1)(a). Like its predecessor, that subsection continues to provide that a party may request Director review of disputed medical treatment if it "wishes" Director review of the treatment. Therefore, the medical review statute does not prevent an insurer from denying treatment which it alleges to be excessive or otherwise inappropriate.

Because the Director review procedure remains discretionary and does not preclude an insurer from denying treatment, we cannot join in the majority's conclusion that ORS 656.327 provides a procedure for resolving all disputes regarding treatment that is allegedly excessive or otherwise inappropriate. Based on our reading, ORS 656.327 only provides a procedure where one of the parties is challenging the propriety of treatment and wishes to submit the matter for Director review. More importantly, it does not provide an avenue for the worker to establish the compensability of treatment that the insurer, through inaction or by formal denial, refuses to provide.

This case is illustrative. The insurer refuses to pay for treatment alleged to be excessive. Under the majority's interpretation of the law, claimant is precluded from bringing the matter to hearing and must, instead, wait for the insurer to submit the matter for Director review under ORS 656.327. The wait could be infinite, because ORS 656.327 does not provide a time limit for submitting a request for Director review.⁷

We note the majority's belief that the legislature intended to authorize an injured worker to request Director review where the insurer denies treatment on the grounds listed in ORS 656.327. (See majority opinion, footnote 4). As we read the express language of that statute, the injured worker may request review if he believes himself to be receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules. The likelihood that the worker would choose such an administrative remedy rather than terminating the treatment in question is arguable. In any event, there is no provision for a worker to request Director review when the insurer fails to do so. And while it

may well be that the legislature intended the worker to request such review on the insurer's behalf, it is not what the legislature said in the only document that counts: the statute.

The majority goes on to note that an "implied denial would arise when an insurer fails either to initiate review or timely pay the medical bills." We agree. The remedy, however, is provided in ORS 656.283, based on ORS 656.262(6). If the insurer does not pay the bills within 90 days, it is an implied or "de facto" denial, and the worker's sole remedy is to request a hearing before the Board's Hearings Division, not to request Director review.

We are also puzzled by the majority's assertion that penalties and attorney fees could be assessed for the insurer's failure to initiate Director review or pay medical bills within 90 days. Under prevailing law, penalties and attorney fees cannot be assessed for refusal to pay medical bills unless the worker is entitled to the payment of those bills. See ORS 656.262(10), 656.382(1). As we discussed above, ORS 656.327 does not provide the worker with an avenue for establishing the compensability of disputed treatment that the insurer refuses to provide. Therefore, if the insurer refuses to pay medical bills and does not request Director review, the worker cannot prove his entitlement to the payment of the medical bills, and penalties and attorney fees cannot be assessed. These concerns persuade us that the majority's interpretation of ORS 656.327 is flawed.⁸

We would conclude that the insurer in this case properly declined to seek Director review of the allegedly excessive treatment and chose, instead, to issue a formal denial of treatment. Because ORS 656.327 does not provide a procedure for resolving this dispute, it is a matter concerning a claim within the meaning of ORS 656.704(3) and was appropriately before the Referee.

We therefore proceed to the merits of the disputed medical treatment. After reviewing the record, we conclude that claimant has established by a preponderance of the evidence that the disputed treatments were reasonable and necessary for his compensable injury. Accordingly, we would set aside the insurer's denial of treatment in excess of the administrative guidelines.

⁷ The majority asserts that an insurer has 90 days to initiate Director review or pay medical bills. That limitation period appears to be based on the Director's Notice of Proposed Amendment of Rules, which was filed in the Secretary of State's office on October 15, 1991. According to that notice, the Director proposes to amend OAR 436-10-046 to provide that an insurer must notify a medical service provider of its intent to request Director review of disputed treatment within 90 days after its receipt of the treatment bill, and that the insurer must request Director review within 30 days after issuing the notice or lose all rights to Director review of the disputed treatment. See proposed OAR 436-10-046(2), (3). We note that this proposed rule allows for a 120-day processing period, which is beyond the statutory period of 90 days, and which would continue to leave claimant in limbo. In any event, the proposed amendments are not applicable until they are adopted by the Director. Even if the amendments were adopted, we find no statutory authority mandating that an insurer seek Director review of disputed treatment. Finally, we note that the proposed rule amendments do not provide the worker with an avenue for establishing the compensability of treatment that the insurer refuses to provide.

⁸ We are not persuaded by the legislative history cited by the majority. (See majority opinion, note 1). Although a member of the Governor's Workers' Compensation Labor-Management Advisory Committee expressed his belief that the 1990 amendments to ORS 656.327 would transfer questions concerning the

appropriateness of treatment from the litigation process to physicians, the amendments themselves do not accomplish that result. As we stated above, the discretionary language of former ORS 656.327(1) has been retained without substantial changes. The 1990 amendments do not require an insurer to request medical review of disputed treatment; they merely revised the procedure that follows when such review is requested. Therefore, inasmuch as the legislative history conflicts with the plain language of the statute, we decline to rely on that history.

December 6, 1991

Cite as 43 Van Natta 2652 (1991)

In the Matter of the Compensation of

FRANCISCO RAMIREZ, Claimant

WCB Case No. 90-00879

ORDER ON REMAND

Michael B. Dye, Claimant Attorney

Nelson, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. The court has reversed our prior order, which affirmed and adopted a Referee's order that declined to award a carrier-paid attorney fee when the insurer rescinded its denial of claimant's right index finger injury claim prior to hearing. The court has reversed and remanded our order for further proceedings consistent with Jones v. OSCI, 108 Or App 230 (1991).

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

On January 12, 1990, the Board received a hearing request from claimant's attorney. Among other issues, the hearing request raised compensability concerning the insurer's January 5, 1990 denial of claimant's right index finger injury claim.

On May 9, 1990, Dr. Cummings, claimant's treating chiropractor, reported a history that claimant had injured his finger while performing his work activities. In response to a May 3, 1990 letter from claimant's attorney, Dr. Cummings concluded that, within a reasonable medical probability, the treatment claimant had received was materially caused by the work incident claimant had described.

On May 10, 1990, the date of the scheduled hearing, the insurer accepted claimant's right index finger injury claim. Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

Considering that claimant's attorney filed a hearing request contesting the insurer's January 5, 1990 denial of claimant's right index finger injury claim and solicited a medical report supporting a causal relationship between the claim and a work incident prior to the rescission of the insurer's denial before the scheduled hearing, we find that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. Consequently, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1). Jones v. OSCI, *supra*.

We further agree with the Referee's conclusion that the insurer's denial of claimant's right index finger injury claim was unreasonable. However, we disagree with the Referee's reasoning that claimant was not entitled to an attorney fee under ORS 656.382(1) for such unreasonable conduct.

Subsequent to the Referee's order, we have held that ORS 656.382(1) warrants an attorney fee when a carrier engages in conduct which constitutes unreasonable resistance to the payment of compensation, even though there are no amounts then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991). Here, we agree with the Referee's finding that there were no amounts "then due" at the time of the insurer's denial. Consequently, there is no basis for a penalty under ORS 656.262(10). Nevertheless, the insurer's unreasonable denial constitutes an unreasonable resistance to the payment of compensation, thereby justifying an attorney fee award pursuant to ORS 656.382(1). See Richard J. Stevenson, 43 Van Natta 1883 (1991).

Consequently, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee concerning the insurer's unreasonable denial and the rescission of the insurer's denial prior to hearing is \$1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record and claimant's attorney's statement of service), the complexity of the issues, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services provided concerning issues from which he did not prevail. (Compensability of his neck, back, and right shoulder claim; entitlement to temporary total disability; rate of temporary total disability; and unreasonable refusal to pay interim compensation).

Accordingly, on reconsideration, the Referee's order dated June 8, 1990 is reversed in part and affirmed in part. For services concerning the insurer's unreasonable denial of claimant's right index finger injury claim and the rescission of that portion of the insurer's denial, claimant's attorney is awarded \$1,200, to be paid by the insurer. The remainder of the Referee's order is affirmed.

IT IS SO ORDERED.

December 6, 1991

Cite as 43 Van Natta 2653 (1991)

In the Matter of the Compensation of
RONALD WALTZ, Claimant
WCB Case No. C1-02519
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Robert Webber, Claimant Attorney
R. Ray Heysell, Defense Attorney

Reviewed by Board Members Neidig and Moller.

On November 25, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Here, the agreement notes that an attached medical bill and an additional attorney fee is "also to be included" with the proposed disposition. The attachment consists of an unpaid medical bill and a statement from claimant that

the insurer will pay \$180 for the medical bill and a \$60 attorney fee "along with" claimant's release of this claim. It is not clear whether the parties have attempted to agree to pay claimant's medical bills from the settlement proceeds. Such an agreement would constitute a relinquishment of claimant's claim for medical benefits, which is an impermissible limitation on his right to medical services for his compensable injury. See e.g. Jean E. Nealy, 42 Van Natta 2378 (1990). Moreover, because the attachment provides for an additional attorney fee of \$60, the total attorney fee of \$185 exceeds the strictures of OAR 438-15-0052(1).

Finally, we note that the parties have not submitted the information required by the summary sheet, as the total amount of consideration and total attorney fee have not been provided. For the above reasons, we conclude that the proposed disposition exceeds the bounds of our rules and is unreasonable as a matter of law. See OAR 438-09-020(2); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROLAND DIR, Applicant
WCB Case No. CV-91012
CRIME VICTIM ORDER OF REMAND
Gerri Fitzgerald, Department of Justice

Roland Dir, Applicant, requested Board review concerning a decision by the Department of Justice concerning his application for benefits as a victim of a crime under the Crime Victim Compensation Program. The Department has notified applicant that it has decided to reconsider applicant's claim for benefits and therefore, asks that we "cancel" the applicant's request for Board review.

We interpret the Department's submission as a motion to remand for reconsideration of its decision. In the interests of substantial justice, the motion is granted.

Accordingly, the request for Board review is dismissed. This matter is remanded to the Department of Justice for reconsideration.

IT IS SO ORDERED.

November 27, 1991

Cite as 43 Van Natta 2655 (1991)

In the Matter of the Compensation of
STEPHEN G. MEYER, Claimant
WCB Case No. 89-13499
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Claimant, pro se, requests review of Referee Neal's order that: (1) upheld the insurer's denial of claimant's current psychological condition; (2) concluded that claimant's claim was not prematurely closed by a July 11, 1989 Determination Order; (3) affirmed a Determination Order that did not award additional permanent disability beyond the 38 percent (121.6 degrees) unscheduled permanent partial disability he had been previously granted; and (4) upheld the insurer's denial of claimant's aggravation claim. On review, the issues are medical services, premature closure, extent of permanent disability and aggravation.

We affirm and adopt the Referee's order with the following supplementation.

In the introductory paragraph of her order, the Referee stated that a hearing in this matter was first convened on July 6, 1990. After our review of the record, we agree with claimant that the hearing was actually convened on June 25, 1990. Nonetheless, despite that error, the Referee correctly decided this case pursuant to the law in effect prior to July 1, 1990. See Oregon Laws 1990 (Special Session), chapter 2, 54(2); John K. French, 43 Van Natta 836 (1991). In other words, we are not persuaded that claimant's 1984 compensable injury is a material contributing cause of his current psychological condition.

Claimant also contends that the denial of his current psychological condition was improper, because the insurer had accepted the psychological condition in two prior stipulations. We agree that an insurer may not retroactively deny the compensability of an accepted claim. Bauman v. SAIF, 295 Or 788 (1983). In this case, however, the insurer does not dispute the compensability of the original claim. Rather, it asserts that claimant's "current condition" is unrelated

to his industrial injury. That is a valid denial under Green Thumb v. Basl, 106 Or App 98 (1991).

ORDER

The Referee's order dated February 19, 1991 is affirmed.

November 27, 1991

Cite as 43 Van Natta 2656 (1991)

In the Matter of the Compensation of

PAT E. NORMANDEAU, Claimant

WCB Case No. 90-14753

ORDER ON REVIEW

Patrick Lavis, Claimant Attorney

Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Knapp's order that amended a Determination Order to reflect that the aggravation date begins on May 14, 1986. On review, the issue is the commencement date of aggravation rights. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant suffered an exacerbation in October 1986 which required increased chiropractic treatments but did not cause any time loss or impairment. (Ex. 4). On June 12, 1989, Dr. Sherman, chiropractor, noted that the May 14, 1986 injury resulted in permanent impairment. (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusion concerning the commencement date of claimant's aggravation rights with the following supplementation.

If a claim that a nondisabling injury has become disabling is not made within one year of the injury, the claim is treated as one for aggravation under ORS 656.273. Where an injury has been in nondisabling status for one year or more after the date of the injury, aggravation rights run from the date of injury. ORS 656.273(4)(b).

Claimant was injured on May 14, 1986. The insurer accepted this injury as nondisabling. Claimant asserts that medical reports dated December 1, 1986 and March 16, 1987 notified the insurer that claimant's nondisabling claim became disabling within a year after the injury. Relying on Donald R. Fussell, 42 Van Natta 1084 (1990), claimant argues that his claim: (1) was not properly processed; (2) was disabling within a year of the injury; and (3) therefore, was misclassified as nondisabling. Under these circumstances, claimant argues, his aggravation rights commence on the date of closure, not the date of injury. We disagree.

Fussell is distinguishable on the facts. There, the record established that the claimant could not perform his regular work immediately after the injury. On that basis, we found that: (1) the claim was disabling from the outset; (2) the insurer misclassified the claim as nondisabling; and (3) the aggravation period extended for five years after the first determination order under former ORS 656.273(4)(a). Donald R. Fussell, supra.

Here, nothing in the record establishes that claimant's claim became disabling within one year of the injury. The two reports relied on by claimant are not in the record. The first report noting any impairment resulting from the work injury is dated more than three years after the injury. (Ex. 5). Therefore, under the statutory scheme noted above, claimant's aggravation rights run from the date of injury.

ORDER

The Referee's order dated January 18, 1991 is affirmed.

December 9, 1991

Cite as 43 Van Natta 2657 (1991)

In the Matter of the Compensation of
ELVIN SIMONIS, Claimant
Own Motion No. 66-0303M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a claim for medical benefits relating to claimant's July 9, 1962 industrial injury to his right eye. SAIF recommends reopening of claimant's claim to provide prescriptions, mileage, meals and lodging. In addition, SAIF requests that claimant's claim remain reopened to provide surgery and related medical services.

For conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b). Here, we find that the requested medical services are reasonable and necessary for the compensable injury and are required to maintain claimant's medically stationary status. Accordingly, claimant's claim is reopened to provide prescriptions, mileage, meals and lodging in an approximate amount of \$709.22. See OAR 438-12-037(1)(d).

In addition, we find that the requested surgery is reasonable and necessary for the compensable injury and is required to maintain and monitor the status of a prosthetic device. Accordingly, claimant's claim shall remain open to provide surgery to enucleate the right eye and related medical services, including the cost of a prosthetic eye, until claimant is again medically stationary. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. After those medical services are provided, SAIF shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

December 11, 1991

Cite as 43 Van Natta 2657 (1991)

In the Matter of the Compensation of
CONNIE VON EYNERN, Claimant
WCB Case No. 90-18428
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Lipton's order that upheld the insurer's backup denial of claimant's psychological condition. On review, the issue is propriety of the backup denial. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception and supplementation. We do not adopt the last sentence of the findings.

Claimant requested a hearing on the insurer's backup denial on September 21, 1990. The hearing was held on December 11, 1990.

On September 5, 1990, Dr. Gross, treating psychiatrist, essentially agreed with the opinion of Dr. Parvaresh, examining psychiatrist, with the exception that Dr. Gross opined that there was an organic or physiological trigger to claimant's somatic, psychological complaints. (Ex. 23). Since claimant had no physiological problem apart from her accepted compensable injury for which she was awarded permanent partial disability, Dr. Gross was referring to claimant's compensable injury when he opined that there was an organic or physiological trigger to her complaints.

The history reported by Dr. Gross in his December 5, 1990 report is essentially the same as that testified to by claimant at hearing. The testimonial history differs in this respect: Dr. Gross reported that claimant replaced depressive thoughts with fantasies about her boss; however, claimant testified that she went to counseling for an emotional flirtation a year or more before the injury. (Ex. 27-1, Tr. 19-20).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had the burden of proving that her compensable injury was the major contributing cause of her consequential psychiatric condition, and that she failed to carry her burden. We disagree that claimant has the burden of proof in this case. We conclude that, concerning the propriety of its backup denial, the insurer had the burden of proof, and failed to carry its burden.

Where a request for hearing is filed after May 1, 1990, and the hearing is convened after July 1, 1990, the 1990 amendments to the Workers' Compensation Law are generally applied retroactively, unless retroactive application produces an absurd or unjust result inconsistent with the purposes and policies of the Workers' Compensation Law. Ida M. Walker, 43 Van Natta 1402 (1991); see also Or Laws 1990, (Special Session), ch. 2, 54(1), (2). The matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, 54(3). Moreover, we do not find that the application of this change retroactively to this case will produce an absurd or unjust result inconsistent with the purposes and policies of the Workers' Compensation Law. Ida M. Walker, supra. Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Under the 1990 amendments, an insurer has two years, rather than 60 days, from the date of claim acceptance to revoke such acceptance and issue a formal notice of claim denial. However, if claimant requests a hearing from such a denial, the insurer "must prove by clear and convincing evidence that the claim is not compensable" ORS 656.262(6) (Emphasis added). Therefore, the insurer can prevail if it proves by clear and convincing evidence that claimant did not experience a compensable psychiatric condition as a consequence of the compensable injury. See Ervin E. Young, 43 Van Natta 2379 (1991). To be clear and convincing, the evidence must be free from confusion, fully intelligible and distinct. Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 407 (1987).

The record contains opinions from two psychiatrists relating to the cause of claimant's psychiatric condition. Dr. Gross, treating psychiatrist, opined that, given claimant's history, it was probable that the work injury was the major contributing cause of her depression. (Ex. 27). The Referee did not rely on Dr. Gross's opinion because he found it to be: (1) diametrically opposed to the opinion Dr. Gross expressed during his two years of treatment of claimant; and (2) based on a history which was different from that to which claimant testified. We disagree with these characterizations.

On March 30, 1988, Dr. Gross opined, after his initial examination of claimant, that there was much more to her psychological problem than her disability from a shoulder injury. (Ex. 7). However, after treating her for two years, he noted that claimant had a chronic pain condition that exacerbated in times of stress. (Ex. 17). Furthermore, although Dr. Gross essentially agreed with the opinion of Dr. Parvaresh, Dr. Gross disagreed in part and found that there seemed to be an organic or physiological trigger to claimant's somatic, psychological complaints. (Ex. 23). Although Dr. Gross's opinions contain some inconsistencies, we do not find them to be diametrically opposed to his ultimate conclusion that the injury was the major contributing cause of claimant's depression.

Furthermore, the history upon which Dr. Gross based his opinion is essentially the same as that testified to by claimant. (Compare Ex. 27 with Tr. 6, 7, 12, 13, 15, 16, 24). Some items of claimant's history noted by Dr. Gross were not discussed in claimant's testimony. However, there was an inconsistency with her testimony in that Dr. Gross noted that claimant replaced depressive thoughts with fantasies of her boss and claimant testified that she went to church counseling for an emotional flirtation at least a year before her injury. (Ex. 27-1, Tr. 19-20).

Dr. Parvaresh opined that claimant's psychological problems were due to other stressful events and not the result of the work injury. (Ex. 18-5). However, Dr. Parvaresh's report also contains inconsistencies. (Ex. 18). He found that claimant had no lasting orthopedic impairment. However, claimant was awarded five percent permanent partial disability, and Dr. Smith, treating chiropractor, continued to limit claimant to working 25 to 30 hours per week to minimize exacerbation of her symptoms. Furthermore, Dr. Parvaresh noted that claimant had claustrophobia, anxiety attacks, and problems dealing with her father's death and her husband's anxiety problem. Claimant credibly testified that she had none of these conditions or problems. (Tr. 9, 10, 11, 12, 18, 23, 25).

On this record, we are not persuaded that Dr. Parvaresh's opinion and the alleged "inconsistencies" in Dr. Gross's opinions constitute proof by clear and convincing evidence that claimant's psychological condition is not compensable. Therefore, the insurer has failed to carry its burden of proof.¹ Accordingly, we reverse the Referee's order which upheld the insurer's backup denial.

Claimant has prevailed in a rejected case. Hence, she is entitled to an

¹ Claimant contends that the insurer had the burden of proving by clear and convincing evidence that the work injury was not a material contributing cause of her psychological condition. Whether the evidence is analyzed under the "material contributing cause" or "major contributing cause" test, we conclude, for the reasons indicated, that the insurer failed to carry its burden of proving, by clear and convincing evidence, that claimant's psychological condition was not compensable.

assessed fee. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the backup denial issue is \$3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by the hearing and the record as a whole, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 15, 1991 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review concerning the backup denial issue, claimant's counsel is awarded an assessed fee of \$3,000, payable by the insurer.

December 11, 1991

Cite as 43 Van Natta 2660 (1991)

In the Matter of the Compensation of

ROGER J. FREI, Claimant

WCB Case No. 89-25550

ORDER ON REVIEW

Brothers, Drew, & Steelhammer, Claimant Attorneys

Schwabe, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The self-insured employer requests review of Referee Otto's order that increased claimant's unscheduled permanent disability award for a low back injury from 8 percent (25.6 degrees), as awarded by a Determination Order, to 53 percent (169.6 degrees). On review, the issue is extent of permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was entitled to a total award of 53 percent unscheduled permanent disability. We agree and, with the exception of the last two paragraphs on page 5 of his order, we adopt his conclusions and add the following supplementation.

On review, the employer does not dispute that claimant has developed a residual moderate depression condition as a result of his compensable injuries. It contends, however, that claimant is not entitled to an award of unscheduled disability for the condition because there is no evidence that the condition is permanent. We disagree.

In October 1990, physicians at the Oregon Pain Center concluded that claimant suffered from chronic pain behavior and moderate to severe depression related to his compensable injuries. They indicated that claimant tended to deal with his anxiety through perfectionistic and compulsive activities, which he was unable to perform as well as he normally would due to his chronic pain. They believed that his depression condition would resolve with significant improvement of his chronic pain syndrome.

Claimant subsequently enrolled in an eight-week treatment program at the Oregon Pain Center for the management of his pain. Despite some initial

objective improvements, however, claimant failed to subjectively recognize any changes and was unable to complete the program. The medical record reveals that claimant had a sincere desire to improve and was well motivated during the program, but his underlying personality and need for control prevented him from understanding the psycho-physical connection of doing that which might improve his condition. In the closing report, the medical staff at the pain center concluded that claimant's case should remain in medically stationary status and that he had continuing psychological impairment.

Based on those reports, as well as a review of other medical evidence, we believe that claimant has maximized his psychological improvement and, as the record now shows, that he is not likely to be able to make more progress. Accordingly, we conclude that claimant's depression condition is permanent under former OAR 436-35-400, and that the Referee properly considered the condition in rating the extent of claimant's permanent disability.

The employer next contends that claimant failed to mitigate the extent of his psychiatric impairment by unreasonably refusing to take psychoactive medication. We disagree. Claimant tried Prozac and had unacceptable side effects and lethargy. While it is true that several doctors reported that medication might be helpful in controlling claimant's panic and agitation, Dr. Holmes, the medical director at the pain center, concluded that he would not recommend the medication because claimant preferred the use of more conservative and self-directed approaches. Under those circumstances, we cannot say that claimant unreasonably failed to follow medical advice.

The employer last contends that, in increasing claimant's award of unscheduled permanent disability, the Referee failed to consider claimant's award of 10 percent unscheduled disability that he received after the 1985 compensable injury. We agree that an injured worker is not entitled to be doubly compensated for a permanent loss of earning capacity that would have resulted from the injury in question, but which had already been produced by an earlier accident and compensated by a prior award. See ORS 656.214(5); Mary A. Vogelaar, 42 Van Natta 2846 (1990). Although the Referee did not discuss his reasoning, we infer from his order that he considered the prior award and declined to allow an offset, based on his finding that, while claimant had not been released to heavy work following the 1985 injury, his first surgery was very successful and he had experienced a nearly complete resolution of his symptoms and pain. Although a loss of wage earning capacity was anticipated as a result of his first injury, such did not turn out to be the case. Claimant had no lost earning capacity at the time of this injury. After our review of the record, we reach the same conclusion.

Because the employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of permanent disability is \$900, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated March 18, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable fee of \$900, to be paid by the self-insured employer.

In the Matter of the Compensation of
RODNEY H. GABEL, Claimant
WCB Case Nos. 90-01883 & 90-14619
ORDER ON REVIEW
Allen, Stortz, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of those portions of Referee Garaventa's order that set aside its denial of the compensability of and responsibility for claimant's left carpal tunnel and tenosynovitis conditions. The issues on review are compensability and responsibility. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the exception of the last sentence on page two and the first sentence on page three. In addition, we supplement the facts as follows. Claimant is left hand dominant. After claimant's first carpal tunnel syndrome (CTS) surgery and before he went to work for SAIF's insured, claimant had constant numbness in the thumb and first two fingers of his left hand. During this period of time, after using his left hand from 20 minutes to two hours, his whole hand would become numb up to the wrist and he would experience a burning sensation with sharp pain going up into his left elbow. (Tr. 36, 39, 40, 43, 44).

The hearing on the December 19, 1989 denial by CNA Insurance Companies (WCB Case No. 90-01883) was scheduled to convene on May 23, 1990. CNA's motion to join SAIF and its insured was denied by Referee Holtan on May 16, 1990, and the Referee instructed claimant's attorney to file a claim against SAIF and its insured. Referee Holtan then took WCB Case No. 90-01883 off the docket for consolidation and joinder with the claim against SAIF. SAIF's denial issued July 11, 1990 and claimant timely requested a hearing. (WCB Case No. 90-14619). The two cases were consolidated and a hearing was convened on September 6, 1990.

FINDINGS OF ULTIMATE FACT

The major contributing cause of the tenosynovitis condition was claimant's work at SAIF's insured.

The major contributing cause of the recurrent CTS and the need for the second surgery was claimant's work at CNA's insured, the first surgery and the scar tissue which resulted from the first surgery.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

The Referee applied (to the claim denied by CNA) the law as it existed prior to the effective date of Senate Bill 1197, and applied (to the claim denied by SAIF) the law as amended by Senate Bill 1197. We disagree.

The hearing on CNA's denial, which was scheduled for May 23, 1990, never convened. Instead, it was taken off the docket and later consolidated with the hearing on SAIF's denial. That consolidated hearing convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Senate Bill 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See

e.g. SB 1197, 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze both claims under the Workers' Compensation Act as amended, effective July 1, 1990.

Compensability

The Referee found, in relying on Dr. Ellison, that the gross motor movements required in using the pressure washer at SAIF's insured were the major contributing cause of claimant's tenosynovitis and recurrent CTS and, thus, found claimant's current conditions to be compensable. ORS 656.802(1)(c). We adopt the Referee's analysis insofar as she found that work activities were the major contributing cause of the tenosynovitis condition. However, we disagree that claimant's work activities at SAIF's insured were the major contributing cause of the recurrent CTS condition. Nevertheless, we agree with the Referee's ultimate conclusion that the CTS condition is compensable.

Claimant can establish compensability of his CTS condition by proving by objective findings that his work activities were the major contributing cause of a worsening of that condition. ORS 656.802(1)(c). Causation in this matter presents a complex medical question that requires expert medical opinion in order for claimant to meet his burden of proof. Uris v. Compensation Department, 247 Or 420 (1967), Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

Dr. Ellison is claimant's treating physician and performed both CTS surgeries. Ellison stated that as a result of the first surgery, claimant developed significant scar tissue which was evident when the second surgery was performed. Furthermore, when given the history of the continuing numbness in claimant's left hand after the first surgery, Dr. Ellison opined that such numbness would be consistent with CTS flowing from scar tissue from the first surgery. (Ex. 40-24). He concluded that the major cause of the combined pathology, disability, and need for treatment was the original accepted injury with CNA, the first CTS surgery, and the resultant scarring from that surgery. (Ex. 39, 40-27).

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, we find no reason not to defer to the well-reasoned and un rebutted opinion of Dr. Ellison. (Exs. 33, 35). Accordingly, claimant has established a compensable occupational disease claim for his current CTS condition.

Responsibility

The Referee assigned responsibility for both the tenosynovitis and the CTS to SAIF. She based this ruling on her findings that the work activity at SAIF's insured was the major contributing cause of his tenosynovitis, and the tenosynovitis was the major contributing cause of the recurrent CTS. The Board affirms and adopts the Referee's reasoning and conclusion that SAIF is responsible for the tenosynovitis condition. However, we disagree with the Referee's assignment of responsibility for the recurrent CTS.

Section 49 of Senate Bill 1197 provides, in part:

"(1) When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable

medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability shall be processed as a new injury claim by the subsequent employer." Or Laws 1990 (Special Session), ch. 2, 49. (Emphasis added).

As the last carrier against whom claimant had an accepted CTS condition, CNA remains responsible unless it establishes that work activities with SAIF's insured were the major contributing cause of an occupational disease "involving the same condition." ORS 656.802(2): Donald C. Moon, 43 Van Natta 2595 (1991); Ricardo Vasquez, 43 Van Natta 1678 (1991). The deciding factor here is the interpretation of the phrase "involving the same condition."

In adding Section 49 regarding responsibility, the legislators were primarily concerned with protecting an injured worker's chances of being hired. On May 4, 1990, Representative Mannix testified:

"This says that there is going to have to be a new compensable injury and this bill defines compensable injury. And so if there isn't a new compensable injury under the definition of the law, then responsibility remains with the first employer. And the problems we have right now about people not being willing to hire workers with prior injuries should be reduced." Minutes, Interim Special Committee on Workers' Compensation, May 4, 1990, Tape 18, Side A at 407.

Interpreting "the same condition" to mean the identical condition for which the first employer was responsible will best carry out the legislative intent of making it more difficult to shift responsibility to a subsequent employer, thereby protecting injured workers' chances for employment. Accordingly, we adopt this interpretation of Section 49.

Thus, in order to shift responsibility to SAIF, CNA must establish that work activity with SAIF's insured was the major contributing cause of the recurrent CTS. As noted in the above discussion of compensability, the unrebutted and well-reasoned opinion of Dr. Ellison establishes that the major contributing cause of the recurrent CTS was claimant's accepted injury with CNA, the first surgery, and the scar tissue resulting from that first surgery. (Exs. 32, 39, 40-24, 40-25, 40-26, 40-27). Thus, claimant's work activity with SAIF was not the major contributing cause of the recurrent condition. Accordingly, we find that CNA remains responsible for claimant's recurrent CTS.

Attorney Fees

Because the Referee set aside SAIF's denial of both the CTS and tenosynovitis conditions, she assessed an \$1,800 attorney fee payable by SAIF for claimant's counsel's services at hearing in overcoming that denial. As discussed above, we set aside: (1) SAIF's denial only as it relates to the tenosynovitis condition; and (2) CNA's denial as it relates to the CTS condition. Therefore, we modify the attorney fee awarded at hearing. We find that a reasonable fee for claimant's counsel's services at hearing concerning: (1) claimant's tenosynovitis condition is \$900, to be paid by SAIF; and (2) claimant's recurrent CTS condition is \$900, to be paid by CNA. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issues, and the value of the interest involved. OAR 438-15-010(4).

Because SAIF initiated review and compensation was not disallowed or reduced with regard to the tenosynovitis condition, claimant's counsel is entitled

to an assessed fee under ORS 656.382(2), payable by SAIF. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the tenosynovitis condition is \$600, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 5, 1990 is reversed in part, modified in part and affirmed in part. The SAIF Corporation's denial of claimant's carpal tunnel syndrome is reinstated and upheld. CNA Insurance Companies' denial of claimant's carpal tunnel syndrome is set aside and that claim is remanded to CNA for further processing according to law. In lieu of the attorney fee assessed by the Referee, claimant's attorney is awarded an \$1,100 fee for services at hearing regarding claimant's carpal tunnel syndrome condition, payable by CNA, and a \$700 fee for services at hearing regarding claimant's tenosynovitis condition, payable by SAIF. For services on review, claimant's attorney is awarded an assessed fee of \$600, payable by SAIF. The remainder of the order is affirmed.

December 11, 1991

Cite as 43 Van Natta 2665 (1991)

In the Matter of the Compensation of
LEONARD R. GLAZIER, Claimant
WCB Case No. 90-14349
ORDER ON REVIEW
Flaxel, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerland.

Claimant requests review of Referee McWilliams' order that upheld the SAIF Corporation's: (1) denial of claimant's aggravation claim for a low back injury; and (2) partial denial of claimant's claim for cervical, chest, and left arm complaints. On review, the issues are aggravation and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Dr. Whitney, orthopedist, first treated claimant in 1979 and remained claimant's treating physician at hearing.

At the time of the September 21, 1987 Stipulated Order, claimant was able to perform his regular work as a truck driver.

FINDINGS OF ULTIMATE FACT

Claimant's cervical, chest, and left arm conditions are not causally related to the accepted low back strain.

Claimant experienced a symptomatic worsening of his lumbar spine, supported by objective medical findings, since his last arrangement of compensation (the September 21, 1987 Stipulated Order).

Claimant's symptomatic worsening resulted in a diminished earning capacity below the level fixed at the time of the last arrangement of compensation.

The Stipulated Order did not contemplate future periods of increased symptoms accompanied by a diminished earning capacity.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's aggravation claim for his accepted lumbar strain failed on two grounds: (1) claimant's symptoms were not more than waxing and waning of symptoms associated with the accepted condition; and (2) the major contributing cause of his current lumbar condition was the prior work injury which precipitated the 1981 surgery. Furthermore, the Referee found that claimant had not established that his cervical, chest, and left arm conditions were causally related to the 1986 accepted lumbar strain. Although we agree that claimant has not established the required causal relationship between his cervical, chest, and left arm conditions and the accepted lumbar strain; we find that he has established a compensable aggravation claim for his lumbar condition.

To establish an aggravation claim, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, he has suffered a symptomatic or pathologic worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991). See Larry L. Bowen, 43 Van Natta 1164 (1991). Furthermore, the major contributing cause of the worsened condition cannot be an injury occurring outside the course and scope of employment. ORS 656.273(1).

Lumbar Condition

Dr. Whitney, treating orthopedist, opined that claimant's lumbar condition had worsened since September 1987 based on the fact that claimant's tolerance for walking had decreased and claimant complained more about numbness in his legs, a symptom which had almost resolved before the March 1990 exacerbation. (Ex. 17-18). Dr. Whitney provides the only medical evidence as to whether claimant's lumbar condition worsened since the last arrangement of compensation.

A physician's evaluation based on claimant's subjective complaints can provide the requisite "medical evidence supported by objective findings." Suzanne Robertson, 43 Van Natta 1505 (1991); Robert E. Leatherman, 43 Van Natta 1678 (1991). Such findings may be based on a physically verifiable impairment, but may also be based on a physician's evaluation of the worker's description of the pain that he is experiencing. Jacquelyn L. Hetrick, 43 Van Natta 2357 (1991). Thus, we find that Dr. Whitney's opinion established a worsening of claimant's lumbar condition, based on objective medical findings, since the last arrangement of compensation.

The Referee found that claimant had not established a compensable aggravation of his lumbar condition because the major contributing cause of the worsened condition was the work injury precipitating the 1981 surgery. On review, SAIF also argues that claimant has not established that the 1986 injury was the major contributing cause of any worsening.

However, in Robert E. Leatherman, *supra*, we held that a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition, provided that no off-the-job injury is the major contributing cause of the condition. SAIF does not contend, and there is no evidence, that any off-the-job injury is the major contributing cause of claimant's worsened condition.¹

Dr. Whitney's deposition testimony, as a whole, establishes that the 1986 injury was a material contributing cause of claimant's worsened lumbar condition, although the major cause was the work injury which precipitated the 1981 surgery. (Ex. 17, pp. 13-23). Dr. Woolpert, orthopedist, examined claimant only once and provides the only other medical opinion as to causation. Like Dr. Whitney, Dr. Woolpert opined that the major cause of claimant's lumbar problems is the 1981 surgery. However, Dr. Woolpert also opined that the 1986 injury had little to do with claimant's current lumbar condition. (Ex. 13-6).

We find Dr. Whitney's opinion more persuasive, given his extensive treatment history with claimant. Thus, claimant has established that the 1986 injury is a material contributing cause of his worsened lumbar condition.

We further conclude that the exacerbation resulted in further diminished earning capacity. At the time of the September 1987 Stipulated Order, claimant was performing his regular work as a truck driver. (Exs. 5-1, 5-2). By comparison, claimant was released from all work after his alleged aggravation. (Ex. 11). Accordingly, we conclude that claimant's symptomatic exacerbation resulted in diminished earning capacity below the level fixed at the time of the September 1987 Stipulated Order.

We next consider whether the Stipulated Order contemplated future periods of increased symptoms accompanied by a diminished earning capacity. The Referee found that claimant's symptoms were not more than waxing and waning of symptoms associated with the accepted condition. On review, SAIF argues that Dr. Whitney's notation that claimant "has good days and bad days" prior to the September 1987 Stipulated Order indicates that future periods of waxing and waning were contemplated by the Stipulated Order. We disagree that the record establishes that the Stipulated Order contemplated any future periods of waxing and waning.

In Lucas v. Clark, 106 Or App 687 (1991), the court reaffirmed its position that "if there was medical evidence of the possibility of future flare-ups, the assumption is that the parties considered that evidence, unless there are indications to the contrary." *Id.* at 690. However, the court concluded that mere evidence of past flare-ups is not enough to establish that future flare-ups were contemplated given the fact that: (1) the Stipulated Order made no reference to the prognosis of the claimant's back condition and made no additional award for that condition; and (2) prior to the Stipulated Order no doctor had predicted future flare-ups of the condition. *Id.* at 691.

We find Lucas v. Clark, *supra*, dispositive on the issue of whether future flare-ups were contemplated by the September 1987 Stipulated Order. Here, the September 1987 Stipulated Order did not reference future flare-ups. Also, prior to this Stipulated Order, no physician predicted future flare-ups. We do not consider Dr. Whitney's comment that claimant "has good days and bad days" to be a prediction of future flare-ups. Therefore, we conclude that the September

¹ To clarify matters, claimant's 1981 injury also arose in the course of employment, and was accepted by SAIF.

1987 Stipulated Order did not contemplate future periods of increased lumbar symptoms accompanied by diminished earning capacity.

Furthermore, assuming arguendo that Dr. Whitney's comment establishes a prediction of future flare-ups that was considered by the Stipulated Order; Dr. Whitney also noted that, in spite of having good and bad days, claimant "is able to work." (Ex. 5-1). Assuming that Dr. Whitney's comments amount to a contemplation of future flare-ups, we find that claimant's release from work following the March 1990 exacerbation establishes that exacerbation as more severe than any contemplated on the basis of Dr. Whitney's statement.

On the basis of the above reasoning, we reverse the Referee on this issue and find that claimant has established a compensable lumbar aggravation claim.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the lumbar aggravation issue is \$2,750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's brief), the complexity of the issue, and the value of the interest involved.

Cervical, Chest, and Left Arm Conditions

The Referee found that the record did not establish the necessary causal relationship between the accepted lumbar strain and the cervical, chest, and arm conditions. We agree. Claimant contends that his cervical condition, including symptoms that radiate to his chest and left arm, was caused by the 1986 lumbar injury.

Claimant had preexisting cervical problems, including cervical degeneration. Furthermore, the 1986 incident injured only claimant's low back, not his neck. (Exs. 1, 2, 3). SAIF accepted only a low back strain as the 1986 claim; it did not accept any cervical, chest, or arm conditions. (Ex. 4).

If the compensable lumbar injury later resulted in a cervical condition, the resultant cervical condition would be considered a consequential condition. To establish compensability of his cervical condition, claimant must prove that the original compensable lumbar injury was the major contributing cause of his consequential cervical condition. See ORS 656.005(7)(a)(A); Julie K. Gasperino, 43 Van Natta 1151 (1991).

The record contains no medical evidence that the compensable lumbar injury is the major contributing cause of claimant's cervical condition. Dr. Whitney stated that the 1986 injury was a material cause of the cervical condition, but not the major contributing cause. (Ex. 17-20). Accordingly, we find that claimant has not established that his cervical, chest, and left arm conditions are compensable as a consequence of the 1986 lumbar injury.

ORDER

The Referee's order dated February 8, 1991 is reversed in part and affirmed in part. That portion of the SAIF Corporation's denial which denied an aggravation of claimant's lumbar strain is set aside and that portion of the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review, concerning the lumbar aggravation issue, claimant's attorney is awarded an assessed fee of \$2,750, to be paid by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
JAMES R. HANLEY, Deceased, Claimant
WCB Case No. 90-04221
ORDER ON REVIEW
Dennis Skarstad, Claimant Attorney
Tooze, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Neidig.

The insurer requests review of Referee Mills' order which set aside its denial of widow's benefits. In its brief, the insurer objects to the Referee's exclusion of Exhibit H, a certified copy of a portion of 1979 court records, and Exhibit 160, an article from a medical journal. On review the issues are evidence, entitlement to widow's benefits, and extent of permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

Claimant was 41 years old when he committed suicide on August 4, 1989.

Claimant had been an auto mechanic. He had a preexisting low back condition from a 1973 noncompensable incident lifting a transmission. He had his first back surgery that year and a second in 1974. Claimant continued to work as an auto mechanic. He sustained a compensable low back injury in 1982 while pulling out a transmission. (Ex. 1). A CT scan showed a bulge at L4-5 and a herniation at L5-S1. Claimant underwent a third back surgery performed by Dr. Nash on October 1, 1982. Claimant complained that his back condition was worse after the 1982 surgery, and he was admitted to the hospital in January 1983 for evaluation and treatment. (Ex. 32). A fourth low back surgery was performed by Dr. Nash on January 17, 1983. (Ex. 33). Claimant's postsurgical course was one of "definite improvement." He was discharged from the hospital "markedly improved" on January 28, 1983. (Ex. 34).

On the way home from the hospital in January 1983, claimant purchased a fifth of whiskey. (Ex. 121A-5). On arrival home from the hospital, claimant "threatened to kill [his] wife if she touched the phones," locked himself in his bedroom and attempted suicide by taking an overdose of percodan along with a fifth of whiskey. (Exs. 36, 98-2, 121A-5). Claimant was taken to the emergency room on January 29, 1983 and hospitalized to monitor his vital signs. (Ex. 36).

Dr. Mease, internist, started treating claimant in April 1983. His examinations showed that claimant was suffering from "an acute left L5 nerve root irritation, on top of an old L5 radiculopathy, and a new right S1 nerve root irritation, which was a new finding since August of 1983." (Ex. 61). Dr. Mease, and consulting physician, Dr. Gunn, did not think that there was a specific enough target to warrant another surgery at that time. (Ex. 61).

In November 1983, Dr. Mease wrote that claimant had come into his office intoxicated on at least two occasions. (Ex. 50-1). Dr. Mease referred claimant, upon claimant's request, to an in-patient alcohol treatment center. (Ex. 50). On December 4, 1983, claimant admitted himself for treatment of his chronic alcoholism. (Exs. 53, 54). On admittance, claimant's "screening blood chemistries were normal." (Ex. 53-2). Claimant reported on in-take that alcohol had caused problems in his life for "10-11 yrs." (Ex. 54-4). Claimant reported that he had experienced morning tremors (shakes), blackouts, that his alcohol use caused or worsened marital discord, had caused job problems and that he had been arrested or ticketed while intoxicated "3 yrs ago." (Ex. 54-4). Claimant was discharged from the alcohol treatment center on December 16, 1983. (Ex. 53-2). Claimant attended AA meetings for a few months thereafter. (Tr. 103).

Claimant's back pain continued. In 1984 he was taken to the emergency room due to complaints of severe pain. (Ex. 60). Dr. Nelson, neurologist, noted that claimant was depressed in April 1984. (Ex. 62). Claimant was examined by Dr. Pipe, psychiatrist, who gave claimant the MMPI test in May 1984. (Ex. 63). The test results, as reported by Dr. Pipe, indicated that claimant had a somatoform disorder on Axis I and a Dependent Personality Disorder on Axis II. (Ex. 63-2). Dr. Pipe opined that treatment of claimant by psychological insight did not portend a satisfactory outcome. (Ex. 63-2). Following a consultation with claimant, Dr. Pipe deferred a diagnosis on Axis I, and concluded that claimant had a hysteroid adjustment in a dependent personality on Axis II. (Ex. 67-3). Because he noted claimant's depression scale was "abnormally elevated," Dr. Pipe recommended that claimant take antidepressant medication. (Ex. 67-3). Claimant counseled with Dr. Pipe three times and then unilaterally ended treatment in October 1984. (Ex. 93).

From September 1983 through 1985, claimant received vocational rehabilitation counseling from Norman Alverson and Linda Young of Columbia Rehabilitation Consultants, Inc. (Tr. 296). Alverson saw claimant not only as a client, but also as a friend. (Tr. 296). Claimant discussed his drinking history and marital problems with Alverson. On Sunday night, October 30, 1983, claimant called Alverson at 9:00 p.m. Claimant was very agitated and sounded drunk. (Tr. 298, 299). Claimant told Alverson that he was upset about a number of things: his marital situation--he thought his wife was going to leave him, "the insurance system...he talked about a quarter million dollar award relative to things that he had gone through," and his anger with his treatment. (Tr. 299, 312). He told Alverson that he would "commit suicide and let payments go to his wife if he didn't get what he wanted." (Tr. 299, 312).

Claimant's claim was closed on November 8, 1985 with an award of 25 percent unscheduled disability, 40 percent scheduled disability for loss of use of the left lower leg and 5 percent scheduled disability for loss of use of the right lower leg. (Ex. 95).

In the Spring of 1985, claimant opened his own auto repair business. (Ex. 96). Claimant began bankruptcy proceedings for this business in January 1987, which culminated in April 1987. (Ex. 100A, 113A). On March 10, 1987, claimant was questioned by the insurer's investigator. (Ex. 102A). Claimant said that his physical condition had gradually worsened since he opened up the shop. (Ex. 102A-6). Claimant denied that his business had failed. Claimant said that he had to give up his business because he physically had not been able to handle it. (Ex. 102A-8). Claimant said that he had given his auto repair business, in its entirety, to his friend and shop supervisor, Duane Donovan, in December 1986. (Ex. 102A-12). Claimant said that he had not worked in the shop since November 1986, that he no longer had a financial interest in the business, and had received no income from the business since turning it over to Donovan in November 1986. (Ex. 102A-8&9). A business Income Statement, prepared by a bookkeeper, for the business, shows that claimant drew \$4,500 from the business for the month of December 1986, and \$600 for the month of November 1986. (Ex. 104-50 & 51).

A Referee's Opinion and Order, issued on November 17, 1987 and amended on December 11, 1987, awarded claimant an additional 35 percent unscheduled permanent disability, and 15 percent scheduled permanent disability for his right foot. (Ex. 112).

Claimant went to work for a trucking company in 1987, followed by a job in another auto repair shop, followed by two more jobs for truckings companies. (Tr. 100-102). Claimant worked 40-hour work weeks at each job. (Tr. 114). Claimant's back pain became worse. (Tr. 114).

On March 6, 1989, Dr. Dudley, M.D., performed a nerve block on claimant's lumbar spine at the S1 level to relieve claimant's radiating right leg pain. (Ex. 116). Claimant's back complaints continued through the Spring of 1989. On March 9, 1989, Dr. Herring, orthopedist, authorized time loss. (Ex. 116A). On April 13, 1989, Dr. Chaplin, orthopedic surgeon, performed a fifth surgery on claimant's low back--fusion and decompression of his lumbar spine. (Exs. 121, 127).

On April 22, 1989, a friend of claimant's, police Officer Ostrander, handwrote a 15-page letter to an attorney, signed by claimant, explaining claimant's medical history for purposes of pursuing a medical malpractice suit. (Ex. 121A; Tr. 27).

Claimant's wife moved out of the house around July 22, 1989. (Tr. 107). Claimant was drinking heavily at this time. On July 31, 1989, claimant "was drunk and fell down [the] stairs" in his home and was taken to the emergency room by ambulance complaining of back pain. (Ex. 129A-7). Emergency room staff recommended that claimant be admitted for observation but claimant was belligerent and refused to stay. (Ex. 129A-9, 130).

At 5:45 a.m., August 4, 1989, claimant was taken to the emergency room by ambulance complaining of chest pains. (Ex. 133B-1). Claimant was intoxicated and agitated. (Ex. 133B). Claimant's blood alcohol was .286. (Ex. 133B-4). Claimant was ultimately released and returned home by cab. (Ex. 133B-1). After returning home, claimant called his wife a few times between 7 and 8 a.m. (Tr. 90, 109). Claimant told his wife he was going to the beauty shop where she worked and that he would have a gun with him. (Tr. 109). Claimant told his wife that he was going to kill her and himself. (Tr. 44, 109).

Later that morning, at approximately 9:40 a.m., claimant called the police station and talked with his friend, Officer Ostrander. (Ex. 134). Claimant told Officer Ostrander that he had a gun in his hand and was going to kill himself. Claimant said that he had already tried to pull the trigger once "but couldn't do it." (Ex. 134-2). At times during the call claimant cried, at other times, claimant talked in a monotone. Claimant said that he was going to kill himself because he loved his wife and she was not coming back to him. Officer Ostrander tried to talk claimant down, but he was unable to do so. Claimant shot himself in the head and died later in the hospital.

ULTIMATE FINDINGS OF FACT

At the time claimant committed suicide, he was not suffering from a compensable impairment of his reasoning facilities that caused his suicidal act to be an involuntary one.

Claimant's abuse of alcohol preexisted his compensable injury. Claimant's abuse of alcohol was not causally related to his compensable injury.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters

The Referee sustained claimant's widow's hearsay objections to documentary evidence of claimant's former wife's 1979 affidavit for a restraining order against claimant, Exhibit H, and a medical journal article, Exhibit 160.

A referee is not strictly bound by formal rules of evidence. See ORS 656.283(7). Hearsay evidence may be admitted in workers' compensation proceedings when there are sufficient indicia of reliability and when it is in the

interest of substantial justice to do so. See Armstrong v. SAIF, 67 Or App 498, 501 n.2 (1984).

With respect to the former wife's 1979 affidavit, the referee erred in failing to admit it. The affidavit was executed to prevent physical abuse, not to achieve any gains in the divorce action. Physical restraining orders are not part of every dissolution proceeding. Its sworn nature is sufficient indication of its reliability for the purpose it was offered. Inasmuch as the exhibit is in the record, we have considered it on review.

A journal article offered alone is usually admitted only if it forms the basis for an admitted, expert opinion. Joseph J. Hahn, 42 Van Natta 1621 (1990). In the present case, the insurer's witness, Dr. Glass, psychiatrist, brought a medical journal article to the hearing on the second day of his testimony to demonstrate support for his medical opinion. There is no indication that Dr. Glass based his opinion on this article. He brought it with him in order to show that others in the field thought as he did about alcoholism. Therefore, the article was intended to be used as substantive evidence. As the authors of the article were not available for cross-examination, it was hearsay and the Referee did not abuse his discretion by declining to admit the exhibit. Consequently, the article will not be considered on review.

Claimant requested a hearing before May 7, 1990 and that hearing convened before July 1, 1990. Therefore, this matter was in litigation before July 1, 1990 and shall be determined pursuant to the law in effect before the legislative amendments became effective July 1, 1990. Or Laws 1990, ch. 2, 54(2).

Compensability

The Referee concluded that claimant's surviving spouse had established that claimant suffered from a work-related psychological condition which caused, or was itself, a mental derangement that impaired claimant's ability to resist the compulsion to take his own life. Therefore, the Referee concluded, claimant's spouse was entitled to death benefits stemming from claimant's suicide. We disagree.

ORS 656.156(1) requires that:

"If injury or death results to a worker from the deliberate intention of the worker to produce such injury or death, neither the worker nor the widow, widower, child or dependent of the worker shall receive any payment whatsoever under ORS 656.001-656.794."

However, under the "chain-of-causation" test, the beneficiaries of a worker who commits suicide will be entitled to payments under ORS 656.001 to 656.794 if it is shown that the worker acted from an uncontrollable impulse resulting from a compensable impairment of the worker's reasoning facilities which caused the suicidal act to be an involuntary one. Ahn v. Frito Lay, Inc., 91 Or App 443, 446 (1988).

The insurer argues that claimant's suicide was a conscious, deliberate and premeditated act, precluding benefits to claimant's widow under ORS 656.156(1). Claimant's widow argues that claimant's compensable injury and consequential years of chronic pain caused claimant to suffer from a major depression which impaired claimant's reasoning facilities so that his suicide was an involuntary act.

Although the record consists of three days of testimony and depositions from medical experts regarding claimant's mental condition at the time of his

suicide, all the opinions testified to are, by necessity, suppositions developed posthumously from the experts' exhaustive review of the documentary evidence. The only medical expert to provide testimony from firsthand personal experience with claimant's psychological condition is Dr. Colbach, psychiatrist, who examined claimant once in 1986 as part of a panel examination for the insurer. At that time, Dr. Colbach diagnosed claimant with "alcohol abuse, in the past," and an "adjustment disorder with depressed mood, better at this point in time." (Ex. 98-3 & 4). However, no other medical diagnosis of claimant's psychological condition was made between the time of Dr. Colbach's 1986 diagnosis and claimant's suicide.

The expert testimony displays differing views of claimant's psychological condition. We are persuaded by the well-reasoned and supported opinions of Drs. Scott and Glass. Dr. Scott, psychologist, whose specialty is the treatment of alcoholism, did not find that claimant could have suffered from a compensable psychological condition. He opined that claimant suffered from alcoholism on Axis I, a personality disorder on Axis II and that the alcoholism and personality disorder fed into each other causing claimant's suicide. Dr. Scott opined that claimant would have been an alcoholic without his back pain. Dr. Scott based his alcoholism diagnosis on claimant's early use of alcohol and family history.

Dr. Glass, psychiatrist, whose specialty is also the treatment of alcoholism, did not find that claimant could have suffered from a compensable psychological condition at the time of his suicide. He diagnosed claimant's psychological condition on Axis I as chemical dependency, chronic and acute, along with, perhaps, an adjustment disorder or dysthymic condition. On Axis II, Dr. Glass opined that claimant might have had a borderline personality disorder. Dr. Glass's testimony supports a finding that claimant's alcoholism preexisted his injury, caused claimant's depression and was a cause of claimant's suicide.

Although Dr. Colbach testified that, in his opinion, claimant "probably obviously had a bad depression, major depression, because he committed suicide," we do not think that his opinion varies that greatly from Drs. Scott and Glass because he attributed claimant's suicide to claimant's use of alcohol. (Ex. 153-7). Dr. Colbach explained that, in his opinion, "anyone who ends up killing themselves has to be thought to have a major depression." (Ex. 153-8). However, he opined that "alcohol was the real villain" in this case "if [claimant] was dry, we will have a lot less pain and we would have a lot less of different things, depression and alcohol." (Ex. 153-34). Furthermore, in his opinion, chronic pain did not cause claimant's alcoholism.

We are not persuaded by the opinions of Dr. Smith, forensic psychiatrist, and Dr. Colistro, psychologist, the experts supporting claimant's widow's argument that claimant's psychological condition at the time of his suicide was work-related and impaired his ability to resist the compulsion to take his own life.

Dr. Smith opined that claimant had a work-related mental disorder beginning soon after his initial surgery in 1982 until his death in 1989. Dr. Smith opined that claimant's use of alcohol was secondary to his depression and that claimant only used alcohol to self-treat his pain, and that claimant was not an alcoholic. Dr. Smith did not take into consideration the fact that claimant said his father was an alcoholic, that claimant admitted early use of alcohol and a long history of problems with alcohol and an alcohol-related arrest. Furthermore, Dr. Smith testified that he based his opinion on claimant's "lack of prior preoccupation" with the idea of suicide and because claimant's suicide was sudden. (Tr. 148). Dr. Smith does not appear aware that claimant attempted suicide in 1983 and later discussed suicide with his rehabilitation counselor. Dr. Colistro provides insufficient support for his opinion that claimant's 1982

compensable injury caused claimant's alcohol abuse as well as claimant's psychological condition.

The expert testimony displays a variety of opinions regarding alcoholism, the effects alcohol and alcoholism have on an individual's behavior and psychological condition, and whether claimant should be considered to have been an "alcoholic." The threshold question is whether claimant's alcohol abuse/ alcoholism preexisted his compensable injury. We conclude that it did. The Referee discounted claimant's statements on the 1983 intake form for his admission for treatment of his then-admitted, chronic alcoholism. We find that claimant's statements on the intake form--that alcohol had caused problems in his life for "10-11 yrs, "that he had experienced morning tremors (shakes), blackouts, that his alcohol use caused or worsened marital discord, had caused job problems and that he had been arrested or ticketed while intoxicated "3 yrs ago"--are reliable and supported by other evidence in the record, such as claimant's statements to his rehabilitation counselor regarding his drinking history and his widow's testimony affirming his alcohol-related arrest. Therefore, we must decide whether claimant's worsened abuse of alcohol was compensably related to his compensable injury.

The Referee concluded that claimant's abuse of alcohol coincided with his attempts to control his chronic, injury-related pain. In reaching this conclusion, he relied heavily upon claimant's April 1989 letter. (Ex. 121A). The Referee found this letter reliable because it was not prepared for purposes of this litigation. Therefore, the Referee concluded, claimant had no reason not to be truthful about his alcohol use. We do not agree. The letter was written to a law firm for purposes of pursuing a medical malpractice suit against one of his surgeons. Therefore, claimant had considerable incentive for attributing all negative factors, including his alcohol abuse, to his compensable injury and subsequent surgery. Accordingly, we do not attach the same persuasive value to this letter as did the Referee.

Other than claimant's allegations that he used alcohol for his pain, which we have discounted, there is insufficient persuasive evidence to conclude that there is a causal relationship between claimant's abuse of alcohol and his compensable injury.

Moreover, the factual evidence and persuasive medical testimony indicates that claimant's psychological condition was not so impaired as to preclude his ability to resist an impulse to kill himself. Drs. Scott and Glass opined that claimant's reasoning ability was not so impaired and that claimant made a deliberate decision to kill himself. Claimant had attempted suicide before in 1983 by the use of pills and alcohol. Claimant told his rehabilitation counselor in 1983 that he had thought about a suicide plan and that he would "commit suicide and let payments go to his wife if he didn't get what he wanted." Finally, as part of his suicide act, claimant called the police station and talked to Officer Ostrander for a period of time, expressing his intention to kill himself. As Dr. Scott explained, claimant's conversation with Officer Ostrander indicates that claimant's decision to commit suicide was well thought out. Dr. Glass explained that claimant's dialogue with Officer Ostrander indicates that claimant had already debated his suicide in his own mind. Dr. Scott opined that alcohol does not preclude a person who is intoxicated from forming an intent to commit a certain act and that the alcohol probably bolstered claimant's plan to commit suicide. In this regard, four hours before his death, claimant's blood alcohol level was more than 1-1/2 times above the legal intoxication level. (Ex. 133B).

Accordingly, because claimant's suicide did not occur as a result of his compensable injury, claimant's widow is precluded from receiving death benefits. In the alternative, claimant's widow raised the issue of the extent of

claimant's disability at the time of his suicide and we proceed with that analysis.

Permanent Total Disability

Claimant's widow argues that claimant was permanently, totally disabled at the time of his death.

We have concluded that claimant's widow has not sustained her burden to show that claimant had a compensable psychological condition. Additionally, the prognosis for claimant's physical condition subsequent to his April 1989 surgery was good. Claimant's treating physician, Dr. Chaplin, F.R.C.S., reported on June 5, 1989 that he had last seen claimant on May 23, 1989 and that claimant had been doing very well, had very little pain and was feeling better. (Ex. 126). In fact, on July 28, 1989, Dr. Chaplin wrote that he thought claimant was "ready to enter a work hardening program with a view to return to the work force." (Ex. 127).

Accordingly, we conclude that there is no evidence to show that claimant was permanently totally disabled at the time of his death.

Extent of Permanent Partial Disability

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and .295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). A determination of permanent partial disability cannot be made before claimant has been determined to be medically stationary, i.e., that no further material improvement of his compensable condition would reasonably be expected from medical treatment or the passage of time. Since reopening of claimant's claim for his April 1989 surgery, claimant's condition had not been determined to be medically stationary. Accordingly, we cannot determine permanent disability based upon a medical expert's speculation of what claimant's disabilities might have been had he lived.

ORDER

The Referee's order dated December 17, 1990 is reversed. The insurer's denial of widow's benefits is reinstated and upheld. The Referee's attorney fee award is reversed.

December 11, 1991

Cite as 43 Van Natta 2675 (1991)

In the Matter of the Compensation of

HAMANA MAHUIKA, Claimant

WCB Case No. 90-17598

ORDER ON REVIEW

Carney, et al., Claimant Attorneys

Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Galton's order which: (1) affirmed a Determination Order that awarded 15 percent (48 degrees) unscheduled permanent disability for a low back injury; (2) assessed a penalty against the insurer under ORS 656.262(10) for improperly terminating temporary total disability; (3) awarded an attorney fee under ORS 656.382(1), for the same conduct; and (4) awarded a \$950 assessed fee for prevailing against the insurer's cross-request for hearing concerning the Determination Order. On

review, the issues are permanent disability, claims processing, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant attended the University of Hawaii as a biology major until his junior year. (Ex. 9-3). He is capable of work in the medium work category. (Ex. 48-5). Claimant found work as a dump truck driver in November 1990. (Ex. 48-3). At hearing, he was not working because he did not have enough seniority to work through the winter months. (Tr. 23).

Dr. Christensen, chiropractor, saw claimant on March 16, 1988 and found 24 percent impairment. (Ex. 13-8). Dr. Christensen reexamined claimant on May 9, 1990. Dr. Christensen found claimant had 21 percent impairment of the whole person. (Ex. 34-7).

Dr. Howell, osteopath, first saw claimant on July 26, 1987 and reexamined him on November 13, 1990. (Exs. 9; 48). Howell concluded that claimant's condition was unchanged or minimally improved compared to his condition before the February 1990 compensable injury. (Ex. 48-5). Dr. Howell also opined that claimant's permanent impairment was due to his injuries before the February 27, 1990 compensable injury. (Ex. 48-6). Dr. Ho, orthopedist, could find no permanent impairment. (Ex. 50).

FINDINGS OF ULTIMATE FACT

Claimant has not suffered a permanent loss of earning capacity as a result of the February 1990 compensable low back injury in excess of the 15 percent scheduled permanent disability award he received for his 1985 compensable injury.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

The insurer argues that claimant has not shown any permanent impairment due to the February 1990 injury and that any permanent disability which claimant has was present before the February 1990 injury. We agree that if claimant does suffer from disability due to preexisting injuries, such disability should be taken into consideration in arriving at a permanent disability award for the current injury. See ORS 656.214(5); Mary A. Vogelaar, 43 Van Natta 1370 (1991).

In Vogelaar, we determined the extent of the claimant's unscheduled permanent disability by first determining the extent of disability under the "standards." Then, a determination was made whether, and to what extent, that determination included unscheduled permanent disability which was not due to the current injury because it was already existing before the current injury. We reasoned that, pursuant to ORS 656.214(5), an injured worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question, but which had already been produced by an earlier accident and compensated by a prior award.

Accordingly, we first proceed to rate claimant's permanent disability under the "standards."

The Referee affirmed the Determination Order which awarded claimant 15 percent unscheduled permanent disability. We apply the "standards" in effect on July 11, 1990, the date of the Determination Order. Former OAR 436-35-270

through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Age and Education

The appropriate value for claimant's age of 41 years is 1. Former OAR 436-35-290.

The appropriate value for claimant's 15 years of formal education is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was a bus driver (DOT # 913.463-010). Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in a specific vocational pursuit. Claimant was a four-year apprentice carpenter and reached journeyman status. Claimant has also received training as a bus driver and as a dump truck driver. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Adaptability

The adaptability value for a claimant who has either returned to modified work or received a work offer [see former OAR 436-35-270(3)(d)] is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required a light physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3).

Impairment

We find Dr. Howell's report to be most persuasive. He examined claimant in 1987 after his first injury, and examined him again in November 1990 after the second injury. He provides the most well-reasoned and complete opinion. Somers v. SAIF, 77 Or App 259 (1986). Dr. Howell finds that claimant's current condition is unchanged to minimally improved from his condition in 1987. Dr. Howell states that claimant now shows some minor improvement since 1987 in that his right thoracolumbar lateral flexion is now normal whereas in 1987 it was 25

degrees. Dr. Howell found that claimant had a normal thoracolumbar range of motion with the exception of 24 degrees left thoracolumbar flexion. This equals an impairment value of 1.2 under former OAR 436-35-360(8).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to his education value 2, the sum is 3. When that value is multiplied by claimant's adaptability value 2.5, the product is 7.5. When that value is added to claimant's impairment value 1.2, the result is 8.7. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 9 percent.

Consideration of Prior Award

We now turn to the question of whether a portion of claimant's permanent loss of earning capacity had already been produced by his earlier accidents and compensated by his prior award of 15 percent unscheduled permanent disability.

The Referee reasoned that until the February 1990 compensable injury claimant could perform all his regular duties. However, Dr. Howell opined on July 26, 1987 that claimant was not physically qualified to safely resume his job activities as a bus driver. Nevertheless, claimant resumed this work and was injured. We conclude that claimant was already unable to perform his regular duties when he was injured in February 1990.

Dr. Howell examined claimant in 1987 after his first injury, and examined him again in November 1990 after the second injury. Dr. Howell found that claimant's current condition is unchanged to minimally improved from his condition in 1987. Dr. Howell concludes that claimant's condition prior to February 27, 1990 is the major and probably the sole cause of his current impairment.

Dr. Ho, an orthopedist, examined claimant on January 9, 1991. He found no impairment of function with regard to loss of range of motion.

Dr. Christensen, a consulting chiropractor, examined claimant on May 5, 1990. Dr. Christensen opined that claimant had 21 percent impairment of the whole person, including 9 percent loss of range of motion in the thoracolumbar spine. Dr. Christensen did not differentiate between impairment caused by the February 27, 1990 injury and the June 23, 1985 injury.

Based on these medical evaluations, we are inclined to conclude that claimant has not suffered measurable impairment as a result of his February 1990 compensable injury. Without measurable impairment, claimant is not entitled to an award under the standards. See former OAR 436-35-270(2). In any event, even if claimant has sustained permanent impairment as a result of the February 1990 compensable injury, such impairment is so minimal that when claimant's prior award of 15 percent unscheduled permanent disability is considered claimant's permanent disability does not exceed the 15 percent value previously granted to him.

Penalties and Attorney Fees

The Referee found that the insurer's action in reducing claimant's temporary total disability benefits to temporary partial disability violated OAR 436-60-030(5) and was unreasonable. The Referee assessed a 25 percent penalty under ORS 656.262(10). We adopt the Referee's conclusions and reasoning that the

insurer's termination of temporary total disability in violation of the administrative rule was unreasonable.

While we agree that a penalty was warranted here, we do not agree that claimant is also entitled to an attorney fee under ORS 656.382(1) for this same unreasonable conduct. Subsequent to the date of the Referee's order, we held that the simultaneous assessment of an attorney fee under ORS 656.382(1) and a penalty under ORS 656.262(10) would contravene the intent of the legislature expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the penalty; "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991). Therefore, claimant's attorney is not entitled to a separate attorney fee under ORS 656.382(1). Instead, claimant's attorney is entitled to one-half of the penalty assessed under ORS 656.262(10)(a) as granted by the Referee.

Attorney Fee for Prevailing Against a Cross-Request for Hearing.

Because claimant did not prevail against the insurer's cross-request for hearing he is not entitled to an assessed attorney fee. In addition, we note that claimant is not entitled to an attorney fee on Board review for successfully defending the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 7, 1991 is affirmed in part and reversed in part. The Determination Order award of 15 percent (48 degrees) unscheduled permanent disability is reversed. The Referee's attorney fee awards of \$850 and \$950 are reversed. The remainder of the Referee's order is affirmed.

December 11, 1991

Cite as 43 Van Natta 2679 (1991)

In the Matter of the Compensation of
DONALD C. MOON, Claimant
WCB Case Nos. 90-14189 & 90-09730
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Pamela Schultz, Defense Attorney
Davis & Bostwick, Defense Attorneys

Claimant has requested reconsideration of our November 27, 1991 Order on Review. Specifically, claimant contends he is entitled to an assessed attorney fee of review for services on review. After considering claimant's motion and memorandum in support, we issue the following order.

Compensability was litigated and decided at hearing. The Referee's order resolved compensability and responsibility issues. Therefore, claimant's right to compensation remained at risk by virtue of the Board's de novo review authority. See Riley E. Lott, Jr., 43 Van Natta 209 (1991). Because Liberty Northwest requested review and claimant's compensation was not reduced or disallowed, claimant is entitled to an assessed fee under ORS 656.382(2). Tanya L. Baker, 42 Van Natta 2818 (1990). Although the compensability issue arose from Aetna's denial, since Liberty Northwest sought Board review, Liberty Northwest shall be responsible for the assessed attorney fee for claimant's counsel's services on Board review. See Cigna Insurance Companies v. Crawford & Co., 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$150 to be paid by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order in its entirety, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

December 11, 1991

Cite as 43 Van Natta 2680 (1991)

In the Matter of the Compensation of
DAVE G. OWEN, Claimant
And, In the Matter of the Complying Status of
CHARLES W. AND MINERVA A. BLAIN dba WESCO TRUCKING, Employer
WCB Case No. 86-09303
ORDER ON REMAND
Kenneth D. Peterson, Claimant Attorney
Leeroy Ehlers, Attorney
DebraAnn Kronenberg (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Blain v. Owen, 106 Or App 285 (1991). The court affirmed that portion of our order in Dave G. Owen, 41 Van Natta 2069 (1989), which held that claimant was a subject worker and that Blain was a noncomplying employer. However, the court reversed that portion of our order in which we concluded that we could not consider Blain's contention that claimant's injury did not arise out of and in the course of his employment. Reasoning that, as an employer, Blain could request a hearing on compensability "at any time" pursuant to ORS 656.283(1), the court remanded for consideration of the compensability issue.

FINDINGS OF FACT

We adopt the Referee's findings of fact as set forth in the "Findings of Fact and Conclusions" section of the Referee's order with the following supplementation and modification.

Claimant drove one of Blain's potato-hauling trucks. Claimant's work schedule varied, depending on the amount of potatoes available for transport. The only day of the week that claimant did not work for Blain driving truck was Sunday.

In addition to driving, claimant was responsible for adding oil and water to the engine of the truck. The truck's other mechanical needs were handled by Shirley. On one occasion, claimant was paid \$5 per hour by Blain to perform some welding on a trailer owned by Blain.

On Sunday, September 8, 1985, the truck was parked in front of Shirley's garage in preparation for Shirley to repair the hydraulic lift cylinder. At the time he was injured, claimant had lifted the truck's cab and was attempting to repair the hydraulic lift cylinder. Neither Blain nor Shirley were aware of claimant's presence at the garage until a friend of claimant told them that claimant was trapped under the cab of the truck.

CONCLUSIONS OF LAW AND OPINION

In order to be compensable, claimant's injury must arise "out of and in the course of employment." ORS 656.005(7)(a). The statute is satisfied if the injury is sufficiently work-related that it should be compensable. Rogers v. SAIF, 289 Or 633, 642 (1985).

There are seven factors for determining whether an injury is sufficiently work-related, including: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee at the time of hiring or later; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; (7) whether the employee was on a personal mission of his or her own. Mellis v. McEwen, Hanna, Griswold, 74 Or App 571, 574, rev den 300 Or 249 (1985). A claimant need not satisfy every criteria; no single factor is dispositive. Preston v. SAIF, 88 Or App 327, 331 (1987). Each claim is decided on a case-by-case basis. Haugen v. SAIF, 37 Or App 601, 604 (1978).

In addition to the above guidelines, we also note that, as a general rule, an employee who performs an act outside of his regular duties which is undertaken in good faith to advance the employer's interests is within the course of employment. 1A Larson, Workmen's Compensation Law 27.00 (1979). Not every act, however, which benefits the employer is in the course of employment and therefore compensable; for instance, although advancing the employer's interests, the act may be outside the reasonable bounds of employment or expressly prohibited by the employer. Id. at 27.13-27.14.

Turning to the facts of this case, we first conclude that, because he was attempting to repair the hydraulic lift cylinder on Blain's truck, claimant's activity at the time he was injured was for the benefit of the employer. As we previously stated, that is an important consideration in determining whether the injury is related to claimant's work. The activity, however, was not contemplated by Blain or claimant at the time of hiring since claimant's responsibilities regarding engine maintenance were limited to adding oil and water. Claimant, therefore, went beyond his regular duties when he began working on the truck at Shirley's garage.

Moreover, we conclude that claimant went beyond the reasonable bounds of his employment when he undertook the repair of the hydraulic lift cylinder. Blain did not direct claimant to repair, or even examine, the truck. On the contrary, Blain had hired another person, Shirley, to repair the truck. Blain was not even aware that claimant had raised the cab or was on Shirley's premises. Claimant was not paid for repairing the truck. Finally, the act occurred on a Sunday, a day when claimant was not scheduled to work.

Accordingly, we conclude that claimant's injury did not arise "out of and in the course of employment" as required by ORS 656.005(7)(a). Consequently, we hold that claimant's injury claim is not compensable.

On reconsideration, we reverse the Referee's March 29, 1988 order approving SAIF's acceptance of claimant's injury claim. In addition, we reverse the Referee's attorney fee award.

IT IS SO ORDERED.

In the Matter of the Compensation of
VICKIE L. PASTORINO, Claimant
WCB Case No. 90-16645
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Crumme's order which: (1) upheld the insurer's denial of her claim of injury to her neck, back and arms; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" except findings (1) and (6), and supplement the adopted findings as follows. The employer hired claimant in the first part of May 1990. She told the employer that she could not perform heavy lifting because she had back problems. Claimant had a history of neck, arm and back problems since 1984, when she was thrown from a porch and landed on her head and back.

On May 31, 1990, claimant sought chiropractic treatment from Dr. Jackson for reported low back pain and bilateral arm numbness.

FINDINGS OF ULTIMATE FACT

We adopt the Referee's "Finding of Ultimate Fact" with the following supplementation. Claimant did not have any incident at work on May 29, 1990 which was a material contributing cause of claimant's disability or need for treatment.

CONCLUSIONS OF LAW

The Referee found that claimant became disabled and needed treatment commencing on May 29, 1990 due to a combination of an injury at work on the said date and claimant's preexisting neck, back and arm conditions. Finding the case governed by ORS 656.005(7)(a)(B), the Referee concluded that claimant was not entitled to disability compensation or treatment because her preexisting conditions were the major contributing cause of any disability or need for treatment. We agree that the case is governed by ORS 656.005(7)(a) and that claimant failed to carry her burden of proof.

In Bahman M. Nazari, 43 Van Natta 2368 (1991), the Board held that a determination of compensability under ORS 656.005(7)(a)(B) is a two-part test, if there is a preexisting condition. First, it must be determined whether there was a "compensable injury" under ORS 656.005(7)(a), i.e., an accidental injury arising out of and in the course of employment. Thus, claimant must first prove by a preponderance of the evidence that an incident at work on May 29, 1990 was a material contributing cause of her disability or need for medical treatment.

The alleged incident of May 29, 1990 was unwitnessed. Claimant testified that while yanking hard on some screens that were slightly above her head, her head snapped back, she heard a "crack," and immediately experienced a numbing feeling which moved upward through the back of her head, through her neck and down her shoulders. Also, severe pain that had a numbing effect shot through her arms and neck.

We conclude that claimant has failed to carry her burden of proving that the incident she described, in fact occurred. Claimant was examined on several occasions by several doctors during the two months after the alleged incident. Her treating physician, Dr. Brus, initially diagnosed carpal tunnel syndrome and "post-old injury in the mid-upper back area," based on the following history:

"Here today complaining of an aching and tingling feeling in her right forearm and fingers. She notices she has difficulty holding on to things [because of] her fingers and hand. She is awakened in the middle of the night [because of] the pain and has difficulty driving [because of] that hand. She works as a cook in one of the local restaurants and has to carry around a lot of heavy pots and pans. She also indicates that about 6 years ago she injured the mid-upper back area and has had some pain in that area, shooting up into the neck on the left side of the face, giving her some numb, tingling sensations. She has visited a chiropractor and had x-rays done and was told she has some curvature of the spine." (Ex. 4).

Claimant did not report to any physician that her problems resulted from a specific incident at work until July 26, 1990, when she saw Dr. Aberdeen. This was almost two months after her first doctor visit following the alleged incident. (Ex. 10-2). After examinations, including x-rays and an MRI scan, Dr. Brus ultimately withdrew his diagnosis of carpal tunnel syndrome, and opined that claimant had no physical problems, except that which is due to a lack of any regular exercise. (Ex. 13). Dr. Aberdeen ultimately opined that if claimant had any problems, they are recurring and attributable to preexisting conditions. (Ex. 10-2, Ex. 15).

Dr. Jackson, claimant's chiropractor, is the only doctor who attributes claimant's complaints to an injury occurring on May 29, 1990. We agree with the Referee that the opinions of Dr. Brus and Dr. Jackson are more comprehensive and persuasive. We conclude that claimant has failed to prove by a preponderance of the evidence that she suffered a compensable injury on May 29, 1990. At most, the evidence suggests that claimant's normal work activities made her preexisting condition symptomatic. See Taylor v. Multnomah Co. School District No. 1, 109 Or App 499 (1991).

Assuming, arguendo, that a specific incident did occur on May 29, 1990, and claimant proved a "compensable injury," within the meaning of ORS 656.005(7)(a), we affirm and adopt the reasoning and conclusion of the Referee that claimant failed to establish that her compensable injury is and remains the major contributing cause of any disability and need for treatment commencing May 29, 1990.

Penalties and Attorney Fees

We adopt the Referee's order as it pertains to penalties and attorney fees.

ORDER

The Referee's order dated February 11, 1991 is affirmed.

In the Matter of the Compensation of
MICHAEL L. PINDER, Claimant
Own Motion No. 91-0440M
OWN MOTION ORDER REFERRING FOR FACTFINDING HEARING
Saif Legal Department, Defense Attorney

The SAIF Corporation voluntarily reopened claimant's 1985 claim for the payment of temporary disability compensation pursuant to ORS 656.278(4) when claimant was hospitalized for left shoulder surgery on May 3, 1991. Claimant's aggravation rights expired March 7, 1991. SAIF requests that we authorize reimbursement from the Reopened Claims Reserve.

The Reopened Claims Reserve was established to reimburse additional amounts of compensation paid to injured workers that result from any award made by the Board pursuant to its own motion authority after January 1, 1988. ORS 656.625. If a carrier voluntarily reopens a claim for the payment of temporary disability compensation or medical benefits, we may authorize reimbursement from the Reopened Claims Reserve for those benefits which were properly paid pursuant to ORS 656.278. To determine whether benefits were properly paid, we review the evidence in the record to determine whether claimant qualified for claim reopening under our own motion jurisdiction.

In early 1990, claimant commenced treatment for his compensable condition that eventually culminated in the May 3, 1991 surgical procedure. SAIF contends that there was no objective worsening of claimant's condition prior to the expiration of his aggravation rights, because he had experienced pain and limitation of his range of motion for many years. Claimant contends that his condition worsened before his aggravation rights expired. However, we are unable to establish the date of worsening from the record. Absent such evidence, we decline to authorize reimbursement from the Reopened Claims Reserve.

Inasmuch as we are unable to establish our jurisdiction from the record, we conclude that this is an appropriate matter for referral to the Hearings Division for an evidentiary hearing. Accordingly, we refer this matter to the Hearings Division for an evidentiary hearing. The Referee shall take evidence and make findings of fact regarding whether claimant did in fact perfect an aggravation claim prior to the expiration of his aggravation rights. The Referee shall then make a recommendation regarding whether claimant is entitled to reopening under our own motion jurisdiction. The Referee shall forward the recommendation to us. Thereafter, we shall issue an order in this own motion matter.

IT IS SO ORDERED.

In the Matter of the Compensation of

CARLOS C. SANTIBANEZ, Claimant

WCB Case No. 10175

ORDER ON REVIEW

Whitehead & Klosterman, Claimant Attorneys

Terrall, et al., Defense Attorneys

Reviewed by Board Members Moller and Tenenbaum.

The self-insured employer requests review of those portions of Referee Quillinan's order which: (1) awarded interim compensation between September 6, 1989 and November 9, 1989; and (2) assessed a penalty and related attorney fees for failure to pay interim compensation. Claimant cross-requests review of those portions of the order which: (1) upheld the employer's denial of an aggravation claim for a low back condition; and (2) failed to award interim compensation between August 30, 1989 and September 5, 1989. On review, the issues are aggravation, interim compensation and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACTAggravation

We adopt the Referee's discussion of this with the following supplementation.

Shortly before his last award of compensation, Dr. Holzapfel stated that claimant was "predisposed * * * to exacerbations and worsenings of his condition not ordinarily affecting a normal person." (Ex. 76). Similarly, Dr. Butler reported that "as a result of this initial injury, [claimant] will be subject to recurrent problems in the area of the injury, and the severity of this condition is dependent upon his work and environmental activities * * *." (Ex. 79). In light of this evidence, and in the absence of evidence to the contrary, we assume that future flare-ups were anticipated in arriving at claimant's prior permanent disability award. See Lucas v. Clark, 106 Or App 687 (1991). Furthermore, we agree with the Referee that claimant has failed to establish that the symptomatic worsening which occurred in August 1989 exceeded anticipated future exacerbations.

Interim Compensation

We adopt the Referee's discussion of this issue with the following supplementation.

The employer contends that claimant was not active in the labor market at the time of the symptomatic flare-up; therefore, the employer asserts, claimant was not a "worker" for purposes of entitlement to temporary disability benefits. See Cutright v. Weyerhaeuser Co., 299 Or 290 (1985).

The Referee found that, at the time of his symptomatic exacerbation, claimant was self-employed as a professional pool player. In reaching this conclusion, the Referee impliedly relied upon claimant's testimony, as well as medical reports apparently based on claimant's statements to that effect. (Tr. 6-7; Ex. 83). In order to reach a contrary conclusion, it would be necessary for us to reject claimant's testimony as lacking credibility. We find no grounds for doing so. Accordingly, we agree with the Referee's conclusion that, at the time of his symptomatic exacerbation, claimant was active in the labor market as a self-employed professional pool player.

The employer further contends that claimant lost no wages as a result of his symptomatic exacerbation and, therefore, he is not entitled to interim compensation benefits. In support of this contention, the employer notes that, despite service on claimant of a subpoena duces tecum, at hearing claimant failed to produce a copy of his 1988 and 1989 tax returns. The employer reasons that claimant must not have had earnings during that time. We do not agree. Claimant explained that he did not file tax returns for those years. Without condoning such conduct, claimant's failure to file tax returns does not compel the conclusion that claimant earned no money during those years. In addition, the fact that claimant has not proven a particular loss of wages does not negate entitlement to temporary disability benefits. See International Paper Co. v. Hubbard, 109 Or App 452 (1991).

The Referee found that claimant was entitled to interim compensation commencing September 6, 1989. Claimant contends that his entitlement to interim compensation commenced as of August 30, 1989, the date on which Dr. Brennan examined claimant and declared him to be unable to work. However, interim compensation runs only from the date of the carrier's notice of disability, not the date of disability. Kosanke v. SAIF, 41 Or App 17 (1979). Accordingly, the Referee did not err by failing to award interim compensation commencing August 30, 1989.

Penalties/Attorney Fees

The Referee assessed a penalty and related attorney fee for the employer's failure to timely pay interim compensation. We agree that the employer's conduct was unreasonable and supports the assessment of a penalty. However, we further agree with the employer that the Referee's award of a separate attorney fee was inappropriate.

When the factual basis in support of the penalty under ORS 656.262 (10)(a) is identical to the factual basis for which an attorney fee under ORS 656.382(1) might be awarded, the simultaneous assessment of an attorney fee and a penalty would contravene the legislative intent expressed in ORS 656.262(10) that claimant's attorney receive one-half the penalty "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991). That is the case here. Under such circumstances, claimant's attorney is not entitled to an attorney fee under ORS 656.382(1) in addition to the penalty awarded. Rather, claimant's counsel is entitled to one-half the penalty in lieu of an attorney fee.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the interim compensation issue is \$500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 20, 1990 is affirmed in part and reversed in part. That portion of the Referee's order that awarded a penalty-related attorney fee of \$250 is reversed. Claimant's counsel is awarded one-half of the 25 percent penalty awarded to claimant. The remainder of the order is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of \$500, to be paid by the self-insured employer.

In the Matter of the Compensation of
RAYMOND J. SEEBACH, Claimant
WCB Case No. 90-18793
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Referee Peterson's order that: (1) directed the insurer to pay temporary disability pursuant to an earlier referee's order; and (2) assessed penalties and attorney fees for the insurer's allegedly unreasonable failure to pay the aforementioned benefits pending Board review of the earlier referee's order. On review, the insurer contends that, because it requested Board review of the earlier referee's order after amended ORS 656.313 became effective, it was not required to pay a portion of the aforementioned temporary disability benefits pending review. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

On March 15, 1990, the insurer denied claimant's back injury claim. On March 21, 1990, the Board received claimant's hearing request, which raised the issues of compensability, penalties and attorney fees.

A hearing concerning the issues of compensability, penalties and attorney fees was convened and continued on June 25, 1990. The hearing reconvened on August 7, 1990. On August 28, 1990, a referee issued an order finding the claim compensable and setting aside the insurer's denial. The order directed the insurer to commence the payment of temporary disability benefits effective retroactive to March 1, 1990 and to continue the payment of such benefits until the claim qualified for closure.

On August 31, 1990, the insurer filed a request for Board review of the referee's order. The insurer began paying claimant temporary disability benefits effective September 18, 1990. The insurer did not pay temporary disability benefits to claimant from March 1, 1990 through August 28, 1990, the date of the earlier referee's order. In addition, the insurer did not pay temporary disability benefits from August 28, 1990 through September 17, 1990.

On September 28, 1990, claimant requested a hearing, seeking temporary disability, penalties, and attorney fees for the insurer's allegedly unreasonable failure to comply with the earlier referee's order. At hearing, the insurer stipulated that it should have begun paying temporary disability from August 28, 1990. However, contending that the amendments to ORS 656.313 were applicable, the insurer argued that its filing of the request for Board review stayed payment of temporary disability from March 1, 1990 through August 27, 1990, pending its appeal of the earlier referee's order.

CONCLUSIONS OF LAW AND OPINION

Prior to July 1, 1990, ORS 656.313 provided that "[f]iling by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant." The legislature, however, amended ORS 656.313, effective July 1, 1990. As amended, ORS 656.313 states, in relevant part:

"(1)(a) Filing by an employer or the insurer of a * * * request for board review or court appeal stays payment of the compensation appealed, except for:

"(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs; and

"(B) Permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed."

The question we must answer is whether the insurer properly relied on amended ORS 656.313 to stay compensation.

Whether amended ORS 656.313 applies to this case turns on the meaning and proper application of section 54(2) of Oregon Laws 1990 (Special Session), which states:

"Any matter regarding a claim which is in litigation before the Hearings Division, the Board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990." (Emphasis supplied).

The apparent legislative intent behind section 54(2) was two-fold: (1) to ensure that cases which had been prepared for litigation under the pre-July 1, 1990 law were, in fact, litigated at hearing under that law; and (2) to require that the same legal standards applied at hearing also be applied by the Board and the courts on review. Testimony of Rep. Mannix, Special Committee on Workers' Compensation, May 4, 1990, Tape 19, Side B at 230; Rep. Mannix, House Special Session, May 7, 1990, p.34.

Here, the insurer issued its denial of compensability in March 1990. Claimant's hearing request from that denial was filed before May 1, 1990 and a hearing was convened before July 1, 1990. Therefore, litigation of the compensability issue under the former law was "saved" by operation of section 54(2). It is undisputed that further Board and court review of the compensability of claimant's condition is subject to the standards set forth in the pre-July 1, 1990 law. See Or Laws 1990 (Special Session), ch 2, 54(2); John K. French, 43 Van Natta 836 (1991). This result is consistent with the intent of the Legislature as found in the legislative history.

The Referee concluded, however, that because the law prior to July 1, 1990 controlled the compensability determination, it also controlled the question of what compensation, if any, was stayed pending the insurer's appeal. We disagree. The insurer's claim processing obligations and, correspondingly, claimant's objections to the insurer's conduct in processing his claim, were a separate procedural "matter" which did not arise until after the issuance of the earlier referee's compensability determination. Inasmuch as claimant's hearing request regarding this procedural, claim processing "matter" was not filed before May 1, 1990 and a hearing regarding that "matter" was not convened before July 1, 1990, the matter involved here was not "in litigation" for purposes of section 54(2). Therefore amended ORS 656.313 applies to this case. This conclusion is consistent, we believe, with the expressed legislative intent supporting section 54(2), i.e., that cases, the merits of which are prepared and litigated under the former law, be reviewed under that law.

Consequently, the insurer was entitled to stay payment of the compensation awarded by the earlier referee's order which was payable from March 1, 1990

through August 27, 1990, the day before the earlier referee's August 28, 1990 order. ORS 656.313(1)(a)(A).

Accordingly, we reverse that portion of the Referee's order which held that the insurer was obligated to pay claimant's temporary disability compensation for the period of March 1, 1990 through August 27, 1990 pending Board review of the earlier referee's August 28, 1990 order. Furthermore, since we have concluded that the insurer was entitled to stay payment of the aforementioned compensation, it follows that the insurer's failure to pay these benefits was not unreasonable. Therefore, we also reverse the Referee's assessment of a penalty for unreasonable conduct based upon this stayed compensation.

Finally, we agree with the Referee that the insurer's failure to pay temporary disability benefits from the date of the earlier referee's August 28, 1990 order through September 17, 1990 was unreasonable. Regardless of which version of ORS 656.313 was applicable, the insurer was obligated to provide such benefits pending its appeal of the earlier referee's order. Thus, we affirm the Referee's order to the extent that the insurer was assessed a 25 percent penalty based upon temporary disability compensation due from August 28, 1990 through September 17, 1990.

However, we reverse that portion of the Referee's order which awarded an insurer-paid attorney fee for the insurer's unreasonable conduct. Subsequent to the Referee's order, we held that when the factual basis asserted in support of an attorney fee for unreasonable resistance to the payment of compensation under ORS 656.382(1) is identical to the factual basis for the assessment of a penalty under ORS 656.262(10)(a), the assessment of an attorney fee award pursuant to ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991).

Here, the factual basis for an attorney fee under ORS 656.382(1) is identical to the factual basis for the assessment of a penalty pursuant to ORS 656.262(10)(a), i.e., the insurer's failure to pay compensation awarded by an earlier referee's order pending the insurer's appeal of that order. Consequently, in place of the Referee's \$1,000 attorney fee award, claimant's attorney shall receive one-half of the penalty assessed above.

ORDER

The Referee's order dated February 1, 1991 is reversed in part, modified in part, and affirmed in part. The Referee's order is reversed to the extent that it directed the insurer to pay temporary disability compensation from March 1, 1990 through August 27, 1990 pending the insurer's request for Board review of the earlier referee's order. The Referee's \$1,000 attorney fee award is reversed. The Referee's order is affirmed to the extent that it directed the insurer to pay temporary disability compensation from August 28, 1990 through September 17, 1990. In lieu of the Referee's penalty assessment, the insurer shall pay a penalty equal to 25 percent of the temporary disability compensation payable from August 28, 1990 through September 17, 1990. This penalty shall be paid in equal shares to claimant and his attorney.

Board Members Tenenbaum and Gunn dissenting.

The facts are not disputed. On August 28, 1990, Referee Schultz issued an order that set aside the insurer's denial of claimant's injury claim and directed the insurer to pay temporary disability benefits from March 1, 1990 until closure. In reaching his decision, Referee Schultz applied the law in effect prior to the 1990 amendments, concluding that this case had been saved by the

"savings clause" found in section 54(2) of Oregon Laws 1990 (Special Session), chapter 2.

On August 31, 1990, the insurer requested Board review of that order and stayed payment of temporary disability benefits pending appeal. This marks the end of Round One and the beginning of Round Two. Claimant subsequently commenced this action, seeking enforcement of the order and a penalty for the insurer's failure to commence payment of benefits awarded.¹ After another hearing, Referee Peterson concluded that the insurer had not been entitled to stay the payment of compensation under former ORS 656.313 and assessed a penalty for its unreasonable conduct.

We first examine the insurer's action, staying compensation, in Round One. The carrier contends, and the majority agrees, that because the appeal was filed after July 1, 1990 and the amendments to ORS 656.313 are not otherwise exempted, the amendments to ORS 656.313 became effective July 1, thereby allowing the carrier to stay payment of the compensation ordered.

However, application of amended ORS 656.313 to this case is in direct conflict with the more specific dictate of section 54(2), which provides that "any matter regarding a claim which is in litigation before ...the Board..." shall be determined pursuant to the "old" law, if the hearing request was filed before May 1 and the hearing held before July 1, as was the case here.

The processing of the Round One referee's order was as much a "matter regarding a claim...in litigation" as was the issue of compensability. The prior version of ORS 656.313 applied to this litigation as much as the prior version of ORS 656.005, governing compensability, did. According to former ORS 656.313, the payment of compensation was not stayed pending appeal. Section 54(2) froze, or saved, all of the workers' compensation law as it existed prior to SB 1197 with respect to any case in litigation prior to the May 1/July 1 cutoff. Inasmuch as the "old" law which had been saved, included former ORS 656.313, the insurer was obligated to comply with the Referee's order under that law, which prohibited staying of any compensation appealed.²

It seems to us that the majority has focused on the language of section 54(1), which, standing alone, would appear to make amended ORS 656.313 apply to the insurer's August 31, 1990 appeal, without regard to section 54(2).

How shall we resolve the conflict created by application of both statutes in this situation? Amended ORS 656.313 provides general direction for claims processing in "the future" after July 1, 1990. Section 54(2) is a very specific statute designed to ensure that certain cases, already in the litigation system, are concluded with application of the "old" law. Not to apply the provision of section 54(2) relating to cases on Board appeal, as the majority proposes, means giving no meaning to the explicit statutory language relating to cases on

¹ We agree with the majority with respect to benefits for the period after August 28, 1990; our dissent is with respect to benefits for the period March 1 through August 27, 1990.

² We note that the referee specifically ordered the insurer not only to accept and process the claim, but to begin time loss payments effective March 1. The latter portion of that order was surplussage, as the carrier's obligation would have been no different had the referee only ordered the insurer to accept and process the claim. The inclusion of the specific date for commencing time loss benefits is not determinative to the dissent, and we premise our dissent on the order to accept and process the claim.

appeal. Basic principles of statutory construction dictate that we must assume the legislature put that language there for a reason and intended it to have its obvious meaning: If a claimant filed a hearing request before May 1, 1990, and the case went to hearing before July 1, 1990, all pre-July 1 law continues to apply to that case throughout the appeal process. To conclude otherwise leads to a result in obvious contradiction to the statutory intent.

We would conclude, in the first instance, therefore, that the insurer erred in staying payment of the compensation which necessarily flowed from Referee Schultz's August 28, 1990 order.

How was claimant to right this wrong? He filed a request for hearing which was purely an enforcement action. This brings us to the second inquiry, whether "new" law or "old" law applies to Round Two, claimant's enforcement action. There is no dispute that, under former ORS 656.313, the insurer's actions would have been unlawful and might have warranted the assessment of a penalty. On the other hand, if amended ORS 656.313 controls, the insurer's actions were proper and Referee Peterson's order must be reversed. The majority asserts that the instant request for hearing does not involve "a matter concerning a claim which was in litigation before" the May 1/July 1 cutoff, that the instant litigation involves some other "matter," of claims processing related to which a request for hearing was not filed before May 1, 1990, and that therefore, amended ORS 656.313 applies and the insurer's stay of payment of compensation was proper. We disagree.

The majority errs in concluding that the "savings clause," of section 54(2), is not applicable to the enforcement of that order on the ground that it (Round two) was not a "matter" for which a request for hearing was filed and litigated before the effective date of the new law.

By inserting the "savings clause," the legislature did not merely save from extinction the compensability standard of the old law, but all of the old law, including former ORS 656.313, for purposes of enforcement of such liability.

The majority avers that the only "matter" concerning this claim which was saved by the "savings clause" was the narrowest issue of pure compensability. We disagree. The "savings clause" found in section 54(2) of Senate Bill 1197 was proposed by Representative Mannix on May 4, 1990. In explaining the amendment to fellow committee members, Mannix testified:

"There [are] literally at least 20,000 cases in litigation right now. Without some special exemption with the operative dates here, technically any of those cases going to hearing or going through the appellate process would have to be revisited as to the language of this Act and, as the lawyers on this committee know, that would be a nightmare. So it would allow those cases where there's been a request for hearing filed before May 1st, and the hearing is held by July 1st of this year, to continue through the system under the standards in effect at the time that the cases were filed, and not apply this law to them." Minutes, Special Committee on Workers' Compensation, May 4, 1990, Tape 19, Side B at 230. (Emphasis supplied.)

Later, while explaining the "savings clause" on the House floor, Mannix stated:

"For once our Legislature has recognized that there are actually tens of thousands of cases in litigation and we're not going to reinvent the wheel on those cases. We will let those cases proceed

under the standards in which they were tried, so that you again will not be creating more work for lawyers." House Special Session, May 7, 1990. (At page 48.) (Emphasis supplied.)

That history demonstrates the clear legislative intent to save cases which were in litigation prior to the operative date of the amendments and to have them proceed through the system under the pre-1990 law. To give meaningful effect to that intent, the Board should conclude that the Legislature also saved the law for the payment of and enforcement of orders and compensation awarded in those actions. Indeed, an action under the old law is only half-saved if the Board holds that the provisions governing enforcement of the action have become extinct.³

Finally, we urge that this case presents precisely the situation in which application of the test enunciated in Ida M. Walker, 43 Van Natta 1402 (1991) should be applied to mandate application of pre-SB 1197 law. The Walker test requires resolution of this apparent statutory conflict as suggested by the dissent. If the majority's reasoning is followed, the result will be an absurd and unjust result, contrary to the clear intent of section 54(2). The majority is in the unconscionable position of telling claimant that although his claim was held to be compensable under the old law, and although the referee ordered the carrier to accept and process it, and although the carrier applied the wrong law in deciding not to pay claimant compensation due him, he had no enforcement remedy because he did not ask the Hearings' Division to rectify the error until after May 1, 1990. This "Catch 22" is a sad, but not an inevitable conclusion.

For all these reasons, we would conclude that the instant enforcement litigation, Round Two, was with regard to a matter on which a request for hearing was filed before May 1, 1990 and heard before July 1, 1990. Pursuant to section 54(2), therefore, Referee Peterson was correct in looking to the former version of ORS 656.313 to determine whether the carrier's action in staying payment of compensation was correct. Further, because the compensability of this case was initially litigated prior to July 1, 1990, amended ORS 656.313 did not apply to the appeal of Referee Schultz's decision, and the insurer erred in staying payment of the compensation ordered.

We would affirm the Referee.

³ This reasoning would apply only to a "pure" enforcement action, such as in this case. We do not suggest that all litigation involving this claim would ever-after be conducted under pre-SB 1197 law.

December 12, 1991

Cite as 43 Van Natta 2692 (1991)

In the Matter of the Compensation of
RAYMOND W. BROWN, Claimant
WCB Case No. 90-21936
ORDER ON REVIEW
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

Claimant, pro se, requests review of Referee Quillinan's order that upheld the SAIF Corporation's denial of his aggravation claim for a worsened cervical condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact." We also adopt her "Ultimate Findings of Fact," except for the last sentence.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion," with the following modification and supplementation.

The Referee stated that claimant must prove a worsened condition in order to establish a compensable worsening under new ORS 656.273(1). We agree with her conclusion that claimant did not suffer a pathological worsening of his compensable cervical condition in November 1990. However, we have determined that the traditional definition of a "worsened condition," *i.e.*, an increase in symptoms or a pathological change resulting in diminished earning capacity, remains intact. See Jacquelyn L. Hetrick, 43 Van Natta 2357 (1991) (citing Leroy Frank, 43 Van Natta 1950 (1991)). Therefore, a claimant may establish a compensable worsening by showing either a worsened underlying condition or increased symptoms and a resultant diminishment of earning capacity since the last award or arrangement of compensation. See Edward D. Lucas, 41 Van Natta 2272 (1989), reversed on other grounds Lucas v. Clark, 106 Or App 687 (1991). In addition, "[i]f the last award or arrangement of compensation included consideration of anticipated future exacerbations of the condition or symptoms, the claimant must prove that the worsening has been greater than was anticipated." Lucas v. Clark supra.

Here, there is evidence that claimant suffered a temporary increase of symptoms and a related diminishment of earning capacity. (See Exs. 34-37, 41-2). However, Dr. Sutherland, claimant's treating physician prior to the June 21, 1988 Stipulation (the last arrangement of compensation), noted that claimant's neck movement was limited due to pain. Sutherland opined:

"Because of [claimant's] limitation with neck movement, I do not believe that he will be able to return to truck driving. . . . [He] will probably continue to have some symptoms related to neck movements for some time yet, and there will be some permanent residual disability related to the cervical disc problem and subsequent fusion." (Ex. 28-1).

Based on this medical evidence of the possibility of future flare-ups, we conclude that exacerbations were anticipated at the time of the last arrangement of compensation. Therefore, claimant bears the additional burden of proving that his worsening was greater than anticipated. Gwynn v. SAIF, 304 Or 345, 352-353 (1987).

As we have noted, Dr. Sutherland advised that claimant should not return to truck driving, because of his neck condition and permanent disability following his cervical surgery. Nevertheless, claimant returned to his regular work, long haul driving. After a lengthy period of truck driving in November 1990, claimant experienced worsened neck symptoms. (Exs. 34-1, 37). Dr. Van Veen authorized time loss as of November 9, 1990. (Ex. 35). Dr. Collada related claimant's complaints to his work activities. (Ex. 39). Claimant was released to return to work on December 27, 1990, though restricted from continuous neck flexion, extension and rotation. (Ex. 40A).

Western Medical Consultants examined claimant on February 16, 1991. They noted that claimant's then-current symptoms had subsided to the level where they had been prior to his November 1990 exacerbation. They opined:

"[Claimant] has experienced intermittent discomfort as might be anticipated with a man subsequent to surgery and with significant degree of permanent partial impairment as has been deemed to be present in his situation. . . [H]e has symptoms with activity, which might be predicted given the degree of impairment felt to be operative in his cervical spine." (Ex. 41-3-4).

Claimant's former treating doctor advised that claimant should not return to truck driving, because of its probable effect on his cervical problems. He anticipated symptoms with neck movement. Claimant continued truck driving and suffered a temporary worsening of symptoms related to his work. Inasmuch as work-related cervical problems were anticipated and there is no evidence that claimant's exacerbation was more than anticipated at the time of his last arrangement of compensation, we agree with the Referee's conclusion that claimant has not established an aggravation.

ORDER

The Referee's order dated March 25, 1991 is affirmed.

December 12, 1991

Cite as 43 Van Natta 2694 (1991)

In the Matter of the Compensation of
MICHAEL C. GORMAN, Claimant

WCB Case No. 90-18008

ORDER ON REVIEW

Engle & Schmidtman, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of that portion of Referee Qullinan's order that set aside its denial of claimant's aggravation claim for a left shoulder injury, to the extent it denied medical treatment. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), Chapter 2. Claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we agree with the Referee that this matter is properly analyzed under the 1990 revisions to the Workers' Compensation Act.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in

diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Following the gardening incident in March 1990, claimant returned to his family physician, Dr. McDonald, M.D. Dr. McDonald reported that claimant had tenderness with a "clunk" on extension and abduction. Dr. McDonald diagnosed left rotator cuff tendinitis and possible rotator cuff tear. He also referred claimant to Dr. Schader, an orthopaedic surgeon, who ordered an arthrogram. Claimant's arthrogram showed evidence of a partial thickness rotator cuff tear. Following the March 1990 incident, claimant was unable to fully perform his job duties.

We conclude that claimant sustained a worsening of his left shoulder condition that is supported by objective findings and resulted in diminished earning capacity. Consequently, claimant has established a worsened condition. However, inasmuch as the gardening incident, which did not occur in the course and scope of his employment, contributed to his worsened condition, claimant must also prove legal causation.

The Referee found, and we agree, that claimant's worsened left shoulder condition is not compensable. See ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991). (Generally, a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition. However, if there is an off-work injury which is the major contributing cause of the worsened condition, the worsening is not compensable). Here, Dr. Webb, D.C., claimant's treating doctor, reported in August 1990 that the major contributing cause of claimant's aggravation and current need for treatment was his gardening activities which resulted in an acute exacerbation of his chronic condition. Accordingly, we agree that the off-work incident was the major contributing cause of claimant's worsened condition and claimant's aggravation claim is not compensable.

Although the Referee concluded that claimant's aggravation was not compensable, she further concluded that medical services for the temporary worsening were compensable. We disagree.

Since her decision, we have published Elizabeth A. Bonar-Hanson, supra, which involves similar facts. We concluded that, if an injury not occurring in the course and scope of employment is the major contributing cause of a worsened condition, then claimant is not entitled to additional compensation, including medical services, for the worsened condition. We reasoned that ORS 656.273(1) makes no distinction between medical services and other forms of compensation, and, therefore, if a claimant has not established a compensable aggravation, he is not entitled to medical services for the worsened condition. Id.

Under the circumstances, we conclude that, because claimant's off-work injury is the major contributing cause of his condition, medical services for the worsened condition are similarly not compensable. Accordingly, we reverse the portion of the Referee's order that directed the insurer to accept claimant's medical services claim.

In reaching this conclusion, we wish to make clear that, claimant may be entitled to continuing medical services provided that such services are related to the compensable condition, rather than the noncompensable worsened condition. Elizabeth A. Bonar-Hanson, supra. Here, the medical services are related to the noncompensable worsened condition.

ORDER

The Referee's order dated February 12, 1991, as reconsidered March 13, 1991, is affirmed in part and reversed in part. That portion of the Referee's order that set aside the insurer's aggravation denial to the extent it pertained to medical services is reversed. The insurer's denial is reinstated and upheld in its entirety. The Referee's award of a \$2,000 assessed attorney fee is also reversed. The remainder of the order is affirmed.

December 12, 1991

Cite as 43 Van Natta 2696 (1991)

In the Matter of the Compensation of
CAROL A. HAYES, Claimant

WCB Case No. 90-16834

ORDER ON REVIEW

Karen M. Werner, Claimant Attorney
Bottini, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Brazeau's order that upheld the self-insured employer's denial of her claim for bilateral epicondylitis. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant contends that her epicondylitis claim is compensable as an injury, under a "material contributing cause" standard. She also contends that the Referee erred in applying "aggravation" law to this case, because she claims that her current epicondylitis condition is directly causally related to her 1985 work exposure. We disagree with both contentions.

The Referee analyzed the issue under ORS 656.005(7)(a)(A), and reasoned that claimant had to prove that her compensable "injury" in 1985 remains the major cause of her consequential condition; he concluded that claimant did not carry her burden. We do not adopt that reasoning, but affirm the result.

Subsequent to the Referee's order, we construed the phrase "consequential conditions" to include only problems that arise from conditions previously deemed compensable, as opposed to conditions that arise directly from the injurious event. Julie K. Gasperino, 43 Van Natta 1151 (1991). Although claimant is correct that the 1990 amendments to the definition of a "compensable injury" do not affect the standard of compensability for conditions intrinsically related to the underlying compensable event, that does not affect the outcome in the present case. The criteria for determining whether a work injury is compensable is still whether the injury was a material contributing cause of the worker's need for treatment or of disability.

However, we find that claimant's epicondylitis claim is for an occupational disease, not injury. The onset of claimant's elbow symptoms was gradual rather than sudden. It has been described as having arisen from repetitive hand and arm activities over time, rather than having been caused by one discrete identifiable event. For these reasons, the epicondylitis claim is properly analyzed as an occupational disease, rather than an injury. James v. SAIF, 290 Or

343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). Accordingly, the claim is compensable only if claimant establishes that her work activities or exposures were the major contributing cause of her current disability or need for treatment for bilateral epicondylitis. ORS 656.802; Aetna Causality Co. v. Aschbacher, 107 Or App 494 (1991).

Notwithstanding claimant's testimony, the extensive medical record reflects no complaints of elbow pain or problems until March 1, 1989. (Dr. Poulson, Ex 50). Prior to that time, the histories given to various doctors, and their attention, was directed to claimant's hands and wrists, with some suggestion of forearm pain caused by tendonitis. Notwithstanding claimant's argument to the contrary, the elbow is a distinct body part from "the arm," and there is no suggestion in the medical reports that, when claimant referred to "arm" problems, she was actually indicating elbow problems.

Dr. Burr was claimant's treating physician from the time she first sought treatment in 1985 until February 1986. He has confirmed that she made no complaints of elbow (or cervical or shoulder) problems during that period, that such complaints must have arisen after that time, and that her work in 1985 would not have caused those complaints.

Dr. Johnson, a chiropractor who examined claimant on referral from her treating chiropractor, Dr. Stearns, opined that claimant's work history was "consistent with the etiology of [her] disorder." (Ex. 64; see also Ex. 62). Inasmuch as Johnson's opinion is framed in terms of possibility, rather than probability, we do not find it to be persuasive. Gormley v. SAIF, 52 Or App 1055 (1981). Drs. Stearns and Buza offered no opinion on causation. Moreover, because we agree with the Referee's reasoning concerning Dr. Poulson's opinion, we adopt his "Conclusions and Opinion" in that regard. Therefore, we conclude, as did the Referee, that claimant has not carried her burden of proving a compensable occupational disease claim.

ORDER

The Referee's order dated January 30, 1991 is affirmed.

December 12, 1991

Cite as 43 Van Natta 2697 (1991)

In the Matter of the Compensation of
MARY A. NORRIS, Claimant

WCB Case Nos. 90-18365 & 90-02299

ORDER ON REVIEW

Robert G. Dolton, Claimant Attorney

David O. Horne, Defense Attorney

Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of her aggravation claim for a low back condition; and (2) upheld Employers Insurance of Wausau's denial of her "new injury" claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. In 1981, in Washington state, claimant suffered a work-related injury to her low back which resulted in six to eight months of time loss. (Exs. 10-3, 15-1).

A hearing on WCB case number 90-02299 was originally set for June 14, 1990. This hearing was postponed at claimant's request. On December 10, 1990, a consolidated hearing on WCB case numbers 90-02299 and 90-18365 was convened.

FINDINGS OF ULTIMATE FACT

Claimant did not suffer a "new injury" while working for Wausau's insured.

Claimant's last arrangement of compensation was the January 2, 1990 amended Determination Order which awarded claimant 3 percent unscheduled permanent disability under the Liberty claim.

Claimant's low back condition is not a symptomatic or pathological worsening of her 1986 compensable cervical injury with Liberty.

CONCLUSIONS OF LAW AND OPINION

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

On May 7, 1990, the legislature enacted Senate Bill 1197, an extensive revision of the workers' compensation law. Because a hearing was convened on December 10, 1990, this matter is properly analyzed under those provisions, which generally became operative on July 1, 1990. Or Laws 1990 (Special Session), ch. 2, 54; Ida M. Walker, 43 Van Natta 1402, 1405 (1991).

Compensability of "Aggravation" Claim

The Referee found that the evidence did not establish that claimant's low back condition was causally related to her 1986 work injury with Liberty. We agree.

To establish an aggravation claim, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

Claimant argues that the 1986 injury injured her low back, as well as her neck and upper back, although the low back injury manifested itself over a period of time.

The first report of low back pain in this record appeared in a December 1987 report, more than a year after the October 1986 incident which injured claimant's cervical and dorsal spine. (Ex. 10-3). Claimant has degenerative disc disease in her lumbar spine and suffered a work-related injury to her low back in 1981. Therefore, the issue of whether her low back condition is compensably related to her 1986 injury is a complex medical question. Although claimant's testimony is probative, the resolution of this medical question 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), rev den 300 Or 546 (1986).

Claimant argues that we should rely on the opinions of Dr. Gray, treating osteopathic physician, and Dr. Grewe, treating neurosurgeon. It is true that we generally give greater weight to the conclusions of a treating physician; however, we will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, there are persuasive reasons not to defer to Drs. Grewe and Gray.

As the Referee found, Dr. Grewe offered unexplained contradictory opinions. On July 3, 1990, Dr. Grewe opined that claimant's lumbar problems began with her initial fall in 1986. (Ex. 52-1). Later, on August 23, 1990, he opined that claimant had an ongoing degenerative disc disease process at the L5-S1 level. (Ex. 54-1). Dr. Grewe did not explain these contradictions. Because of the inconsistencies in Dr. Grewe's opinion, we do not find them persuasive and, accordingly, give them little weight. See David H. Olson Jr., 42 Van Natta 1336 (1990).

Furthermore, claimant suffered a work-related low back injury in 1981 which resulted in six to eight months of time loss. (Exs. 10-3, 15-1). Both Drs. Gray and Grewe were apparently unaware of this 1981 injury and attributed claimant's lumbar problems to the 1986 fall based, in part, on their belief that this was her only work-related fall. (Exs. 41-2, 44-2, 50, 50A, 52, 54). Therefore, because we find the opinions of Drs. Gray and Grewe to be based on an inaccurate history, we do not find them persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977); Weiland v. SAIF, 64 Or App 810 (1983).

Dr. Rosenbaum, an examining neurosurgeon, provides the only other medical opinion on causation. (Ex. 51). He had a complete history and opined that claimant did not sustain a lumbar injury. (Ex. 51-5). Even if we agree with claimant's contention that Rosenbaum's opinion is conclusory, because we find the opinions of Drs. Gray and Grewe unpersuasive, claimant has failed to establish that her lumbar condition is causally related to the 1986 injury. Therefore, we conclude that claimant has not proven an aggravation of her compensable condition.

Compensability of "New Injury" Claim

The Referee found that claimant had not suffered a new injury during the less than two weeks she worked as a telephone solicitor at Wausau's insured. We agree. Furthermore, on review, claimant does not argue that she suffered an industrial injury while working at Wausau's insured. Moreover, no persuasive evidence supports a finding of a new injury there.

Because we find that claimant has not established the requisite causal relationship between her lumbar condition and either an "aggravation" at Liberty's insured or a "new injury" at Wausau's insured, we do not address the issue of responsibility.

ORDER

The Referee's order dated January 9, 1991 is affirmed.

In the Matter of the Compensation of
CARL L. STEVENS, Deceased, Claimant
WCB Case No. 90-09211

ORDER ON REVIEW

Parker & Bush, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Fink's order which: (1) found that the mother of the deceased worker's minor child could pursue an appeal of a Determination Order concerning the deceased worker's claim on behalf of the child; and (2) awarded 22 percent (70.4 degrees) unscheduled permanent disability for his upper neck, back and shoulder condition, whereas a Determination Order had awarded no permanent disability. On review, the issues are standing and permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation.

As of December 4, 1989, no further medical improvement in claimant's condition could reasonably be expected with further medical treatment or the passage of time.

CONCLUSION OF LAW AND OPINION

Reasoning that the minor child was the deceased worker's sole beneficiary, the Referee concluded that the child's mother could proceed on the child's behalf. The Referee, therefore, saw no reason to comment on whether a personal representative of the deceased has standing to seek unpaid workers' compensation benefits when the deceased has a child. We agree with the Referee's result, but for a different reason.

The right to pursue a deceased claimant's hearing rights is limited to those who are entitled to death benefits under ORS 656.204; i.e. a surviving spouse, children under 18 or a "dependent." ORS 656.218. A personal representative lacks authority to claim benefits on behalf of a deceased claimant. Trice v. Textronix, 104 Or App 461, 465 (1991). We conclude, however, that the mother of claimant's child may seek benefits on behalf of the deceased worker's minor child. See Javier Mendoza (Deceased), 43 Van Natta 412, 413 (1991) (Ex-wife and mother of the deceased worker's disputable presumptive children allowed to proceed on minor children's behalf); also see Javier Mendoza (Deceased), 42 Van Natta 373, 374 (1990) (Cohabitor and mother of deceased worker's putative "stepchild" allowed to proceed on minor child's behalf).

Accordingly, we reject SAIF's contention that the request for hearing, filed by the child's mother on the minor child's behalf, is invalid. We conclude that the mother of the deceased worker's minor child has the authority to seek benefits on the child's behalf. Therefore, we turn to the merits of the case.

Permanent disability

Claimant's beneficiaries are entitled to recover the injured worker's benefits. Jeannie E. Spunaugle (Deceased), 42 Van Natta 2546, 2547 (1990). However, claimant must be entitled to the benefits before claimant's beneficiaries can receive those benefits. ORS 656.218(1); Spunaugle, supra. Where a claimant is not found medically stationary before his death (unrelated to the compensable

injury), and has not been released to return to work, an award of permanent disability may be discerned from medical reports which show measurements of a worker's residual permanent impairment. Id.

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 65 Or App 810 (1983). We find persuasive reasons to defer to Dr. Matthews.

On January 6, 1989, Dr. Matthews, chiropractor, tested claimant's cervical and lumbar ranges of motion. (Ex. 7). On December 4, 1989, two days before claimant's fatal motor vehicle accident, Dr. Matthews re-tested claimant's cervical and lumbar ranges of motion. (Ex. 15). The results show that in almost a year's time, claimant's condition had not improved. There had been no significant change in claimant's condition, absent a few minor decreased ranges of motion. Dr. Matthews further reported:

"Discussion: [Claimant] is not working due to this injury, and in my opinion I do not feel that he will be able to return to his former line of employment. I strongly recommend vocational rehabilitation. I will continue treating him approximately once per week, and more if he has flare ups. We will reevaluate in 60 days." (Ex. 15).

Based on the above facts, we find claimant medically stationary as of December 4, 1989. See Milford W. Hayes, 42 Van Natta 2865 (1990) (Prescribing medication, placing claimant on restricted work duty and seeking vocational assistance for claimant do not indicate that the doctor expected claimant to get better); Harold D. Ward, 42 Van Natta 381 (1990) (A worker who continues to need vocational services may be medically stationary); Linda F. Wright, 42 Van Natta 2570, 2571 (1990) (Need for continued palliative treatment and further evaluation does not preclude a finding of medically stationary status); Willa D. Tucker, 42 Van Natta 1281, 1283 (1990) (Doctor recommended further care on an as needed basis and saw no reason to set more frequent appointments unless claimant's condition worsened supported a finding that no further material improvement was anticipated); Tommy L. Brown, 42 Van Natta 558, 550 (1990) (No significant change in claimant's condition supported a finding of medically stationary).

Permanent Disability

We adopt the Referee's Conclusion of Law and Opinion concerning this issue.

Inasmuch as SAIF has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on review is \$900 to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 11, 1991 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of \$900, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
ROBERT L. BEDWELL, Claimant
WCB Case No. 89-08167
ORDER ON RECONSIDERATION
Olson, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Claimant, pro se, has requested reconsideration of the Board's Order on Review dated November 13, 1991, which reversed a Referee's order that set aside the SAIF Corporation's denial of claimant's aggravation claim. Claimant contends, amongst other arguments, that he did not receive proper notice of his appeal rights on several occasions and that he was prejudiced thereby.

We reconsider our order to clarify the scope of our review and the information in the file concerning claimant's receipt of notice.

Claimant was represented at hearing and prevailed. He was also represented on review, as evidenced by his counsel's timely filing of a Respondent's Brief. Moreover, claimant's request for reconsideration, on his own behalf, was timely filed. Inasmuch as claimant has missed no appeal deadlines, we are persuaded that claimant received actual notice of his appeal rights in each instance, or at least, that he has not proven he was prejudiced due to lack of any such notice in the present case.

In his request for reconsideration, claimant raises issues related to a 1988 Determination Order. He asserts that he did not appeal the 1988 Determination Order because he was not notified of his right to do so. However, because the issue concerning the 1988 Determination Order was raised for the first time on reconsideration, we do not address it. See Donald A. Hacker, 37 Van Natta 706 (1985) (Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy).

After conducting our review of the evidence in the record, we continue to conclude that claimant has not proven a worsened condition resulting from his industrial injury. Accordingly, our November 13, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our November 13, 1991 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

December 13, 1991

Cite as 43 Van Natta 2702 (1991)

In the Matter of the Compensation of
HARRY L. CRAIG, JR., Claimant
WCB Case Nos. 90-18638 & 90-18637
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Myzak's order that set aside its denial of claimant's herniated disc injury claim. In her brief, claimant contests that portion of the Referee's order which, after assessing a penalty under ORS 656.262(10)(a) for the employer's unreasonable failure to pay interim compensation, declined to award claimant's counsel an attorney fee under

ORS 656.382(1) for the same conduct. On review, the issues are compensability and attorney fees.

We affirm and adopt the Referee's order with the following supplementation.

The Referee concluded that claimant had sustained a compensable herniated disc as a result of a work-related incident on July 30, 1990. The employer argues that claimant was not a credible witness and the work-related incident claimant described did not occur.

This case is governed by ORS 656.005(7)(a). The Board has recently held that, under ORS 656.005(7)(a), a determination of compensability is a two-part test if there is a preexisting condition. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, it must be determined whether there was a "compensable injury" under ORS 656.005(7)(a), i.e., an accidental injury arising out of and in the course of employment. If it is shown that a preexisting condition combines with the injury to cause or prolong disability or need for treatment, claimant is entitled to disability compensation and treatment only if the compensable injury is the major contributing cause of that disability or need for particular treatment. ORS 656.005(7)(a)(B).

The evidence establishes that claimant has degenerative disc disease, the onset of which predated the July 30, 1990 incident. The employer, however, denied the claim on the ground that claimant did not have an accidental injury on July 30, 1990.¹ Furthermore, in its appellant's brief on Board review, as was the case at hearing, the employer argues solely that no injurious incident occurred on July 30, 1990. Thus, in addition to claimant's request for an attorney fee under ORS 656.382(2), the issue before us is limited to whether or not claimant sustained an injury arising out and in the course of employment on July 30, 1990. On that question, we affirm and adopt the Referee's order. Laverne J. Butler, 43 Van Natta 2454 (1991); Bahman M. Nazari, supra.

We also affirm and adopt the Referee's order on the issue of penalties and attorney fees for the employer's failure to pay interim compensation. Under ORS 656.262(10)(a), a claimant is not entitled to both a penalty and a ".382(1)" fee for the same processing infraction. Nicolasa Martinez, 43 Van Natta 1638 (1991); Ronald A. Stock, 43 Van Natta 1889 (1991).

The employer requested review, and we have found that claimant's injury claim should not be disallowed. Therefore, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and the statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 5, 1991 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed fee of \$1,000, to be paid by the self-insured employer.

¹ Although the denial refers to August 1, 1990 as the date of the alleged injury, the Referee found that the accident occurred on July 30, 1990.

In the Matter of the Compensation of
HELEN M. ELLIS, Claimant
WCB Case No. 90-18171
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Brown's order that: (1) upheld the insurer's denial of her occupational disease claim for a right ankle condition; and (2) declined to assess penalties and related attorney fees for the insurer's allegedly unreasonable denial of the claim. On review, the issues are compensability and penalties and attorney fees.

We affirm and adopt the Referee's order with the following supplementation.

Compensability

The Referee correctly concluded that this was an occupational disease claim. In deciding this matter, he applied the law as amended by Or Laws 1990 (Special Session), ch. 2. Claimant requested a hearing in this case after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, we concur with the Referee and apply the 1990 amendments to ORS 656.802. Or Laws 1990 (Special Session), ch.2 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

In order to establish an occupational disease, claimant must prove, by medical evidence supported by objective findings, that her employment conditions were the major contributing cause of her ankle condition. ORS 656.802(2). A "major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset of the condition than all other activities or exposures combined. See Dethlefs v. Hyster Co., 295 Or 298 (1983).

The only medical opinion was that of Dr. Kuzmitz. In his January 1, 1991 letter, he opined that claimant's condition was most likely secondary to her employment. (Ex. 8). We recognize that "magic words" are not required to establish compensability. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Nevertheless, we do not find Kuzmitz's opinion to be persuasive. To begin, we agree with the Referee that Dr. Kuzmitz's opinion is lacking because it did not discuss the relative contribution of claimant's off-work activities. See Mal v. Unique Building Maintenance, 93 Or App 703 (1988); Robert A. Gebhard, 41 Van Natta 22 (1989). Moreover, we consider the opinion to be unpersuasive because it is primarily based on claimant's subjective complaints. Inasmuch as the Referee found claimant to lack credibility (based on her demeanor) and since we defer to that finding, we find Dr. Kuzmitz's opinion unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473 (1977); Richard A. Huckins, 43 Van Natta 1308 (1991).

Unreasonable Denial

The Referee found, and we concur, that the insurer's denial of claimant's claim was not unreasonable. In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability. If the insurer based its denial upon that doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id. When an insurer "has no information with which

to determine whether a condition was, or was not, work-related, a legitimate doubt exists as to its liability." Joan M. Alvarado, 43 Van Natta 477 (1991).

Here, the only information available to the insurer prior to its denial on August 6, 1990, was claimant's Form 801 and 827 (Exs. 1 and 2), a negative x-ray report (Ex. 3) and Dr. Kuzmitz's three chart notes. (Ex. 4-6). While we concede that Kuzmitz's July 10, 1990 chart note indicates that claimant quit work on June 30, 1990 because of her ankle problems and gives a brief history of the onset of the problems, that note merely recites the history claimant reported to Kuzmitz. (See Ex. 4 and Tr. 10). Moreover, Kuzmitz's notes neither discuss claimant's off-work activities nor indicate whether claimant's work activities caused her current ankle disability. Finally, the employer had indicated on the 801 Form that claimant's condition did not occur during the course of her employment. (Ex. 2).

Under these circumstances, we conclude that the insurer had a legitimate doubt in regard to its liability for the claim. The insurer's denial was, therefore, not unreasonable.

ORDER

The Referee's order dated February 19, 1991 is affirmed.

December 13, 1991

Cite as 43 Van Natta 2705 (1991)

In the Matter of the Compensation of

GARY L. WALDRUPE, Claimant

WCB Case Nos. 90-17606 & 90-13576

ORDER ON REVIEW

Welch, et al., Claimant Attorneys

Roderick D. Peters (Saif), Defense Attorney

Vavrosky, et al, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee Leahy's order that: (1) found that Dr. Puziss was claimant's attending physician; and (2) set aside the employer's denial of claimant's surgery claim for a radial neuropathy condition, which was based on the employer's refusal to authorize claimant's change of attending physician. The employer has moved for remand for consideration of a post-hearing medical report from an independent medical examiner. On review, the issues are remand and jurisdiction. We deny the motion to remand and vacate the Referee's order.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSION OF LAW AND OPINION

Jurisdiction

On May 7, 1990, the Oregon Legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Law. Or Laws 1990 (Special Session), ch. 2. Because a hearing was convened after July 1, 1990, this matter is properly analyzed under those revisions. Or Laws 1990 (Special Session), ch. 2, 54; Ida M. Walker, 43 Van Natta 1402 (1991).

Here, claimant wished to change attending physicians. (Ex. 96). This doctor recommended additional surgery. (Ex. 90). The employer, relying on OAR 436-10-060 (the number of times claimant may change physicians by choice), denied claimant's request for further surgery. (Ex. 91).

Claimant requested a hearing. Claimant also requested authorization from the Director to change attending physicians. (Ex. 96). The Medical Review and Abuse Section denied authorization pending the outcome of claimant's pending hearing.

At hearing, claimant narrowed the issues to: (1) whether he had exceeded the number of physicians allowed by choice; and (2) the employer's denial of claimant's surgery request.

With regard to the first issue, we recently held in Tracy Johnson, 43 Van Natta 2546 (1991), that the Hearings Division lacks jurisdiction to review the Director's refusal to authorize a claimant's request for an additional change of attending physician. Accordingly, the Referee lacked jurisdiction over the subject matter of the first issue.

The Referee also lacked jurisdiction over the issue of the employer's denial. Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Here, the employer's denial is based on its contention that the surgery is inappropriate and in violation of the Director's rule regarding the change of attending physician. See OAR 436-10-060. Original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See Stanley Meyers, supra.

Inasmuch as the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate the Referee's order and dismiss claimant's hearing request. We also vacate the Referee's attorney fee award for prevailing against the denial. See Stanley Meyers, supra.

Remand

The employer moves for remand to allow it to admit an August 19, 1991 post-hearing medical report authored by an independent medical examiner, Dr. Button. We decline to do so.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Because we conclude that the Hearings Division lacks jurisdiction of this matter, we further conclude that the record is not insufficiently developed. The motion for remand is denied.

ORDER

The Referee's order dated March 12, 1991 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction. The Referee's attorney fee award is vacated.

In the Matter of the Compensation of
ROXANNE McBRIDE-FINCHER, Claimant
Own Motion No. 88-0385M
OWN MOTION ORDER
Emmons, et al., Claimant Attorneys

Claimant requests review of a May 3, 1991 Notice of Closure, contending that she is not medically stationary and is therefore entitled to additional compensation. Claimant's claim was voluntarily reopened in July 1987 under ORS 656.278. Temporary disability compensation was terminated in February 1988 when claimant returned to regular work, although the claim was not closed. By a July 8, 1988 Own Motion Order, we authorized the payment of additional temporary disability compensation commencing the date of an authorized surgery. By Notice of Closure dated May 3, 1990, the insurer closed the claim with an award of temporary disability compensation from July 1, 1987 through April 3, 1990. The Notice of Closure declared claimant medically stationary as of January 1, 1990 and indicated that temporary disability compensation paid during the open claim period totaled \$16,860.52. Claimant did not request Board review of this claim closure.

On March 7, 1991, the insurer issued an amended Notice of Closure, which is identical to the May 3, 1990 Notice of Closure in all respects but one: The temporary disability compensation paid during the open claim period was revised to a total of \$21,837.21. Claimant timely requested Board review of the amended Notice of Closure, contending that she is not medically stationary and is therefore entitled to additional compensation.

Here, there are two Notices of Closure. The first Notice of Closure actually closed the claim and established January 1, 1990 as the date claimant became medically stationary. The second notice changed the total of temporary disability compensation paid but did not alter the medically stationary date or the period for which the compensation was paid.

Claimant's right to challenge the medically stationary date is barred by waiver if claimant knowingly and intentionally relinquished her right to do so. See Drews v. EBI Companies, 310 Or 134, 150-151 (1990). Payments of temporary disability compensation ceased as of April 3, 1990. The May 3, 1990 Notice of Closure established January 1, 1990 as the date claimant became medically stationary and thereby put claimant on notice that she must act on the Notice by challenging the medically stationary date in order to preserve continuing temporary disability payments. Here, claimant knowingly waived those payments when she failed to request Board review of the May 3, 1990 Notice of Closure that established January 1, 1990 as the medically stationary date.

Accordingly, the request for review of the March 7, 1991 Notice of Closure is denied.

Entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order. In addition, claimant's claim may be reopened for additional temporary disability compensation if she sustains a worsening of her compensable injury requiring either inpatient or outpatient surgery, or other treatment requiring hospitalization. ORS656.278(1)(a).

IT IS SO ORDERED.

In the Matter of the Compensation of
BONNIE J. McCABE, Claimant
WCB Case No. 90-19744
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Hoguet's order that: awarded claimant 3 percent (4.5 degrees) scheduled permanent disability for loss of function of her right hand, and awarded claimant 12 percent (18 degrees) scheduled permanent disability for loss of function of her left hand, whereas a Notice of Closure awarded no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the "standards" in effect at the time of the May 22, 1990 Notice of Closure and awarded claimant 3 percent scheduled permanent disability for loss of use or function of her right hand and 12 percent scheduled disability for loss of use or function of her left hand. We apply the same "standards" and modify.

Grip strength

The Referee awarded claimant 5 percent for lost grip strength in her left hand. On review, SAIF contends that the only assessment of grip strength in the record consisted of claimant's treating doctor, Dr. Sirounian, squeezing her hand and subsequently concluding that her grip was weaker.

We agree that a 5 percent award is not warranted in this case. We agree with the Referee's reasoning that, in light of claimant's testimony and Dr. Sirounian's statement that grip strength was only "slightly diminished," the fact that Exhibit 20 demonstrates that he circled the maximum award of 39 percent for lost grip strength is not persuasive without further explanation. In addition, although claimant contends that Dr. Sirounian has measured her impairment, we are not persuaded by his report. In a December 5, 1990 letter, Dr. Sirounian stated:

"The patient has loss of grip strength, which is basically a qualitative examination on my part. I suggest for a more quantitative examination that she be referred for a Functional Capacities Evaluation of the hand to determine the percent of grip strength loss in the right and left upper extremity."

Accordingly, because Dr. Sirounian has suggested that his assessment of claimant's lost grip strength was only qualitative and he recommended further testing, we are not persuaded that his report establishes measurable impairment under the "standards". In addition, although claimant credibly testified that her grip strength was diminished, we have previously concluded that lay testimony on this issue is not sufficient. Dachel Snocker, 43 Van Natta 1173 (1991). Under the circumstances, we agree with SAIF that an award for lost grip strength under the "standards" is not appropriate.

Chronic condition

We adopt the Referee's opinion and conclusions on the issue of impairment values for claimant's chronic conditions. However, because we have concluded that no impairment value should be awarded for grip strength, we modify claimant's total impairment of the left hand to 7 percent.

We agree with the Referee's conclusion that claimant is entitled to 3 percent scheduled permanent disability for loss of use or function of her right hand. Furthermore, claimant is entitled to 7 percent scheduled permanent disability for loss of use or function of her left hand. Although the Referee's "Order" awarded disability for claimant's left and right "arm," claimant suffers no "arm" impairment under the "standards." We correct this apparent scrivener's error.

We note that, although SAIF requested review of the Referee's scheduled permanent disability awards, SAIF did not request a reduction of claimant's scheduled award for her right hand. Accordingly, although we affirm the Referee's award for the right hand, we do not award an attorney fee on the issue.

ORDER

The Referee's order dated January 18, 1991 is modified. In lieu of the Referee's award of 12 percent (18 degrees) scheduled permanent disability for claimant's loss of use or function of her left hand, claimant is awarded a total of 7 percent (10.5 degrees) scheduled permanent disability. The remainder of the order and the Referee's award of 3 percent (4.5 degrees) scheduled permanent disability for claimant's loss of use or function of her right hand is affirmed.

December 16, 1991

Cite as 43 Van Natta 2709 (1991)

In the Matter of the Compensation of
JEFF A. NEWMAN, Claimant
WCB Case No. 90-22099
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Brazeau's order that set aside its partial denial of claimant's current left intrascapular, left side, and neck conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's denial on the grounds that claimant had satisfied ORS 656.005(7)(a)(A), which provides that a consequential condition is compensable if the compensable injury is the major contributing cause of the consequential condition, and ORS 656.005(7)(a), which provides that a claim must be established by medical evidence supported by objective findings. We agree with the Referee's analysis regarding ORS 656.005(7)(a), and his ultimate conclusion that claimant's condition is compensable, and adopt the Referee's order except

for that portion concerning ORS 656.005(7)(a)(A), for which we provide the following analysis.

In Julie K. Gasperino, 43 Van Natta 1151, 1153 (1991), which issued subsequent to the Referee's order, we held that the "major contributing cause" standard required by ORS 656.005(7)(a)(A) applies to "secondarily consequential conditions" while the "material contributing cause" standard remains to prove "primarily consequential conditions." The Referee, in applying the major contributing cause standard, found that claimant's condition was a secondary consequential condition.

We agree with claimant's assertion that his condition is properly characterized as a primary consequence of the June 1990 injury. The medical evidence shows that claimant reported experiencing at least some of his current symptoms shortly after the accident. Those symptoms continued to plague claimant, prompting him to seek treatment from Dr. Purtzer. The medical evidence therefore demonstrates that claimant's current condition arose from the June 1990 accident, as opposed to being a "consequence" of the injuries that he sustained in the accident. We thus conclude that claimant's condition is a primary consequence. See Julie K. Gasperino, *supra*, 43 Van Natta at 1153. Accordingly, claimant must prove that the June 1990 accident was a material contributing cause of his current condition in order for his claim to be compensable.

We conclude that claimant has carried that burden of proof. We first note that "magic words" are not required in a case in which the record, as a whole, satisfies claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Here, Dr. Purtzer, claimant's treating physician, reported that claimant's condition "is related" to his compensable injury. (Exs. 10, 11). Purtzer also explained that his initial diagnosis of "undetermined etiology" was based on his finding that claimant's symptoms did not fit exactly with a definite neurological diagnosis but that such an occurrence was common "in this type of difficulty." (*Id.*) We are persuaded that the record in this case satisfies claimant's burden of proof.

SAIF asserts, however, that the report of Dr. Purtzer is not reliable and that a report from the Orthopaedic Consultants proved that claimant's subjective complaints were not supported by objective findings but rather were a result of "significant embellishment." Like the Referee, we also defer to Dr. Purtzer's medical opinion because Purtzer is the treating physician and has had the greatest opportunity to observe claimant.

SAIF further contends that, even relying on Dr. Purtzer's opinion, claimant failed to prove that the claim "is established by medical evidence supported by objective findings," as required by ORS 656.005(7)(a).

A claimant may satisfy the "objective findings" requirement of ORS 656.005(7)(a) if he offers evidence that a physician has examined him and determined that he suffers from a disability or a physical condition that requires medical services. Suzanne Robertson, 43 Van Natta 1505 (1991). That determination may be based on purely objective factors, ORS 656.005(19), or on the worker's description of the pain that he is experiencing, as long as the physician indicates that the worker in fact experiences symptoms and does not merely recite the claimant's complaints of pain. Suzanne Robertson *supra*.

In this case, Dr. Purtzer's report that noted decreased pinprick on the left side is an objective finding under ORS 656.005(19). Additionally, Purtzer clearly indicated that claimant was experiencing the symptoms for which he was seeking treatment; although of an "undetermined etiology", Purtzer found that claimant suffered from "neck pain and intrascapular pain and left arm and leg

numbness" and prescribed medication and physical therapy. (Ex. 5-2). Purtzer's opinion therefore also satisfies "objective findings" under Suzanne Robertson. We thus conclude that claimant "established the claim with medical evidence supported by objective findings."

After considering the factors set forth in OAR 438-10-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 22, 1991 is affirmed. For services on Board review, claimant's attorney is awarded \$1,000, to be paid by the SAIF Corporation.

December 16, 1991

Cite as 43 Van Natta 2711 (1991)

In the Matter of the Compensation of
STEVEN M. STARNES, Claimant
WCB Case No. 90-10338
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The insurer requests review of Referee Quillinan's order that: (1) set aside its denial of claimant's low back injury claim; and (2) assessed a penalty and related attorney fee for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found claimant not credible based on his demeanor. We defer to that finding, because of the Referee's opportunity to observe claimant. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Notwithstanding that finding, however, the Referee, relying on the medical evidence and the testimony of other witnesses, concluded that claimant had established a compensable injury. We agree and adopt her conclusions and reasoning.

Penalties

Finding that the insurer had no reasonable basis, either medically or factually, for denying claimant's injury claim, the Referee concluded that the denial was unreasonable and assessed a \$400 penalty and related attorney fee. We agree that the denial was unreasonable and adopt the Referee's conclusion that a penalty was appropriate. However, a penalty for an unreasonable denial is based on a percentage of the amounts then due, with a maximum penalty of 25 percent. See ORS 656.262(10). As the insurer correctly points out, the Referee assessed

a \$400 penalty without reference to or regard for any amounts then due. We modify the penalty accordingly.

We also conclude that claimant was not entitled to a separate attorney fee under the circumstances. If a carrier unreasonably refused to pay compensation, former ORS 656.262(10) authorized the assessment of an attorney fee under ORS 656.382(1). However, the legislature amended ORS 656.262(10) during its 1990 Special Session. See Or Laws 1990 (Special Session), ch. 2, 15. In place of the language authorizing the assessment of a separate attorney fee, ORS 656.262(10) now provides that, if the worker is represented by an attorney, the attorney shall receive one-half of the penalty "in lieu of an attorney fee." Accordingly, claimant's attorney is awarded one-half of the assessed penalty, in lieu of an attorney fee. See Nicolasa Martinez, 43 Van Natta 1638 (1991).

Attorney Fee on Board Review

Because the insurer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the compensability issue is \$800, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated March 29, 1991 is affirmed in part and modified in part. In lieu of the Referee's assessed penalty and related attorney fee, claimant is awarded a penalty equal to 25 percent of the amounts then due as of the date of hearing as a result of the overturning of the insurer's denial. Claimant's attorney is awarded one-half of the assessed penalty in lieu of an attorney fee. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded a reasonable attorney fee of \$800, to be paid by the insurer.

December 16, 1991

Cite as 43 Van Natta 2712 (1991)

In the Matter of the Compensation of

NATHANIEL YOUNG, Claimant

WCB Case No. 90-16703

ORDER ON REVIEW

Doblie & Associates, Claimant Attorneys

Nelson, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Schultz' order that: (1) set aside its August 17, 1990 and October 4, 1990 denials insofar as they denied the compensability of claimant's low back injury claim; and (2) assessed a 25 percent penalty, to be shared by claimant and his attorney, for the insurer's allegedly unreasonable August 17, 1990 denial. In his brief, claimant challenges that portion of the Referee's order that declined to award his attorney a separate attorney fee for securing the penalty. On review, the issues are compensability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as our own.

FINDINGS OF ULTIMATE FACT

Claimant's injury occurred in the course of his employment. Claimant has established by objective evidence that his injury was a material contributing cause of his subsequent disability and need for treatment.

The insurer's August 17, 1990 denial of claimant's low back injury claim was not supported by a legitimate doubt as to its legal liability for claimant's condition.

CONCLUSIONS OF LAW AND OPINIONCompensability

We adopt the Referee's reasoning and conclusion that claimant sustained an injury as opposed to a worsening of a preexisting condition. We further adopt the Referee's reasoning and conclusion that claimant has established by objective medical evidence that his injury was a materially contributing cause of his subsequent disability and need for treatment with the following supplementation.

The insurer argues that there are no objective findings to support compensability as required by ORS 656.005(7)(a). We disagree. "Objective findings" in support of medical evidence are defined to include, but are not limited to, "ranges of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence substantiated by clinical findings." Amended ORS 656.005(19). Based on claimant's reporting to him of the mechanics of injury and his physical examination of claimant, Dr. Daniels noted claimant had focal pain at L5-S1 in the midline and at the SI joints bilaterally, and increased discomfort with flexion but not with torsion. Therefore, he concluded that claimant had sustained a lumbosacral strain at work, requiring rest, ice, heat, narcotic pain relievers, and prescription muscle relaxants. A physician's evaluation of a worker's subjective complaints satisfies the definition of "objective findings." Suzanne Robertson, 43 Van Natta 1505 (1991).

The insurer also argues that, pursuant to ORS 656.005(7)(a)(B), claimant's condition after May 29, 1990 was not compensable. That provision limits the recovery of benefits where a preexisting condition combines with a compensable injury to cause or prolong disability or a need for treatment. Here, there is no medical evidence that claimant's injury has combined with preexisting degenerative condition creating a "resultant condition". Therefore, we reject the insurer's contention.

Penalties and Attorney Fees

We agree with the Referee that the insurer's August 17, 1990 denial was unreasonable, and adopt his order assessing a 25 percent penalty, with one-half of the penalty to be paid to claimant's counsel in lieu of an attorney fee, as provided under amended ORS 656.262(10)(a).

On review, claimant asserts that his attorney is entitled to a separate attorney fee under amended ORS 656.382(1) for securing the penalty. The factual basis asserted in support of the fee, i.e., unreasonableness of the insurer's August 17, 1990 course and scope denial, is the same factual basis for which the penalty under ORS 656.262(10)(a) was assessed. Under these circumstances, claimant's attorney was only entitled to receive one-half of the penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991).

For successfully defending on review against the employer's appeal on the compensability issue, claimant's counsel is entitled to an assessed attorney fee. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on Board review concerning the compensability issue is \$700, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Inasmuch as penalties are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review concerning the Referee's penalty award. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 7, 1991 is affirmed. For services on Board review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of \$700, payable by the insurer.

December 17, 1991

Cite as 43 Van Natta 2714 (1991)

In the Matter of the Compensation of
HOWARD G. GAROUTTE, Claimant
WCB Case No. 90-00259
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

The insurer requests review of Referee Hoguet's order that: (1) set aside its partial denial of claimant's claim for worsened left knee and right hip conditions; (2) found claimant's low back condition to be compensable; and (3) granted permanent total disability effective November 29, 1990, whereas Determination Orders had awarded 20 percent (30 degrees) scheduled permanent partial disability for a left forearm condition, 10 percent (15 degrees) scheduled permanent partial disability for a left knee condition, 19 percent (28.5 degrees) scheduled permanent partial disability for a right knee condition, and 20 percent (64 degrees) unscheduled permanent partial disability for a low back condition. Claimant cross-requests review, contending that his permanent total disability award should be effective November 15, 1989. On review, the issues are compensability, extent of scheduled and unscheduled permanent disability, including permanent total disability, and, if claimant is permanently and totally disabled, the effective date of permanent total disability award. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," but not his "Ultimate Findings of Fact", with the following modifications.

Claimant worked for the insured from September 1974 until October 1, 1986. Between September 1974 and October 1976, he performed as a warehouseman and machine operator (SVP 6/medium).

Claimant's total scheduled disability award for his right knee condition is 19 percent to date.

CONCLUSIONS OF LAW AND OPINIONPreliminary mattersApplicable law

Because the initial hearing request was filed before May 1, 1990, and the hearing first convened prior to July 1, 1990, we apply the law in effect prior to the July 1990 amendments. See Or Laws 1990 (Special Session), ch. 2, 54(2); Brad R. Christie, 43 Van Natta 608 (1991). However, because claimant amended his hearing request to include issues raised by the insurer's July 20, 1990 partial denial (which clearly issued after the statutory amendments became effective), we apply the law as amended to the issue framed by that denial, i.e., the compensability of claimant's left knee, low back and hip conditions "as they relate to the right knee claim." Ex. 82A; see Ida Walker, 43 Van Natta 1402, 1405 (1991).

Res Judicata and Responsibility Defenses

The insurer argues that it cannot be held responsible for claimant's current left knee problems and their sequelae, because the SAIF Corporation accepted the left knee condition and remains responsible for it. In support, the insurer advances two theories. First, it argues that the current claim is precluded by the Board's August 11, 1989 Own Motion Order which reopened claimant's left knee claim with SAIF. (See Ex. 71E). Second, the insurer argues that, if the claim is not barred, SAIF remains responsible for claimant's left knee condition as it is the insurer which accepted that condition and the Referee lacked jurisdiction to shift responsibility from SAIF. We disagree.

Res Judicata

The doctrine of res judicata applies to workers' compensation cases and precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). The doctrine of res judicata has two aspects: "claim preclusion" and "issue preclusion". White, supra.

Because the issues presently before us were not "actually litigated" at the time of the Board's Own Motion Order, issue preclusion does not apply to the present claim. See Jimmy M. Campo, 42 Van Natta 903 (1990).

Under the res judicata doctrine of "claim preclusion," litigation of a claim or cause of action to final judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Drews v. EBI Companies, 310 Or 134 (1990); Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Restatement (Second) of Judgments, Sections 17-19, 24 (1982). For claim preclusion to apply, the subsequent litigation must include: (1) the same parties (or those in privity); (2) the same claim (or a second claim arising from the same transaction or series of connected transactions out of which the first claim arose); and (3) a valid and final judgment on the first claim. Drews v. EBI Companies, supra at 140.

In the present case, claimant and SAIF were the parties involved in the Own Motion proceedings; claimant and the insurer (Liberty Northwest Insurance Corporation) are the parties in the present proceeding. Inasmuch as SAIF and the insurer are not the same parties nor are they in privity, claim preclusion does not apply. Consequently, the current claim is not barred by the doctrine of res judicata.

Responsibility Defense

The insurer's July 20, 1990 denial states in relevant part:

"Your attorney has alleged that your right knee condition has worsened your left knee and hip. Medical evidence does not support that allegation. Therefore, without waiving further questions of compensability, we submit this partial denial for your claim for benefits for your left knee and hip condition [sic] as they relate to the right knee claim." (Ex. 82A).

The Referee described the issues at hearing as follows:

"[I]t's my understanding [that] there [are] essentially two issues. One is permanent total disability and, in the alternative, unscheduled and scheduled PPD and a denial of July 20, 1990. The Referee understands that if the denial is affirmed, the issue would be PTD, permanent total disability, and scheduled--or, in the alternative, scheduled PPD with respect to the right knee. If the denial is set aside, the issues would be PTD or, in the alternative, unscheduled PPD and scheduled PPD with regard to a left knee, a right knee, a low back and a left hip." (Tr. 2-3).

The parties agreed with the Referee's statement of issues. (Tr. 3). However, in opening remarks, the insurer's attorney stated:

"As late as August 1989, there has been a judicial determination by the Workers' Compensation Board that responsibility for the left knee is [with] SAIF Corporation, not Liberty Northwest. . . . I didn't feel the need to go out and get an independent medical examination, because Dr. Manley does not make the case that would shift responsibility for the left knee condition to Liberty Northwest as part of the right knee claim, nor does he do that in terms of bringing in either the hip condition or the low back condition into the right knee claim such that he would then be able to receive the awards. You have to remember that the left knee is being processed by SAIF and the low back has previously been processed by Liberty and received an award of disability on that claim." (Tr. 17-18).

Despite counsel's reference to an arguable responsibility "defense," we conclude that responsibility was not before the Referee. We reach this conclusion primarily because the insurer denied compensability only of the left knee and hip in its July 1990 partial denial. At hearing, the parties agreed that the compensability of claimant's current low back condition was at issue as well. Claimant never agreed that responsibility was an issue and SAIF was not a party to the proceedings. In addition, we note that responsibility was not raised in the "Specification of Issues" prior to hearing. Therefore, the insurer waived its right to assert a responsibility defense on review. See Beverly R. Tillery, 43 Van Natta 2470 (1991); Also see Donald A. Hacker, 37 Van Natta 706 (1985). (Fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy). Under the circumstances, we conclude that it would be unfair to allow the insurer to assert a responsibility defense that was not timely raised. Accordingly, we address the compensability issue as it is framed by the denial and amended at hearing.

We also note that the parties agreed that the denial should have referred to claimant's right hip rather than his left hip. (Tr. 10). However, because

the medical evidence refers to left hip complaints, (see Ex. 82-60), we conclude that the left hip was the body part claimed.

Compensability of left knee, left hip and low back conditions

The Referee determined that claimant had established the compensability of his current left knee, left hip and low back conditions by proving that his compensable right knee injury was a material cause of his worsened left knee, left hip and low back conditions. However, because, as to those body parts, this is not an initial injury claim, material cause is not the standard of proof. Compare Mark N. Wiedle, 43 Van Natta 855 (1991).

Here, claimant had left knee, left hip and low back problems that preexisted the October 1986 right knee injury. Moreover, there is no contention that claimant's left knee, hip or low back conditions are a direct or primary consequence of the October 1986 work incident. Compare Julie K. Gasparino, 43 Van Natta 1151 (1991). Therefore, claimant bears the burden of proving that his compensable right knee injury was the major cause of his left knee, left hip and low back conditions, or their worsening. ORS 656.005(7)(a)(A)&(B). Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other causes, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983); David K. Boyer, 43 Van Natta 561 (1991).

Here, there is evidence that claimant's right knee injury and related surgeries impacted his current left knee, hip and low back problems. The question remains whether claimant's compensable right knee problems rise to the level of being the major cause of those conditions. We proceed to consider the expert evidence.

The only medical evidence addressing the causation of claimant's current problems is the opinion of Dr. Manley, treating physician. At the outset, we note that Manley initially answered questions affirmatively regarding whether the October 1986 right knee injury materially contributed to claimant's worsened left knee, low back and hip conditions. (Ex. 79B-2). Later, however, Manley was unable to say whether either of claimant's knee conditions caused or aggravated the hip problems in particular. (Ex. 82-37). Due to Manley's unexplained reversal of opinion, we find that opinion unpersuasive concerning the causation of claimant's current hip condition.

Regarding claimant's low back, Manley opined--considering the aging process and the preexisting injuries--that the major cause of the acceleration of claimant's low back problems since 1986 had been "the knee problems." (Ex. 82-64). However, Manley also opined that the "primary cause" of claimant's low back pain was arthritis. (Ex. 82-10). And, when asked to explain the relative contributions--as between the aging process, the preexisting injuries and the two knee injuries--Manley responded:

"I would have to think that the preexisting back injuries had probably the primary contribution, age is a constant factor which at his age should not be this much, would be minimal, and somewhere in between there would be the knees." (Ex. 82-21).

Considering the unexplained variation in Manley's opinion, the absence of other evidence on causation, and Manley's assessment of the contribution of the right knee injury, we conclude that Manley's opinion does not support claimant's low back claim as a part of the compensable right knee claim.

Concerning claimant's left knee condition, claimant's attorney reminded Manley that claimant had undergone three left knee surgeries since the October

1986 right knee injury. Then Manley agreed that it was a "fair statement" that the 1986 right knee injury was "a major cause of accelerating the osteoarthritis leading to the left knee surgery in 1989." (Ex. 82-55.) In this regard, we note that claimant had left knee surgeries in 1977 and 1979 and a reinjury in 1985. By June 11, 1986, he had bilateral osteoarthritic changes in his knees and Dr. Duff, his then treating physician, opined that claimant would not be able to keep working for the insured, due to his knee and back problems. (Ex. 8). In 1987, Duff explained that the increasing knee problems which he foresaw would be a natural development of claimant's osteoarthritis. (Ex. 28). Considering Duff's prediction and his explanation for it, as well as Manley's description of the right knee (and its sequelae) as "a" major cause, we do not find that the right knee condition is a more significant cause than all others combined. See McGarrah v. SAIF, supra.

For these reasons, we conclude that claimant has not carried his burden concerning the compensability of the left knee, low back or hip conditions as part of the right knee claim. See Raymun B. Savalas, 42 Van Natta 2582 (1990).

Permanent Total Disability

We adopt the Referee's "Conclusions and Opinion" on this issue, with the following exception and supplementation.

Inasmuch as claimant's left knee and low back conditions were disabling at the time of the 1986 right knee injury, we consider them in determining claimant's eligibility for permanent total disability compensation. On the other hand, because claimant's left elbow and hip conditions were not disabling at that time, we do not consider those conditions.

An award of permanent total disability under the "odd lot" doctrine is effective as of the earliest date that all relevant medical, vocational and social elements exist to support the award. Adams v. Edwards, 90 Or App 365, 370-71 (1988); Morris v. Denny's, 50 Or App 533, modified 53 Or App 863 (1981). Here, these elements existed by the November 15, 1989 medically stationary date. Therefore, claimant's permanent total disability award should be effective as of November 15, 1989.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review concerning his permanent total disability award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of permanent disability issue is \$1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated February 6, 1991 is reversed in part, modified in part and affirmed in part. That portion of the order that set aside the insurer's July 20, 1990 partial denial is reversed. The denial is reinstated and upheld. The Referee's attorney fee for prevailing on the denial is reversed. The Referee's order is modified so that claimant's permanent total disability award is effective November 15, 1989. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, provided the total of fees approved by the Referee and the Board shall not exceed \$4,600. For services on Board review, claimant's attorney is awarded a reasonable assessed fee of \$1,500, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
LYMAN K. HAMPTON, Claimant
WCB Case No. C1-01091
AMENDED ORDER APPROVING CLAIM DISPOSITION AGREEMENT
James Egan, Claimant Attorney
Brian L. Pocock, Defense Attorney

On October 22, 1991, the Board issued an Order on Reconsideration Approving Claim Disposition Agreement in the above-captioned matter. The agreement was not approved until reconsideration was granted on October 22, 1991, as the proposed agreement initially submitted by the parties contained an excessive attorney fee. Consequently, delay caused by the parties' reconsideration request and submission of an addendum reducing the excessive fee resulted in the agreement's approval after the date that the agreement provided for commencement of payments to claimant.

The parties have now requested further amendment of the agreement in order to provide for an amended lump sum payment of \$16,000 to claimant, with seventy-seven total monthly payments of \$1,000 each, to commence December 19, 1991.

We find that the parties have clearly evidenced their intent to amend the amount of lump sum payment and the date of commencement of monthly payments. Additionally, the parties have obtained Division approval of the addendum as required by OAR 436-40-070(1).

This agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, our October 22, 1991 order is abated and withdrawn. As amended herein, we adhere to and republish our October 22, 1991 order in its entirety.

IT IS SO ORDERED.

December 17, 1991

Cite as 43 Van Natta 2719 (1991)

In the Matter of the Compensation of
VICKIE J. HEMMER, Claimant
WCB Case No. 90-11916
ORDER ON REVIEW
Max Rae, Claimant Attorney
Steven Cotton (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The SAIF Corporation requests review of that portion of Referee Harri's order that set aside its denial of claimant's low back injury claim. Claimant cross-requests review of that portion of the order that declined to assess penalties and attorney fees for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees.

We affirm and adopt the Referee's order, with the following comments.

The SAIF Corporation's May 18, 1990 denial was based on "insufficient evidence that [claimant's] lumbosacral strain is the result of either a work-related injury or disease." (Ex. 15). Claimant's hearing request identified that denial and listed compensability and penalties and attorney fees as the issues to be litigated. At hearing, claimant's counsel raised those issues, (Tr. 2), and stated in his opening remarks:

"[T]his is a compensability case, primarily regarding a March 13, 1990 injury. Claimant will describe an incident while working at Fairview wherein while in the process of toileting a client. . .[t]his person had a seizure, this client, and in the course of attending to this person in the seizure, my client who is. . .an employee of Fairview, developed increased back symptoms which led her to see Dr. Rollings the next day, and that's all we need to show for our compensability claim, that she sought compensation as a result of a work injury. There will be no issues as to permanent disability or time loss or any of those other things that come later, after [the] threshold of compensability is resolved." (Tr. 3-4) (emphasis added).

In his Opinion and Order, the Referee set out the controlling statutes and noted that claimant had suffered two back injuries and had a preexisting degenerative disc disease condition prior to the March 1990 incident. He then stated: "Those matters are not dispositive in this case. On March 13, 1990 claimant sustained a low back injury and it is the compensability of that injury in the first instance that is at issue." (Opinion and Order @ 4) (emphasis added).

SAIF contends that the issue is whether this work-related incident is the major contributing cause of claimant's current low back problems, under amended ORS 656.005(7)(a)(B), and contends claimant has failed to carry her burden of proof. We do not agree.

Subsequent to this Referee's order, we addressed the compensability of a claim, under the 1990 amendments to workers' compensation law, where the claimant also suffered from a preexisting condition. See Bahman M. Nazari, 43 Van Natta 2368, 2370 (1991). Based on the plain language of the denial, as well as the employer's presentation of the issue at hearing, we found it clear that the employer wished to challenge the compensability of the entire claim, including claimant's then-'current' condition, on the ground that it did not arise out of and in the course of employment. We then proceeded to address: first, whether an injury sustained in the course and scope of employment was the material cause of claimant's disability and need for medical services; and second, whether the injury was the major cause of the same disability and need for treatment. Nazari, supra.

Here, based on the more limited language of the denial and claimant's counsel's description of the issues to be litigated (to which SAIF did not object)--and in the absence of contrary evidence--we find that SAIF denied the occurrence of a work-related injury only, i.e., without denying specific disability or treatment. Therefore, we conclude, as did the Referee, that claimant need only prove that a work-related injury was a material cause of her disability or need for treatment, to carry her burden of establishing the compensability of her injury. See Mark N. Wiedle, 43 Van Natta 855 (1991).

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$700, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated April 19, 1991 is affirmed. For services on review, claimant's attorney is awarded a reasonable assessed fee of \$700, payable by the SAIF Corporation.

In the Matter of the Compensation of
LORNA D. HILDERBRAND, Claimant
WCB Case No. 90-21719
ORDER ON REVIEW
Darrell E. Bewley, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The SAIF Corporation requests review of those portions of Referee Michael Johnson's order that: (1) found that a Determination Order prematurely closed claimant's back injury claim; and (2) did not address claimant's aggravation claim. On review, the issues are premature closure and, alternatively aggravation. We vacate.

FINDINGS OF FACT

An October 3, 1990 Determination Order closed claimant's back injury claim; found her to be medically stationary as of July 17, 1990; and awarded a total of 36 percent unscheduled permanent partial disability for her back condition. Claimant requested a hearing, contending that she was not medically stationary when her claim was closed, or alternatively, that her condition worsened post-closure. Pursuant to that request, a hearing was held on February 20, 1991.

Claimant apparently also requested that the Department of Insurance and Finance (DIF) reconsider the October 3, 1990 Determination Order which closed her claim. On reconsideration, DIF found that claimant was not medically stationary when her claim was closed and rescinded the Determination Order. There is no indication that the reopened claim was subsequently closed.

CONCLUSIONS OF LAW AND OPINION

Corollary matter: Subsequent case disposition

We note at the outset that DIF's reconsideration of the Determination Order is not part of this record. Indeed, DIF's July 1, 1991 Order on Reconsideration did not issue prior to the February 20, 1991 hearing. Nevertheless, because the Order on Reconsideration reopened the claim, we take administrative notice of it. See Grace B. Simpson, 43 Van Natta 1276, 1277 (1991) ("The Board may take administrative notice of facts 'capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned.'").

Applicable Law and Jurisdiction

A threshold issue, not addressed by the parties, concerns the Hearings Division's subject matter jurisdiction, an issue which may be raised at any time in the course of litigation. See Schlect v. SAIF, 60 Or App 449 (1982). Because we determine herein that claimant's appeal of DIF's claim closure is governed by amended ORS 656.268(5), we also conclude that the Referee lacked jurisdiction to decide the substantive issues raised by the parties. See Glen D. Roles, 43 Van Natta 278, 280 (1990) ("It is fundamental that an administrative agency does not have substantive authority beyond that delegated by the legislature.").

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. We agree.

Section 54 of the 1990 Act sets out the applicability provisions of the amendments. In the present case, claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litiga

tion "savings clause" contained in section 54(2) does not apply. However, this matter is subject to a special exception to the Act's general applicability provision.

In reaching this conclusion, we rely on section 54(3), which provides in relevant part:

"Amendments by this 1990 Act to . . . ORS 656.268(4), (5), (6), (7) and (8) . . . shall apply to all claims which become medically stationary after July 1, 1990."

Because claimant became medically stationary after July 1, 1990 and application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law, the "new" law applies to the present case. See Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, this matter is properly analyzed under the Workers' Compensation Act as amended, effective July 1, 1990.

Amended ORS 656.268 provides, in relevant part:

"(5) . . . If the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order. . . . (6)(b) If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283. * * * *"

In addition, ORS 656.319(4) was amended in 1990. Whereas it formerly provided for a hearing on a "determination or notice of closure," it now provides for a hearing on a "reconsideration order."

Here, because claimant did not request reconsideration of the Determination Order before he requested a hearing, his request for hearing was premature and did not vest the Hearings Division with jurisdiction. Accordingly, the premature closure issue was not properly before the Referee. Moreover, because the claim was reopened pursuant to the DIF's Order on Reconsideration, claimant's alleged aggravation claim is not ripe.

ORDER

The Referee's order dated April 5, 1991 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction.

December 19, 1991

Cite as 43 Van Natta 2722 (1991)

In the Matter of the Compensation of
JOSE L. ARELLANO, Claimant
WCB Case Nos. 90-16995 & 90-15625
ORDER ON REVIEW
Schumaker & Bernstein, Claimant Attorneys
Beers, et al., Defense Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Gunn and Westerland.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Bethlahmy's order which: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) upheld EBI's

denial of claimant's claim for the same condition. On review, the issue is responsibility.

We affirm and adopt the Referee's order with the following supplementation.

The Referee stated there was an accepted compensable occupational disease followed by an increase in disability during employment with a later insurer. Liberty points out that there was no accepted occupational disease and argues that the Referee improperly initially assigned responsibility to it.

We clarify the Referee's reasoning concerning the initial assignment of responsibility in an occupational disease case. In occupational disease cases, the "onset of disability" is the triggering date for determination of which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date upon which he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983); Inez Horsey, 42 Van Natta 331 (1990).

Because we agree with the Referee's conclusion that Liberty was on the risk at the time of the onset of disability, we also agree that the Referee properly assigned responsibility to Liberty in the first instance.

ORDER

The Referee's order dated February 28, 1991 is affirmed.

December 19, 1991

Cite as 43 Van Natta 2723 (1991)

In the Matter of the Compensation of

DONNA E. ASCHBACHER, Claimant

WCB Case No. 88-07257

ORDER ON REMAND

Doblie & Associates, Claimant Attorneys

Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991). The court reversed our prior order, which found that claimant had established that her work activities as a phlebotomist were a material contributing cause of increased symptoms from her preexisting condition and therefore had proved a compensable occupational disease claim under former ORS 656.802(1)(c). Donna E. Aschbacher, 41 Van Natta 1242 (1989). The court remanded for reconsideration in light of its holding that a claimant must establish that her employment was the major contributing cause of a claimed condition or its worsening in order to prove a claim under former ORS 656.802(1)(c).

FINDINGS OF FACT

We republish the "Findings of Fact" and "Ultimate Findings of Fact" set out in our prior order.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to prove a compensable claim for occupational disease under the 1987 amendments to former ORS 656.802(1)(c). We reversed. Donna E. Aschbacher, supra. We held, first, that former ORS

656.802(1)(c) no longer required proof that work was the major contributing cause of a preexisting condition, as had been required by Dethlefs v. Hyster Co., 295 Or 298, 310 (1983). Because the legislature had amended ORS 656.802(1) to include the Dethlefs "major cause" standard language in subsection (a) but not subsections (b) or (c), we found that the legislature intended to require only a material, rather than major, contributing cause of the condition to prove a compensable claim under former ORS 656.802(1)(b) and (c).

We further determined that a claimant no longer needed to prove a worsening of the underlying disease, as had been required by Weller v. Union Carbide, 288 Or 27 (1979). Instead, we construed former ORS 656.802(1)(c) as being satisfied if a claimant showed an increase in symptoms of a preexisting condition if they were disabling and required medical services. Applying those determinations to the facts of the case, we concluded that claimant had established that work was a material contributing cause of increased symptoms from her preexisting condition and, therefore, she proved a compensable claim under former ORS 656.802(1)(c).

The Court of Appeals reversed. Aetna Casualty Co. v. Aschbacher, *supra*. After reviewing the legislative history of former ORS 656.802(1)(c), the court found that the legislature did not intend to change the standard of proof and held that the standard of proof for establishing all types of occupational disease claims under former ORS 656.802 remained the major contributing cause test. *Id.* at 499-500. The court also determined that the 1987 amendments did not affect the applicability of Weller based on the lack of any indication in the legislative record to make such a change in the law. *Id.* at 502-03. The court therefore held that a claimant must prove a worsening of her preexisting disease in order for an occupational disease claim to be compensable. This case consequently was remanded for reconsideration in light of the court's holdings.

In this case, as our previous order determined, claimant's degenerative foraminal stenosis condition was neither caused nor worsened in major part by her work exposure. Dr. Waller, neurosurgeon, who treated claimant's low back condition, stated that claimant's walking and standing activities would cause microtrauma to the root nerve, thereby producing her symptoms. (Ex 15-14). Dr. Waller also stated, however, that the degenerative bone spur developed over the bulk of claimant's life and was due to aging rather than work activities. (Ex 15-15). Claimant therefore failed to prove that her work was the major contributing cause of a worsening of her underlying condition. Consequently, her claim fails under former ORS 656.802(1)(c).

Accordingly, on reconsideration, the Referee's order dated September 26, 1988 is affirmed.

IT IS SO ORDERED.

December 19, 1991

Cite as 43 Van Natta 2724 (1991)

In the Matter of the Compensation of
GARY O. BROWN, Claimant
Own Motion No. 84-0266M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's August 22, 1991 Notice of Closure which closed his claim with an award of temporary disability compensation from September 14, 1983 through August 6, 1991. SAIF declared claimant

medically stationary as of July 31, 1991. Claimant contends that he was not medically stationary on July 31, 1991 and is therefore entitled to additional temporary disability compensation.

Medically stationary means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). Claimant provided post-closure reports from Drs. Stringham, Naito and Black. We will consider post-closure medical reports regarding whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

Dr. Stringham first saw claimant on August 17, 1991. He provided no assessment of claimant's condition, stating that claimant's described problems "are beyond the scope of my expertise." Dr. Naito, who saw claimant on September 23, 1991, relied on Dr. Black's treatment of claimant. We give Dr. Naito's conclusory statement that claimant was not medically stationary no weight.

Claimant has been diagnosed as having a perilymph fistula in the right ear; Dr. Black operated on this condition in 1983. After claimant's symptoms returned, his right ear was reexplored in 1984. There were no signs of a fistula. In an August 24, 1990 letter, Dr. Black reported that claimant's fistula tests were negative bilaterally, as they had been in March, 1986 (see September 16, 1986 letter, Black to Bork). Claimant also has a high frequency hearing loss, slightly worse on the right, which has remained the same for many years. Claimant was also diagnosed with benign paroxysmal positional nystagmus (BPPN) (recurrent involuntary rapid movement of the eyeball) and endolymphatic hydrops (also known as labyrinthine hydrops and Meniere's syndrome). Claimant's current symptoms consist of dizziness and vertigo, symptoms of the hydrops condition. In his September 1991 report, Dr. Black stated that claimant was not medically stationary because "we've had a great deal of difficulty getting [claimant's] hydrops under control. His most recent electrocochleography (August 9, 1990) indicated that his left ear was most active from the standpoint of the hydrops." However, Dr. Black's report of the August 9, 1990 assessment conflicts with this statement. (See August 24, 1990 letter from Black to Albin). In it, he stated that electrocochleography indicated that the SP/AP ratio was elevated in the left ear only, but not at hydrops levels. He also stated, "I think the next step is to give him a trial of hydrops therapy. In the past diets and diuretics have not worked." Nevertheless, in March 1991, Dr. Black recommended a diuretic.

Dr. Black also stated in the September 3, 1991 report that claimant was "leaning toward titrated streptomycin" to treat the hydrops condition. However, in contradiction to this report, Black noted as late as July 1991 that claimant "does not want to consider a shunt or titrated streptomycin." Instead, he prescribed a different diuretic from the one prescribed the previous March and planned for claimant to return in three months.

We give greater weight to the conclusions of a treating physician unless there are persuasive reasons to do otherwise. Wieland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, based on the inconsistencies among Dr. Black's statements, as well as the unsuccessful treatment, we are persuaded to do otherwise.

We are more persuaded by the July 31, 1991 report by Dr. Hodgson, who performed an independent medical evaluation and medical file review of claimant's dizziness symptoms. Dr. Hodgson found no clinical or objective signs to support a diagnosis of endolymphatic hydrops. He added that claimant's clinical history and the failure to respond to diuretics also suggested the same. He noted that claimant had had surgery seven years previously, and, although claimant had ex

perienced some improvement since then, there had been no significant change in claimant's symptoms for some time. He therefore did not expect further significant improvement in claimant's situation with further treatment or surgery and concluded that claimant was medically stationary.

Based on this record, we do not find a reasonable medical expectation that, as of August 22, 1991, further material improvement was reasonably expected from medical treatment or the passage of time. Accordingly, we find that claimant became medically stationary on July 31, 1991 and conclude that SAIF's closure was proper.

Accordingly, we affirm SAIF's August 22, 1991 Notice of Closure in its entirety.

IT IS SO ORDERED.

December 19, 1991

Cite as 43 Van Natta 2726 (1991)

In the Matter of the Compensation of
ROBERT D. COX, Claimant
WCB Case No. 90-20080
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Powell, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Knapp's order that dismissed claimant's hearing request for lack of subject matter jurisdiction. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Ultimate Findings of Fact."

CONCLUSION OF LAW AND OPINION

The self-insured employer denied payment of medical services on the grounds that claimant was medically stationary and, therefore, palliative care was not compensable. The Referee concurred and concluded that, pursuant to amended ORS 656.245 and amended ORS 656.327, the Hearings Division does not have jurisdiction to determine issues regarding entitlement to palliative care and penalty and fees for refusal to pay for medical services. We agree.

On May 7, 1990, the Oregon Legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Law. Or Laws 1990 (Special Session), ch. 2. Because a hearing was convened after July 1, 1990, this matter is properly analyzed under those revisions. Or Laws 1990 (Special Session), ch. 2, 54; Ida M. Walker, 43 Van Natta 1402 (1991).

Here, claimant sought an order requiring the self-insured employer to pay for denied medical services. Relying on the medical records as a whole, the Referee characterized these services as palliative care. We agree.

Amended ORS 656.245, which addresses compensability of palliative care, in pertinent part, provides:

"(b) * * * If the worker's attending physician referred to in ORS 656.005(12)(b)(A) believes that palliative care which would

otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the attending physician may request approval from the director for such treatment. . . ."

Here, claimant's attending physician did not request Director approval. Accordingly, we conclude the Referee properly dismissed claimant's hearing request for lack of subject matter jurisdiction.

Claimant asserts that his care was curative, not palliative, and therefore, that the Hearings Division retains jurisdiction over this matter. Even if we were to agree that the medical care was curative, we would nevertheless conclude that the Hearings Division lacks jurisdiction over this matter.

Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Here, the employer's denial is also based on its contention that claimant's medical treatment is unreasonable and unnecessary. (Exs. 12, 17, 19). Original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See Stanley Meyers, supra.

Inasmuch as the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we affirm the Referee's order which dismissed claimant's hearing request.

ORDER

The Referee's order dated February 21, 1991 is affirmed.

December 19, 1991

Cite as 43 Van Natta 2727 (1991)

In the Matter of the Compensation of
TAMI L. FARRELL, Claimant
WCB Case No. 90-16890
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Erhman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Black's order that: (1) declined to assess an attorney fee for services concerning the SAIF Corporation's rescission of its denial of claimant's occupational disease claim for left shoulder tendinitis prior to hearing; and (2) declined to assess penalties and related attorney fees for SAIF's allegedly unreasonable claims processing. On review, the issues are penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact," with the following supplementation.

SAIF denied claimant's left shoulder tendinitis claim because there was insufficient evidence that her condition was work-related.

Claimant's counsel was instrumental in obtaining compensation for claimant's tendinitis condition without a hearing.

At the time of its denial, SAIF had a legitimate doubt as to its liability for claimant's left shoulder claim.

SAIF failed to deny the claim within the required 90 days. At the time of the denial, the only amount due was for payment of medical bills.

CONCLUSIONS OF LAW AND OPINION

Attorney Fee for Rescission of Denial

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available for the rescission of a denial prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even if a hearing is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540 3. Here, SAIF rescinded its denial prior to hearing.

We conclude that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. We base our conclusion upon the fact that claimant's attorney filed a hearing request and solicited medical reports prior to the rescission of SAIF's denial. Because claimant's counsel was instrumental in obtaining compensation for claimant without a hearing, an attorney fee for services prior to the hearing is warranted. ORS 656.386(1).

Unreasonable Denial

We adopt the Referee's "Conclusions of Law and Reasoning," with the following supplementation.

As set forth in the Referee's order, where the insurer has a legitimate doubt as to its liability and issues a denial based upon that doubt, its denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id. When an insurer "has no information with which to determine whether a condition was, or was not, work-related, a legitimate doubt exists as to its liability." Joan M. Alvarado, 43 Van Natta 477 (1991).

Here, the only information available to SAIF prior to the denial was several diagnostic reports that did not indicate whether claimant's employment was, or was not, the major contributing cause of her condition. (See, Ex. 1, 2, 4 and 5). Moreover, the employer indicated on claimant's 801 Form that it was "unknown" whether the injury occurred during the course of claimant's employment. (Ex. 3). It was not until Dr. Nagel's December 27, 1990 letter (Ex. 8), which was solicited by claimant's counsel, that SAIF had sufficient information

to reasonably determine whether claimant's condition was work-related. Immediately thereafter, it rescinded its denial and accepted the claim.

Under these circumstances, we concur with the Referee that SAIF had a legitimate doubt prior to December 28, 1990 in regard to its liability for the claim. SAIF's denial was, therefore, not unreasonable and penalties and an attorney fee are not warranted.

Unreasonable Delay in Denying the Claim

Claimant also seeks the assessment of a penalty and related attorney fee for SAIF's allegedly unreasonable delay in denying the claim. While the Referee did not address this issue in his order, we consider it because claimant's counsel raised the issue at hearing. (Tr. 2).

On review, claimant argues that SAIF unreasonably delayed in denying her claim. We agree.

As a preliminary matter, we note that the 1990 workers' compensation law controls in this matter because claimant's request for hearing was made after May 1, 1990 and the hearing convened after July 1, 1990. See 1990 Or Laws, ch. 2, Senate Bill 1197, 54 (2).

Under ORS 656.262(6) as amended, the insurer must accept or deny a claim within 90 days, or risk imposition of a penalty. See Brian L. Dunn, 43 Van Natta 1673 (1991). In this case, the April 13, 1990 claim was not denied until August 7, 1990. Because SAIF did not accept or deny the claim within 90 days, a penalty may be assessed if there were amounts then due between the date when an acceptance or denial should have issued and the date of the denial. Jeffrey D. Dennis, 43 Van Natta 857 (1991). Inasmuch as the only amount due at the time of the unreasonable delay was payment of medical bills, there is no basis for a penalty. See Wacker Siltronic v. Satcher, 103 Or App 513 (1990).

However, ORS 656.382(1) also provides for an assessed attorney fee when an insurer engages in conduct, which constitutes an unreasonable resistance to the payment of compensation, even though there are no amounts then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991).

In the present case, SAIF did not respond within 90 days as required by ORS 656.262(6). By failing to timely respond to the claim, it delayed the process and the ultimate resolution as to the compensability issue. We find that its failure to respond to claimant's claim was unreasonable and its nonaction had the effect of delaying benefits which were eventually compensable as a result of the rescission of SAIF's denial and its acceptance of the claim. Therefore, SAIF unreasonably resisted the payment of compensation and an attorney fee pursuant to ORS 656.382(1) is assessed on this basis. See Richard J. Stevenson, 43 Van Natta 1883 (1991); Steve Chambers, 42 Van Natta 524 (1990); Cindi A. Cadieux, 41 Van Natta 2259 (1989).

Attorney Fee Award

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services prior to the hearing concerning the rescission of the denial issue and his services in pursuing the untimely denial issue is \$2,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record and claimant's attorney's statement of services), the complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated February 13, 1991 is reversed in part and affirmed in part. For services rendered prior to hearing concerning the rescinded

denial and for services concerning SAIF's untimely denial, claimant's attorney is awarded an assessed attorney fee of \$2,000, to be paid by the SAIF Corporation.

December 19, 1991

Cite as 43 Van Natta 2730 (1991)

In the Matter of the Compensation of
JOAN E. HATHAWAY, Claimant
WCB Case No. 90-21435
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Holtan's order which approved claimant's palliative chiropractic care. On review, the issue is medical services. We vacate.

FINDINGS OF FACT

On October 5, 1988, claimant suffered a compensable injury. She became medically stationary on February 14, 1989. The claim was closed by a February 28, 1989 Notice of Closure with no permanent disability awarded.

By letter to SAIF dated September 6, 1990, claimant's treating physician recommended and requested that claimant receive palliative chiropractic treatments. By letter dated September 13, 1990, SAIF denied the request.

On November 28, 1990, claimant filed a hearing request.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the Hearings Division had jurisdiction to hear this matter and approved claimant's chiropractic treatments. We disagree with the Referee's conclusion that the Hearings Division had jurisdiction over this matter.

Applicable Law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Medical Services

At the time of claimant's injury, ORS 656.245(1) provided for purely palliative services for compensable injuries. Wait v. Montgomery Ward, Inc., 10 Or App 333 (1972). However, the legislature amended ORS 656.245(1) in 1990. As amended, that statute now provides, in pertinent part:

"(b) Notwithstanding paragraph (a) of this subsection, after a worker has become medically stationary, palliative care is not compensable, except [for specified condition not applicable here]. If the worker's attending physician referred to in ORS 656.005(12)(b)(A) believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the attending physician may request approval from the director for such treatment. The director shall appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment." (Emphasis added).

Thus, as amended, ORS 656.245 required claimant's attending physician to request approval for palliative care before such services were rendered. Furthermore, it authorized claimant's attending physician to request approval from the Director, where, as here, the insurer denies the request. Ida M. Walker, supra.

We recently held that under amended ORS 656.704(3) "matters concerning a claim" over which the Board and thus the Hearings Division has jurisdiction, do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. Stanley Meyers, 43 Van Natta 2463 (1991). ORS 656.245, as amended, provides a procedure for the resolution of this dispute.

We conclude that the appropriateness of palliative chiropractic treatment is not a "matter concerning a claim" over which the Hearings Division had jurisdiction. Because such disputes are no longer matters concerning a claim, original jurisdiction lies exclusively with the Director. Stanley Meyers, supra. Accordingly, we must vacate the Referee's order for lack of jurisdiction.

ORDER

The Referee's order dated February 15, 1991 is vacated.

December 19, 1991

Cite as 43 Van Natta 2731 (1991)

In the Matter of the Compensation of
RICHARD C. HOY, Claimant
WCB Case No. 90-20367
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of that portion of Referee Quillinan's order which upheld the SAIF Corporation's denial of claimant's aggravation and surgery claim for a cervical condition. On review, the issues are compensability and aggravation. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The first issue before us concerns the compensability of claimant's surgery claim for a cervical condition. Specifically, claimant seeks compensation for

treatment of a degenerative disc disease. The medical evidence is in agreement that the degenerative condition preexisted the claimant's compensable injury. We therefore look to ORS 656.005(7)(a)(B) to determine the compensability of claimant's condition. That statute provides:

"If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

As we determined in Bahman M. Nazari, 43 Van Natta 2368, 2370 (1991), ORS 656.005(7)(a)(B) requires a worker whose disability or need for treatment is caused by a compensable injury and a preexisting condition to prove that the injury is the major contributing cause of the disability or need for treatment.

We conclude that claimant has carried his burden of proof on the surgery issue. The medical evidence shows that, in regards to his degenerative condition, claimant was asymptomatic prior to the injury. Claimant did not experience the severe headaches, neck and shoulder pain he now suffers from until he was injured. Dr. Berkeley expressly concluded that the injury caused claimant's degenerative condition to progress and become symptomatic. (Ex 36). We are persuaded that claimant has proved that the injury was the major contributing cause of his current condition and therefore his claim for surgical treatment is compensable under ORS 656.005(7)(a)(B).

While we conclude that claimant has established that his need for surgery is compensable, we are not persuaded that he has established a compensable aggravation.

To establish his aggravation claim, claimant must show a worsening of his compensable neck condition since his last award or arrangement of compensation, which was the Opinion and Order of July 18, 1990, based on the July 3, 1990 hearing.

We conclude that claimant has not carried his burden. The record reveals that he consulted Dr. Berkeley on referral from Dr. Anderson, for the same problems he had been complaining of for some time. He did not consult Dr. Berkeley because his compensable condition had changed since July 3; Dr. Berkeley's report confirms it had not. (See Ex. 27). We conclude therefore, that the denial of aggravation should stand.¹

After considering the factors set forth in OAR 438-10-010(4), we find that a reasonable fee for claimant's counsel's services at hearing and on Board review concerning the compensability of claimant's surgery claim is \$2,250, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interests involved.

ORDER

The Referee's order dated February 1, 1991 is reversed in part and affirmed in part. The portion of the Referee's order that upheld the SAIF Corporation's denial of surgery is reversed. That denial is set aside and the surgery claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed. For services at hearing and on Board review concerning the compensability issue, claimant's attorney is awarded a reasonable assessed fee of \$2,250, payable by the SAIF Corporation.

¹ We of course recognize that at such time as claimant has the surgery, he will become unable to work and his condition will have worsened so that re-opening would then be appropriate.

In the Matter of the Compensation of

DANIEL MARTUSHEV, Claimant

Own Motion No. 88-0772M

SECOND OWN MOTION ORDER ON RECONSIDERATION REVIEWING CARRIER CLOSURE

Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 30, 1991 Own Motion Order on Reconsideration that denied reconsideration of our August 13, 1991 Order Reviewing Carrier Closure on the ground that claimant's request was received untimely. In order to allow sufficient time to consider the matter we abated our September 30, 1991 order on October 29, 1991.

Claimant contends that his first request for reconsideration was timely filed, that SAIF has failed to provide diagnostic tests as stipulated, and that he was not medically stationary at the time of claim closure.

Filing is the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing by first class mail, postage prepaid. See OAR 438-05-046(1)(a) and (c). If the thing is not received within the prescribed time and no attorney's certificate of mailing is furnished, it shall be presumed that the filing was untimely unless the filing party establishes that the filing was timely. OAR 438-05-046(1)(c). Here, our order issued on August 13, 1991. The thirtieth day fell on September 12, 1991. Although claimant's first request for reconsideration was not received by the Board until September 16, 1991, and no attorney's certificate of mailing was provided, we have the envelope showing that the request was mailed by first class mail postmarked September 12, 1991. We thus conclude that our August 13, 1991 Order was in error and that claimant's request for review was timely filed. We compute the time by excluding the day of the act or event from which the designated period of time begins to run, and including the last day unless it falls upon any legal holiday or on Saturday, in which case the last day is also excluded. See ORCP 10 and ORS 174.120. See also Anita L. Clifton, 43 Van Natta 1921 (1991). Inasmuch as we incorrectly stated our procedures in Richard S. Hookland, 42 Van Natta 2769 (1990), we disavow that portion of that order. We accordingly proceed to consider claimant's remaining arguments.

Claimant contends that SAIF failed to provide diagnostic tests as stipulated to in 1990. Our own motion authority to reopen a claim is limited to two situations: a) to provide temporary disability compensation; and b) to provide medical services related to injuries that occurred prior to 1966. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); ORS 656.278(1). Medical services related to injuries that occurred after 1966, as here, are to be provided by the insurer or self-insured employer pursuant to ORS 656.245. Consequently, we decline to address this issue for lack of own motion jurisdiction regarding the provision of tests, i.e., additional medical services. Any alleged failure to provide medical services is addressed by a request for hearing. ORS 656.245(2) and 656.283(1).

Claimant finally contends that he was not medically stationary when his claim was closed. Our August 13, 1991 order adequately addresses claimant's contention on the merits.

Accordingly, our August 13, 1991 order is withdrawn. On reconsideration, as amended herein, we republish our August 13, 1991 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CALINA NEATHERY, Claimant
WCB Case No. TP-91020
THIRD PARTY DISTRIBUTION ORDER
Gatti, et al., Claimant Attorneys
J. David Thurber (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board to resolve a dispute concerning whether SAIF is entitled to a share of a judgment claimant has recovered stemming from injuries she sustained as a result of a non-work-related motor vehicle accident which occurred while claimant's compensable injury claim was in open status. Contending that no portion of the judgment was granted for disability or medical expenses resulting from the compensable injury, claimant asserts that SAIF is not entitled to a share of the recovery. We agree with claimant's contentions.

FINDINGS OF FACT

On December 30, 1987, while performing her work activities as a dairy milker, claimant was struck from behind by a cow causing her to collide with a wall. Claimant sought emergency room treatment complaining of shoulder and low back pain. X-rays were negative. Dr. Lewis diagnosed shoulder contusion and low back strain.

On January 5, 1988, claimant sought treatment from Dr. Freeman, chiropractor. Freeman diagnosed "lumbar plexus disorder, thoracic strain, lumbosacral strain and L2 left posterior subluxation." On January 12, 1988, SAIF, the dairy's insurer, accepted claimant's injury claim.

In February 1988, Dr. Freeman referred claimant to Dr. Buza, neurologist, to determine whether claimant was experiencing a cervical disc involvement. Although claimant's cervical range of motion was "probably 50% of normal," Buza concluded that claimant did not have a cervical disc and would not require surgical considerations. Buza recommended that claimant continue her medication/therapy with Dr. Freeman.

In March 1988, Freeman reported that claimant was making gradual progress. Concluding that it would be "extremely premature" to release claimant to work, Freeman predicted that a determination regarding the extent of claimant's permanent injuries would be made in "approximately 8-10 weeks." In September 1988, Freeman reported that claimant was receiving physical therapy/rehabilitation for her shoulder pain. In addition, Freeman continued to monitor claimant's progress with her cervical condition.

Dr. Boyd, orthopedist, confirmed Dr. Freeman's report that claimant had been participating in physical therapy for the past 3 months concerning the shoulder. Boyd recommended that claimant participate in a work hardening program.

In December 1988, Freeman reported that claimant was receiving treatment twice per month. She was "making very good progress in her cervical condition," but occasionally was experiencing some radiating pain from her neck into her shoulder. Freeman further noted that physical therapy continued with claimant's shoulder, which appeared to be a "very slowly resolving condition." Concluding that claimant's condition was not medically stationary, Freeman predicted that claimant's shoulder could still improve to a point where she could return to work.

In January 1989, Dr. Fry, orthopedist, performed an independent medical examination (IME). X-rays demonstrated a slight posterior narrowing at C5-6. Shoulder x-rays were essentially normal. Recommending instructions in active exercise of the shoulder, Fry anticipated claim closure in 4-6 weeks.

In February 1989, Freeman reported that claimant's neck condition was "currently stable" and that her shoulder condition was "getting better but very slowly." Although claimant was "not completely medically stationary," Freeman noted that claimant had been released to modified work (no lifting or repetitive right arm motion) for approximately the past 2 months. Rather than Fry's 4-6 week prediction, Freeman anticipated that it would be "more on the order of 3 or 4 months" before claim closure.

In May 1989, Dr. Freeman reported that aside from occasional headaches or cervical discomfort, claimant was "doing very well." Concerning her shoulder condition, Freeman stated that claimant was experiencing difficulty when the shoulder was overused because her condition was "still improving very slowly." Freeman concluded that claimant was "quite close to being stationary."

On October 20, 1989, Dr. Freeman reported that claimant continued to receive chiropractic manipulations and myofascial trigger point therapy. Freeman declined to consider claimant's condition medically stationary until she was employed steadily and her shoulder, arm, and neck symptoms were stable. Freeman recommended further vocational rehabilitation.

On November 29, 1989, claimant was involved in a non-work-related motor vehicle accident when the car she was operating was struck from the rear by a vehicle driven by a third party. On December 13, 1989, Dr. Freeman reported that claimant's cervical spine "was re-injured rather badly" as a result of the motor vehicle accident, necessitating a delay in evaluating claimant's physical capacities for the next 2-3 months or until claimant had returned to a pre-accident status.

On January 4, 1990, Freeman reiterated that the motor vehicle accident had injured claimant's "somewhat weakened" neck area "rather more severely." Freeman was unable to determine whether claimant would make a full recovery without disability from the motor vehicle accident. Although claimant's shoulder did not appear to have suffered further injury, Freeman predicted it would be at least another 3 months before claimant's neck completely returned to a medically stationary state.

In March 1990, Freeman reported that claimant was not medically stationary from the November 1989 motor vehicle accident. Specifically, claimant was still recovering from her neck which was "re-injured" in the motor vehicle accident. Under such circumstances, Freeman could not describe the residuals from claimant's on-the-job injury.

In April 1990, BBV Medical Services performed an IME. Concluding that claimant's condition was medically stationary, BBV rated claimant's permanent impairment of the upper extremity at 5 percent. Identifying no further reason for ongoing treatment, BBV recommended that claimant return to the work force.

Dr. Freeman disagreed with most of the BBV conclusions. To begin, Freeman considered a rating of 5 percent permanent impairment in the upper extremity to be inadequate. Although Freeman agreed that claimant's neck injury had mostly resolved, he disagreed with BBV's recommendation that further palliative care be terminated.

In May 1990, Dr. Freeman reported that claimant had received chiropractic manipulations and myofascial trigger point therapy from November 1989 to mid-April 1990 for a moderate cervicothoracic sprain and a mild lumbar strain. Freeman also attributed claimant's neck symptoms to a mild to moderate degree of degenerative arthritis in the cervical spine which was partially due to her age and her prior injuries. Stating that claimant had made an excellent recovery

and was no longer experiencing symptoms due to the November 1989 injury, Freeman recommended that claimant receive palliative care twice a month for the next 6 months.

In August 1990, the Independent Chiropractic Consultants (ICC) performed an IME. Identifying no strong objective findings, ICC rated claimant's shoulder permanent impairment at no greater than 5 percent, based on her chronic ongoing pain. ICC agreed with BBV that claimant's continuing care was not curative and not of significant palliative benefit.

A September 6, 1990 Determination Order closed claimant's December 1987 injury claim. Claimant was awarded temporary disability through July 31, 1990 and 19 percent unscheduled permanent disability.

On November 6, 1990, Dr. Freeman noted that claimant experienced occasional neck discomfort attributable to over exertion and lifting. Such episodes resulted in an occasional restriction of her activities. Due to a slight amount of preexisting osteoarthritis in claimant's cervical spine, Freeman opined that claimant was more susceptible to future degenerative changes following neck traumas such as the November 1989 motor vehicle accident. Concluding that the degree of claimant's permanent impairment due to her injury from the accident was mild, Freeman rated her in the 3 to 4 percent range.

Claimant filed a cause of action against the driver of the automobile involved in the November 1989 motor vehicle accident. When settlement could not be achieved, an arbitration hearing was convened on November 13, 1990. At that proceeding, medical reports concerning claimant's ongoing treatment and SAIF's records were admitted into evidence. Following the proceeding, the Arbitrator awarded claimant \$8,719.03 in damages (\$1,719.03 in economic damages and \$7,000 in non-economic damages) and \$281.50 in litigation costs.

According to the Arbitrator's affidavit, claimant's award was granted "solely for the injuries and damages she sustained in the motor vehicle accident of November 29, 1989." The Arbitrator further stated that "no part of the compensation awarded to [claimant] in this auto accident claim was for pain and suffering, disability, nor medical expenses incurred as a result of the work-related injury." The judgment was disbursed in the following manner: (1) \$1,719.03 for claimant's medical expenses; (2) \$2,912.60 in attorney fees; (3) \$561.78 in litigation costs; and (4) \$3,807.12 to claimant.

A May 3, 1991 Order on Reconsideration modified the September 1990 Determination Order. Finding that claimant was not entitled to an award for a disc bulge, the Evaluation Section reduced the Determination Order award from 19 percent unscheduled permanent disability to 13 percent.

In June 1991, SAIF sought reimbursement for its claim costs. Contending that claimant's compensable injury had been exacerbated as a result of the November 1989 motor vehicle accident, SAIF asserted a lien of \$11,281.76 (\$4,897.80 in temporary disability, \$5,481.22 in permanent disability, and \$902.74 in medical expenses). When claimant contested SAIF's entitlement to a share of the judgment, SAIF petitioned the Board for resolution of the dispute.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker shall elect whether to recover damages from the third person. ORS 656.578. The paying agency has a lien against the worker's cause of action as provided by ORS 656.591 to 656.593. ORS 656.580(2). An off-

the-job injury that aggravates a compensable condition is a "compensable injury" within the meaning of ORS 656.578. SAIF v. Dooley, 107 Or App 287, 290 (1991).

In Dooley, the claimant was nearing a medically stationary status and still receiving temporary disability when he was involved in a motor vehicle accident unrelated to his employment. The accident resulted in new injuries and worsened the claimant's compensable condition. The claimant's physician was able to distinguish both the medical costs and the time loss attributable to the auto accident from those attributable to the original injury. As a paying agency, SAIF did not pay the medical costs resulting from the accident. However, SAIF sought reimbursement from the claimant's settlement with the third party for four months of additional temporary disability attributable to the worsened compensable condition. Reasoning that SAIF was obligated to pay the additional benefits for the aggravated compensable condition, the court held that SAIF was entitled to receive a share of the settlement proceeds.

Here, as in Dooley, claimant had not reached medically stationary status and she was still receiving temporary disability when she was injured in a motor vehicle accident unrelated to her employment. Also, as was the case in Dooley, the accident worsened some of claimant's compensable conditions. Nevertheless, unlike Dooley, the present record does not distinguish between the medical expenses and disability benefits attributable to the motor vehicle accident from those resulting from the original compensable injury. Without such evidence, we are unable to determine what, if any, portion of the compensation SAIF has provided is directly attributable to the November 1989 motor vehicle accident.

Although claimant's compensable conditions were nearing a medically stationary state prior to the November 1989 accident, Dr. Freeman, claimant's treating physician, had expressly refrained from making such a determination. In fact, one month before the accident, Freeman had recommended that further vocational rehabilitation be instituted, thereby demonstrating that the claim would remain open for an indeterminate period.

In May 1990, Freeman did report that claimant had received chiropractic manipulations and myofascial trigger point therapy between November 29, 1989 and mid-April 1990 for neck, thoracic, and low back injuries sustained in the November 29, 1989 motor vehicle accident. Yet, Freeman further noted that claimant's neck symptoms were also due to a mild to moderate degree of degenerative arthritis in the cervical spine which was partially due to claimant's age and her prior injuries.

Considering the history of claimant's prior complaints, Freeman's report does not establish that the aforementioned modes of conservative treatment, which were also provided prior to the November 1989 accident and continued to be conducted after Freeman's May 1990 report, would not have otherwise occurred in connection with the processing of claimant's compensable injury claim. Moreover, following the stabilization of claimant's compensable condition and the eventual closure of her claim in September 1990, neither Dr. Freeman nor any other physician expressly differentiated between disability and medical expenses attributable to the November 1989 motor vehicle accident from those resulting from the original compensable injury. Such circumstances are of little assistance to us in determining the amount of additional disability or medical expenses SAIF has incurred as a result of the motor vehicle accident.

Finally, and most importantly, according to his unrebutted affidavit, the Arbitrator granted claimant's award "solely for the injuries and damages she sustained in the motor vehicle accident of November 29, 1989." The Arbitrator further explained that "no part of the compensation awarded to [claimant] in

this auto accident claim was for pain and suffering, disability, nor medical expenses incurred as a result of the work-related injury."

In conclusion, it would be mere speculation to find that the November 1989 accident required SAIF to provide additional compensation that it would not have otherwise paid. Inasmuch as our decision must be based on more than speculation, we hold that SAIF is not entitled to a share of the proceeds from claimant's arbitration judgment stemming from her November 29, 1989 motor vehicle accident.

IT IS SO ORDERED.

December 19, 1991

Cite as 43 Van Natta 2738 (1991)

In the Matter of the Compensation of
OLIVER M. PAYTON, Claimant
WCB Case Nos. 90-18991 & 90-13541
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Westerband and Moller.

The SAIF Corporation requests review of those portions of Referee Brazeau's order that: (1) found that the Hearings Division had jurisdiction to consider claimant's aggravation claim for a neck condition; (2) set aside its denial of claimant's aggravation claim for the same condition; and (3) assessed a penalty and attorney fee for an allegedly unreasonable failure to pay medical billings. On review, the issues are jurisdiction, aggravation and penalties and attorney fees. We vacate in part and reverse in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

Claimant requested a hearing, concerning the aggravation denial, on June 27, 1990. The hearing was held on November 6, 1990.

FINDINGS OF ULTIMATE FACT

Claimant's 1981 compensable cervical injury was in nondisabling status for more than one year.

Claimant's 1990 aggravation claim for his cervical condition was filed more than five years after the date of injury.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that SAIF was precluded from challenging the date claimant's aggravation rights began running as it had not appealed that issue in conjunction with the April 1988 Determination Order. Therefore, the Referee found that he had jurisdiction to hear claimant's aggravation claim. We disagree.

The issue of subject matter jurisdiction may be raised at any time during the course of litigation. Schlect v. SAIF, 60 Or App 449 (1982). The filing

requirements of ORS 656.273 are jurisdictional. Lyle L. Smith, 43 Van Natta 1079 (1991); Timothy D. Beard, 43 Van Natta 432 (1991).

The April 1, 1988 Determination Order stated that claimant's aggravation rights began running as of April 1, 1988. This Determination Order was litigated in an earlier proceeding with regard to extent of permanent disability, but the beginning date of claimant's aggravation rights was not contested. However, inasmuch as the filing requirements of ORS 656.273 are jurisdictional, the failure by SAIF to raise this issue at the earlier proceeding does not render the issue of jurisdiction moot in the instant proceeding. Therefore, the issue becomes whether claimant's aggravation rights expired prior to filing of the 1990 aggravation claim.

In deciding this matter, we apply the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

As amended, ORS 656.273(4)(b) provides:

"If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

Here, claimant's 1981 cervical injury was in a nondisabling status for more than one year from the date of injury. Therefore, any claim for aggravation had to be filed within five years after the date of injury. Inasmuch as claimant's 1990 aggravation claim was filed more than five years after the date of injury, the Referee did not have jurisdiction to decide the 1990 aggravation claim. Rather, claimant's request for benefits is within the sole jurisdiction of the Board under its Own Motion authority. See ORS 656.278.

In reaching this decision, we note that the April 1, 1988 date given by the Determination Order is not controlling, if in fact claimant's aggravation rights have expired. Beard, *supra* at 433; see also Bert E. Miltenberger, 39 Van Natta 68 (1987), Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Margarette I. Schaffer-Wright, 39 Van Natta 1113 (1987). Finally, we also note that, although the amendments to ORS 656.273(4)(b) appear to have effectively eliminated the rationale behind Davison v. SAIF, 80 Or App 541 (1986), this case would fall under the court's decision in Smith v. Ridgeline, Inc., 88 Or App 147 (1987), as there is no evidence that claimant's cervical condition was misclassified from the outset.

Accordingly, we vacate that portion of the Referee's order which set aside the insurer's denial of claimant's aggravation claim.

Penalties and Attorney Fees

The Referee awarded claimant a 25 percent penalty and a \$300 attorney fee for unreasonable failure to pay for certain medical billings. However, following the hearing and prior to the close of the record, the parties entered into an "Interim Stipulation and Order." The stipulation was signed by the Referee on January 15, 1991 and settled the issue of untimely payment of medical

services bills and the corresponding penalties and attorney fees regarding that issue under claim numbers 4421678G and 4528416F.

Inasmuch as the January 15, 1990 Stipulation resolved the issue of penalties and attorney fees for unreasonable failure to pay medical billings, the Referee erred in awarding further penalties and attorney fees. Accordingly, we reverse that portion of the Referee's order.

ORDER

The Referee's order dated April 2, 1991 is vacated in part and reversed in part. That portion which set aside the insurer's aggravation denial and assessed a \$1,100 attorney fee is vacated. That portion which assessed a 25 percent penalty and awarded a \$300 related attorney fee is reversed.

December 19, 1991

Cite as 43 Van Natta 2740 (1991)

In the Matter of the Compensation of
ANDREW L. WATKINS, Claimant
WCB Case No. 90-20276
ORDER ON RECONSIDERATION
Jackson & Vause, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests reconsideration of our November 27, 1991 Order on Review that affirmed a Referee's order which upheld the SAIF Corporation's denial of his aggravation claim for a low back condition. Claimant contends that the Board applied the incorrect standard for determining diminished earning capacity. Citing Smith v. SAIF, 302 Or 396 (1986), claimant argues that diminished earning capacity need not be based upon a showing of actual loss of earnings. We agree with this statement of law. However, diminished earning capacity must be the result of a worsening of claimant's condition.

Our conclusion that claimant had not proved that he suffered a diminished earning capacity was based primarily on our finding that his lack of employment may be due to factors other than his symptomatic worsening. Claimant testified that he was unable to work because his back pain limited his ability to sit. However, claimant's vocational assistance program was terminated because he declined or was unavailable for such assistance. (Ex. 28). Furthermore, the pain center noted that claimant stated that it would be difficult for him to attend the full program because of his involvement in his volunteer work. (Ex. 19-3). These items indicate that claimant's unemployment may be due to factors other than back pain.

On this record, we remain persuaded that claimant did not prove that he suffered diminished earning capacity as a result of his symptomatic worsening. Accordingly, our November 27, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order in its entirety, effective this date. The parties' appeal rights shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTOPHER CAMARA, Claimant
Own Motion No. 91-0546M
OWN MOTION ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney

Claimant has moved for reconsideration of our October 10, 1991 Own Motion Order which denied reopening of his claim for payment of temporary total disability compensation. The basis of our denial was that claimant failed to demonstrate that he required either inpatient or outpatient surgery, or other treatment requiring inpatient hospitalization. In order to allow sufficient time to consider claimant's motion, we abated our October 10, 1991 order.

Claimant contends that he underwent outpatient surgery on August 1, 1991.

Within the meaning of ORS 656.278(1)(a), "surgery" is an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker. Fred E. Smith, 42 Van Natta 1538 (1990). Claimant has a history of multiple lateral and medial meniscus tears in his left knee. He underwent a left knee arthrogram on August 1, 1991 in order to rule out a torn medial meniscus as a cause of his chronic left knee pain and tenderness. As a result of the surgery, claimant was disabled for five days. We accordingly find that claimant underwent surgery within the meaning of ORS 656.278(1)(a).

However, in order to qualify for temporary disability compensation, claimant must prove that he was in the work force at the time of surgery or hospitalization. Fred Lofti, 43 Van Natta 430 (1991). Claimant contends that he was willing to work, but not looking for work at the time the condition worsened, because the injury made it impossible to obtain and perform any type of work for which he was qualified. However, Dr. Puziss' August 1, 1991 letter indicates only that claimant was disabled from work for five days after his surgery. There is no medical opinion that claimant was in the work force immediately prior to his surgery. In addition, claimant had been declared ineligible for vocational assistance on May 20, 1991 on the basis that he possessed the necessary skills and abilities to return to an appropriate job. Furthermore, Dr. Puziss stated on the same date that claimant was capable of sedentary work. We find that claimant has failed to provide persuasive evidence that he was in the work force at the time of surgery on August 1, 1991. Therefore, claimant does not qualify for the reopening of his claim to provide temporary disability compensation.

Accordingly, as supplemented herein, we adhere to and republish our October 10, 1991 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATHLEEN A. HOFF, Claimant
WCB Case No. 90-18230
ORDER DENYING RECONSIDERATION
Pozzi, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

The self-insured employer requests reconsideration of our November 29, 1991 Order on Review. In that order, we concluded that claimant could not receive a

chronic condition award for her injury to her coccyx under the standards, because the coccyx was not an unscheduled body part that was recognized as a separate system under the standards. Nonetheless, we awarded claimant 5 percent unscheduled permanent disability outside the standards, finding clear and convincing evidence that claimant has sustained a loss of earning capacity in excess of that indicated by the standards.

On reconsideration, the employer contends that the award under what it calls the "statutory loophole" was in error. It acknowledges that an injured worker may prove by clear and convincing evidence that her disability is greater than that allowed by the standards. It maintains, however, that the clear and convincing evidence exception does not allow an award of permanent partial disability for body parts not separately covered by the standards. We disagree.

The applicable provision is former ORS 656.295, which governs the Board's review of cases and provides, in pertinent part:

"The board shall apply to the review of the claim such standards for the evaluation of disabilities as may be adopted by the director pursuant to ORS 656.726. Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence to establish by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the director under ORS 656.726." (Emphasis supplied).

We find nothing in that provision to support the employer's contention. To the contrary, it expressly provides that an injured worker is not limited to any specific evidence for purposes of proving entitlement to permanent disability in excess of that indicated by the standards. See generally Rick L. Tarbox, 42 Van Natta 2354 (1990).

Accordingly, the request for reconsideration is denied. We adhere to our November 29, 1991 Order on Review. The parties' rights of appeal shall continue to run from the date of our November 29, 1991 order.

IT IS SO ORDERED.

December 20, 1991

Cite as 43 Van Natta 2742 (1991)

In the Matter of the Compensation of
STEVEN K. MILES, Claimant
WCB Case No. 88-17001
ORDER OF ABATEMENT
Galton, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The self-insured employer has requested reconsideration of our November 26, 1991 Order on Remand, which reversed the Referee's order and set aside the employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. In order to consider the matter, we withdraw our November 26, 1991 order. Claimant is granted an opportunity to respond to the employer's motion. To be considered, claimant's response must be submitted within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
TIMOTHY E. DOOLEY, Claimant
WCB Case No. TP-89026
THIRD PARTY DISTRIBUTION ORDER ON REMAND
Gary K. Jenson, Claimant Attorney
Katherine H. Waldo (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Dooley, 107 Or App 287 (1991). The court reversed our prior order, Timothy E. Dooley, 41 Van Natta 2322 (1989), which held that SAIF was not entitled to a share of settlement proceeds arising from an automobile accident unrelated to claimant's employment that occurred while claimant was receiving temporary total disability and nearing a medically stationary status under his compensable injury claim. Concluding that SAIF was obligated to pay additional compensation as a result of the worsening of claimant's compensable condition which was attributable to the automobile accident, the court held that SAIF was entitled under ORS 656.593(3) to receive its just and proper share of the third party settlement proceeds resulting from the accident. Consequently, the court has remanded for a determination of SAIF's just and proper share.

FINDINGS OF FACT

We republish our "Findings of Fact" from our December 13, 1989 order with the following supplementation. As a result of the May 1987 automobile accident, SAIF expended four months of additional temporary disability compensation (\$5,481.43) that it would otherwise have not incurred. SAIF's "just and proper" share of the \$24,593.75 third party settlement is \$5,481.43.

CONCLUSIONS OF LAW

If the worker settles a 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 that 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 concerning what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

Here, the sole dispute pertains to SAIF's reimbursement for \$5,481.43, which constitutes of four months of additional temporary disability compensation directly attributable to the effects of the automobile accident on claimant's compensable condition. Claimant has not contested that figure, but rather has argued that SAIF is not entitled to a share of the settlement proceeds. The court has rejected claimant's argument. Inasmuch as the court has held that SAIF is entitled to a "just and proper" share of the proceeds and since claimant does not contest the amount of SAIF's asserted lien, we conclude that \$5,481.43 constitutes SAIF's "just and proper" share of the third party settlement. See ORS 656.593(3).

Accordingly, claimant's attorney is directed to distribute to SAIF the \$5,481.43 in settlement proceeds which has been held in claimant's attorney's trust account pending resolution of this dispute.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN L. HENSHAW, Claimant
Own Motion No. 91-0650M
OWN MOTION ORDER ON RECONSIDERATION
Myrick, et al., Claimant Attorneys

Claimant requests reconsideration of our November 21, 1991 Own Motion Order that reopened his claim as of October 9, 1991 for the payment of temporary disability compensation related to a right L-5 microlumbar diskectomy. Claimant contends that he was hospitalized on November 19, 1990 for a left L-5 microlumbar diskectomy and that his claim should have been reopened as of that date. We agree.

The insurer initially denied the compensability of claimant's November 1990 surgery. By a July 30, 1991 Stipulation and Order of Dismissal, the insurer agreed to accept the surgery claim and to submit the issue of entitlement to benefits for temporary disability to the Board under its own motion jurisdiction. This the insurer failed to do, contending that, because claimant was not employed at the time of the November 1990 surgery, there was no need to submit the claim to the Board under own motion. The insurer erred in its failure to submit claimant's request for own motion relief to the Board for the following reasons.

First, the insurer stipulated that it would submit claimant's request to the Board. Second, whether or not it so stipulates, when an insurer receives a request for temporary disability compensation, by or on behalf of a claimant whose aggravation rights have expired, the insurer is required to submit the request for own motion relief to the Board. OAR 438-12-025(1). In addition, the own motion insurer is required to notify the claimant and the Board in writing, no later than the 90th day after receipt of an own motion claim, whether the own motion insurer recommends that the claim be reopened or denied. OAR 438-12-025(2). Even if an insurer voluntarily reopens a claim, reimbursement from the reopened claims reserve is authorized by the Board only if the claim qualifies for own motion relief under ORS 656.278 and the Board's rules. Hence, the insurer, not the Board, performs the claims processing function, but only the Board, not the insurer, has the jurisdiction to decide whether a claimant meets all the criteria for own motion relief. See OAR 656.278; OAR 438-12-025 and 438-12-030. The insurer also requests that no penalties be assessed for unreasonable claims processing. As claimant has not requested a penalty, we decline to address this issue.

After review of the record, we find that claimant worked as a forest aide under the vocational rehabilitation program for the severely handicapped from May 20, 1990 until September 28, 1990, when he was laid off because he was unable to work, (November 15, 1990 report from Dr. Campagna). Although claimant was not working in mid-November, he was in the work force, and is entitled to temporary disability compensation beginning November 19, 1990, the date he was hospitalized for a left L-5 microlumbar diskectomy.

Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed \$1,050, payable by the insurer directly to claimant's attorney. In reaching this conclusion, we have particularly considered the time devoted to the case and complexity of the issues. See OAR 438-15-010(4); 438-15-080.

Accordingly, our November 21, 1991 order is abated and withdrawn. As amended and supplemented herein, we adhere to and republish our November 21, 1991 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA D. JENNESS, Claimant
WCB Case No. C1-02182
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
S. David Eves, Claimant Attorney
Craig Creel, Defense Attorney

Reviewed by Board Members Neidig and Moller.

By order dated November 27, 1991, the Board disapproved the parties' Claim Disposition Agreement (CDA) on the basis that the agreement as amended was accompanied by a superseded version of the summary sheet; failed to provide the identity of the accepted conditions subject to the disposition; and recited differing amounts of attorney fees and amounts due claimant. The parties failed to submit an addendum as requested within the 21-day time period. The parties have requested reconsideration of that order contending that the failure to file within the original 21-day period was due to inadvertence.

The Rules of Practice and Procedure relating to requests for reconsideration of orders disapproving claim disposition agreements were amended effective September 2, 1991. WCB Admin. Order 5-1991 (August 21, 1991). OAR 438-09-035 provides that:

"(1) A motion for reconsideration of final orders issued by the Board under ORS 656.236 and these rules shall be filed within 10 days of the date of mailing of the order.

(2) The Board may reconsider final orders under ORS 656.236, provided that the motion for reconsideration:

(a) Is filed in accordance with section (1); and

(b) States specifically the reasons(s) reconsideration is requested.

(3) Reconsideration of a final order issued by the Board under ORS 656.236 and these rules shall be limited to the record before the Board at the time its final order was mailed and no additional information will be considered, unless the Board finds good cause for allowing the additional submission."

The Board may reconsider final orders under ORS 656.236, provided that the motion for reconsideration is filed within ten days of the date of mailing of the order. OAR 438-09-035(2)(a) and (1).

Here, the disapproval order was mailed on November 27, 1991, and the insurer's request for reconsideration was filed on December 5, 1991, 8 days after the date of mailing of the order. The parties state their reason for requesting reconsideration is an inadvertent error. Thus, the Board finds claimant's request for reconsideration was timely filed and is in accordance with OAR 438-09-035. Consequently, we may consider the motion for reconsideration. OAR 438-09-035(2). Moreover, upon review of the addendum, we find good cause for allowing the additional submission. Accordingly, we will consider this information on reconsideration. See OAR 438-09-035(3); Robert S. Robinson, 43 Van Natta 1893 (1991).

In support of their motion for reconsideration, the parties have submitted a revised agreement to clarify that the correct amount of consideration is -- \$6,500 (\$1,625 attorney fee and \$4,875 proceeds to claimant) -- as noted on page

two of the agreement. Further, the parties have identified the accepted conditions as: (1) right thumb tendonitis; (2) loss of flexion in the interphalangeal joint of the right thumb; (3) loss of flexion in the interphalangeal joint of the left thumb; (4) loss of flexion in the metacarpophalangeal joint of left thumb; (5) chronic pain syndrome which limits repetitive use of both the right and left hands.

The submitted revised disposition agreement contains the requested information in all aspects except one. The parties have again sent a superseded version of the summary page.

Under these circumstances, we find that the submission of the superseded version of the summary page constitutes a technical error. Therefore, we approve the proposed agreement and attach and integrate this new document into the original CDA.

Accordingly, we grant the motion for reconsideration. On reconsideration, we find that this agreement is now in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We do not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of this agreement is also approved.

The Board sent an acknowledgment letter concerning the parties' motion for reconsideration in this matter. It has come to the Board's attention, however, that the letter of acknowledgment was inadvertently sent. We correct the error accordingly.

Our December 5, 1991 acknowledgment is abated and withdrawn.

IT IS SO ORDERED.

December 23, 1991

Cite as 43 Van Natta 2746 (1991)

In the Matter of the Compensation of

GARY R. LACHANCE, SR., Claimant

WCB Case No. 90-19321

ORDER ON REVIEW

Welch, et al., Claimant Attorneys

Roderick D. Peters (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Leahy's order that: (1) directed it to pay temporary disability benefits payable prior to the date of an earlier Referee's order which SAIF had stayed pending appeal of that Referee's order; and (2) assessed penalties and attorney fees for an allegedly unreasonable refusal to pay temporary disability. On review, the issues are stay of compensation pending Board review, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant filed a claim for a left middle cerebral artery aneurysm with subarachnoid hemorrhage that resulted from a work-related motor vehicle accident occurring on May 5, 1989. SAIF denied the claim on October 10, 1989.

A hearing was held on April 3, 1990, before Referee Menashe. (WCB Case No. 89-23834). By Opinion and Order dated September 20, 1990, the Referee found

the claim compensable and set aside SAIF's denial. SAIF requested Board review of the Referee's order on September 27, 1990.

On October 3, 1990, SAIF paid temporary disability benefits for the period of September 20, 1990 through September 27, 1990. SAIF did not pay further compensation pending review.

On October 10, 1990, claimant requested a hearing, seeking temporary disability benefits, penalties and attorney fees.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law in effect prior to July 1, 1990. Thus, he concluded that compensation could not be stayed pending appeal, and awarded temporary disability from May 5, 1989, continuously until claim closure. See former ORS 656.313. We disagree.

We conclude that the law as amended by Oregon Laws 1990 (Special Session), Chapter 2 applies. Claimant requested a hearing concerning SAIF's failure to pay compensation. The hearing request was filed after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in Section 54(2) does not apply.

Claimant argues, however, that the litigation "savings clause" is applicable, and that the law in effect prior to July 1, 1990 applies. Section 54(2) provides:

"Any matter regarding a claim which is in litigation before the Hearings Division, the Board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990."

Claimant first argues that his entitlement to temporary disability was decided pursuant to the law in effect prior to July 1, 1990, by Referee Menashe at the prior hearing. The order, which issued on September 20, 1990, was promptly appealed to the Board by SAIF. Because SAIF declined to pay compensation pending review, claimant filed a request for hearing seeking temporary disability benefits stayed pending appeal, and penalties and related attorney fees for an allegedly unreasonable resistance to the payment of the stayed compensation. The hearing stemming from that request was held on January 23, 1991. Thus, because the second request for hearing had its origins in the prior hearing, claimant argues the second request was a "matter regarding a claim" in litigation before the Hearings Division, and the law in effect prior to July 1, 1990, applies to the second hearing as well. Accordingly, in accordance with former ORS 656.313, claimant concludes that it was improper to stay compensation pending appeal.

We have recently held, under substantially similar facts, that the issues of stayed compensation and penalties and attorney fees cannot be considered the same "matter regarding a claim" which was previously in litigation. Raymond J. Seebach, 43 Van Natta 2687 (1991). Here, the issues presented to Referee Leahy did not arise until issuance of Referee Menashe's order on September 20, 1990. Therefore, these issues could not have been before Referee Menashe. Rather, the issues before Referee Leahy were separate and distinct from the compensability issue before Referee Menashe. Claimant's request for hearing was not filed until October 10, 1990, and the hearing was not convened until January 23, 1991.

Thus, we find that the litigation "savings clause" does not apply. Raymond J. Seebach, supra.

Further, the matter at issue here is not subject to a special exception to the act's general applicability provision. See e.g. Section 54(3). Moreover, neither party contends that application of the 1990 amendments will produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, this case is properly analyzed under the Workers' Compensation Act as amended, effective July 1, 1990.

As amended, ORS 656.313(1)(a) provides:

"(1)(a) Filing by an employer or the insurer of a request for hearing on a reconsideration order or a request for board review or court appeal stays payment of the compensation appealed, except for:

(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs[.]"

Under this statute, payment of compensation is stayed upon the timely filing by the insurer of an appeal. Walden J. Beebe, 43 Van Natta 2352 (1991). However, the insurer is obligated to provide temporary disability payments from the date of the order appealed from until the claim closes or until the order appealed from is reversed. In other words, although an insurer which timely appeals may stay payment of temporary disability benefits occurring until the day before the order appealed from issues, it must pay such benefits from the date of the order appealed from until claim closure or reversal.

Turning to the facts of this case, SAIF timely filed a request for Board review of Referee Menashe's September 20, 1990 order. Consequently, SAIF was entitled to stay payment of the compensation awarded by Referee Menashe's order from May 5, 1989, the date of the accident, through September 19, 1990. We further conclude, however, that SAIF is obligated to provide temporary disability payments from September 20, 1990, the date of the Referee's order, until the claim closes. SAIF has paid claimant temporary disability benefits only from September 20, 1990 through September 27, 1990. We therefore affirm the Referee's order to the extent that SAIF is directed to pay temporary disability compensation from September 28, 1990 until the claim closes.

Furthermore, since we have concluded that the insurer was entitled to stay payment of benefits from May 5, 1989 through September 19, 1990, it follows that the insurer's failure to pay these benefits was not unreasonable. We therefore reverse the Referee's assessment of a penalty for unreasonable conduct based upon this stayed compensation. However, SAIF's failure to pay temporary disability benefits from September 28, 1990 through claim closure was unreasonable. Regardless of which version of ORS 656.313 was applicable, SAIF was obligated to provide such benefits pending its appeal of Referee Menashe's order. Thus, we affirm the Referee's penalty award to the extent that SAIF was assessed a 25 percent penalty based upon temporary disability compensation due from September 28, 1990 through the date of the January 23, 1991 hearing.

Finally, we reverse that portion of the Referee's order which awarded claimant's counsel an attorney fee for SAIF's unreasonable conduct. When the factual basis asserted in support of an attorney fee for unreasonable resistance to the payment of compensation under ORS 656.382(1) is identical to the factual basis for the assessment of a penalty under ORS 656.262(10)(a), the claimant's

attorney receives one-half the penalty "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991). Consequently, in place of the Referee's attorney fee award, claimant's attorney shall receive one-half of the assessed penalty.

ORDER

The Referee's order dated February 22, 1991 is affirmed in part and reversed in part. The Referee's order is reversed to the extent that it directed SAIF to pay temporary disability benefits from May 5, 1989 through September 19, 1990 pending SAIF's request for Board review of Referee Menashe's order. The Referee's \$2,500 assessed attorney fee award is reversed. In lieu of the Referee's penalty assessment, SAIF shall pay a penalty equal to 25 percent of the temporary disability compensation payable from September 28, 1990 through the date of the January 23, 1991 hearing. This penalty shall be paid in equal shares to claimant and his attorney. The remainder of the Referee's order is affirmed.

December 23, 1991

Cite as 43 Van Natta 2749 (1991)

In the Matter of the Compensation of
WILLIAM W. TRUNKEY, Claimant
WCB Case Nos. 90-01546, 90-00361 & 89-14485
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee McWilliams' order which set aside SAIF's December 20 and 27, 1989 denials insofar as they denied responsibility for claimant's degenerative hip condition. On review, the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSION OF LAW AND OPINION

The Referee concluded that claimant's condition is not compensable. We agree. The Referee further concluded that SAIF is responsible for claimant's noncompensable condition because it did not contest compensability at hearing. We disagree.

Compensability

We adopt the Referee's Conclusion of Law and Opinion concerning this issue, with the following supplementation.

The same evidence that the Referee relied on to uphold Liberty Northwest's compensability denial also establishes that claimant's bilateral hip condition is unrelated to both his 1984 injury and his work activities at SAIF's insured.

Responsibility

SAIF contends that Rodney L. Kosta, 43 Van Natta 180 (1991), issued subsequent to the Referee's order, is controlling on the issue on review. We agree.

In Kosta, three employers contested compensability and responsibility. One employer contested only responsibility. The Board found that the fact that one potentially responsible party has stipulated that its denial is solely one of responsibility, does not alter the fact that compensability remained in issue. In Kosta, we upheld all three employers' denials.

We expressly reject claimant's contention that the Referee's decision in Kosta, which we affirmed, was based solely on responsibility. We stated:

"When compensability and responsibility are both at issue, as here, the threshold issue is compensability. Elizabeth Coomer, 41 Van Natta 2300, 2302 (1989). In our de novo review, we found that claimant had not experienced a compensable aggravation. Further, we concluded that the subsequent employers did not materially contribute to claimant's disability or need for treatment. Consequently, inasmuch as claimant's claim was found to be noncompensable, there was no basis for shifting responsibility. See Columbia County School District #13 v. Thurston, 96 Or App 686 (1989)."

In Kosta, inasmuch as we found the claimant's claim to be noncompensable, we upheld all of the denials. Further, on grounds of noncompensability, we concluded that there was no basis to shift responsibility to the employer who did not raise the issue of compensability.

We also rely on Neely v. SAIF, 43 Or App 319 (1979). In Neely, the insurer accepted a low back condition. A Determination Order was issued. The claimant appealed the order as insufficient. At hearing, the insurer did not contest compensability. The Referee affirmed the Determination Order.

The claimant appealed the Referee's order. On Board review, the insurer's brief did not appeal the Determination Order but stated that there was no basis for the award. On review, we agreed that there was no basis for the Determination Order because the claimant's condition was not compensable.

On appeal, the claimant alleged that, in denying his accepted claim, the Board denied him a fair hearing because he only prepared on the issue of extent of disability. He contended that the Board's finding on causation did not allow him to present evidence on that issue. The court disagreed.

The court held that, although the Workers' Compensation Act establishes a means for a party to petition the Board for cross-review, ORS 656.289(3), a party does not need to cross-petition and that the reviewing body may reach the issue on its de novo review. The Board may reverse or modify an order of a Referee or make such disposition of the case as it determines to be appropriate. ORS 656.295(6).

Fundamental fairness may dictate that the Board should not decide a claim on the basis of evidence not in the record or on issues to which no evidence was presented. Neely, supra, at 323. If claimant has been given no opportunity to present evidence on an issue at hearing, the proper procedure would be for the Board to remand the case to the Referee, ORS 656.295(5), for the taking of evidence on that issue. That was not the case in Neely, nor is it here.

Here, compensability of claimant's claim was raised at hearing by another insurer. Claimant submitted his medical reports and it is from these reports that the Referee concluded that claimant's present condition is not related to his industrial injury. All the evidence necessary to decide compensability was in the record.

Claimant has not been denied fundamental fairness. His medical reports would be unchanged regardless of whether they were introduced to challenge compensability with SAIF, grounded on the fact that a relationship is lacking between claimant's compensable injury or work activities and his present condition.

Moreover, we are unpersuaded by the cases claimant relies on to support his argument for affirming the Referee's conclusion. After careful scrutiny, we conclude they do not control as they are distinguishable on the facts from the instant case.

In the present case, compensability was raised at the beginning of the hearing. All the parties had notice that compensability was an issue. Evidence was presented on the issue. The record was complete for the presentation of evidence on compensability. Therefore, the cases presented by claimant are not applicable because they all deal with situations where the issue being decided was never raised or was not raised at the beginning of the hearing or required different evidence other than what was required by the question being decided.

Our de novo review is based on the record submitted to us. ORS 656.295(5). Consequently, inasmuch as claimant's claim was found to be noncompensable, there is no basis for shifting responsibility. Runft v. SAIF, 303 Or 493, 498-99 (1987); Elizabeth Coomer, supra. Accordingly, we do not hold SAIF responsible for claimant's noncompensable condition. Kosta, supra; Neely, supra.

ORDER

The Referee's order dated October 12, 1990 is reversed in part and affirmed in part. That portion of the Referee's order which set aside SAIF's December 20 and 27, 1989 denials is reversed. SAIF's denials are reinstated and upheld. The remainder of the order is affirmed.

December 24, 1991

Cite as 43 Van Natta 2751 (1991)

In the Matter of the Compensation of

STEVEN E. WILSON, Claimant

WCB Case No. C1-02707

ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT

Malagon, et al., Claimant Attorneys

Liberty Northwest Insurance Corporation, Defense Attorney

Reviewed by Board Members Neidig and Moller.

On December 16, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Entitlement to an attorney fee in connection with a CDA is expressly subject to OAR 438-15-052. When a claim disposition agreement is approved under the provisions of ORS 656.236 and OAR 438-09-020, an attorney fee may be approved by the Board in an amount up to 25 percent of the first \$12,500 of the agreement proceeds plus 10 percent of any amount of proceeds in excess of \$12,500. See OAR 438-15-052(1). However, under extraordinary circumstances, a fee may be approved in excess of the strictures of OAR 438-15-052. Id.

Here, the attorney fee exceeds the amount allowed under OAR 438-15-052(1). Although the proposed agreement provides for consideration in the amount of \$15,000, revised pages one and two of the agreement provide that the permanent

partial disability awarded pursuant to the November 8, 1991 Notice of Closure shall be considered an "advance" towards the above-stated consideration. Because the insurer already had a legal duty to pay such benefits pursuant to ORS 656.214, the proposed deduction of those benefits from the settlement proceeds would effectively reduce the amount of consideration that claimant receives for the disposition of his claim. See, e.g., George T. Taylor, 43 Van Natta 676 (1991). The actual consideration, i.e., consideration remaining following the proposed deduction of the permanent disability award, would be \$8,920. Therefore, based on our calculations, the proposed attorney fee exceeds the strictures of OAR 438-15-052(1) by \$770. Moreover, the agreement does not indicate any extraordinary circumstances which would justify the excessive fee. Because the proposed disposition exceeds the bounds of our rules, we find it is unreasonable as a matter of law. See OAR 438-09-020(2); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

December 26, 1991

Cite as 43 Van Natta 2752 (1991)

In the Matter of the Compensation of
DEBRA L. BEESON, Claimant
WCB Case No. 90-01924
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee McGeorge's order which: (1) set aside its May 10, 1990 denial of claimant's aggravation claim for contact dermatitis; (2) awarded interim compensation with regard to the April 1990 aggravation claim; (3) assessed a penalty and related attorney fee for its allegedly unreasonable failure to pay interim compensation; and (4) assessed a penalty for its allegedly unreasonable failure to timely provide an exhibit. On review, the issues are aggravation, and alternatively, extent of unscheduled permanent disability, interim compensation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant had been a floral arranger for over five years. Claimant worked for the employer as a floral arranger for one and a half years. In April 1989, claimant sustained compensable contact dermatitis due to exposure to chemicals, roses and other plants. She sought treatment from Dr. O'Hollaren, allergist & immunologist. Dr. O'Hollaren released claimant to modified work, restricting her from working with "roses or mums" and requiring that she wear gloves while working. In May and June 1989, claimant attempted to return to modified work for the employer. Because of a negative reaction to cortisone treatment, claimant could not continue in the modified employment.

Subsequently, one of claimant's family physicians, Dr. Eidenberg, M.D., gave claimant a release to modified work, as of June 9, 1989, with the restriction that claimant avoid contact with roses. On October 20, 1989, Dr. O'Hollaren reported that claimant was medically stationary. Additionally, Dr. O'Hollaren reported that because claimant had developed an allergy to a chemical commonly used on flowers for floral arrangements, she was precluded from "working in any job as a florist."

Claimant's claim was closed by a December 1989 Determination Order that awarded 9 percent unscheduled permanent disability. On January 25, 1990, claimant, pro se, requested a hearing regarding the December 20, 1989 Determination Order.

The employer offered claimant a second modified job which claimant declined because the job provided less hours and less money per hour than her regular work. Prior to claimant's return to a modified job in March 1990, claimant called her supervisor and told him that her doctor had released her to work as long as she wore special gloves. Neither Dr. O'Hollaren nor her family physician, Dr. Longland, had given claimant a release to work with flowers.

In March 1990, claimant returned to work with the employer as a floral arranger. Claimant wore gloves to prevent physical contact with flowers sprayed with chemicals. As the month progressed, claimant developed recurrence of her dermatitis. Additionally, claimant experienced nausea, and vomited. On March 26, 1990, claimant received care at the emergency room. At the end of March, claimant's family physician, Dr. Longland, gave her a release from working around flowers sprayed with chemicals. Claimant terminated her employment at the end of March 1990. Claimant did not give Dr. Longland's release to the employer until a week after she terminated her employment.

On April 26, 1990, claimant telephoned the employer's claims adjuster and requested reinstatement of her time loss benefits because, she alleged, her condition had worsened. On May 10, 1990, the employer denied claimant's aggravation claim. At the June 8, 1990 "convened-and-continued" hearing, claimant, through counsel, orally protested the aggravation denial. On June 11, 1990, claimant filed a request for hearing raising compensability under injury and/or occupational disease theories, temporary total disability, unscheduled permanent partial disability, medical services and penalties and attorney fees.

At hearing, for the first time, the employer produced Dr. Longland's March 29, 1990 note releasing claimant from working around flowers sprayed with chemicals. This note was admitted as Exhibit 30. (Tr. 32, 34, 38-39).

Claimant is 38 years old and has 13 years of formal education. Her highest SVP in the last 10 years was as a floral designer. In March 1990 claimant returned to modified work as a floral arranger.

FINDINGS OF ULTIMATE FACT

Claimant experienced a symptomatic exacerbation of her allergic dermatitis since the last arrangement of compensation. The March 1990 symptomatic exacerbation did not result in diminished earning capacity to a level below that fixed at the time of the last arrangement of compensation.

The employer did not have notice or knowledge that claimant was medically unable to work as a result of a compensable worsening.

Failure to provide documents pertaining to claimant's claim 20 days prior to hearing did not result in an unreasonable delay or refusal to pay compensation.

CONCLUSIONS OF LAW AND OPINIONAggravation

The Referee concluded, and the parties do not dispute, that the law effective July 1, 1990, is applicable to claimant's aggravation claim. We agree that the law effective July 1, 1990 is applicable to this matter. See Ida M. Walker, 43 Van Natta 1402 (1991). However, we disagree that claimant has shown that she sustained a compensable aggravation.

To establish a compensable aggravation, claimant must prove by a preponderance of the evidence that she has sustained increased symptoms or a worsened underlying condition since the last arrangement of compensation, resulting in diminished earning capacity. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). The worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) & (3).

At the time the December 1989 Determination Order issued, claimant was asymptomatic. From that time until claimant returned to the modified job arranging flowers, she remained asymptomatic. Claimant returned to modified work in March 1990, and on March 26, 1990, she received care at the emergency room where she was diagnosed as having a severe allergic reaction to floral chemicals. We conclude that the emergency room reports constitute medical evidence, supported by objective findings, that claimant's condition symptomatically worsened since the last arrangement of compensation.

However, claimant has not shown that her earning capacity has been diminished as a result of the increased symptoms. Claimant was not working at the time the Determination Order issued. Furthermore, Dr. O'Hollaren answered "no" to the question, "Does this flare-up make her any less able to maintain gainful employment [other] than the restrictions you imposed last fall, of not returning to an environment involving roses/mums and the chemicals used?" (Ex. 26).

Claimant argues that Dr. Longland's March 29, 1990 release from working around flowers sprayed with chemicals indicates that claimant has sustained a diminished earning capacity. We disagree. Dr. Longland's note constitutes nothing more than the same restriction already placed on claimant's employment by Dr. O'Hollaren prior to claim closure.

Therefore, we conclude that claimant has not shown by medical evidence supported by objective findings that she suffered from increased symptoms that resulted in diminished earning capacity. Accordingly, claimant has not established a compensable aggravation.

Extent of Unscheduled Disability

The Referee concluded that claimant had sustained a compensable aggravation. Therefore, the Referee did not address the issue of the extent of claimant's unscheduled disability. Because we have found that claimant did not sustain an aggravation, and since claimant's condition was medically stationary at the time of hearing the issue of the extent of her unscheduled disability becomes ripe. The record is adequately developed, and we proceed to consider the issue of extent of claimant's unscheduled permanent disability.

The December 1989 Determination Order awarded claimant 9 percent unscheduled permanent disability as a result of her allergic skin condition. We modify.

Because claimant became medically stationary before July 1, 1990, we apply the workers' compensation law in existence prior to its amendment by the Legislature on May 7, 1990. See Or Laws 1990 (Special Session), Ch. 2, Sec. 54(3).

In this case, the "standards" effective January 1, 1989 through October 1, 1990 (former OAR 436-35-001 et seq), apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disability. Former OAR 436-35-270(1). We rate claimant's disability according to the facts as they exist at the time of hearing.

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age and Education

The appropriate value for claimant's age of 38 years is 0. Former OAR 436-35-290.

The appropriate value for claimant's 13 years of formal education is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was a floral designer (DOT # 142.081-010), with an SVP value of 6. Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990). Here, claimant has demonstrated competence in a specific vocational pursuit, i.e., floral design. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

The values for age, formal education, skills and training are added to arrive at a value of 2. Former OAR 436-35-300(6).

Adaptability

The adaptability value for a claimant who returns to modified work is determined by the difference between the physical capacity necessary to perform the usual and customary work and the physical capacity required to perform the modified job. Former OAR 436-35-310(3). Here, claimant returned to her job as a floral arranger modifying her job by wearing gloves. The physical capacity required for a floral arranger is light. Claimant's job modifications did not change the physical capacity requirement. Therefore, the appropriate adaptability value is 1. Former OAR 436-35-310(3).

Impairment

Claimant has dermatitis secondary to contact to chemicals used on flowers in floral arrangements. Because claimant has contact dermatitis, has developed an allergic reaction to the physical or chemical agents, and with treatment, has no limitation, or minimal limitation, in the performance of the activities of her daily living, although exposure to certain physical or chemical agents might increase limitation temporarily, claimant is entitled to a value of 5 percent impairment. Former OAR 436-35-440, class 1.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to her education value, 2, the sum is 2. When that value is multiplied by claimant's adaptability value, 1, the product is 2. When that value is added to claimant's impairment value, 5, the result is 7 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

Further, we conclude that the record, as a whole, does not constitute clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more than the entitlement indicated by the "standards." See former ORS 656.283(7) and 656.295(5); Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987). Therefore, claimant's permanent disability under the "standards" is 7 percent.

Although we have concluded that claimant's unscheduled permanent disability is 7 percent, the self-insured employer has not requested a reduction. Therefore, the Determination Order award of 9 percent will be left undisturbed.

Interim Compensation

The Referee concluded that claimant was entitled to interim compensation with regard to the April 1990 aggravation claim. We disagree.

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

A carrier must pay interim compensation, on an aggravation claim, no later than the 14th day after it receives medical verification of an inability to work as documented in a medical report which constitutes prima facie evidence of a compensable worsening. ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991).

Here, Dr. Longland's note does not constitute prima facie evidence of an inability to work due to a compensable worsening. Further, claimant's phone call to the claims adjuster is not medical verification of an inability to work. Finally, assuming claimant's phone call is sufficient, the employer denied the aggravation claim within 14 days. Under these circumstances, we find that the employer did not receive medical verification of an inability to work as documented in a medical report which provided prima facie evidence of a compensable worsening. Accordingly, claimant is not entitled to interim compensation as a result of her April 1990 aggravation claim. Id.

Inasmuch as we have concluded that the employer did not receive medical verification of an inability to work due to a compensable worsening, it follows that the employer had no duty to pay interim compensation. Accordingly, we reverse the Referee's award of a penalty and attorney fee for an allegedly unreasonable failure to pay interim compensation. Richard J. Stevenson, 43 Van Natta 1883 (1991).

Penalty and Attorney Fees for Failure to Submit Documents

The Referee concluded that the employer's failure to provide documents pertaining to claimant's claim was an unreasonable delay or refusal to pay compensation under ORS 656.262(10) and awarded a penalty and related attorney fee. We disagree.

OAR 438-07-018(1) requires the employer to submit all relevant and material documents 20 days prior to hearing. The employer apparently concedes that it violated the rule. However, although we assume the violation is unreasonable, it did not result in an unreasonable delay or refusal to pay compensation as we have found that claimant did not establish a compensable aggravation. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292, 295 (1991). Accordingly, neither a penalty nor related attorney fee is warranted in this instance. Id.; Randall v. Liberty Northwest Ins Corp., 107 Or App 599 (1991).

ORDER

The Referee's order dated January 28, 1991 is reversed. The employer's May 10, 1990 aggravation denial is reinstated and upheld. The Referee's award of an assessed attorney fee of \$3,000 to claimant's counsel is reversed. The Determination Order is affirmed. The Referee's assessment of penalties and attorney fee awards are reversed.

December 26, 1991

Cite as 43 Van Natta 2757 (1991)

In the Matter of the Compensation of
REBECCA GRAY, Claimant
WCB Case No. 90-09187
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the insurer's denial of her occupational disease claim for right carpal tunnel syndrome. On review, the issue is compensability.

We affirm and adopt the Referee's order with the following supplementation. Inability to assign a diagnostic label does not amount to a failure of proof where it is known to a medical probability that the condition is work related. Tripp v. Ridge Runner Timber Services, 89 OR App 355 (1988). However, we agree with the Referee that claimant has failed to prove that her work activities are the major contributing cause of her hand pain condition.

ORDER

The Referee's order dated March 12, 1991 is affirmed.

In the Matter of the Compensation of
JERRY J. JOHNSON, Claimant
WCB Case Nos. 90-18892 & 89-25816
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Garrett, et al., Defense Attorneys
Atherly, et al., Defense Attorneys
Doug Oliver (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The noncomplying employer requests review of Referee Tenenbaum's order that: (1) dismissed Safeco Insurance as a party because claimant had never requested a hearing from Safeco's denial of claimant's left elbow injury claim; (2) found that claimant's left elbow injury claim with the employer was compensable; (3) upheld the SAIF Corporation's acceptance of the claim issued on behalf of the employer; (4) approved a stipulation between claimant and SAIF which increased claimant's scheduled permanent disability award for loss of use or function of the left arm from 11 percent (21.12 degrees), as granted by a Determination Order, to 16 percent (30.72 degrees); and (5) awarded claimant a \$2,000 carrier-paid fee for prevailing against the employer's challenge to SAIF's acceptance of the claim.

On review, the employer contends that: (1) the claim is not compensable; (2) if a compensable injury did occur, the employer's responsibility for the claim should be shared with Safeco's insured; (3) the stipulation should be set aside; and (4) the attorney fee should be eliminated. We affirm.

FINDINGS OF FACTS

We adopt the Referee's "Findings of Facts."

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's "Opinions and Conclusions" with the following supplementation.

The employer asserts that the doctrine of "concurrent employment" is applicable because claimant worked at two separate jobs when he was injured. The employer contends that claimant's work at Safeco's insured substantially aggravated, if not caused, the condition of claimant's left arm during his concurrent employment. (App. Br. at 3).

In order to establish a case of "dual (concurrent) employment," three elements are necessary: (1) a worker must be under contract with two employers; (2) the worker must be under the separate control of each employer; and (3) the worker must perform distinct and separate services for each employer. Mission Insurance Company v. Miller, 73 Or App 159, 163 (1985); Dallas H. Greenslitt, 40 Van Natta 1038, 1040 (1988).

Here, we conclude that claimant was concurrently employed. However, this conclusion does not result in a reduction of liability for the noncomplying employer.

The dispositive question is whether the roofing work activity that claimant was performing at the time of his injury with the noncomplying employer was severable from his raking work activity with Safeco's insured. Mission, supra

at 163. If so, the noncomplying employer is solely responsible for the injury; otherwise, the noncomplying employer may argue a reduction of his liability.

We find that claimant's activity at the time of injury was severable because the roofing and raking activities were not performed simultaneously. Moreover, the evidence is highly persuasive that claimant injured his left arm in the course and scope of his employment with the noncomplying employer. The work activity at Safeco's insured did not contribute to claimant's disability. Accordingly, we conclude that the noncomplying employer is liable for the full amount of claimant's compensation for his May 2, 1989 left arm injury.

Stipulation

The employer contends that SAIF cannot enter into a Stipulation on its behalf. We disagree.

In Daniel C. King, 42 Van Natta 1377 (1990), we held that SAIF, as the workers' compensation carrier for an employer, assumed the obligation to process claimant's injury under the Workers' Compensation law. ORS 656.005(14); 656.419(1). Such obligations necessarily include the acceptance of the claim and the payment of benefits. ORS 656.262; OAR 436-60-140. Here, SAIF is the statutory processing agent, rather than the insurer under a guaranty contract. Nevertheless, the employer refers us to no authority supporting the proposition that it is entitled to participate in a stipulation whereas an insured employer is not. Nor do we find any such authority.

Accordingly, we conclude that SAIF had the authority to enter into the Stipulation on behalf of the noncomplying employer. See Daniel C. King, *supra*.

Attorney Fee

The employer further contends that the assessed attorney fee award is excessive. We disagree.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$2,000 is a reasonable attorney fee for claimant's counsel's services at hearing. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

Inasmuch as the employer has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel services on review concerning the compensability and stipulation issues is \$750 to be paid by SAIF on behalf of the noncomplying employer.

ORDER

The Referee's order dated March 13, 1991 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of \$750, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of
JENNIFER J. KAHN, Claimant
WCB Case No. 90-21629
ORDER ON REVIEW
Hedges & Mitchell, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Westerband and Moller.

The insurer requests review of Referee Schultz' order which set aside its denial of claimant's injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for his finding that the area where claimant fell was maintained by the Portland Public Schools. The Portland Public Schools, the landlord of claimant's employer, removed snow and ice from the sidewalk in the winter. (Tr 45). The Portland Public Schools did not otherwise maintain the public sidewalk where claimant was injured. (Tr. 39).

ULTIMATE FINDINGS OF FACT

Claimant's injury did not arise within the course and scope of her employment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's injury arose out of and in the course of her employment. We disagree.

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?" Id at 642.

Injuries sustained while going to or coming from work are generally not deemed to arise out of and in the course of employment. SAIF v. Reel, 303 Or 210 (1987); Gwin v. Liberty Northwest Ins. Corp., 105 Or App 171 (1991). If an injury occurs in a parking lot or other off premises area over which the employer has no control, it is generally not compensable. Montgomery Ward v. Cutter, 64 Or App 759 (1983). Employer control is manifested either by employer ownership, employer actions or the presence of employer created special hazards. Sheri V. Hiltner, 42 Van Natta 1039 (1990). When an employee is injured on a public sidewalk over which the employer has no control, and on which there are no employer-created hazards, the connection between the injury and the employment is insufficient to make the injury compensable. Cope v. West American Ins. Co., 309 Or 232, 240 (1990).

Here, claimant, an instructional assistant for a middle school teacher, fell on a public sidewalk, when a co-worker intentionally tripped her, while she was returning to work from a lunch break with her co-workers. Claimant's employer, an educational service district, rented space in a school building owned by the Portland Public Schools. The employer did not own the sidewalk, did not create any special hazards on the sidewalk, and took no action asserting control over the sidewalk. In the winter, if there was snow or ice on the sidewalk, it was removed by claimant's employer's landlord, the Portland Public Schools.

This case is similar to Montgomery Ward v. Malinen, 71 Or App 457 (1984). In Malinen, the claimant was returning to work from jury duty when she slipped on ice on the sidewalk in front of the employer's building. The city had a code

requiring the employer to keep the sidewalk clear of snow and ice, and it was the employer's policy to do so. The court found that the "going and coming" rule did not bar compensation because the policy of removing snow and ice established employer control over the area of injury.

Here, claimant did not slip on ice or snow but was intentionally tripped by a co-worker. Furthermore, although the employer's landlord had a policy of removing snow and ice from the sidewalk and therefore exercised control over it, claimant's employer did not exercise control over the sidewalk. Actual control by the employer of the area of injury is necessary to establish control. Cope, supra; Janet V. Dollens, 42 Van Natta 2004 (1990). Accordingly, under the "going and coming rule," we find that claimant was not within the course and scope of her employment when her injury occurred.

We also, in the alternative, apply the seven factor test first set forth in Jordan v. Western Electric, 1 Or App 441 (1970). These factors are: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered; no one factor is dispositive. Id.

We agree with the Referee's conclusion that the employer was aware of, and anticipated, that claimant would take a lunch break with the employer's staff. We also agree with the Referee that there was some benefit to claimant's employer in having its staff spend time together. However, being tripped by a co-worker while returning from a lunch break was not an ordinary risk of, or incidental to claimant's employment.

We contrast the present case from the situation in Fred H. Jacobson, 43 Van Natta 1420 (1991), where because of the nature of the claimant's job, it was not feasible for him to take lunch breaks on his employer's premises. It was, in fact, an ordinary risk of the claimant's job in Jacobson, to eat in restaurants. By contrast, in the present case, it was feasible for claimant to eat her lunch on the employer's premises if she chose to.

Generally, an accidental injury to an employee is not covered by workers' compensation as being one arising out of and in the course of employment if it occurs off the employer's premises while the employee is going to or coming from lunch on unpaid time. See Casper v. SAIF, 13 Or App 464 (1973). As discussed previously, we find that claimant's injury did not occur on the employer's premises or in an area over which the employer exercised control.

Claimant did not establish that she was paid during the time in which the injury occurred. Claimant was allowed a half hour unpaid lunch. She had not returned to work at the time of her injury. Although claimant's employer allowed the staff to return from lunch late during the three day period before classes actually started, claimant was not normally paid for lunch breaks and she had not yet entered the school grounds or resumed work. The Referee found that claimant was "back on the clock" and was being paid even though she had not entered the school grounds. The insurer argues that even if a portion of claimant's lunch hour was paid and a portion unpaid, it is just as likely that the paid portion occurred at the end of the lunch break as at the beginning. We conclude that this factor is inconclusive and give it little weight in reaching our determination.

The Referee found that claimant was not on a personal mission at the time of her injury, because claimant was being paid and was walking back into the building to continue her work activity. We disagree. As previously discussed, the evidence is inconclusive that claimant was paid when she was injured on the sidewalk outside the school grounds. In any event, she testified that she was not required to go to lunch with her co-workers, but could have run errands or engaged in any activity she chose during her lunch break. Consequently, we conclude that claimant was on a personal mission.

After considering all of these factors, we are not persuaded that claimant's injury arose out of or in the course and scope of her employment. In reaching this conclusion, we are particularly persuaded by the fact that: (1) claimant was under no obligation to attend the lunch; (2) her injury resulted from an act which was not an ordinary risk of, or incidental to, her employment; and (3) the injury did not occur on claimant's employer's premises.

Consequently, under the "going and coming" rule, as well as the seven factor test set out in Mellis v. McEwen, Hanna, Gisvold, supra, claimant was not in the course and scope of her employment at the time of her injury. Accordingly, we conclude that the claim was not compensable.

ORDER

The Referee's order dated March 4, 1991 is reversed. The insurer's denial is reinstated and upheld. The Referee's \$950 attorney fee award is reversed.

December 26, 1991

Cite as 43 Van Natta 2762 (1991)

In the Matter of the Compensation of
CATHERINE L. MARTIN, Claimant
WCB Case No. 90-20150
ORDER ON REVIEW
Jaques & Sharp, Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Tenenbaum's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral wrist and forearm condition. On review, the issue is compensability. We affirm.

PRELIMINARY MATTERS

The Referee's Opinion and Order erroneously stated that Exhibit 12A was not admitted. That exhibit, a report from Dr. Button dated January 16, 1990, in fact was admitted at the hearing and has been considered on review.

FINDINGS OF FACT

Claimant has been a county Justice of the Peace for 10 years. Although the position is funded for 32 hours a week, claimant estimates that she normally works at least 40 hours per week. Claimant has judicial and clerical duties; the latter includes typing, filing, and data entry. Claimant estimates that she requires 24 hours per week of clerical help. Presently, she is funded for 8 hours per week. For the past five years, claimant has unsuccessfully attempted to secure additional clerical help.

In early 1988, claimant had bilateral carpal tunnel surgeries. Her surgeon, Dr. Sessions, released her to return to her regular work on May 1, 1988.

In the Fall of 1989, claimant began experiencing reduced strength in her arms and increased pain from her wrists to her elbows. In June 1990, claimant saw Dr. Sessions, who referred her to Dr. Wilson, a neurologist. Dr. Wilson found give-away weakness of the left grip and "exquisite tenderness over the lateral epicondyles, wrists and elbows," as well as positive Tinel's and Phalen's signs. (Ex. 7-2). Dr. Wilson diagnosed overuse syndrome, "related to her work activities, according to her history." (Id.)

About the same time, claimant also saw Dr. Henderson, her family physician, who also diagnosed overuse syndrome. Dr. Henderson reported "bilateral moderately severe arm pains involving both wrists and elbows and to some extent the shoulders." (Ex.10A-1).

On July 18, 1990, claimant filed her claim, stating as the nature of injury or disease, "over-use syndrome," and attributing her condition to "increased work-load and clerical duties." (Ex. 9).

Dr. Henderson then referred claimant to Dr. Dewey, Ph.D, a clinical psychologist. Dewey found that claimant suffered from a major depression, single episode, attributing her psychological condition to the "injustice of her [work] situation" as well as the "exacerbation of her tendonitis in both arms." (Ex. 10AA-3).

After SAIF denied her claim on August 28, 1990, claimant was examined by Dr. Button, an independent medical examiner, in January 1991. He diagnosed "severe psychologic stress, secondary to work environment," and found "no objective findings of any organic disease process of the neuro and musculoskeletal systems of the upper extremities." Button attributed claimant's subjective complaints to "the stress of her job." (Ex. 12A-3).

Dr. Wilson subsequently stated that he was "in basic agreement with Dr. Button's conclusions", (Ex. 13A), but then elaborated that an overuse syndrome, in combination with psychological factors, was responsible for claimant's symptoms. (Ex. 19). Dr. Henderson did not concur with Button's report, stating that he agreed with the "main conclusion" but that his examinations of claimant supported a diagnosis of overuse syndrome.

FINDINGS OF ULTIMATE FACT

Claimant's work activities were not the major contributing cause of her bilateral wrist and forearm condition.

CONCLUSIONS OF LAW AND OPINION

ORS 656.802(2) requires claimant to establish her occupational disease claim "by medical evidence supported by objective findings." The Referee upheld the denial of the claim based on her conclusion that claimant failed to establish her claim by medical evidence supported by objective findings. We agree with claimant that she succeeded in carrying her burden of proof with regard to this requirement.

Claimant may satisfy the "objective findings" requirement if she offers evidence that a physician has examined her and determined that she suffers from a disability or a physical condition that requires medical services. See Suzanne Robertson, 43 Van Natta 1505 (1991) (construing "objective findings" in context of compensable injury). That determination may be based on purely

objective factors, ORS 656.005(19), or on the worker's description of the pain that she is experiencing, as long as the physician indicates that the worker in fact experiences symptoms and does not merely recite the worker's complaints of pain. Suzanne Robertson, supra.

In this case, Dr. Wilson found give-away weakness of the left grip and positive Tinel's and Phalen's signs. Those findings satisfy ORS 656.005(19). Moreover, Wilson and Dr. Henderson both found tenderness of the lateral epicondyles and diagnosed overuse syndrome. Their reports clearly indicate that claimant in fact experienced the symptoms for which she was seeking treatment, thus satisfying "objective findings" under Suzanne Robertson, supra.

However, ORS 656.802(2) further requires that the "worker must prove that employment conditions were the major contributing cause of the disease or its worsening." The Referee concluded that, "in light of the role of psychological or emotional factors and the role of residuals of her carpal tunnel conditions," claimant failed to satisfy this requirement. Claimant disagrees, asserting that the evidence demonstrates that her clerical duties were the major contributing factor of her overuse syndrome, and, assuming that carpal tunnel residuals or stress contributed to her condition, "those conditions were both caused by her work with this same employer."

We find, first, that there is no evidence that claimant's condition is a residual of her earlier carpal tunnel syndrome. None of the doctors who examined claimant concluded that this was a factor; the only mention of such a possibility is in Dr. Henderson's notes, where he states that "bilateral elbow lateral epicondylitis is present with probable mild muscle weakness contributing to this, and probably secondary to the carpal tunnel surgeries and post operative." (Ex. 12-2). However, in light of Henderson's subsequent diagnosis of overuse syndrome, this statement carries little weight.

Nonetheless, we are not persuaded that claimant proved that a series of traumatic events or occurrences were the major contributing cause of her overuse syndrome. ORS 656.802(1)(c) and (2). The medical evidence from Dr. Wilson shows that he found that an overuse syndrome "was probably contributing to her symptoms." However, he stated that "psychological factors were also likely involved" and could not "sort out" the "relative contribution of the overuse syndrome and the psychological component to her symptomatology." (Ex. 19). Dr. Button clearly found that claimant's symptoms were due to psychological factors. Dr. Henderson provides the most supportive evidence for claimant; he finds that claimant's symptoms are "work related from doing prolonged hours at the typewriter and computer/filing[.]" (Ex. 12-3). However, even Henderson states that "overload stress [claimant] takes on her present job certainly contributes to these problems." (Id.) Henderson also agreed with Button's "main conclusion" of "severe psychologic stress" and reiterated his diagnosis of overuse syndrome. In short, there is insufficient evidence for us to conclude that clerical duties were the major contributing cause of claimant's condition. See Sibley v. City of Phoenix, 107 Or App 606 (1991) ("trauma" under ORS 656.802(1)(c) must be physical, not emotional, for overuse syndrome to be compensable).

Moreover, despite claimant's argument to the contrary, we are unable to address whether the claim is compensable as a stress-related physical condition. After filing the claim at issue here, claimant filed a separate claim for stress, which was denied by SAIF. The parties agreed at the hearing that the stress claim would be considered at a future hearing. (Tr. 1). Subsequently, the stress claim was heard by Referee Peterson, who set aside SAIF's denial on July 22, 1991. SAIF did not appeal that order.

Because claimant filed this claim alleging only an overuse syndrome caused by the clerical duties of her job and because claimant had filed a separate claim for stress, the Referee limited the hearing to the issue of whether claimant proved a compensable claim for her overuse syndrome. Accordingly, the Referee refused to allow any evidence relevant to her stress claim. Claimant does not object to those rulings here or allege that the Referee erred in limiting the hearing to the issue of compensability based on clerical duties. Consequently, we conclude that it would not be appropriate for us to consider whether claimant has a compensable stress-related physical condition.

ORDER

The Referee's order dated February 28, 1991 is affirmed.

December 26, 1991

Cite as 43 Van Natta 2765 (1991)

In the Matter of the Compensation of
ISABEL MENDOZA-LOPEZ, Claimant
WCB Case Nos. 89-12064 & 88-20465
And, In the Matter of the Complying Status of
RON P. TANKERSLEY, dba RON P. TANKERSLEY FARMS, Employer
WCB Case No. 88-20466
ORDER ON REVIEW (REMANDING)
Ginsburg, et al., Claimant Attorneys
Tollefsen & Co., Attorneys
Norman P. Cole (Saif), Defense Attorney

Reviewed by Board Members Moller and Westerband.

Ron Tankersley Farms (Tankersley), a noncomplying employer, requests review of Referee Mills' order which: (1) held that Tankersley's failure to appear at hearing constituted a waiver of appearance; and (2) found that claimant sustained a compensable injury during the period Tankersley was a noncomplying employer. With his appellant's brief, Tankersley has submitted copies of several documents which were not admitted into evidence. In addition, Tankersley's counsel has provided an explanation for Tankersley's failure to appear at the hearing. SAIF and claimant move to strike Tankersley's references to the submitted materials and statements which are not otherwise in the record.

We treat the submitted materials as a motion to remand for additional evidence. We also consider Tankersley's post-order explanation concerning his failure to appear at hearing to be a motion for postponement or continuance of the hearing. Inasmuch as the Referee has not had an opportunity to consider Tankersley's explanation, we remand.

FINDINGS OF FACT

On December 13, 1990, we remanded this matter to the Referee for a hearing concerning the compensability of claimant's injury claim. We reasoned that Tankersley was entitled to contest compensability of the claim.

A hearing was scheduled for February 15, 1991. On that date, the Referee granted Tankersley's request for postponement of the hearing after Tankersley's attorney withdrew from the case. The referee also advised Tankersley that "there will be no further postponements of this matter to allow further attempts to obtain representation. If Mr. Tankersley continues to be unrepresented at the time of the next hearing, the hearing will proceed regardless."

Notice was given and a second hearing was convened on June 20, 1991. Neither Tankersley nor any legal representative on his behalf was present at the hearing.

The Referee issued an Opinion and Order on June 25, 1991 finding that: (1) Tankersley's failure to appear constituted a waiver of appearance; and (2) claimant sustained a compensable injury on August 3, 1988 at a time when Tankersley was noncomplying. Thereafter, through his current attorney, Tankersley requested Board review. Included with his appellant's brief was Tankersley's attorney's representation that Tankersley was unable to attend the scheduled hearing because the hearing convened during "peak harvest time when it was essential for [Tankersley] to be at work in the fields."

CONCLUSIONS OF LAW AND OPINION

Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. OAR 438-06-071(2). If the party that waives appearance is the party that requests the hearing, the referee shall dismiss a request for hearing unless extraordinary circumstances justify postponement or continuance of the hearing. Id.

A postponement requires "a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." OAR 438-06-081. We have interpreted these rules to allow a party alleging extraordinary circumstances the opportunity to establish such circumstances for the purpose of justifying his or her nonappearance at a scheduled hearing. We have previously held that a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Vincent G. Jacoban, 42 Van Natta 2866, 2867 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989).

In Ray Eaglin, 43 Van Natta 1175 (1991), an unrepresented claimant submitted a letter expressing his dissatisfaction with a Referee's dismissal order based on the claimant's failure to appear at hearing. Specifically, the claimant in Eaglin contended the scheduled hearing date conflicted with his work schedule and that the insurer had informed him the hearing would be rescheduled to accommodate his work schedule. We interpreted the claimant's letter as a motion for postponement of the scheduled hearing and, because the Referee had no opportunity to rule on the motion, we remanded the case to the Referee for consideration of the motion. In Eaglin we emphasized that our decision should not be interpreted as a finding on whether postponement was warranted, but should rather be regarded as an acknowledgement that the Referee is the appropriate adjudicator to evaluate the grounds on which the motion was based and to determine whether postponement of the scheduled hearing was justified.

We reach a similar conclusion. Here, the Referee found that Tankersley's failure to attend the scheduled hearing constituted a waiver of appearance. Instead of dismissing the hearing request, the Referee proceeded with the hearing and closed the record based on the evidence presented by SAIF and claimant. Due to Tankersley's nonappearance, no contrary evidence was submitted. Thus, for all intents and purposes, Tankersley's failure to appear at the hearing effectively operated as a rejection of his challenge to the compensability of the claim.

In response to the Referee's conclusion that Tankersley's failure to attend the scheduled hearing constituted a waiver of appearance, Tankersley has provided an explanation attempting to justify his nonappearance. Rather than submitting this justification to the Referee, Tankersley has requested review rather than reconsideration. Considering Tankersley's assertions about the circumstances which allegedly prevented his appearance at the hearing, we treat his

request as a motion for reconsideration of the Referee's conclusion that Tankersley's failure to attend the hearing was unjustified and constituted a waiver of appearance. See Laurie Frick, 43 Van Natta 2584 (1991); Ray Eaglin, supra. Inasmuch as the Referee did not have an opportunity to rule on Tankersley's motion, we remand.

Accordingly, the Referee's order dated June 25, 1991 is vacated. This matter is remanded to Referee Mills to determine whether Tankersley's failure to appear at the scheduled hearing was justified. In making this determination, the Referee shall have the discretion to proceed in any manner that will achieve substantial justice to all parties and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the Referee finds that Tankersley's failure to attend the hearing was justified, a further hearing will be convened at which time additional evidence from the parties bearing on the compensability issue may be submitted and admitted. If the Referee finds that Tankersley's failure to attend the hearing was not justified, the Referee shall reinstate his prior Opinion and Order.

In light of our conclusion concerning Tankersley's justification for failing to attend the hearing, we need not address the other issues raised by the submission of additional documents in Tankersley's appellant's brief.

IT IS SO ORDERED.

December 26, 1991

Cite as 43 Van Natta 2767 (1991)

In the Matter of the Compensation of
WILLIAM K. NESVOLD, Claimant
WCB Case No. 90-10102
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Breathouwer, et al., Defense Attorneys

Reviewed by Board Members Westerland and Moller.

The self-insured employer requests review of Referee Tenenbaum's order that awarded 5 percent (16 degrees) unscheduled permanent disability for a chest injury, whereas a Determination Order awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of the last two paragraphs. Claimant has not sustained any loss of earning capacity as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

Because claimant became medically stationary prior to July 1, 1990, the issue of the extent of his unscheduled permanent disability is subject to a special exception to the 1990 Workers' Compensation Act's general applicability provision. See e.g. Section 54(3). Therefore, we analyze this issue under the Workers' Compensation Act in effect prior to the 1990 amendments.

For purposes of determining injury-related permanent partial disability, former ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to former ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination

Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010. We apply the standards in effect on March 29, 1990, the date of the Determination Order. (WCD Admin. Order 7-1988).

The Referee concluded that, based on claimant's credible testimony, claimant suffered from a chronic condition limiting repetitive use of his chest wall. On this basis, she found that claimant was entitled to 5 percent unscheduled permanent disability under the standards. We disagree.

The applicable standards define "impairment" as a decrease in the function of a body part or system, as measured by a physician. Former OAR 436-35-005(1) [Emphasis supplied]. Former OAR 436-35-320(4) provides for a five percent disability award for chronic conditions which limit repetitive use of an unscheduled body part. However, the record contains no medical opinion documenting loss of repetitive use of claimant's chest wall. To the contrary, claimant's treating physician noted that claimant had no impairment and had fully recovered from a minor chest wall strain. (Exs. 2, 3). On this record, we find that claimant has not established that he has a chronic condition limiting repetitive use of his chest wall as defined by the "standards." See Bonnie S. Burke, 43 Van Natta 2466 (1991); Ovid D. Brown, 42 Van Natta 2767 (1990); Martha L. Brunner, 42 Van Natta 2587 (1990).

Where claimant fails to establish any measurable impairment resulting from his compensable injury, no award of disability is allowed. Former OAR 436-35-010(2)(b); OAR 436-35-280(1). Here, claimant has failed to establish measurable impairment resulting from his compensable injury. Therefore, we find that claimant has failed to establish entitlement to an award of permanent disability.

In reaching this conclusion we note that claimant argues that his testimony alone is sufficient to establish impairment under former OAR 436-35-320(4). In support of this argument, he cites Mary A. Nagel, 43 Van Natta 449 (1991) and Carlos A. Aguilar-Ramos, 42 Van Natta 2391 (1990). Those cases do appear to have awarded 5 percent impairment for a chronic condition limiting repetitive use based solely on claimant's testimony. However, to be entitled to unscheduled permanent disability under the "standards", a claimant must establish "impairment" which is defined by the "standards" as a decrease in the function of a body part or system. Former OAR 436-35-005(1). Here, claimant did not establish any impairment under the "standards." To the extent the cases claimant relies on are inconsistent with our holding in the present case, they are disavowed.

ORDER

The Referee's order dated April 11, 1991 is reversed. The Determination Order is reinstated and affirmed.

In the Matter of the Compensation of
PAULA A. RITCHERSON, Claimant
WCB Case No. 90-22278
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Moller.

The self-insured employer requests review of those portions of Referee Knapp's order that: (1) awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use of the left forearm, whereas a Determination Order awarded no permanent disability for the left forearm; and (2) directed the employer to pay claimant's scheduled permanent disability for the right forearm at the rate of \$305 per degree. On review, the issues are compensability and rate of scheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

FINDINGS OF ULTIMATE FACT

Claimant's compensable right upper extremity injury is not the major contributing cause of her left upper extremity condition.

CONCLUSIONS OF LAW AND OPINION

Compensability of Left Arm Condition

The Referee found that claimant's consequential left arm symptoms were compensable and awarded her 5 percent scheduled permanent disability for a chronic condition limiting repetitive use. The employer argues that: (1) as a consequential condition, claimant must prove that the compensable injury was the major contributing cause of the left arm symptoms; and (2) claimant has not met her burden of proof. We agree with the employer.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

ORS 656.005(7)(a)(A) provides, in relevant part, that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." In Julie K. Gasperino, 43 Van Natta 1151 (1991), which issued subsequent to the Referee's order, we interpreted the phrase "consequential condition" to include only problems that arise from conditions previously deemed compensable ("secondarily consequential" conditions requiring proof of a major contributing cause), as opposed to conditions that arise directly from the injurious event ("primarily consequential" conditions requiring proof of a material contributing cause).

Here, claimant's injury claim was limited to her right wrist, and the October 24, 1989 incident did not result in an onset of left arm and hand symptoms. (Exs. 1, 2, 3, Tr. 15). The employer accepted a claim for tendinitis of the right wrist. (Ex. 4). As a result of the October 1989 incident, claimant's right wrist was splinted. Approximately three weeks after the incident, claimant reported that both of her wrists were painful. (Ex. 5-1). She attributed these new symptoms to having used the left arm while the right arm was partially immobilized. (Tr. 22-23). On these facts, we find that any left wrist condition is properly classified as a "secondarily consequential" condition. To establish compensability, claimant must prove that the compensable injury (tendinitis of the right wrist) is the major contributing cause of the left wrist condition.

The issue of whether her left arm symptoms are caused in major part by her right wrist tendinitis is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

The only medical report addressing any causal relationship is a response from Dr. Dougan, a treating physician, to a letter from the employer. (Ex. 11). In response to the question "what is the major contributing factor in the cause of the injury," Dr. Dougan referred to the specific incident and three prior medical reports. (Ex. 11-1). However, the only "injury" resulting from the October 24, 1989 incident was to claimant's right wrist, as noted above. Furthermore, the three medical reports Dr. Dougan referred to contain no discussion of the causation of claimant's left arm symptoms. (Exs. 5, 6, 7). Consequently, on this record, claimant has not established that the accepted right arm injury was the major contributing cause of her left arm condition. Inasmuch as claimant's left arm condition is not compensable, she is not entitled to an award of permanent disability for that condition. In other words, any loss of use or function in claimant's left arm is not "due to the industrial injury." ORS 656.214(2). Accordingly, we reverse the Referee's award of 5 percent scheduled permanent disability for loss of use of the left forearm.

Rate of Scheduled Permanent Disability

We adopt the conclusions and reasoning as set forth in the Referee's order with the following supplementation.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the 1990 Oregon Laws, Chapter 2, section 7 amendment to ORS 656.214(2), which increased the value per degree of scheduled permanent disability from \$145 to \$305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Accordingly, because the Determination Order award of scheduled permanent disability for the right forearm was made after May 7, 1990, the Referee correctly concluded that the award should be paid at the rate of \$305 per degree.

The employer requested the reduction of claimant's rate of scheduled permanent disability as granted by the Referee, and we have affirmed the Referee's order on that issue. If claimant had submitted a brief on Board review, she would have been entitled to a reasonable attorney fee pursuant to ORS 656.382(2). See Kordon v. Mercer Industries, 308 Or 290, 295-96 (1989). However, inasmuch as claimant submitted no brief, we conclude that she is not entitled to an attorney fee. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated March 20, 1991 is reversed in part and affirmed in part. The Referee's award of 5 percent (7.5 degrees) scheduled permanent disability for loss of use of the left forearm (wrist) is reversed. The remainder of the order is affirmed.

December 26, 1991

Cite as 43 Van Natta 2771 (1991)

In the Matter of the Compensation of
MELVIN O. ROBERTS, Claimant
WCB Case No. 91-00810
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Mills' order which: (1) upheld the insurer's partial denial of his degenerative disc condition and need for medical services for the same condition; and (2) declined to assess a penalty and attorney fee for an allegedly unreasonable denial. Claimant also contends that the Referee erred in admitting Exhibit 19. On review, the issues are evidence, compensability and penalties and attorney fees.

We affirm and adopt the Referee's order with the following comment concerning the evidence and penalty and attorney fee issues.

Claimant objects to the Referee's evidentiary ruling in which he admitted Exhibit 19. The document at issue is a memorialization of a telephone conversation between the insurer's counsel and Dr. Wilson of Medical Consultants Northwest. The document was faxed to the doctor, signed by the doctor and faxed back to the attorney's office. The document has continuity of meaning and does not appear to have had pages removed or added. Claimant asserts that this document is double hearsay. Claimant also objects to the document because after the three page document was faxed back to the insurer's attorney, page three of the original document indicated it was page nine of the fax transmission from Medical Consultants Northwest.

Referees are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). Furthermore, referees have discretion to exclude evidence which would be inadmissible under the rules of evidence when it is in the interest of substantial justice to do so. ORS 656.283(7).

Here, above the doctor's signature, the document states that it is an accurate reflection of the phone conversation and the doctor's medical opinion. Further, the Referee accorded claimant an opportunity to cross-examine Dr. Wilson. Claimant's counsel declined. Under these circumstances, we conclude that the Referee did not abuse his discretion by allowing the document into evidence.

Finally, inasmuch as we have affirmed the Referee's conclusion that the insurer's denial should be upheld, there are no amounts due on which to base a penalty. ORS 656.262(10); Lloyd V. Cripe, 41 Van Natta 1774 (1989). Moreover, as the claim is not compensable, there is no unreasonable resistance to the payment of compensation. Randall v. Liberty Northwest Ins. Corp., 107 Or App 599

(1991). Accordingly, we agree with the Referee that penalties and attorney fees are not warranted.

ORDER

The Referee's order dated April 10, 1991 is affirmed.

December 26, 1991

Cite as 43 Van Natta 2772 (1991)

In the Matter of the Compensation of
CAROLYN M. SNELL, Claimant
WCB Case No. 90-21209
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Baker's order which affirmed a Determination Order awarding no permanent partial disability. On review, the issue is the extent of unscheduled permanent partial disability.

We affirm and adopt the order of the Referee with the following supplementation.

The only medical evidence in the record that supports claimant's assertion that she is entitled to unscheduled permanent partial disability benefits is the January 15, 1991 report from Dr. Michels, D.C. Although that report contains the results of claimant's most recent examination, we do not find it to be reliable. In August 1990, Dr. Michel concurred with the report of the Northwest Pain Center Associates. That report found that claimant was medically stationary and had normal ranges of motion and strength. Dr. Michel does not explain why he now finds a loss of cervical extension and a chronic condition, nor does he assert that claimant's condition has worsened since August. Dr. Michel's report also is based on inaccurate information; it states that claimant has declined to work overtime due to pain and discomfort when, in fact, claimant testified that she worked 31 hours of overtime in January 1991.

Because the remaining medical evidence does not support an entitlement to unscheduled permanent partial disability benefits, we affirm the Referee.

ORDER

The Referee's order dated March 5, 1991 is affirmed.

In the Matter of the Compensation of
LARRY D. ARCHER, Claimant
WCB Case No. 89-25212
ORDER ON REVIEW (REMANDING)
Karen M. Werner, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Spangler's order which dismissed claimant's hearing request concerning an October 20, 1988 Determination Order as untimely and, therefore, held that the Hearings Division was without jurisdiction to consider the issues of premature claim closure and extent of permanent disability. On review, the issue is jurisdiction. We remand.

FINDINGS OF FACTS

We adopt the Referee's "Findings of Facts."

CONCLUSION OF LAW AND OPINION

In August 1988, claimant requested a hearing, raising the issues of temporary total disability, interim compensation, aggravation, failure to accept or deny aggravation, and penalties and attorney fees (Ex. 2A-2a). This hearing request was designated as WCB Case No. 88-13729. Thereafter, the SAIF Corporation accepted claimant's aggravation claim. The claim was subsequently closed by an October 1988 Determination Order. Claimant requested a hearing concerning that Determination Order in March 1989. This hearing request was apparently administratively consolidated with claimant's August 1988 Request for Hearing in WCB Case No. 88-13729.

On September 19, 1989, claimant signed a Stipulation. The Stipulation, which referred to WCB Case No. 88-13729, provided:

"The parties agree to settle all issue(s) raised or raisable at this time as follows:

"* * *

"b. The parties agree that claimant reserves his right to appeal the Determination Order of October 22, 1988, until the claimant's appeal rights expire as provided therein."

The Stipulation dismissed claimant's Request for Hearing in WCB Case No. 88-13729.

In December 1989, following the approval of the September 1989 Stipulation, claimant filed another hearing request concerning the October 1988 Determination Order. The hearing request was assigned WCB Case No. 89-25212. Thereafter, SAIF moved for dismissal of the hearing request as untimely under ORS 656.319(4).

The Referee dismissed the hearing request for lack of subject matter jurisdiction. The Referee reasoned that the Stipulation had dismissed claimant's prior hearing request concerning the Determination Order and because claimant's subsequent hearing request was filed more than one year after the Determination Order, it was untimely under ORS 656.319(4). Accordingly, the Referee concluded that the Hearings Division lacked subject matter jurisdiction

to hear claimant's objections concerning the October 20, 1988 Determination Order.

In Robert P. Davis, 42 Van Natta 835, 837 (1990), an additional hearing request was treated as a "supplemental Request for Hearing," merged with a prior request and assigned one WCB case number. An Order of Dismissal was entered in that WCB case number. Claimant subsequently filed a new request for hearing which was itself ultimately dismissed based upon the prior Order of Dismissal. Claimant requested review. On Board review, we were unable to reach a finding as to whether the Hearings Division did, in fact, acknowledge receipt of the second hearing request. We reasoned that if such an acknowledgment had occurred the parties would have been provided notice of the merger of the two hearing requests. Because we were unable to make the necessary determination, we remanded for further evidence taking.

Here, claimant's August 1988 and March 1989 hearing requests were consolidated. However, we are unable to reach a finding as to whether the Hearings Division did, in fact, acknowledge receipt of the second hearing request. Accordingly, we remand to the Referee for further development of the record concerning whether the Hearings Division acknowledged receipt of claimant's March 1989 hearing request.

This matter is remanded to Referee Spangler with instructions to take further evidence concerning the matters discussed in this order. The Referee shall have the discretion to proceed in any manner that will achieve substantial justice to all parties and that will insure a complete and accurate record. If the Referee determines that no acknowledgment of the March 1989 hearing request was provided to claimant, the Referee shall proceed to a hearing on the issues raised by claimant's March 1989 hearing request. If the Referee determines that acknowledgment of the March 1989 hearing request was provided to claimant, the Referee shall supplement and reinstate his prior order.

ORDER

The Referee's order dated February 19, 1991 is vacated and the case is remanded to Referee Spangler for further proceedings consistent with this order.

December 27, 1991

Cite as 43 Van Natta 2774 (1991)

In the Matter of the Compensation of
DEANN L. BORGES, Claimant
WCB Case No. 90-12022
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee Lipton's order that upheld the insurer's denial of her left knee injury claim. On review, the issue is compensability.

We affirm and adopt the Referee's order, with the following comment. Dr. Farris presumed that claimant had sustained a contusion on May 8, 1990 (See ex. 30-24), but there are no objective findings of that. (See ex. 4-5). Moreover, Dr. Farris persuasively opined that claimant's objective knee findings were the same before and after this incident. His opinion that there "might" have been

or "could" have been additional swelling is insufficient proof of objective findings.

ORDER

The Referee's order dated January 8, 1991 is affirmed.

December 27, 1991

Cite as 43 Van Natta 2775 (1991)

In the Matter of the Compensation of
RALPH A. FERRANTE, Claimant
WCB Case No. 90-21847
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Claimant Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

The self-insured employer requests review of Referee Bethlahmy's order that affirmed a Determination Order awarding 38 percent (121.6 degrees) unscheduled permanent partial disability for a low back injury. In its Reply Brief, the employer moves to strike those portions of claimant's brief which refer to the "Handbook for Analyzing Jobs." On review, the issues are evidence and extent of unscheduled permanent disability. We grant the motion to strike, and affirm.

FINDINGS OF FACT

On August 28, 1989, claimant sustained a compensable low back injury while working as a security guard at a high school.

When claimant was examined by Western Medical Consultants on December 18, 1989, he was not medically stationary.

On February 6, 1990, the employer sent claimant a letter inviting him to report for work at the U.S. West Communications Building. Claimant went to the job site for a "training shift." However, after several hours of activity, which included climbing stairs, his back began hurting and he sat down. Soon thereafter, a supervisor told him that no job was available. Claimant left the job site. There was no subsequent communication concerning the alleged job offer.

On February 7, 1990, Dr. Christensen, treating chiropractor, released claimant to "some modified form of full-time employment." (Ex. 10). On March 14, 1990, Christensen performed a final examination and reported claimant's "date of return to regular work" as March 19, 1990. (Ex. 11-3). On January 30, 1991, Christensen opined that claimant could not return to his job-at-injury. (Ex. 19).

Claimant was medically stationary on March 14, 1990.

Claimant has injury-related lost range of motion in his low back. He retains: 15 degrees left rotation, 35 degrees lumbar flexion, 20 degrees sacral hip flexion, 5 degrees lumbar extension, 15 degrees right lateral flexion, and 20 degrees left lateral flexion.

A July 11, 1990 Determination Order awarded claimant time loss and 38 percent unscheduled permanent partial disability.

At the time of hearing, claimant was not working for reasons related to his compensable injury.

At hearing, the parties agreed that the Evaluation Division properly assigned the following values: 0 for age; 5 for education; and 18 percent for injury-related impairment. (See Tr. 4-5; Ex. 12).

CONCLUSIONS OF LAW AND OPINION

Evidentiary Matter

The employer objects to claimant's arguments which refer to the "Handbook for Analyzing Jobs," because that text was not admitted as evidence. We agree with the employer's objection, because we are not at liberty to rely on such information. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); see also Sharon A. Ipox, 42 Van Natta 1568 (1990).

Accordingly, we grant the employer's motion to strike those portions of claimant's brief which refer to the "Handbook for Analyzing Jobs."

Permanent Disability

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

Because claimant's condition became medically stationary on March 14, 1990, and his claim was closed by Determination Order on July 11, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

The parties dispute claimant's adaptability factor under the standards. There is no serious argument that claimant successfully returned to work. Although the employer concedes that claimant was not released to his regular work, it contends that the issue is whether claimant was released to "any work which was suitable." We do not agree. Instead, we find that resolution of the dispute turns on whether the employer offered claimant work, within the meaning of former OAR 436-35-310.

Former OAR 436-35-310 provides in relevant part:

"(3) For workers who have received a work offer for, or have returned to modified work, the value for this [adaptability] factor shall be based on the difference between the physical capacity necessary to perform the usual and customary work and the physical capacity required to perform the modified work. . . .

"(4) If, as a result of the injury, the worker is not working and no employment has been offered, the value for this factor shall be based on [residual] physical capacity. . . ."

Here, the first question is whether the employer offered claimant modified work, within the meaning of subsection (3). In this regard, we note at the outset that the version of former OAR 436-35-310(3) applicable to the present case no longer contains subsection (b) which provided:

"If workers are unable to return to their usual and customary work and an employer offers a job that the attending physician agrees is within the worker's physical capacity, the value of this [adaptability] factor shall be based on the table in [subsection (3)] above." (Emphasis added).

Even though the older version of subsection (4) contained no express definition of "offer," we have previously required that the attending physician release the worker to the offered job, in order for the offer to be valid under the rule so that the less generous matrix of subsection (3) must be applied to determine a claimant's adaptability. See Donna L. Yancey, 42 Van Natta 2651 (1990) (Applying the standards effective between July 1, 1988 and January 1, 1989, we interpreted the term "offer" in subsection (4) in the same manner as that term is expressly defined in subsection (3).).

Assuming for the moment that the employer's offer must be for a position which the attending physician agrees is within the worker's physical capacity (under the standards which apply to this case), we are not persuaded that Dr. Christensen agreed that the position at the US West Communications Building is within claimant's residual physical capacity. In this regard, we note that the employer's alleged job offer is dated February 6, 1990. (Ex. 9). Dr. Christensen, treating chiropractor, opined, in a report dated February 7, 1990, that claimant "at this time is authorized to return to some modified form of full-time employment." (Ex. 10). Based on the timing of the offer and the general language of the release, we do not find that Christensen approved the specific job offered to claimant.

Nevertheless, we need not determine whether Christensen approved specific modified work for claimant in the present case, because we conclude that the employer's February 6, 1990 letter is not an "offer," within the meaning of the rule. This conclusion is based on our finding, infra, that there was no position available when claimant reported for work, or thereafter.

Claimant described the following events on the day he reported to the job site:

"I was downstairs for a few hours, and they had me walking up stairs. I started complaining about my back starting to hurt, so I told them, I'm going back downstairs and I'm going to sit there and just, you know, calm down a little bit because my back started hurting me. So after that the supervisor came downstairs, and he was explaining to me that there is [sic] no openings here, and he says, if there was an opening here, there'd be 20 guys ahead of me, so he said, stay here and I'm going upstairs to talk to Roy Murphy [personnel manager]. So I said, okay.

So he come [sic] down about a half hour later and he said, well you can go home because there's no position here for you. So a half hour after that, I left, and when I--immediately when I got home I called Roy Murphy on the phone, and he told me he'd get back to me in an hour, and he never called me back." (Tr. 20-21).

The employer contends that claimant "left work" of his own accord and denies that it informed claimant that no job was available. The employer's evidence in support of the alleged job offer directly contradicts claimant's description of events.

The Referee did not make an explicit credibility finding. However, he did find that claimant "was told that there was no job available." (Opinion and Order at 2). Clearly, the Referee believed claimant's version of events, rather

than the employer's. That preference amounts to an implicit credibility finding in claimant's favor. We find no reason to disagree with the Referee's opinion concerning claimant's credibility in the present case. Under these circumstances, we conclude, as did the Referee, that the employer's alleged job offer did not represent a position which was available to claimant. Moreover, because claimant attempted to perform the duties of the work which he believed was offered to him and the employer told claimant to go home, we conclude that the employer did not offer claimant modified work.

Because the employer has not established that it offered claimant modified work, within the meaning of former OAR 436-35-310, claimant's adaptability is determined under former OAR 436-35-310(4). See Robin M. Glover, 42 Van Natta 1081, 1082 (1990) (Where claimant was offered and returned to modified work, but was not working at the time of hearing because the employer had no work available, adaptability was properly rated under the more favorable matrix in section (4).)

Claimant's adaptability is therefore evaluated according to his residual physical capacity, without regard for his physical capacity prior to the injury. See Kenneth H. Parks, 42 Van Natta 2620 (1990). After reviewing the record, we find that claimant's residual physical capacity is for light work. (Exs. 3A, 9, 11). Thus, he is entitled to an adaptability value of 4. See former OAR 436-35-310(4)(c).

Having determined each value necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. When claimant's age value 0 is added to his education value 5, the sum is 5. When that value is multiplied by claimant's adaptability value 4, the product is 20. When that value is added to claimant's impairment value 18, the result is 38 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 38 percent.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of disability issue is \$600, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 27, 1991, is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$600, to be paid by the self-insured employer.

In the Matter of the Compensation of

LISA M. HAWKINS, Claimant

WCB Case No. 91-00524

ORDER ON REVIEW

Robert E. Nelson, Claimant Attorney

C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Thye's order that: (1) set aside its denial of claimant's aggravation claim for her cervical and lumbar sprain condition; and (2) assessed a penalty and attorney fee for SAIF's allegedly unreasonable denial. On review, the issues are aggravation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion" with the following supplementation.

The Referee concluded that claimant had established a compensable aggravation claim, supported by objective findings. We agree.

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, her claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 22 (1989) rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

On review, SAIF contends that claimant's lumbar and cervical condition did not worsen. We disagree. At the time of claimant's last arrangement of compensation, i.e., the May 22, 1990 Notice of Closure, claimant had mild muscular spasms, mild muscular palpatory pain and decreased ranges of motion. Dr. Cowan, claimant's then treating chiropractor, reported that claimant's condition continued to improve and her cervical and lumbar sprain condition had resolved. Claimant testified that she was working at the time of the Notice of Closure, although her condition fluctuated and she was never entirely free of pain.

Following the October 23, 1990 incident, Dr. Rushold, M.D., claimant's treating physician, reported that claimant exacerbated her lumbar strain injury. Dr. Rushold reported that, upon examination, claimant reported a "lot of pain" over the lumbar spine, with lateral bending limited to 10 degrees on both sides. Claimant could flex to 45 degrees, but could not extend at all.

At hearing, claimant testified that she was taken off work for over a month following the October 23, 1990 incident. She testified that she had

continuing low back pain and headaches and she was somewhat restricted in her ability to perform chores at home and at work.

In sum, we agree with the Referee that claimant has established a worsening of her condition since the May 22, 1990 Notice of Closure which is supported by objective findings and has resulted in diminished earning capacity.

Finally, SAIF argues that the October 23, 1990 incident amounts to an injury which did not occur in the course and scope of claimant's employment. In this regard, a compensable worsening is generally established by proof that the compensable injury is a material contributing cause of the worsened condition. Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if an off-work injury is the major contributing cause of the worsened condition, then the worsening is not compensable. ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991).

We decline to address SAIF's argument. SAIF's denial was based solely on the contention that claimant's condition had not worsened since the last arrangement of compensation. (Ex. 17). Similarly, at hearing, SAIF argued only that claimant's condition was "not anything more than a mere waxing and waning of symptoms, and as such, it doesn't constitute aggravation." (Tr. 5). Given the different standard of proof arising from an off-work injury situation, we conclude that claimant would be prejudiced were we to allow SAIF to raise this defense for the first time on Board review. See Gunther H. Jacobi, 41 Van Natta 1031 (1989). Accordingly, we decline to consider SAIF's argument.

Inasmuch as SAIF requested review, claimant is entitled to an attorney fee pursuant to ORS 656.382(2). However, claimant did not file a brief, therefore no attorney fee shall be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated May 3, 1991 is affirmed.

December 27, 1991

Cite as 43 Van Natta 2780 (1991)

In the Matter of the Compensation of
DUANE L. JONES, Claimant
WCB Case No. 88-10417
ORDER ON REMAND
Merrill Schneider, Claimant Attorney

This matter is before the Board on remand from the Court of Appeals. Jones v. OSCI, 107 Or App 78, on recon 108 Or App 230 (1991). The court has reversed our prior order, Duane L. Jones, 42 Van Natta 875 (1990), which affirmed a Referee's order that declined to award a carrier-paid attorney fee when the Inmate Injury Fund rescinded its denial of claimant's injury claim prior to hearing. Relying on the amendments to ORS 656.386(1) as adopted by SB 540, the court has reversed our order and remanded for an award of attorney fees.

FINDINGS OF FACT

We republish the "Findings of Fact" contained in our prior order with the following supplementation.

Claimant's June 20, 1988 hearing request concerning the Fund's May 1988 denial was filed by his attorney on claimant's behalf. The hearing request raised the issues of compensability, penalties, and attorney fees.

On July 12, 1988, six days before the scheduled July 18, 1988 hearing, the Fund accepted claimant's injury claim. Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

Considering that claimant's attorney filed a hearing request contesting the Fund's denial of claimant's injury claim and that, prior to the scheduled hearing, the Fund rescinded its denial and accepted the claim, we find that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. Consequently, we hold that claimant is entitled to an insurer-paid attorney fee under amended ORS 656.386(1). SB 540; Jones v. OSCI, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee concerning the rescission of the Fund's denial prior to hearing is \$750, to be paid by the Fund. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's statement of service), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, the Referee's order dated September 28, 1988 is reversed. For services concerning the rescission of the Fund's denial prior to hearing, claimant's attorney is awarded \$750, to be paid by the Inmate Injury Fund.

IT IS SO ORDERED.

December 27, 1991

Cite as 43 Van Natta 2781 (1991)

In the Matter of the Compensation of

DAVID D. KERR, Claimant

WCB Case No. 91-00792

ORDER ON REVIEW

Pozzi et al., Claimant Attorneys

Roberts, et al., Defense Attorneys

Reviewed by Board Members en banc.

The insurer requests review of Referee Galton's order that directed it to pay claimant's scheduled permanent disability award at the rate of \$305 per degree. On review, the issue is the rate of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following modification and supplementation. In place of the Referee's finding that claimant's claim was closed by Determination Order dated March 20, 1989, we find that the Determination Order actually issued on March 7, 1990, and that it declared claimant medically stationary as of February 1, 1990.

CONCLUSIONS OF LAW AND OPINION

The Referee directed the insurer to pay claimant's total award of 37 percent scheduled permanent disability at the rate of \$305 per degree. Because only a portion of that award should be paid at the rate of \$305, we modify.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the Oregon Laws 1990, Chapter 2, section 7 amendment to ORS

656.214(2), which increased the value per degree of scheduled permanent disability from \$145 to \$305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Here, claimant was awarded 31 percent scheduled disability by Determination Order on March 7, 1990. Because that award was made before May 7, 1990, it must be paid at the rate of \$145 per degree, in accordance with former ORS 656.214(2). See Vasile Chiricea, 43 Van Natta 1750 (1991); Alfonso S. Alvarado, 43 Van Natta 1217 (1991). On the other hand, because a prior Referee approved an additional 6 percent scheduled permanent disability by Stipulated Order after May 7, 1990, that increased award must be paid at the rate of \$305 per degree. Alan G. Herron, *supra*.

ORDER

The Referee's order dated April 29, 1991, is modified. The insurer shall pay 31 percent (59.52 degrees) scheduled permanent disability, as awarded by Determination Order on March 7, 1990, at the rate of \$145 per degree, and pay 6 percent (11.52 degrees) scheduled permanent disability, as awarded by Stipulated Order on November 15, 1990, at the rate of \$305 per degree.

December 27, 1991

Cite as 43 Van Natta 2782 (1991)

In the Matter of the Compensation of
WARREN G. KUCERA, Claimant

WCB Case Nos. 89-23045, 90-07857, 90-07858, 90-10125, 90-10126 & 90-10127

ORDER ON REVIEW

Olson, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney
Cummins, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

Claimant requests review of Arbitrator Spangler's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition; (2) set aside the National American Insurance Company's (National) denial of the same condition; and (3) declined to award an attorney fee. In their briefs, claimant and National object to the Referee's refusal to consider evidence of claimant's post-hearing surgery and release from work. National requests remand for "admission" of this evidence. On review, the issues are evidence, remand, responsibility and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Arbitrator's "Findings of Fact," except for those findings on page 3 of the Decision, with the following supplementation.

Claimant's temporary disability rate will be greater if SAIF, rather than National is responsible for the current claim. [Ex. 34].

Claimant first sought treatment for his compensable wrist condition, subsequently diagnosed as bilateral CTS, on April 26, 1989. [Ex. 15-3; see Opinion and Order at 4]. Claimant's need for CTS surgery for that condition arose by July 20, 1989. [Ex. 26]. On June 19, 1990 a right carpal tunnel release was performed. Surgery on the left was subsequently scheduled as well.

CONCLUSIONS OF LAW AND OPINIONApplicable Law

Claimant requested a hearing on November 16, 1989 and the hearing convened on June 13, 1990. Consequently, we apply the law in effect prior to the July 1990 amendments. See Or Laws 1990, (Special Session), Ch. 2, 54.

Scope of Board Review

Claimant requests review of the Arbitrator's responsibility determination. Inasmuch as the record establishes that claimant's temporary disability rate would be higher if SAIF is responsible--as claimant contends it is--our review resolves a matter concerning a claim. ORS 656.704(3). Therefore, we are not confined by the Arbitrator's findings of fact and review de novo. ORS 656.307(2). Jon E. Robinson, 42 Van Natta 512 (1990).

Evidentiary Matter and Motion to Remand

The Arbitrator stated that the record remained open following the hearing for the sole purpose of admitting the opinion of Dr. Poulson. Based on his understanding that no party requested that the record remain open for submission of evidence of post-proceeding factual events [specifically, the occurrence of claimant's CTS surgery and related release from work], the Arbitrator declined to consider the facts revealed in Poulson's post-hearing deposition. Reasoning that these facts are not part of the record, the Arbitrator concluded, contrary to the facts revealed by the deposition, that claimant was "never" disabled by his CTS condition.

Claimant and National contend that the Arbitrator erred in refusing to consider the post-hearing evidence. National requests remand for consideration of the disputed evidence.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

In this case, we agree that the Arbitrator should have considered the evidence before him, as it was submitted without objection while the record was open. However, because the disputed evidence is already in the record, we admit it into the record and proceed with our review. Herbert D. Rustrum, 37 Van Natta 1291 (1985). Consequently remand is not necessary.

Responsibility

The Arbitrator found that claimant first sought treatment for his left wrist symptoms in April 1989, when National was on the risk. The Arbitrator also found that claimant's subsequent work exposure, while SAIF was on the risk, did not cause or exacerbate claimant's bilateral wrist condition. He concluded that National, the insurer on the risk when claimant first sought treatment for his compensable condition, is responsible. We agree.

However, the Arbitrator also stated that SAIF would have been responsible, apparently under the "last injurious exposure rule", if he had considered the evidence of claimant's post-hearing disability. We disagree, for the following reasons.

Although claimant did not miss work due to the injury until his surgery, while SAIF was on the risk, Dr. Poulson, the treating physician, first sought

authorization for surgery in July 1989. Although surgery was delayed, Dr. Poulson has opined that claimant's condition did not worsen after that time.

Inasmuch as claimant sought treatment for his compensable wrist condition in April 1989, before SAIF came on the risk in October 1989, and his condition remained unchanged until his post-hearing surgery, claimant was "disabled," for responsibility purposes, when he first sought treatment. See Bracke v. Baza'r, Inc., 293 Or 239 (1982); see also United Pacific Ins. v. Harris, 63 Or App 256, 260, rev den 295 Or 730 (1983).

In Harris, a claimant sought treatment in December for symptoms that interfered with her ability to work. In January, after another insurer had come on the risk, claimant was released from work by her doctor. Claimant's condition was unchanged in the interim. Given these facts, the court held that the date of disability was in December while the first insurer was on the risk, making the first insurer responsible for the claim.

Attorney Fees

We adopt the Arbitrator's "Conclusions of Law" on this issue, noting that claimant's attorney did not prevail in the responsibility issue at hearing. See Jean Novotny, 42 Van Natta 1060, 1061 (1990).

ORDER

The Arbitrator's order dated August 27, 1990 is affirmed.

December 27, 1991

Cite as 43 Van Natta 2784 (1991)

In the Matter of the Compensation of
ROSE A. MEADE, Claimant
WCB Case No. 90-09535
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Don Dickerson, Attorney
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Tenenbaum.

The noncomplying employer requests review of Referee Livesley's order that increased claimant's scheduled permanent disability award for a left knee injury from 25 percent (37.5 degrees), as awarded by a prior Determination Order and an earlier Referee's order, to 36 percent (54 degrees). On review, the issue is extent of permanent disability. We reverse.

FINDINGS OF FACT

Claimant worked as a breakfast cook for the employer. On June 3, 1986, she injured her left knee when she tripped over a drainage hole in the kitchen. She consulted Dr. Matteri, an orthopedic surgeon, who diagnosed a chondromalacia patella and performed an extensor realignment with tibial tubercle transfer. On May 9, 1987, he declared claimant medically stationary with mild permanent disability and indicated that her chondromalacia may require future surgery.

Claimant's claim was closed by a Determination Order dated November 12, 1987, which awarded compensation of 10 percent scheduled permanent partial disability for loss of use of the left leg. Claimant appealed the Determination

Order and, by an Opinion and Order dated January 9, 1988, her award was increased to a total of 25 percent scheduled permanent disability.

In May 1989, claimant sought treatment from Dr. Boughal, D.O., for increased left knee pain. After x-rays showed mild degenerative changes in the left patella, Boughal sought and obtained authorization for additional surgery. Matteri successfully performed a Maquet surgical procedure on September 6, 1989, and declared claimant medically stationary on February 14, 1990.

Claimant's claim was reclosed by a Determination Order on April 20, 1990, which awarded claimant compensation for periods of temporary total disability but no additional permanent disability.

Claimant returned to Matteri on July 26, 1990, seeking continued chiropractic treatment for her knee. At that time, claimant's knee had normal range of motion and there was no evidence of any material worsening.

ULTIMATE FINDING OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The issue on review is whether claimant has established a permanent worsening of her left knee condition sufficient to support an additional award of permanent disability. The Referee concluded that she had and increased her scheduled permanent disability award to 36 percent. We disagree.

To prove entitlement to additional permanent disability, a claimant must show that the condition that gave rise to the original award or arrangement of compensation has itself permanently worsened since the last award or arrangement of compensation. Stepp v. SAIF, 304 Or 375, 381 (1975). Because this case involves a scheduled body part, such a worsening must result in a permanent loss of use or function. ORS 656.214(2). The last award of compensation in this case was a January 9, 1988 Opinion and Order, which awarded claimant an additional 15 percent scheduled disability.

In reaching his decision that claimant's left knee condition had worsened, the Referee relied on a June 1989 x-ray that revealed "some mild degenerative change in the left patella." (Ex. 3). As the employer correctly notes, however, there is no evidence that the noted degenerative change occurred since the last award of compensation. The change could have occurred before the date of injury. Furthermore, there is no evidence that the change was causally related to claimant's compensable injury.

The Referee also relied on claimant's testimony that, since the second knee surgery, she is unable to ride her bicycle or fish, and is less able to drive a standard shift automobile due to the pain experienced depressing the clutch pedal. A permanent worsening, however, must be established by medical evidence supported by objective findings. See ORS 656.273(1). Claimant's subjective testimony, without more, is insufficient to establish a worsening claim for additional permanent disability, particularly in light of Dr. Matteri's July 26, 1990 finding of no material worsening. See generally Suzanne Robertson, 43 Van Natta 1505 (1991).

After our review of the record, we conclude that claimant has failed to prove a permanent worsening of her compensable condition since the last award of compensation. Although claimant sustained an aggravation of her condition in

May 1989, the medical evidence indicates that the worsening was temporary and that claimant has since returned to her pre-aggravation status with no additional impairment. Accordingly, claimant is not entitled to an award of additional permanent disability.

Even if we assume that claimant's condition had permanently worsened, we find that the extent of her scheduled permanent disability is not greater than the 25 percent already awarded. The medical evidence establishes, and the employer does not dispute, that claimant suffers from a chronic condition that limits the repetitive use of her knee. Therefore, she is entitled to an award of 5 percent scheduled permanent disability under former OAR 436-35-010(7).

The Referee also awarded claimant 10 percent scheduled disability for quadricep weakness and atrophy. Former OAR 436-35-230(5)(b). In making that award, the Referee relied on reports from Dr. Boughal and Dr. Baker, dated May 12, 1989 and July 12, 1989 respectively. (Exs. 2 and 3A). We reject those findings, however, as they were made at the time claimant's condition had temporarily worsened and before she returned to medically stationary status. There is no statement from Dr. Matteri, the treating surgeon, that claimant had thigh weakness or atrophy after she completed physical therapy and her condition became medically stationary.

The Referee also found that claimant had retained only 115 degrees of flexion in her left knee and, therefore, concluded that she was also entitled to an award of 12.5 percent scheduled disability under former OAR 436-35-220. The employer disputes that award, relying on Dr. Matteri's report that claimant had normal range of motion on July 26, 1990. Nonetheless, for purposes of this analysis, we accept the Referee's finding and, when we combine that award with the award for claimant's chronic condition, we conclude that claimant's permanent disability under the standards equals 17 percent. Former OAR 436-35-240(5), 436-35-101(6).

The Referee also awarded claimant an additional 10 percent scheduled disability outside the standards for her chronic chondromalacia. We agree that the record suggests that claimant does, in fact, suffer from chondromalacia, but the degree of permanent impairment caused by that condition is not quantified. We believe that claimant's inability to repetitively bend or climb--limitations used to support the award for a chronic condition under the standards--are similar to those that Dr. Matteri thought would be the limitations for the chondromalacia. Accordingly, those two factors overlap and, when this condition is considered with the 17 percent scheduled disability awarded under the standards, we conclude that claimant has been adequately compensated by the 25 percent scheduled award.

ORDER

The Referee's order dated November 26, 1990, as amended February 15, 1991, is reversed. The Determination Order of April 20, 1990 is reinstated and affirmed in its entirety. The Referee's attorney fee award based on the increased compensation made payable by the order is reversed.

In the Matter of the Compensation of
BARBARA J. NORMAN, Claimant
WCB Case Nos. 91-00813 & 90-18160
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee Leahy's order that: (1) increased claimant's scheduled permanent disability award for her left forearm (wrist) condition from 4 percent (6 degrees), as awarded by Determination Order, to 11 percent (16.5 degrees) scheduled permanent disability; (2) increased claimant's scheduled permanent disability award for her right arm condition from 5 percent (9.6 degrees), as awarded by Determination Order, to 14 percent (26.88 degrees) scheduled permanent disability; (3) awarded 9 percent (28.8 degrees) unscheduled permanent disability for each of claimant's shoulder conditions, whereas a Determination Order awarded no unscheduled permanent disability; and (4) directed the employer to pay claimant's scheduled permanent disability awards at the rate of \$305 per degree. On review, the issues are extent of scheduled and unscheduled disability and rate of scheduled disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

In determining extent of disability, the Referee applied the "standards" in effect at the time of the August 13, 1990 and September 19, 1990 Determination Orders. We apply the same standards and reverse in part and affirm in part.

At the outset, the employer contends that the Referee erred by relying upon the impairment measurements taken by an occupational therapist. The employer cites several Board cases in which we declined to rely upon the reports of physical therapists.

We conclude that the cases cited by the employer are distinguishable from the present case. In Linda F. Wright, 42 Van Natta 2570 (1990) and Edwin C. Elliott, 42 Van Natta 2720 (1990), we declined to use impairment findings reported by physical therapists. However, in Wright, supra, there was no documentation by a physician that claimant had measureable impairment. Additionally, in Elliott, supra, claimant's treating surgeon disagreed with the physical therapist's measurements of impairment.

In the present case, however, the Referee found, and we agree, that claimant's treating physician, Dr. Jewell, reviewed the findings of the physical therapist and ratified or adopted his measurements. Accordingly, we conclude that such measurements satisfy the requirements of former OAR 436-35-005(1). See Don O. Adams, 43 Van Natta 972 (1991) (Impairment ratings of a physical therapist used where the treating physician ratified the therapist's findings). We therefore adopt the Referee's conclusions and opinion on the issue of scheduled impairment.

The employer next argues that the Referee should not have made an award for a chronic condition limiting the repetitive use of each of claimant's shoulders. The employer contends that claimant's testimony does not establish a

chronic condition limiting repetitive use of her shoulders. The employer also asserts that, although Dr. Jewell completed a "fill-in-the-blank" letter indicating that claimant had a chronic condition, there are no other references to such a condition in his reports.

We agree that claimant has not proven that she is entitled to an award for a chronic condition limiting repetitive use of her shoulders. Except for his conclusory opinion in response to claimant's counsel, Dr. Jewell has not documented a chronic condition limiting repetitive use of claimant's shoulders. In addition, even if Dr. Jewell's response is considered in conjunction with claimant's testimony, we are not persuaded that claimant has shown evidence of a ratable chronic condition. Claimant testified that she had problems with her forearm and her shoulder becoming sore after use. However, her testimony regarding soreness does not establish a chronic condition limiting repetitive use of her shoulders. Accordingly, we reverse the portion of the Referee's order that awarded claimant unscheduled permanent disability for her left and right shoulders.

Finally, the employer contends that the Referee should have directed it to pay claimant's scheduled award at the rate of \$145 per degree rather than \$305 per degree. We agree with the Referee that the correct rate for payment of scheduled permanent disability is \$305 per degree. See Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991).

Claimant is entitled to an assessed fee for prevailing on the issue of rate of scheduled permanent disability. Claimant is also entitled to a fee for prevailing against the employer's request for reduction of his scheduled permanent disability award. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the issues of rate and extent of scheduled permanent disability is \$750. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated April 29, 1991 is reversed in part and affirmed in part. That portion of the Referee's order that awarded claimant 9 percent (28.8 degrees) unscheduled permanent disability for each shoulder is reversed. The remainder of the Referee's order is affirmed. For services on review concerning the issues of extent of scheduled permanent disability and rate of scheduled permanent disability, claimant's counsel is awarded an assessed fee of \$750, payable by the employer.

In the Matter of the Compensation of

RYAN R. PANTER, Claimant

WCB Case No. MS-91003

ORDER OF DISMISSAL

Nichols & Bogardus, Claimant Attorneys

Rick Dawson (Saif), Defense Attorney

D. Kevin Carlson, Assistant Attorney General

Miller, et al., Defense Attorneys

The SAIF Corporation requests Board review pursuant to ORS 656.327(1)(b) of the Director's "orders." Contending that correspondence from the Director to SAIF constitute "orders" finding no bona fide medical services dispute exists, SAIF asks that this case be remanded to the Director for lack of substantial evidence to support the "orders." We dismiss the request for Board review.

FINDINGS OF FACT

On May 7, 1991, SAIF sent a letter to the Workers' Compensation Division (Medical Review and Abuse Section) of the Department of Insurance and Finance (hereafter referred to as "MRAS"). The letter stated:

"Pursuant to OAR 436-10-046, SAIF Corporation requests a Director's review of [claimant's] on-the-job injury on the basis that [claimant's] refusal [based on religious grounds] to accept blood transfusions and/or blood products during the acute stage of his injury was medically unreasonable and seriously compromised his life and recovery. Because [claimant] refused treatment essential to his recovery, there has resulted greater medical costs and disability than necessary for his injury. It is our request that the Medical Director determine a percentage of medical cost and disability that are due to [claimant's] refusal to accept blood transfusions and/or blood products at the time of his treatment."

In a subsequent letter, SAIF stated that its request for the Director's review was made pursuant to ORS 656.327 "in that the medical treatment was excessive and inappropriate" and that claimant's refusal to accept a blood transfusion or blood products violated ORS 656.325. The letter further asserted that SAIF "should not be responsible for that portion of the medical treatment and result in [sic] disability deemed excessive and inappropriate or that which imperiled or retarded his recovery[.]"

On July 31, 1991, MRAS, by letter, directed SAIF to make immediate payment on all outstanding bills relating to claimant's medical care. The letter also stated that MRAS would continue to "investigate the allegations made by SAIF pursuant to ORS 656.325." A subsequent letter from MRAS dated August 13, 1991, also informed SAIF that it

"construed SAIF's letter to be a request for reduction of benefits under the provisions of ORS 656.325 rather than ORS 656.327. The treatment records you submitted indicate that SAIF Corp. is objecting to actions taken by the claimant, specifically his refusal of blood products because of his religious belief, not the medical services provided to the claimant. The records did not indicate that SAIF believed the medical providers made decisions which resulted in them providing treatment excessively, inappropriately, ineffectively, or in violation of the rules. As such, review under ORS 656.327 does not appear to be appropriate."

On August 16, 1991, SAIF requested Board review pursuant to ORS 656.327(1)(b) of the Director's July 31, 1991 and August 13, 1991 "orders."

CONCLUSIONS OF LAW

If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer, or self-insured employer shall so notify the parties and the director. ORS 656.327(1)(a). Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter pursuant to ORS 656.327(2). See ORS 656.327(1)(b).

The appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the board within 30 days after issuance of the order. Id. The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Id.

In Jack H. Glubrecht, 43 Van Natta 1753 (1991), we discussed the Board's jurisdiction to review an order under ORS 656.327(1)(b). In that case, SAIF submitted a petition to MRAS requesting it to declare claimant's home remodeling reimbursement claim to be outside the coverage provided by ORS 656.245 and non-compensable under ORS 656.327. Claimant responded to SAIF's petition by enclosing copies of a hearing request filed with the Hearings Division of the Workers' Compensation Board. The Referee subsequently held that ORS 656.327 was not applicable and that the Hearings Division had jurisdiction to consider the dispute. Responding to SAIF's request that it issue a final, appealable order, MRAS stated on February 12, 1991 that it did not intend to issue either a "Bona Fide Dispute" or "No Bona Fide Dispute" order and expressed its desire that the matter be resolved in the Hearings Division. SAIF then requested Board review under ORS 656.327 of the Director's February 12, 1991 "order."

We held that the Board lacked authority to consider the matter and dismissed the request for Board review. Glubrecht, supra at 1756. We based our decision on our finding that the Director did not issue an order finding "no bona fide medical services dispute exists" because he expressly refused to issue such an order. Id. at 1755.

Here, the Director and medical provider, St. Charles Medical Center, agree that, if the Director's correspondence do not constitute "orders" under ORS 656.327, the holding in Glubrecht governs this case and confirms that the Board lacks jurisdiction. SAIF, however, argues that Glubrecht is distinguishable from the present case because the Director in Glubrecht expressly announced his intention not to issue an order pursuant to ORS 656.327(1)(b), while the Director here only found that SAIF's request was appropriately reviewed under ORS 656.325 rather than 656.327. We disagree.

In Glubrecht, we specifically addressed and rejected SAIF's argument that the Director's refusal to act constituted a final order under 656.327(1)(b). Rather, we declined to treat the Director's refusal to issue an order as the very order that the Director had refused to issue, concluding that a refusal to issue an order "finding no bona fide medical services dispute exists" did not satisfy the statute's requirement for our jurisdiction that such an order be issued. Glubrecht, supra at 1756.

Our decision in Glubrecht, however, should not be construed to mean that, in order for us to conclude that we do not have jurisdiction under ORS 656.327, the Director must expressly refuse to issue an order under that statute. Instead, Glubrecht stands for the proposition that the Director must issue an order "finding no bona fide medical services dispute exists" before the Board

has the authority to review the matter at issue. Id. We therefore next address whether the correspondence from MRAS dated July 31, 1991 and August 13, 1991 qualify as such orders.

SAIF and claimant contend that, in determining that ORS 656.327 did not apply to SAIF's request, the Director necessarily concluded that there was no bona fide medical services dispute. Both parties therefore conclude that the Director's letters qualify as "orders" under ORS 656.327(1)(b) and that this Board has jurisdiction to review whether they are supported by substantial evidence.

The flaw in the above reasoning is in the assumption that the Director found that no bona fide medical services disputes exists when he concluded that "review under ORS 656.327 does not appear to be appropriate." We conclude that the Director's determination regarding the inapplicability of ORS 656.327 does not qualify as an order under that statute. Instead, we find that, because the Director rejected ORS 656.327 as the proper statute to review SAIF's request, the Director never reached the issue of the existence of a bona fide medical services dispute. Much like the Director's actions in Glubrecht, the Director here simply refused to issue an order under ORS 656.327(1)(b), instead concluding that ORS 656.325 was the appropriate statute to review SAIF's request.

Because we hold that the Board is without authority to review the Director's decision under ORS 656.327, we do not address claimant's contention that SAIF failed to properly invoke review by the Director because it did not comply with OAR 436-10-046. The request for review therefore must be dismissed.

IT IS SO ORDERED.

December 27, 1991

Cite as 43 Van Natta 2791 (1991)

In the Matter of the Compensation of
DIANE E. SULLIVAN, Claimant
WCB Case No. 88-09193
ORDER ON REVIEW
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Kinsley.

Claimant, pro se, requests review of Referee Mongrain's Order on Remand that: (1) upheld the insurer's denial, insofar as it denied compensability of claimant's preexisting degenerative low back condition; and (2) affirmed a Determination Order award of 11 percent (35.2 degrees) unscheduled permanent partial disability for a low back condition. In her appellant's brief, claimant requests remand for the taking of additional evidence. In its respondent's brief, the insurer challenges that portion of the Order on Remand that awarded claimant's former attorney a \$1,200 carrier-paid fee for services in partially setting aside the insurer's denial, whereas the original Opinion and Order awarded an assessed fee of \$800. On review, the issues are remand, compensability, extent of permanent partial disability and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant has requested remand, alleging that she received inadequate representation from her former attorney. She contends that her attorney was not

fully prepared for hearing and requests that this matter be remanded to the Referee for a review of the evidence. We deny the motion.

We may remand to the Referee for the taking of additional evidence if we find that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand, however, it must be shown that the evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). By claimant's own assertions, the evidence she seeks to submit into evidence was not only obtainable, but available at hearing. The allegation that her attorney was either unaware of the evidence or unprepared for hearing is insufficient to merit remand. With regards to claimant's assertion that she was not properly represented, we note that the Workers' Compensation Board is not the proper forum to litigate these allegations.

Compensability and Extent of Permanent Disability

We adopt the conclusions and reasoning concerning the compensability and extent of disability issues as set forth in the Referee's order.

Attorney Fees

In his original order, the Referee awarded claimant's former attorney a \$800 carrier-paid fee for services rendered in partially prevailing against the insurer's denial. In our Order on Remand, we vacated that order and remanded for the taking additional evidence. After further evidence was submitted, the Referee issued his second order and increased the assessed attorney fee award to \$1,200.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the compensability issue is \$1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief, statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 13, 1991 is affirmed.

December 27, 1991

Cite as 43 Van Natta 2792 (1991)

In the Matter of the Compensation of
CHARLES W. WILSON, Claimant
WCB Case No. 90-09378
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The SAIF Corporation requests review of Referee Black's order that: (1) set aside its denial of claimant's claim for a low back injury; and (2) assessed a penalty for its untimely denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

The lifting incident at work materially contributed to claimant's disability and need for treatment. SAIF's delay in denying claimant's claim was unreasonable.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. The hearing was convened after July 1, 1990. Therefore, the "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Compensability

We adopt the Referee's conclusions and opinion regarding the compensability issue, with the following supplementation.

Because claimant had a preexisting low back condition, the determination of compensability is a two-part test under ORS 656.005(7)(a)(B). See Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish a compensable injury by proving that the work accident was a material contributing cause of his disability and need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). If so, claimant is entitled to disability compensation and treatment only to the extent the compensable injury is the major contributing cause of that disability or need for particular treatment. Bahman M. Nazari, *supra*.

We agree with the Referee that, based on claimant's credible history and Dr. Carlstrom's opinion (Tr. 61-62), claimant has established that the lifting incident at work was the major contributing cause of his low back condition requiring treatment and resulting in disability. Accordingly, claimant has satisfied both parts of the Nazari test for compensability under ORS 656.005(7)(a)(B). We also conclude, contrary to SAIF's argument on review, that the Referee's finding that claimant was credible was based at least in part on his observation of claimant's demeanor and carriage at hearing.

Penalties

The Referee assessed a penalty for SAIF's unreasonable delay in denying claimant's claim. Claimant filed his claim on November 15, 1989, but it was not denied until March 7, 1990, almost four months later. That delay was unexplained and, therefore, unreasonable. See Lester v. Weyerhaeuser, 70 Or App 307, 312 (1984). For its unreasonable delay, SAIF may be assessed a penalty under ORS 656.262(10)(a) based on any amounts of compensation due at the time of the denial. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). However, there is no evidence that any amounts of compensation were then due; SAIF evidently paid interim compensation and medical benefits up to the date of its denial. Therefore, there is no basis for assessing a penalty. See Wacker Siltronic v. Satcher, 103 Or App 513 (1990).

However, ORS 656.382(1) provides for an assessed attorney fee when an insurer unreasonably resists the payment of compensation, even though there are no

amounts of compensation then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991). We find that SAIF's delay in responding to claimant's claim had the effect of delaying the payment of compensation. Therefore, we assess an attorney fee pursuant to ORS 656.382(1). See Richard J. Stevenson, 43 Van Natta 1883 (1991); Steve Chambers, 42 Van Natta 524 (1990); Cindi A. Cadieux, 41 Van Natta 2259 (1989). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we assess an attorney fee of \$300. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

Attorney Fee On Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$767, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 23, 1990, is affirmed in part and reversed in part. That portion of the Referee's order that assessed a penalty against the SAIF Corporation is reversed. Claimant's attorney is awarded a penalty-related attorney fee of \$300. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of \$767, to be paid by the SAIF Corporation.

November 15, 1991

Cite as 43 Van Natta 2794 (1991)

In the Matter of the Compensation of
LINDA SAWAYA, Applicant
WCB Case No. CV-91010
CRIME VICTIM ORDER
Gerri L. Fitzgerald, Department of Justice

Linda Sawaya, hereafter referred to as applicant, has requested Board review of the Department of Justice's June 5, 1991 Order on Reconsideration. By its order, the Department found applicant was entitled to benefits as a victim of a crime under ORS 147.005 to 147.635. However, the Department denied payment for chiropractic and massage therapy because these treatments were not provided by, nor referred out by, applicant's private health carrier.

Following our receipt of the request for Board review, applicant was advised that she was entitled to present her case to a hearing officer. To exercise her right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed her a copy of the record. The Department mailed a copy of its record to applicant on September 18, 1991. Having received no hearing request within the requisite time period, we have conducted our review based solely on the record. OAR 438-82-030(2).

ISSUE

Whether applicant is entitled to chiropractic treatment and massage therapy that was neither provided by, nor referred out by, her private health carrier.

FINDINGS OF FACT

Applicant was physically assaulted on February 11, 1991. As a result of this unprovoked attack, she sustained injuries to her to the left side of her face and neck. She was treated at the emergency room at Kaiser Permanente, her private carrier. At that time she received stitches for a facial laceration. Three weeks following her emergency room visit, applicant returned to Kaiser Permanente to have her stitches removed. These two visits were the only times applicant sought treatment from her private carrier.

Following the emergency room visit, applicant sought treatment from Dr. Jolley, chiropractor, who had treated her prior to the assault. Applicant also treated with Dr. Green, chiropractor/naturopath, on referral from Dr. Jolley. Dr. Jolley and Dr. Green provided chiropractic and acupuncture treatment for cervical spine pain, spasms and left face numbness. Dr. Green also referred applicant for massage therapy. Applicant also received counseling therapy during this time period from Marsha Graham, L.C.S.W.

On May 21, 1991, the Department issued an order that found that claimant was the victim of a compensable crime and awarded compensation for loss of earnings and compensation for hospital, medical and counseling expenses directly related to the crime. Applicant requested reconsideration of that portion of the order which declined to provide compensation for chiropractic treatment and massage therapy. On June 5, 1991, the Department issued a order on reconsideration that declined to grant compensation for chiropractic treatment and massage therapy on the basis that claimant's private carrier would have paid for these expenses had it referred applicant to a physician for these treatments.

CONCLUSIONS OF LAW AND OPINION

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 147.155(5), no evidence is admissible at a hearing before the Board that has not previously been considered by the Department. However, the Board is also empowered to conduct proceedings in any manner that will achieve substantial justice. Lynda J. Dean, 39 Van Natta 328 (1987).

The Department rejected applicant's request for payment of chiropractic treatment and massage therapy on the basis that the services were neither provided by, nor referred out by, her private carrier. Applicant's letter asking for review of the Department's order indicates that her private carrier neither provides the kind of services in question, nor does its emergency room physicians make referrals for further treatment. The current record contains two emergency room reports from claimant's private carrier, but does not contain evidence concerning her private carrier's method of referral, if any, for treatment it does not provide.

We consider evidence regarding the availability of chiropractic and massage services through applicant's private carrier, as well as the carrier's referral policy, to be vital to a determination of whether the claim for the treatments should be paid. Under these circumstances, we conclude that substantial justice would best be served by consideration of evidence concerning whether chiropractic treatments and massage therapy were available through applicant's private carrier during the period in question and, whether the applicant's private carrier had a referral policy for treatment it does not provide.

Accordingly, this matter is remanded to the Department of Justice Crime Victims' Compensation Fund for further development of the record consistent with this order. Once the record has been sufficiently developed concerning the

issues addressed in this order, the Department shall proceed with its reconsideration and issue an Order on Reconsideration.

IT IS SO ORDERED.

December 30, 1991

Cite as 43 Van Natta 2796 (1991)

In the Matter of the Compensation of
CHARLES S. BUTTS, Claimant
WCB Case Nos. 90-20990 & 90-20991
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerland and Gunn.

The SAIF Corporation requests review of those portions of Referee Daron's order that: (1) directed it to pay temporary disability pursuant to an earlier referee's order; and (2) assessed penalties and attorney fees for an allegedly unreasonable failure to pay the aforementioned benefits pending Board review of the earlier referee's order. On review, SAIF contends that, since it requested Board review of the earlier referee's order after amended ORS 656.313 became effective, it was not required to pay a portion of the aforementioned temporary disability benefits pending review. We reverse.

FINDINGS OF FACT

On February 13, 1987, claimant sustained a compensable injury to his right arm. On April 16, 1987, claimant sustained a compensable injury to his rib cage, mid and upper back on the right side. The April 16, 1987 claim was first closed by a July 30, 1987 Determination Order. The February 13, 1987 claim was first closed by a July 30, 1987 Determination Order.

Claimant's February 13, 1987 claim was subsequently reopened and thereafter closed by a November 30, 1989 Determination Order. In March 1990, claimant requested a hearing contending that the November 1989 Determination Order prematurely closed his claim or alternatively that he had sustained an aggravation. The hearing was convened and continued prior to July 1, 1990. Also prior to July 1, 1990, claimant requested a hearing contending that he had sustained an aggravation of his April 16, 1987 compensable injury. However, this request for hearing was not convened and continued prior to July 1, 1990.

Claimant's hearing requests were consolidated and on July 24, 1990, a hearing was held before an earlier referee. Thereafter, the earlier referee ordered that for claims processing purposes, claimant's April 16, 1987 injury claim was to be merged with his February 13, 1987 claim with February 13, 1987 designated as the date of injury. The referee also ordered that the November 30, 1989 Determination Order be set aside and that the claim be remanded to SAIF for continuing payments of time loss benefits until closure. SAIF appealed the earlier referee's order.

SAIF paid time loss benefits from November 30, 1988 through March 7, 1990. Following the earlier referee's August 17, 1990 order, SAIF resumed paying time loss benefits. SAIF did not retroactively pay time loss benefits for the time period from March 7, 1990 through August 17, 1990. SAIF did not pay time loss benefits from March 7, 1990 through August 17, 1990 pursuant to the July 1990 amendments to ORS 656.313.

In November 1990, claimant requested a hearing concerning SAIF's failure to pay time loss benefits from March 7, 1990 through August 17, 1990. A hearing was held in this matter on January 29, 1991.

On April 30, 1991, the Board affirmed the relevant portions of the earlier Referee's order. See Charles S. Butts, 43 Van Natta 1014 (1991).

CONCLUSIONS OF LAW AND OPINION

Prior to July 1, 1990, ORS 656.313 provided that "[f]iling by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant." The legislature, however, amended ORS 656.313 effective July 1, 1990. As amended, ORS 656.313 states that the filing of such a request or appeal stays the payment of compensation appealed except for: (1) temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs; and (2) permanent total disability benefits that accrue from the date of the order appealed from until the order appealed from is reversed. ORS 656.313(1)(a), (A), (B).

Relying on Section 54(2) of Oregon Laws 1990 (Special Session), the Referee concluded that former ORS 656.313 was applicable since claimant's hearing request which resulted in the earlier referee's August 17, 1990 order was filed before May 1, 1990 and the hearing was convened before July 1, 1990. We disagree.

The claims processing matter of SAIF's failure to pay compensation awarded by the earlier referee's order and claimant's objections to SAIF's conduct, were a separate claims processing matter that did not arise until after the earlier referee's order. See Raymond J. Seebach, 43 Van Natta 2687 (1991). Inasmuch as claimant's hearing request regarding this procedural claims processing matter was not filed before May 1, 1990 and hearing regarding this matter was not convened prior to July 1, 1990, the matter involved here was not "in litigation for the purposes of section 54(2). Id. Therefore, amended ORS 656.313 applies to this case. Id.

Consequently, SAIF was entitled to stay payment of the compensation awarded by the earlier referee's order which was payable from March 7, 1990 through August 16, 1990, the day before the earlier August 17, 1990 order. ORS 656.313(1)(a)(A).

Accordingly, we reverse that portion of the Referee's order which held that SAIF was obligated to pay claimant's temporary disability compensation for the period of March 7, 1990 through August 16, 1990 pending Board review of the earlier referee's August 17, 1990 order. Furthermore, since we have concluded that SAIF was entitled to stay payment of the aforementioned compensation, it follows that the SAIF's failure to pay these benefits was not unreasonable. Therefore, we also reverse the Referee's assessment of a penalty and related attorney fee for unreasonable conduct based upon this stayed compensation.

ORDER

The Referee's order dated March 7, 1991 is reversed.

Board Member Gunn specially concurring.

The result reached in this case is correct under Raymond J. Seebach, 43 Van Natta 2687 (1991), which I feel constrained to follow under the principle of stare decisis. I write only to reiterate the points raised by the dissent in Seebach.

In the Matter of the Compensation of
ROBIN A. COLLINS, Claimant
WCB Case No. 90-18746
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Davis' order that awarded an assessed attorney fee pursuant to ORS 656.382(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF had unreasonably resisted payment of temporary disability compensation. On that basis, he awarded: (1) claimant a penalty of 25 percent of the amount of temporary disability compensation awarded by his order; and (2) claimant's attorney an assessed fee of \$400 pursuant to ORS 656.382(1).

SAIF contends that claimant's attorney was not entitled to an assessed fee pursuant to ORS 656.382(1). Instead, SAIF argues that, pursuant to ORS 656.262(10), claimant's attorney was entitled to one-half of the penalty awarded to claimant, in lieu of an attorney fee. We agree.

Claimant argues that ORS 656.262(10) applies only when the Director has exclusive jurisdiction. She notes that the issue at hearing was not solely limited to penalties and attorney fees under ORS 656.262(10). Thus, she argues, the Director did not have exclusive jurisdiction and the one-half penalty attorney fee provision does not govern this case. Although we agree that the Director did not have exclusive jurisdiction over this case, we disagree that, as a result, ORS 656.262(10) does not apply.

Claimant ignores ORS 656.262(10)(b) which provides that "[w]hen the director does not have exclusive jurisdiction over proceedings regarding the assessment and payment of the additional amount described in this subsection, the provision for attorney fees provided in this subsection shall apply in the other proceeding." ORS 656.262(10) deals with, inter alia, additional amounts in the form of penalties relating to an insurer's unreasonable delay or unreasonable refusal to pay compensation. The hearing dealt with the issue of SAIF's unreasonable resistance to payment of temporary disability compensation. Thus, ORS 656.262(10)(b) applies to this case.

Here, the factual basis supporting the ORS 656.382(1) fee -- SAIF's unreasonable resistance to payment of temporary disability compensation -- is identical to the factual basis for which a penalty is assessable under ORS 656.262(10)(a) and (b). Moreover, there are amounts "then due" on which to assess a penalty under ORS 656.262(10). Under these circumstances, the simultaneous assessment of an attorney fee under ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10)(a) and (b) that claimant's attorney receive one-half the penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991). Accordingly, pursuant to ORS 656.262(10)(b), one-half of the 25 percent

penalty awarded by the Referee shall be paid to claimant's attorney, in lieu of an attorney fee.

ORDER

The Referee's order dated April 16, 1991 is reversed in part and affirmed in part. That portion of the order that assessed a separate attorney fee of \$400 is reversed. In lieu of an attorney fee, claimant's attorney shall receive one-half of the penalty of 25 percent of the amount of temporary disability compensation awarded by the Referee. The remainder of the Referee's order is affirmed.

December 30, 1991

Cite as 43 Van Natta 2799 (1991)

In the Matter of the Compensation of
DENNIS E. CONNOR, Claimant
WCB Case No. 90-19315
ORDER ON REVIEW
Brother, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Myzak's order that increased claimant's unscheduled permanent disability award for a shoulder injury from 10 percent (32 degrees), as awarded by a Determination Order, to 17 percent (54.4 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Relying on amended ORS 656.245(3)(b)(B), the Referee found that claimant was not entitled to any rating for loss of range of motion in his cervical spine, lumbar spine or right shoulder because claimant's attending physician at the time of claim closure did not make, adopt or concur in any range of motion findings. We agree.

ORS 656.245(3)(b)(B) provides, in pertinent part, that "[e]xcept as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." Thus, the clear language of the statute as applied to the present case means that, although the disability is rated at the time of hearing, the attending physician at the time of claim closure provides the findings regarding the worker's impairment.

Here, Dr. Altrocchi resumed his status as claimant's treating neurologist on August 10, 1990. (Ex. 107). Around that date, claimant moved to Montana, and Dr. Altrocchi authorized chiropractic treatment in Montana once a week for the next two months. (Ex. 108-1). On August 17, 1990, Dr. Buzan, a Montana chiropractor, first treated claimant. (Ex. 111). There is no evidence in the record of medical treatment after that date. By January 7, 1991, claimant had returned to Oregon, and on that date he underwent a physical capacity evaluation at the St. Charles Medical Center. (Ex. 115). This evaluation was conducted by physical therapists.

On these facts, we find that Dr. Altrocchi was claimant's attending physician at the time of claim closure. As a chiropractor, Dr. Buzan was not eligible to be the attending physician on October 29, 1990, the date of claim closure. See ORS 656.005(12)(b)(B). Furthermore, Dr. Buzan was providing chiropractic services under the authorization of Dr. Altrocchi.

On August 10, 1990, Dr. Altrocchi noted that claimant had "decreased side-bending to the right" in his lumbar spine. (Ex. 108-1). However, Altrocchi provides no ratable range of motion measurements for the lumbar spine, cervical spine or right shoulder. Furthermore, although Altrocchi adamantly disputes the Western Medical Consultants' findings of marked pain behavior, he does not adopt their range of motion measurements. (Id.)

Claimant argues that he is entitled to an impairment value based on the loss of range of motion measured by Exhibit 115, a physical therapist's report. However, even under the law prior to the 1990 amendments, Exhibit 115 would not support an impairment rating. Under former OAR 436-35-005(1), "'Impairment' means a decrease in the function of a body part or system as measured by a physician...." Therefore, the physical therapist's measurements may not be used to assign impairment values under the standards. Linda F. Wright, 42 Van Natta 2570 (1990). Although the findings of a physical therapist may be used in rating impairment where the treating physician has reviewed and ratified the findings, no such review and ratification occurred in this case. Don O. Adams, 43 Van Natta 972 (1991).

Thus, because the attending physician at the time of claim closure did not make or ratify any measurements of loss of range of motion, we find that claimant has not proved any loss of range of motion. Accordingly, we affirm the Referee's award of 17 percent unscheduled permanent disability.

ORDER

The Referee's order dated February 25, 1991 is affirmed.

December 30, 1991

Cite as 43 Van Natta 2800 (1991)

In the Matter of the Compensation of
KELLY R. EISENBERG, Claimant
WCB Case No. 90-13779
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Quillinan's order that dismissed his request for hearing on the basis that the Hearings Division lacked jurisdiction over this matter. On review, the issue is jurisdiction.

We affirm and adopt the Referee's order with the following supplementation.

Claimant contends that the Referee erred in concluding that she lacked jurisdiction over the issue of whether claimant had exceeded the number of attending physicians he was allowed by choice. We disagree.

Subsequent to the Referee's order, we issued our decision in Tracy Johnson, 43 Van Natta 2546 (1991). In Johnson, we held that the Hearings Division lacks jurisdiction to review the Director's refusal to authorize a claimant's request for an additional change of attending physician. See also Gary L. Waldrup, 43 Van Natta 2705 (1991). Accordingly, the Referee lacked jurisdiction over the issue of whether claimant had exceeded the number of physicians allowed by choice.

The Hearings Division also lacked jurisdiction over the issue of medical billings related to Dr. Trew's treatment and the attendant penalty. Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Here, the employer's denial of pain center treatment and medical billings relating to Dr. Trew's treatment are based on its contention that the medical services are in violation of the Director's rule regarding the change of attending physician. See OAR 436-10-060. Original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. See Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. Id.; Waldrup, supra.

ORDER

The Referee's order dated November 19, 1990 is affirmed.

Board Member Gunn specially concurring.

The result reached in this case is correct under Tracy Johnson, 43 Van Natta 2546 (1991), which I feel constrained to follow under the principle of stare decisis. I write only to reiterate the points raised by the dissent in Johnson.

December 30, 1991

Cite as 43 Van Natta 2801 (1991)

In the Matter of the Compensation of
EDWARD D. LUCAS, Claimant
WCB Case No. 85-08631
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Charles Lisle (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Lucas v. Clark, 106 Or App 687 (1991); rev den 312 Or 150 (1991). In our prior order, Edward D. Lucas, 41 Van Natta 2271 (1989), we upheld the SAIF Corporation's denial of claimant's aggravation claim for a mid back condition. In doing so, we found that the parties, in their August 1984 stipulated order, contemplated future periods of increased mid back symptoms. Finding that the additional diminished earning capacity that claimant experienced as a result of his 1985 mid back exacerbation did not exceed that contemplated by the August 1984 stipulation, we concluded that claimant had not proven a compensable

aggravation. The court reversed. Reasoning that there was no substantial evidence to support our finding that the parties contemplated future flare-ups of claimant's back condition in their August 1984 stipulation, the court remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" set forth in our prior order.

ULTIMATE FINDINGS OF FACT

We adopt paragraphs one and three of the "Ultimate Findings of Fact" contained in our prior order. We add the following supplementation. In 1985 claimant suffered a symptomatic exacerbation, rather than a pathological exacerbation, of his mid back condition. That mid back exacerbation rendered him less able to work than at the time of the August 1984 stipulated order. That stipulation did not contemplate future periods of waxing and waning mid back symptoms resulting in periods of temporary total disability.

CONCLUSIONS OF LAW AND OPINION

Under former ORS 656.273(1), claimant must prove by a preponderance of the evidence that since the last arrangement of compensation: (1) he has suffered a symptomatic or pathologic worsening resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if a worsening involves a symptomatic exacerbation, and if the prior award contemplated symptomatic exacerbations, claimant must also prove that his increased symptoms lasted longer or were greater in degree than was anticipated; or claimant may show that his worsened condition resulted in 14 consecutive days of total disability or inpatient hospitalization. Former ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989); Gwynn v. SAIF, 304 Or 345 (1987); Smith v. SAIF, 302 Or 396 (1986).

We concluded in our prior order that claimant had sustained a symptomatic worsening of his mid back condition. We based our conclusion on claimant's testimony as well as the medical evidence from Dr. Saez that claimant sustained a symptomatic worsening of his mid back condition. We adhere to that holding.

We also adhere to our determination that claimant's symptomatic exacerbation resulted in diminished earning capacity. At the time of the August 1984 stipulation claimant was capable of light and sedentary work. By the time claimant suffered his exacerbation of symptoms, he was totally disabled. In February 1985, Dr. Hulse noted that claimant's condition had worsened and he was temporarily disabled. Dr. Saez also opined that claimant's exacerbated symptoms in 1985 rendered him unable to work. Such circumstances establish that claimant's exacerbation resulted in diminished earning capacity.

We previously concluded that the August 1984 stipulated order contemplated future periods of waxing and waning of claimant's mid back condition resulting in diminished earning capacity. The court reversed our order reasoning that although several flare-ups had occurred before the August 1984 stipulated order was entered, the stipulation made no reference to the prognosis for claimant's back condition and made no additional award for claimant's back condition. The court further noted that until 1985, after the parties had entered into the stipulation, no medical evidence predicted the likelihood of future flare-ups of the back condition.

In light of the court's holding, we conclude that the August 1984 stipulation did not contemplate future periods of increased symptoms accompanied by

diminished earning capacity. Inasmuch as claimant has suffered a symptomatic exacerbation which resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation and since future exacerbations were not contemplated, claimant has proven a compensable aggravation of his mid back condition. See David A. Buswell, 42 Van Natta 123 (1990); Louise A. Duchene, 41 Van Natta 2272 (1989).

When a claimant finally prevails with respect to a claim or award for compensation after remand from the court, the Board shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1); Cleo I. Beswick, 43 Van Natta 1314 (1991). This matter has been before the appellate courts on two separate occasions, each time resulting in remands to the Board. No additional services by claimant's attorney have been rendered before the Board on remand. Since claimant's counsel provided services before the Referee, the Board on review of the Referee's order and the appellate courts (two appeals to the court and a response to SAIF's petition for Supreme Court review), a reasonable attorney fee for such efforts shall be awarded. ORS 656.388(1).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services before all forums concerning the aggravation issue is \$8,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts may go uncompensated.

ORDER

The Referee's order dated December 3, 1986 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services before all prior forums concerning the aggravation issue, claimant's attorney is awarded a reasonable assessed fee of \$8,000, payable by SAIF.

December 30, 1991

Cite as 43 Van Natta 2803 (1991)

In the Matter of the Compensation of
JAMES B. PALMER, Claimant
WCB Case No. 90-08007
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of those portions of Referee Mills' order that: (1) found that the Hearings Division had jurisdiction over the issue of claimant's change of attending physician; (2) set aside its "partial denial" of claimant's request for a change of attending physician; (3) set aside its "de facto" denial of claimant's claim for pain center treatment; (4) directed the employer to pay medical billings related to Dr. Kuller's treatment; (5) assessed a penalty for an allegedly unreasonable failure to pay medical billings; (6) found claimant was entitled to interim compensation; and (7) assessed a penalty for an allegedly unreasonable failure to pay interim compensation. On review, the issues are jurisdiction, change of attending physician, medical services, penalties and interim compensation. We reverse in part and vacate in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to his left shoulder in July 1984. He sought treatment for this injury from Dr. Balme, orthopedist. Dr. Balme referred claimant to various other physicians including two neurologists, Dr. Klump and Dr. Hartmann. Dr. Balme also referred claimant to Dr. Tuttle, a surgeon, who performed a rib resection in 1985.

In 1986, claimant came under the care of the Medford Orthopedic Group. He initially treated with Dr. Matthews, but also received treatment from Drs. Chamberlain and James. Claimant was also referred to Dr. Grant. In April 1987, claimant's claim was closed by a Determination Order that awarded 15 percent unscheduled disability as well as 10 percent scheduled disability for the left arm. Following claim closure, claimant continued to treat with Drs. Chamberlain and James. In November 1987, claimant received an additional 10 percent unscheduled disability by stipulation.

In early 1988, claimant began treating with Dr. Colville who recommended an arthroscopic procedure. In February 1988, Dr. Colville performed a left shoulder arthroscopic procedure. Following the surgery, claimant continued to treat with Dr. Colville. Claimant's claim was closed by a September 18, 1989 Determination Order which awarded an additional 7 percent scheduled permanent disability. Thereafter, on March 13, 1990, claimant received an additional 5 percent unscheduled permanent disability by stipulation.

In December 1989, claimant began treating with Dr. Kuller. Dr. Kuller requested authorization for claimant to participate in pain center treatment. In a letter to the employer dated April 2, 1990, Dr. Kuller reported that claimant had been taken off work due to a worsening of his industrial syndrome. In a letter dated April 5, 1990, the employer notified claimant that it refused to recognize Dr. Kuller as his attending physician on the basis that he had exceeded his number of choices of treating physician. The letter explained that claimant could continue to treat with Dr. Colville and that claimant needed to seek approval of the Director if he wished to change attending physicians.

On April 12, 1990, claimant requested a hearing raising issues related to the employer's refusal to recognize Dr. Kuller as his attending physician. On April 20, 1990, claimant requested the Director to approve his change of attending physician. In a letter dated August 22, 1990, a representative of the Director refused to authorize the requested change.

A hearing was convened on September 27, 1990. The Referee issued an order that set aside the employer's "de facto" denial of the status of Dr. Kuller as claimant's treating physician. The order further set aside "de facto" denials relating to pain center treatment and directed the employer to pay certain medical billings related to Dr. Kuller's treatment as well. Finally, the order found that claimant was entitled to interim compensation and assessed penalties for unreasonable failure to pay medical billings and interim compensation.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

On May 7, 1990, the Oregon Legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Law. Oregon Laws 1990 (Special Session), ch. 2. Because a hearing was convened after July 1, 1990, this matter is properly analyzed under those revisions. Oregon Laws 1990 (Special Session), ch. 2, 54; Ida M. Walker, 43 Van Natta 1402 (1991).

At the outset, we note that the majority of the issues in this matter relate to whether Dr. Kuller is appropriately claimant's treating physician. In

this regard, the employer's denial of pain center treatment, medical billings and penalties relating to failure to pay medical billings are premised on its contention that claimant was not allowed to choose Dr. Kuller as an attending physician. Accordingly, the resolution of these issues is dependent on whether or not the Hearings Division had jurisdiction.

Subsequent to the Referee's order, we issued our decision in Tracy Johnson, 43 Van Natta 2546 (1991). In Johnson, we held that the Hearings Division lacks jurisdiction to review the Director's refusal to authorize a claimant's request for an additional change of attending physician. See also Gary L. Waldrup, 43 Van Natta 2705 (1991). Accordingly, the Referee lacked jurisdiction over the issue of whether claimant had exceeded the number of physicians allowed by choice. Therefore, we vacate the Referee's order and dismiss claimant's hearing request with regard to this issue.

The Referee also lacked jurisdiction over the issues of pain center treatment, medical billings related to Dr. Kuller's treatment and the attendant penalty. Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Here, the employer's denial of pain center treatment and medical billings relating to Dr. Kuller's treatment are based on its contention that the medical services are in violation of the Director's rule regarding the change of attending physician. See OAR 436-10-060. Original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. See Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. Id.; Waldrup, supra.

Accordingly, we vacate the Referee's order and dismiss claimant's hearing request with regard to the issues of pain center treatment, medical billings relating to Dr. Kuller's treatment and penalties for failure to pay medical billings. We also vacate the Referee's attorney fee award for prevailing against the aforementioned denials. Meyers, supra.

Interim Compensation

The Referee concluded that claimant was entitled to interim compensation. We disagree.

A carrier must begin paying interim compensation no later than the 14th day after it receives medical verification of an inability to work as documented in a medical report which constitutes prima facie evidence of a compensable worsening under ORS 656.273(1) or (8). ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991).

Here, Dr. Kuller's April 2, 1990 report indicates that claimant was released from work due to a worsening of his industrial syndrome. However, the report contains no objective findings that claimant's condition had worsened from a medical standpoint as required by ORS 656.273(1). Further, the report does not indicate whether the worsening is more than a contemplated waxing and waning of symptoms which is necessary as claimant has previously been awarded permanent disability. See ORS 656.273(8). Under these circumstances, we conclude that Dr. Kuller's report was not sufficient to trigger the employer's duty

to pay interim compensation. Accordingly, claimant is not entitled to interim compensation.

Inasmuch as we have found that the employer was not obligated to pay interim compensation, its failure to do so was not unreasonable. Accordingly, we also reverse the Referee's award of a penalty for failure to pay interim compensation.

ORDER

The Referee's order dated November 26, 1990 is reversed in part, affirmed in part and vacated in part. That portion which awarded claimant interim compensation is reversed. That portion which awarded a penalty for failure to pay interim compensation is reversed. That portion which found that claimant had not sustained an aggravation is affirmed. The remainder of the order is vacated.

December 30, 1991

Cite as 43 Van Natta 2806 (1991)

In the Matter of the Compensation of

CHARLES T. VANDUNK, Claimant

WCB Case No. 90-09935

ORDER ON REVIEW

Michael B. Dye, Claimant Attorney

Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Garaventa's order which set aside its denial of compensability of claimant's medical services claim for his low back condition. On review, the issue is jurisdiction and compensability. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back in 1985. He treated with P. Ron Romanich, D.C., who diagnosed low back strain/sprain. The claim was closed on January 6, 1987 by a Determination Order with an award of 30 percent (96 degrees) unscheduled permanent partial disability. The award was increased to 40 percent (128 degrees) unscheduled permanent partial disability by a Stipulated Order dated April 13, 1987.

Between March 3, 1988 and May 1, 1988, claimant was treated by Dr. Romanich two to three times per week for pain resulting from the compensable injury. There was no specific triggering incident and the treatment was palliative in nature. After May 1988, claimant received no medical treatment for low back pain until October 5 and 7, 1989, when he saw Dr. Charles, M.D., and visited a hospital emergency room, respectively. In both cases, claimant reported lifting a lawn mower onto a friend's truck and feeling low back pain the next morning. The treatment claimant received was palliative in nature.

By letter dated April 2, 1990, the insurer notified claimant that with respect to the two medical treatments in October 1989, it denied claimant's aggravation claim on the ground that claimant's current condition was not, in any way, related to claimant's 1985 compensable injury. On May 8, 1990, claimant filed a request for hearing. At the hearing, which convened on April 2, 1991, claimant stated in clarification of his hearing request, that the aggravation claim was withdrawn, and a hearing was requested only on that portion of the denial which denied compensability under ORS 656.245 of the two medical treatments in October 1989.

ULTIMATE FINDINGS OF FACT

The disputed medical services were materially related to claimant's 1985 compensable injury.

CONCLUSIONS OF LAW AND OPINIONJurisdiction

On May 7, 1990, the Oregon Legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Law. Or Laws 1990 (Special Session), ch. 2. As amended, ORS 656.245(1) no longer provides, as it did at the time of claimant's injury, for purely palliative medical services for compensable injuries. Under ORS 656.245(1), as amended, palliative care is not compensable, except under conditions that are not presented here. Furthermore, if the worker's attending physician believes that palliative care would nonetheless be appropriate to enable the worker to continue employment, the physician must request insurer approval of the treatment before the treatment is rendered. If approval is not granted, the attending physician may request review of the matter by the Director.

A threshold question not raised by either party is whether ORS 656.245(1) as amended, applies retroactively to the palliative care claimant received before the effective date of the Act. In Ida M. Walker, 43 Van Natta 1402 (1991), we declined to apply the Act retroactively to palliative care treatments rendered before the Act's passage. We said:

"The provision here at issue, amended ORS 656.245(1) requires an attending physician to request approval for palliative care before such services are rendered to a worker who, like claimant, is medically stationary and is not otherwise entitled to full lifetime medical benefits. If applied retroactively in this case, that procedure would disallow the services claimant received before the effective date of the Act unless her physician had performed the impossible and complied with a law not yet in existence. . . .

"Accordingly, we conclude that, notwithstanding Section 54, the legislature, in limiting a claimant's entitlement to palliative care, did not intend to deny the compensability of medical services which would have otherwise been compensable at the time they were rendered." Id at 1406-07.

The same reasoning applies to the present case. Therefore, amended ORS 656.245(1) does not apply to the medical services claimant received in October 1989. Ida M. Walker, supra.

Medical Services

Under former ORS 656.245(1), claimant is entitled to medical services, including those rendered for purely palliative purposes, "for such period as the nature of the injury or the process of recovery requires." Wait v. Montgomery Ward, Inc., 10 Or App 333 (1972). To establish the compensability of medical treatment for the low back condition, claimant must prove by a preponderance of the evidence that her compensable injury was a material contributing cause of his need for medical treatment in October 1989. Jordan v. SAIF, 81 Or App 29 (1987).

The Referee concluded that although the medical evidence on causation was sparse, claimant carried his burden of proof by a preponderance of the evidence. We agree.

Claimant's award of 40 percent unscheduled permanent disability establishes as a matter of law, that rather than fully recovering from the low back injury, claimant suffered substantial permanent impairment. Dr. Romanich predicted that claimant would experience low back pain from time to time as a result of normal life activities, and as an expected residual of his 1985 compensable injury. Further, Dr. Romanich opined that the compensable injury remained the major contributing cause of claimant's condition. Dr. Romanich treated claimant after the 1985 compensable injury. Of the medical reports in this sparse record, his is the most informed about the nature and effect of claimant's compensable injury. We find his opinion the most persuasive.

We conclude that claimant did not suffer a new injury when he lifted the lawn mower and his preexisting condition became painful the next morning. At most, the lifting incident made his compensable condition symptomatic. See Donald J. Taylor v. Multnomah County School District No. 1, 109 Or App 499 (1991). Therefore, claimant's compensable injury was a material contributing cause of his need for medical treatment in October 1989.

The insurer requested review and claimant's compensation has not been disallowed or reduced. Therefore, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$650, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services submitted by claimant's counsel), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 12, 1991 is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed attorney fee of \$650, payable by the insurer.

December 30, 1991

Cite as 43 Van Natta 2808 (1991)

In the Matter of the Compensation of
LORNA J. WRIGHT, Claimant
WCB Case No. 90-19001
ORDER ON REVIEW
William H. Skalak, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Fink's order that: (1) increased claimant's scheduled permanent disability for the loss of use or function of her right forearm (wrist) from 10 percent (15 degrees), as awarded by the Determination Order, to 30 percent (45 degrees); and (2) increased claimant's scheduled permanent disability for loss of use or function of her left forearm (wrist) from 7 percent (10.5 degrees), as awarded by the Determination Order, to 22 percent (33 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

Any loss of grip strength in claimant's right and left forearm (wrist) is not due to nerve damage, atrophy or other anatomical changes.

Claimant experiences aching, numbness and discomfort following repetitive use of her hands.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's total scheduled permanent disability from 10 percent to 30 percent in the right forearm (wrist) and from 7 percent to 22 percent for the left forearm (wrist). In making such a determination, the Referee included a loss of grip strength for each forearm.

On review, the insurer challenges only the Referee's assignment of impairment for loss of grip strength, arguing that claimant failed to establish by medical evidence that she has a ratable grip strength loss under the standards in effect at the time of the September 5, 1990 Determination Order. We agree.

Under those standards, loss of grip strength is ratable only when it is due to nerve damage, atrophy or other anatomical changes. See former OAR 436-35-110(3)(a) and (d). Decreased grip strength caused by amputation or by loss of range of motion in the joints of the hands or fingers receives no rating in addition to that given for the amputation or for the loss of range of motion itself. Former OAR 436-35-110(3)(b) and (c).

In this case, the Referee rated claimant's loss of grip strength under former OAR 436-35-110(3)(d), which provides a rating when loss of grip strength is due to atrophy or other anatomical changes. On review, claimant contends that the Referee used the correct standard because her compensable injuries necessitated carpal tunnel surgeries on both wrists which in turn caused anatomical changes and resulted in her loss of grip strength.

In support of this contention, claimant relies on Dr. Nye's description of claimant's carpal tunnel surgical procedure that he performed in 1990. (Ex. 5). She argues that the procedure in itself created anatomical changes that resulted in her grip strength loss. We do not agree. Claimant's carpal tunnel surgeries are not ratable under former OAR 436-35-001 et seq. Clark D. Griffith, 42 Van Natta 1112 (1990). Moreover, the record is devoid of an expert medical opinion which establishes that claimant's loss of grip strength is due to nerve damage, atrophy or other anatomical changes.

Dr. Nye's description does not attribute claimant's grip strength loss to anatomical changes created by the surgeries, nor does any other medical expert. The only medical evidence in the record establishing the cause of claimant's loss of grip strength is the May 11, 1990 report by the Western Medical Consultants, which both parties stipulated to at hearing as claimant's current condition. (Tr. 1-2).

That report states, "It appears that [claimant] is medically stationary. The permanent impairment as it exists at the time of the examination appears to be related to the limitation of the wrist motion." (Ex. 22-3). The report also indicates that claimant experiences aching, numbness and discomfort following repetitive use of her hands and wrists. (Ex. 22-2). Claimant's treating physician, Dr. Layman, subsequently concurred with these conclusions. (Ex. 23). While under these circumstances, the record does establish that claimant is entitled to a 5 percent rating for loss of repetitive use for each forearm (wrist), it does not support an award for loss of grip strength under the standards. See former OAR 436-35-110(3)(a)-(d); Markus M. Tipler, 43 Van Natta 1968 (1991); Martha L. Brunner, 42 Van Natta 2587 (1990).

With the elimination of the grip strength awards, claimant's impairment consists of the range of motion losses and the chronic condition. These values

total 10 percent for the right forearm (wrist) and 7 percent for the left forearm (wrist). Consequently we reverse the Referee's awards and reinstate the Determination Order awards.

ORDER

The Referee's order dated February 7, 1991 is reversed. The Determination Order awards of 10 percent (15 degrees) scheduled permanent disability for the right forearm (wrist) and 7 percent (10.5 degrees) for the left forearm (wrist) are reinstated and affirmed.

December 31, 1991

Cite as 43 Van Natta 2810 (1991)

In the Matter of the Compensation of
RODNEY E. ANGERBAUER, Claimant
WCB Case No. C1-02715
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Emmons, Kropp, et al., Claimant Attorneys

Reviewed by Board Members Neidig and Gunn.

On December 17, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

ORS 656.236(1) permits parties, by agreement, to make "such disposition of any or all matter regarding a claim, except for medical services, as the parties consider reasonable," subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except medical services, in an accepted claim." OAR 436-60-005(9); see also OAR 438-09-001. The underscored portion of the rule makes it clear that only rights and/or obligations under ORS Chapter 656 may be released by a claim disposition agreement. See Karen A. Vearrier, 42 Van Natta 2071 (1990).

Here, the proposed disposition releases rights and obligations relative to claimant's compensable injury, but it also purports to provide that the insurer shall deduct the current balance owing to the Salem Support Enforcement Division (SED) under the Department of Justice by the claimant, as of the date the Claim Disposition Agreement is signed. Further, the agreement does not identify the amount of the above-stated balance owed to SED. The latter portion could reasonably be interpreted as concerning matters outside of Chapter 656 and therefore is not appropriate for disposition under ORS 656.236 and the rules promulgated thereunder. For this reason, the proposed disposition is not a "claims disposition agreement" as defined by OAR 438-09-001(1). Darilyn Daugherty, 43 Van Natta 262 (1991).

Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of

JUAN F. CARRIZALES, Claimant

WCB Case No. 90-08905

ORDER ON REVIEW

Karen M. Werner, Claimant Attorney

Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Gunn and Moller.

Claimant requests review of Referee T. Laverne Johnson's order which: (1) found that claimant had not perfected an aggravation claim prior to the expiration of claimant's aggravation rights; (2) declined to award temporary disability; and (3) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. We reverse in part and affirm in part.

FINDINGS OF FACTS

We adopt the Referee's "Findings of Facts."

CONCLUSION OF LAW AND OPINION

The Referee concluded that claimant established a worsening of his right shoulder, right arm and neck condition but did not perfect an aggravation claim until after his aggravation rights had expired. We disagree.

Aggravation rights

Claimant requested a hearing before May 1, 1990, but the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Oregon Laws 1990 (Special Session), Chapter 2, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Claimant, while working as a face layer, compensably injured his right shoulder and right arm on November 22, 1983. (Ex. 1). He returned to work as a core feeder (light duty job) approximately 3 to 4 weeks after the injury. (Tr. 4). He had minor complaints related to his neck area. Claimant was treated for a musculoligamentous strain of the right scapular. (Ex. 1A-2). Claimant's claim was closed on March 14, 1984 by a Determination Order. (Ex. 4). No permanent disability was awarded.

Claimant received no medical treatment for his compensable condition from October 10, 1984 to February 23, 1989 during which time he was working as a core feeder. (Exs. 1A-3, 6-1). On February 23, 1989, claimant began seeing Dr. Ellison, an orthopedist, complaining of right shoulder, neck and arm pain. (Exs. 5, 6-1). Dr. Ellison diagnosed right upper extremity pain syndrome and ordered tests to rule out carpal tunnel syndrome; cervical lesion at C5-6, C6-7; and mechanical myofascial injury. (Ex. 5).

Claimant underwent an MRI of his cervical spine on March 3, 1989. (Ex. 7). The MRI revealed a central disc herniation at C5-6.

The SAIF Corporation knew of the above-stated facts by March 3, 1989. Claimant's aggravation rights expired March 14, 1989.

On August 9, 1989, the Workers' Compensation Board reopened claimant's November 1983 industrial injury claim, at SAIF's request, under its own motion authority. SAIF was ordered to pay claimant time loss benefits beginning July 7, 1989, and to continue paying such benefits until claimant returned to regular work at his regular wage or became medically stationary, whichever was earlier. At hearing, the parties stipulated that SAIF complied with this order.

A claim for aggravation must be filed within five years after the first determination or the first notice of closure. ORS 656.273. Claimant's claim was closed by Determination Order on March 14, 1984. Therefore, claimant's aggravation rights expired on March 14, 1989.

We disagree with the Referee that claimant has failed to timely make a claim for an aggravation under current ORS 656.273(3). That statute states:

"A physician's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation."

To establish an aggravation claim, "the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened." Glean A. Finley, 43 Van Natta 1442, 1444 (1991); Herman M. Carlson, 43 Van Natta 963, 964 (1991). This report must establish a causal connection between claimant's noted condition and compensable injury. Carlson, *supra*, at 964; Michael L. Page, 42 Van Natta 1690, 1693 (1990). The Referee concluded that prior to expiration of the five-year aggravation period, medical reports documented an objective worsening of claimant's condition. We agree. However, the Referee further concluded that medical reports establishing a causal relationship between claimant's worsened condition and his compensable injury were not made available to SAIF until after expiration of the aggravation period. We do not agree.

Dr. Ellison's February 23, 1989 report, which was received by SAIF on March 3, 1989, recounts the following:

"Original Symptoms/Causation/Date of Origin: The patient was injured because of the repetitive nature of his work activities at Simpson Timber Company in November 1983 as noted above. . . ."
(Ex. 6-1).

Dr. Ellison further reports: "At the present time the patient continues to have intermittent pain in the right shoulder area, right paracervical region, and in the right upper extremity. . . ." (Ex. 6-1; emphasis supplied.)

Taken as a whole, Dr. Ellison's report is a valid claim for aggravation. While Dr. Ellison suggests several possible diagnoses in his report (carpal tunnel syndrome, a cervical lesion, a mechanical myofascial injury) for the 1989 condition, the most reasonable interpretation is that he is uncertain what claimant's condition was in 1983 and 1984; however, it is the same condition that claimant is experiencing in 1989, except that it has worsened.

We, therefore, conclude that SAIF had notice that claimant's worsened condition was related to his prior industrial injury on March 3, 1989. Accordingly, claimant perfected his aggravation claim before the five-year statutory bar.

Interim Compensation/Penalty and Attorney Fee

We adopt the Referee's Conclusion of Law and Opinion concerning these issues.

For prevailing on the issue of aggravation, claimant's counsel is entitled to an assessed attorney fee. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on Board review is \$2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's statement of services at hearing, and his briefs on review), the complexity of the issue and the value of the interest concerned.

ORDER

The Referee's order dated February 19, 1991 is reversed in part and affirmed in part. The Referee's conclusion that claimant failed to timely perfect his aggravation claim is reversed. The claim is remanded to the SAIF Corporation for processing according to law. For services at hearing and on review concerning the aggravation issue, claimant's counsel is awarded an assessed fee of \$2,000, to be paid by SAIF. The remainder of the order is affirmed.

December 31, 1991

Cite as 43 Van Natta 2813 (1991)

In the Matter of the Compensation of

JUAN A. GARCIA, Claimant

WCB Case No. 89-08301

ORDER ON REMAND

Michael B. Dye, Claimant Attorney

David R. Fowler (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Garcia v. SAIF, 108 Or App 653 (1991). The court has reversed our prior order, Juan A. Garcia, 42 Van Natta 2632, 2797 (1990), which held that, following a proceeding in which it was determined that no employment relationship existed between claimant and the "employer" on the date of injury, the SAIF Corporation could properly deny an injury claim that it had processed and accepted on behalf of the alleged noncomplying employer. The court concluded that SAIF could not deny a previously accepted claim on the basis of a lack of coverage. The court reversed and remanded this matter to us for consideration of penalties and attorney fees.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we concluded that, because SAIF was entitled to deny the claim and terminate temporary disability benefits, SAIF's conduct was not unreasonable. Additionally, we concluded that, even if SAIF's delay in processing claimant's claim was unreasonable, because we had found SAIF was entitled to terminate temporary disability benefits, there were no "amounts then due" on which to base a penalty. We further concluded that, because there was no unreasonable resistance to the payment of compensation, an attorney fee was not assessable.

The court held that SAIF accepted the claim without fulfilling its duty to investigate claimant's employment status and to join other potentially responsible employers or insurers. The court found that, having accepted the claim against the alleged noncomplying employer and advising claimant that he did not need to pursue his claims against the other potentially responsible entities,

SAIF could not deny the previously accepted claim on the basis of a lack of coverage. The court, therefore, "(r) evered and remanded to the Board for consideration of penalties and attorney fees." Garcia v. SAIF, supra at 658.

Former ORS 656.262(10) provides for an assessment of attorney fees and penalties against an employer for an "unreasonable refusal to pay compensation," and former ORS 656.382(1) requires an employer to pay an attorney fee if it "unreasonably resists the payment of compensation." The standard for determining an unreasonable denial is whether the employer had a legitimate doubt as to its liability for the payments. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the employer at that time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

The Referee found that SAIF had no basis for terminating claimant's temporary disability benefits. He concluded that SAIF unreasonably refused to pay and unreasonably resisted payment of temporary disability benefits. Accordingly, the Referee assessed penalties and attorney fees for SAIF's allegedly unreasonable conduct. We disagree.

We conclude that, at the time SAIF terminated claimant's temporary disability payments, it had a legitimate doubt as to its liability for claimant's injury claim. The employer had requested a hearing concerning a Proposed and Final Order which determined that it was a noncomplying employer. An earlier Referee subsequently found that no employment relationship existed between claimant and the "employer" on the date of injury, and the proposed order was set aside. Thereafter, SAIF terminated claimant's temporary disability payments on the ground that it did not provide coverage to the alleged noncomplying employer under ORS 656.054(1), because another employer had purchased the business and the alleged noncomplying employer no longer had control over operations or employees of the business.

We conclude that, notwithstanding the fact that it initially accepted claimant's injury claim, see Oak Crest Care Center v. Bond, 101 Or App 15 (1990), because SAIF was not the insurer for either employer and since the Proposed and Final Order finding the employer to be noncomplying had been set aside, it had a legitimate doubt as to whether it was liable for further processing of claimant's injury claim under ORS 656.054(1). Under the circumstances, we continue to conclude that SAIF's termination of claimant's temporary disability payments was not unreasonable. Consequently, penalties and attorney fees for such conduct are not warranted.

Claimant also contends that he is entitled to penalties and attorney fees for SAIF's unreasonable delay in paying temporary disability payments. We agree. On June 8, 1989, Referee Brown issued an interim order which found that, once SAIF accepted the claim, it could not unilaterally terminate temporary disability benefits, regardless of the fact that the Proposed and Final Order had been set aside. In his order, Referee Brown instructed SAIF to pay temporary disability benefits.

Subsequent to Referee Brown's order, a hearing was scheduled before Referee Mongrain. On September 5, 1989, Referee Mongrain issued an Opinion and Order in which he concluded that SAIF was five days late in reinstating temporary disability benefits following issuance of Referee Brown's interim order. Accordingly, the Referee assessed penalties and attorney fees for SAIF's unreasonable delay.

We affirm the Referee on the issue of penalties and attorney fees for SAIF's unreasonable delay. Although we initially found that Referee Mongrain's order was in error because it was based upon an order we considered to be

invalid, the court has reversed our decision on that issue. Accordingly, we conclude that, because Referee Brown's order was valid, it was not error to direct SAIF to reinstate temporary disability benefits for claimant. Additionally, we agree with Referee Mongrain's conclusion that SAIF has supplied no explanation for its delay in complying with Referee Brown's order and reinstating claimant's temporary disability benefits. Therefore, we affirm the Referee's award of penalties and attorney fees for SAIF's unreasonable delay.

Although claimant has prevailed on the issue of penalties and attorney fees for SAIF's unreasonable delay in complying with Referee Brown's order, we are unable to award claimant an attorney fee for his efforts before every prior forum on that issue. Penalties and attorney fees are not "compensation" under ORS 656.382(2). See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Therefore, claimant did not finally prevail after remand "in respect to any claim or award for compensation" as required by ORS 656.388(1). See e.g. Aguiar v. J. R. Simplot Company, 94 Or App 658 (1989); Cleo I. Beswick, 43 Van Natta 1314 (1991).

Finally, claimant contends that he is entitled to an attorney fee pursuant to ORS 656.388(1) for his counsel's efforts before every prior forum where claimant has requested Board review or petitioned for judicial review and "finally prevailed" at a lower forum after remand. We disagree.

We conclude that claimant has not "finally prevailed" at Board level following remand on the issue of temporary total disability. Rather, claimant prevailed before the Court of Appeals on that issue. The court concluded that, having accepted claimant's injury claim, SAIF could not deny that previously accepted claim on the basis of a lack of coverage. The court reversed and remanded to us only "for consideration of penalties and attorney fees." Accordingly, because claimant did not "finally prevail" on the issue of temporary total disability following remand, we find no statutory basis upon which to award attorney fees for claimant's counsel's efforts on that issue.

Upon reconsideration, for the reasons articulated above, we do not consider SAIF's termination of claimant's temporary disability benefits to have been unreasonable. Consequently, we conclude that penalties and attorney fees are not warranted. Therefore, that portion of the Referee's September 5, 1989 order that assessed penalties and attorney fees for such conduct is reversed. However, we affirm that portion of the Referee's September 5, 1989 order concerning the issue of penalties and attorney fees for SAIF's unreasonable delay in reinstating temporary disability benefits following the interim order which directed it to do so. The Referee's penalty equal to five percent of the temporary total disability benefits due to claimant for the period between March 30 and June 20, 1989 is reinstated and affirmed. The Referee's penalty-related attorney fee of \$200, payable by SAIF, is also reinstated and affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
NORMA J. OVERMAN, Claimant
WCB Case No. 90-01441
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Steven D. Hallock, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Seifert's order which affirmed a Determination Order that: (1) found claimant medically stationary on April 2, 1990; and (2) did not award any permanent disability. On review, the issues are medically stationary date and permanent partial disability benefits.

We affirm and adopt the order of the Referee with the following supplementation.

Claimant first asserts that she is entitled to temporary partial disability benefits through April 17, 1990. Claimant bases this argument on her contention that Dr. Van Veen, M.D., her treating physician, found her medically stationary on April 17, 1990 and that this date should be relied upon rather than April 2, 1990.

The record indicates that Van Veen agreed with the Western Medical Consultants' report, which found claimant medically stationary on April 2, 1990. His testimony during his deposition demonstrates that he meant to continue to rely on this report in regards to the medically stationary date. (Ex. 59-18). We therefore agree with the Referee that claimant is not entitled to temporary disability benefits beyond April 2, 1990.

Claimant also contends that she is entitled to permanent partial disability benefits because there was evidence of permanent impairment. In order to prove entitlement to an award of permanent disability, claimant must establish that she suffers from permanent impairment that is "due to" her compensable injury. ORS 656.214; former OAR 436-35-010 and 436-35-270.

Since her accident of February 15, 1989, claimant has complained of a variety of symptoms, including back pain, abdominal pain, edema, fluid retention, dizziness, headaches, leg aches, loss of balance, frequent urination, leg numbness and arm soreness. A discharge summary from the work-hardening program at Salem Hospital also showed some impairment. (Ex. 20). As the Referee found, however, the medical evidence does not demonstrate the necessary causal connection between claimant's injury and any disability.

During his initial examination of claimant, Dr. Van Veen found that claimant's "biggest problem [with regard to her multiple symptoms] is related to anger and hostility and a pronounced degree of agitated depression." (Ex. 16-1). Upon later examinations, Van Veen stated that he was "at a loss to explain the exact genesis" of claimant's persistent abdominal pain, (id. at 2); claimant was "becoming quite dysfunctional" and that he did not "have the physiological explanation for a lot of her symptoms," (id. at 4); and claimant had "persistent leg pain but * * * the overlying problem is depressive reaction," (id. at 6).

The initial medical evaluation by Salem Hospital's work-hardening program also found that the "etiology of symptoms is obscure" and that "psychosocial contribution to impairment is probably high." (Ex. 18-1). The psychological screening also noted that individuals with claimant's MMPI profile "frequently are focused on their bodies, multiple symptoms, frequently consult doctors, read

material and discuss with friends and acquaintances a variety of physical, somatic, and health concerns. They tend to 'convert' their anger or depression into physical symptoms of expression." The report also found that claimant "endorses numerous somatic or physical problems on testing and seems histrionic and somewhat exaggerated in her presentation and display." (Ex. 19-2-3).

Pursuant to a medical consultation performed for claimant's attorney on June 4, 1990, Dr. Lafrance, neurologist, stated:

"Given the electric shock type of exposure that [claimant] suffered, it is certainly possible that there are elements of a compressive neuropathy present, both of the carpal tunnel and of the lower extremity either of the sciatic nerve diffusely or possibly of even the tarsal tunnel.

"There are in addition however clear elements of psychological factors affecting this disease. I believe that there is a (sic) definite evidence of a depressive illness and there may be an element of hyperventilation panic attack syndrome[.]" (Ex. 31-3).

Moreover, Dr. Lafrance noted that claimant exhibited "a very limping antalgic pattern" gait while in his office, complaining of pain with every step, but that he did not notice this when claimant left his office.

Finally, the report from the Western Medical Consultants found "intense somatic preoccupations and overfocusing and passive dependent behavior." It also found that her examination showed worse results than at the end of the work-hardening program and that the fact that she could drive by herself to and from Arizona "demonstrates that she is exaggerating her limitations and pain." (Ex. 48-3-4).

Because claimant failed to prove that she suffers from permanent impairment that is "due to" the compensable injury, we also conclude that claimant is not entitled to permanent partial disability benefits.

ORDER

The Referee's order dated January 25, 1991 is affirmed.

December 31, 1991

Cite as 43 Van Natta 2817 (1991)

In the Matter of the Compensation of
JAMES H. SMITH, Claimant

WCB Case No. 90-17839

ORDER ON REVIEW

W. Daniel Bates, Jr., Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Black's order that increased his scheduled permanent disability award for his right forearm to 16 percent (24 degrees), whereas a Determination Order awarded 2 percent (3 degrees) scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of his finding that claimant has a grip strength loss of approximately 20 percent.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the Referee erred in his interpretation of Dr. Brooks' report of claimant's loss of grip strength. In his report, Dr. Brooks stated that claimant's grip strength was down and concluded, "I would estimate 15 lbs." The Referee concluded that, because Dr. Brooks had also found claimant had sustained extremely mild hand impairment, he must have meant that claimant's grip strength was down 15 pounds from a normal grip strength of 95 pounds. The Referee, therefore, estimated claimant's grip strength loss at 20 percent, which equated to a 10 percent loss of the forearm under former OAR 436-35-110(3)(d).

Claimant concedes that Dr. Brooks' report is ambiguous. However, claimant argues that his credible testimony that he has lost substantial grip strength requires a different interpretation of Dr. Brooks' report. Claimant contends that Dr. Brooks' statement should be interpreted to mean that his grip strength was down to 15 pounds as a result of his injury. We disagree.

Loss of grip strength is ratable when it is associated with either nerve damage, amputation, or atrophy or other anatomical changes. See former OAR 436-35-110(3)(a), (b) & (d). Even though a claimant is found credible, his testimony alone is insufficient to establish loss of grip strength under the standards. Dachel Snocker, 43 Van Natta 1173 (1991).

In the present case, we do not find that Dr. Brooks' report is sufficient to establish an impairment award for loss of grip strength under the "standards." First, it is not clear whether Dr. Brooks attributes claimant's loss of grip strength to nerve damage, atrophy or other anatomical changes. Moreover, Dr. Brooks' measurement, in addition to being arguably ambiguous, does not equate to the measurement for decreased grip strength provided by the "standards", which measures grip strength as percentage retained rather than using a measurement in pounds. Under the circumstances, we decline to estimate claimant's loss of grip strength under the "standards." See e.g. Lawrence E. Wilson, 43 Van Natta 1131 (1991) (Where the treating physician's range of motion findings do not conform to those found in the "standards," we do not find those range of motion findings persuasive.)

Finally, although the Referee found claimant to be credible, his contention that he has retained minimal grip strength is inconsistent with Dr. Brooks' report that claimant sustained "extremely mild" impairment of the hand and that claimant had "[g]ood strength, a little down." (Ex. 11). Additionally, we do not rely upon claimant's testimony alone to establish measureable grip strength impairment under the standards. See Dachel Snocker, supra.

Accordingly, we conclude that claimant has not established an award for loss of grip strength under the "standards." However, because the insurer has not asked for a reduction, we affirm the Referee's award of 16 percent scheduled permanent disability for claimant's loss of use or function of the right forearm.

ORDER

The Referee's order dated February 25, 1991 is affirmed.

In the Matter of the Compensation of
TAMMY M. TALLMON, Claimant
WCB Case No. 91-00959
ORDER ON REVIEW
Jackson & Vause, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of Referee Schultz's order that set aside its partial denial of claimant's bilateral vestibular dysfunction condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinions," with the following supplementation.

On review, the employer contends that the Referee should have relied upon the opinion of Dr. Wilson, M.D., a neuro-otologist. The employer argues that claimant was referred to Dr. Wilson by Dr. Setera, her treating chiropractor, and, therefore, the Referee should have deferred to his opinion. Finally, the employer contends that Dr. Wilson's examination of claimant was much closer in time to the original injury than Dr. Epley's examination.

We agree with the Referee that Dr. Epley's opinion is more persuasive than the opinion of Dr. Wilson. Dr. Epley is also an otologist, and, although he initially examined claimant several months after Dr. Wilson, he treated claimant numerous times over a period of approximately one-half year. Dr. Wilson, on the other hand, examined claimant upon one occasion and, over a year later, wrote his medical report regarding causation of claimant's condition. Under the circumstances, we do not agree with the employer that the Referee erred by relying upon the report of Dr. Epley, as supported by the other medical opinions in the record.

Finally, we agree with the Referee's Conclusions and Opinion on the issue of the appropriate legal standard of causation, i.e. material contributing cause. See Julie K. Gasperino, 43 Van Natta 1151 (1991).

Claimant is entitled to an attorney fee for prevailing against the employer's request for review on the issue of compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the issue of compensability is \$800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated April 22, 1991 is affirmed. For services on review concerning the issue of compensability, claimant's counsel is awarded an attorney fee of \$800, payable by the self-insured employer.

In the Matter of the Compensation of
CHARLES WRIGHT, Claimant
WCB Case No. C1-02691
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Rasmussen & Henry, Claimant Attorneys
John Hoadley, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On December 13, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

We will not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of the existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). The Board's rules require that a claim disposition agreement be in a separate document from a disputed claim settlement (DCS). OAR 438-09-020(3).

Here, the proposed agreement purports to release claimant's further rights to workers' compensation benefits of any type, except medical services payable under his workers' compensation claim. The disposition then provides that claimant releases all rights to claim any and all conditions stemming from claimant's accepted claim for injury of June 28, 1988. The release of any physical or mental conditions alleged to be a consequence of the compensable injury is language that could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245 for conditions related to the compensable injury. See Roy L. Plumlee, 43 Van Natta 47 (1991). Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Accordingly, the proposed disposition is unreasonable as a matter of law and is set aside on this basis. See ORS 656.236(2).

Further, a claim disposition agreement must contain the terms, conditions and information prescribed in OAR 436-60-145(3) and (4). An agreement that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5), 438-09-020(2). Here, the agreement fails to provide the amount of any permanent disability award(s). See OAR 436-60-145(4)(c).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. See OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

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Cite as 109 Or App 101 (1991)

October 2, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Bill L. Marshall, Claimant.

BILL L. MARSHALL, Petitioner,

v.

BOB KIMMEL TRUCKING and LIBERTY NORTHWEST INSURANCE CORP., Respondents.
(WCB 88-15509; CA A65603)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 11, 1991.

Karsten H. Rasmussen, Eugene, argued the cause for petitioner. With him on the brief was Rasmussen & Henry, Eugene.

Adam T. Stamper, Medford, argued the cause for respondents. With him on the brief was Cowling & Heysell, Medford.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

RICHARDSON, P.J.

Reversed and remanded for reconsideration.

*Joseph, C.J., vice Newman, J., retired.

Claimant petitions for review of an order of the Workers' Compensation Board that denied compensation for injuries received in a truck accident during the course of his employment. The Board adopted the referee's opinion. We reverse.

Claimant was injured in a single vehicle accident when the log truck that he was driving ran off the road and overturned. He recalls nothing between the time when he passed a scaling station and the time when he woke up in the wreckage of his truck one and one-half miles down the highway. He suffered a broken left hand, knee injuries and a concussion. At the hospital, claimant speculated that he had fainted due to a new medication that he was taking for hypertension and headaches. A number of tests were conducted to determine whether claimant had indeed fainted and, if so, what might have been the cause. The tests were inconclusive.

The referee found that the cause of the accident is "unknown." That finding is supported by substantial evidence in the record. The referee denied compensation, concluding that claimant had not satisfied his burden of proving by a preponderance of the evidence that his injuries were work-connected, because he had not been able to rule out all possible idiopathic causes of the accident.¹

Employer argued, and the referee apparently agreed, that previous cases involving injuries sustained in unexplained falls at workplaces were controlling. The cases cited in the referee's opinion all involved claimants who were

¹ An "idiopathic" cause is a pre-existing physical weakness or disease of the claimant which contributes to the accident. The rule that a claimant must eliminate idiopathic causes before injuries due to an unexplained fall will be compensable was explained in *Phil A. Livesley Co. v. Russ*, 296 Or 25, 672 P2d 337 (1983). In that case, the claimant broke his hip when he fell as he walked down a hallway at work. The employer conceded that the cause of the fall was not idiopathic. On review, the court held that, if the cause of a claimant's on-the-job injury is "unexplained," it is compensable, provided that the claimant "eliminates" idiopathic causes. Compensation was allowed. 296 Or at 27.

injured when they fell, for unexplained reasons, from a standing position on the unobstructed floor of their workplace. The injuries sustained were caused solely by the impact of the claimant with the floor. See, e.g., *Phil A. Livesley Co. v. Russ*, 296 Or 25, 27, 672 P2d 337 (1983); *McAdams v. SAIF*, 66 Or App 415, 674 P2d 80, rev den 296 Or 638 (1984).

Larson distinguishes unexplained fall cases from cases in which, due to idiopathic causes, a claimant was injured while in a moving vehicle. He says:

"Awards are uniformly made when the employee's idiopathic loss of his faculties took place while he was in a moving vehicle * * *. It seems obvious that the obligations of their employment had put these employees in a position where the consequences of blacking out were markedly more dangerous than if they had not been so employed." 1 *Larson, Workmen's Compensation Law* 3-356, 12.12 (1990). (Footnotes omitted.)

That distinction makes sense. Claimant's injuries are not the results of a fall but, rather, of the impact of his log truck with the side of a mountain. The risk of serious injury from any loss of consciousness, of idiopathic origin or not, was greatly increased by the fact that claimant was driving a log truck for his employer's benefit. We conclude that the injuries arose out of and in the course of his employment and are compensable.

Reversed and remanded for reconsideration.

Cite as 109 Or App 105 (1991)

October 2, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Randy Strazi, Claimant.

RANDY STRAZI, Petitioner,

v.

SAIF CORPORATION and TURNER AND HAMM LOGGING, Respondents.
(WCB 88-13933; CA A65273)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 25, 1991.

Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were James C. Egan and Emmons, Kropp, Kryger, Alexander & Egan, Albany.

David L. Runner, Assistant Attorney General, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P.J.

Affirmed.

Edmonds, J., specially concurring.

In this workers' compensation case, claimant seeks reversal of the Board's order that he is not entitled to attorney fees for successfully defending against employer's cross-request for an offset for overpayment. We affirm.

Claimant injured his left arm in a logging accident on September 14, 1979. After a hearing on April 28, 1987, he was awarded 70 percent scheduled disability for loss of use of his left arm. Neither party appealed that order. On July 22, 1988, a determination order decreased claimant's permanent disability from 70 percent to 11 percent and ordered a reduction in his award. That

reduction in scheduled disability, if valid, would have meant that claimant had received an overpayment of \$11,328. Claimant appealed the July 22 order; employer cross-appealed to request authorization of an offset against future compensation payments because of the overpayment.

The referee set aside the July 22 order and upheld the April 28 order awarding claimant 70 percent permanent disability. Additionally, the referee awarded claimant attorney fees under ORS 656.382(2), because he had prevailed on employer's request for an offset. Employer appealed. The Board affirmed the referee in setting aside the July 22 order and the denial of the offset, but reversed the award of attorney fees. It concluded that claimant's compensation was not at risk, because an offset does not reduce compensation within the meaning of ORS 656.382(2). Claimant, therefore, was not entitled to attorney fees.

ORS 656.382(2) provides, in part:

"If a request for hearing * * * is initiated by an employer * * *, and the referee * * * finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer * * * shall be required to pay * * * a reasonable attorney fee * * * for legal representation * * * for the claimant at and prior to the hearing * * *."

There are three things that a claimant must prove to get attorney fees under this statute: first, that the employer initiated a request for a hearing to obtain a disallowance or reduction in the claimant's award of compensation or filed a cross-appeal to do so, *Dotson v. Bohemia*, 80 Or App 233, 236, 720 P2d 1345, rev den 302 Or 35 (1986); second, that the claimant's attorney performed legal services in defending the compensation award, *Mobley v. SAIF*, 58 Or App 394, 396, 648 P2d 1357 (1982); and, third, that the referee found on the merits that the claimant's award of compensation should not be disallowed or reduced. *Liberty Northwest Insurance v. McKellips*, 100 Or App 549, 550, 786 P2d 1321 (1990); *Agripac, Inc. v. Kitchel*, 73 Or App 132, 135, 698 P2d 69 (1985).

Employer concedes that its request for an offset on a cross-appeal satisfies the "employer initiated" requirement under ORS 656.382(2). In *Littleton v. Weyerhaeuser Co.*, 93 Or App 659, 662, 763 P2d 741 (1988), we held that the term "initiated" refers to raising issues that would not otherwise have been dealt with by the reviewing body. Employer does argue that claimant's counsel did not perform any legal services contesting the offset; however, we give deference to the agency's determination of that question. *Bentley v. SAIF*, 38 Or App 473, 481, 590 P2d 746 (1979).

The dispositive issue is whether an offset for overpayment against future compensation is a reduction in claimant's award of compensation. ORS 656.382(2) allows employer paid attorney fees if the referee or Board finds "compensation awarded to a claimant should not be disallowed or reduced." (Emphasis supplied.) An offset is a correction of an overpayment. It does not reduce or disallow any portion of the award; the employer will only recover, through reduced payments, the amount that the claimant was not entitled to receive. We agree with the Board's conclusion that a request for an offset is not a threat to the award of compensation.

Affirmed.

EDMONDS, J., specially concurring.

I agree with the majority's result but for a different and more simple reason. The determination order decreased claimant's disability from 70 percent

to 11 percent. Claimant appealed that order. Employer's cross-appeal for an offset was not made to reduce or disallow the determination order award of 11 percent. Therefore, ORS 656.382(2) is inapplicable, because claimant was not defending an appeal that could have resulted in a reduction or disallowance of the compensation awarded.

Cite as 109 Or App 109 (1991)

October 2, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John W. Cross, Claimant.

LIBERTY NORTHWEST INSURANCE CORP. and **ANODIZING, INC.**, Petitioners,
v.
JOHN W. CROSS, **COLUMBIA STEEL CASTING, SAIF CORPORATION** and **CONVOY COMPANY**,
Respondents.
(WCB 88-21374, 88-21281, 88-17850; CA A67592)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 19, 1991.

Stafford J. Hazelett, Portland, argued the cause for petitioners. With him on the brief was Davis and Bostwick, Portland.

Eileen G. Simpson, Eugene, argued the cause for respondent John W. Cross. With her on the brief was Peter O. Hansen, Portland.

Thomas E. Ewing, Assistant Attorney General, and Dave Frohnmayer, Attorney General, Salem, waived appearance for respondents Columbia Steel and SAIF Corporation.

No appearance by respondent Convoy Company.

Before Warren, Presiding Judge, and Joseph, Chief Judge, and Edmonds, Judge.
WARREN, P.J.

Affirmed.

Joseph, C.J., dissenting.

Employer¹ seeks review of the Workers' Compensation Board's order that held that claimant has a compensable occupational disease. ORS 656.802(1)(a). We affirm.

Claimant began working for employer as a welder in the summer of 1987. On the job, he was exposed to several respiratory irritants common in welding, as well as to additional irritants from working with aluminum, such as sulfuric acid, nitric acid, sodium hydroxide and copper dust. After three or four months, he began having respiratory problems, including coughing and shortness of breath. He quit his job on the advice of his doctor in June, 1988, and his symptoms vanished. Claimant had smoked for more than ten years.

The Board found that claimant had a predisposition to respiratory irritant reactions, which was activated when he came to work for employer. It concluded that claimant's irritant reaction was a disease and that the major contributing cause was his work environment.

Employer argues that there is no medical evidence that claimant had a predisposition to the disease. Employer is correct. It fails to explain, however,

¹ We refer to Anodizing, Inc., as employer. Columbia Steel Casting waived appearance in this review. The referee dismissed the claim against Convoy Company.

how that finding affects the result. See ORS 183.482(8)(c). Employer does not argue that claimant had a pre-existing condition, so the applicable test is whether the work activities were the major contributing cause of the disease. *Blakely v. SAIF*, 89 Or App 653, 750 P2d 528, rev den 305 Or 672 (1988). The Board's finding on predisposition was irrelevant to that test and may be disregarded. See *Preston v. Wonder Bread*, 96 Or App 613, 773 P2d 805, rev den 308 Or 405 (1989).

Employer argues next that the Board lacked substantial evidence for its finding that claimant's work activities were the major contributing cause of his irritant reaction. ORS 183.482(8)(c). Dr. Montanaro stated in his report that "it is likely that [claimant's] occupational exposures at [employer's workplace] resulted in significant respiratory irritant effects." Employer contends that Montanaro's report is insufficient, because the doctor does not state how big a role the work activities played in causing the disease and disability. We do not require that medical evidence consist of a specific incantation or that it mimic the statutory language. The Board could infer from Montanaro's statement and the entire report that claimant's work activities were the major contributing cause of his irritant reaction and disability.

Finally, employer contends that the referee's analysis was erroneous. We review only the Board's order. ORS 656.298(6); ORS 183.482(8). Although the Board affirmed and adopted the referee's order, it also made its own independent analysis, which replaced the referee's analysis. Therefore, we need not consider the referee's analysis.

Affirmed.

JOSEPH, C.J., dissenting.

The majority's holding depends on a partial quotation of Dr. Montanaro's report. 109 Or App at 111. The majority's excerpt is misleading. What Montanaro said that is relevant to the issue is:

"3. I do not find any evidence in the medical record that would indicate any significant preexisting conditions other than [claimant's] chronic cigarette smoking prior to his employment with Anodizing, Inc.

"3a. I feel that it is likely that [claimant's] occupational exposures at Anodizing, Inc. resulted in significant respiratory irritant effects. I feel that any irritant effects which may have occurred throughout 1987-1988 have long since resolved. As I have pointed out, I do not feel that the nature and extent of [claimant's] irritant exposures were such that they could explain persistent symptoms or a possible reactive airways dysfunction syndrome.

"4. I do not feel that his employment with Anodizing, Inc. or his work activities at that time were the major contributing cause of his current condition. I do feel that they contributed to respiratory irritant symptoms at that time which may have resulted in intermittent time loss." (Emphasis supplied.)

In the light of that language, the majority's conclusion cannot stand, for there is no evidence in the record that claimant's work activities were the major cause of "the disease," because he does not have a disease.

I dissent.

Cite as 109 Or App 136 (1991)

October 2, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gloria A. Severson, Claimant.

SAIF CORPORATION and **OREGON HEALTH SCIENCES UNIVERSITY**, Petitioners,
v.

GLORIA A. SEVERSON, Respondent.
(87-13614; CA A63131)

Judicial Review from Workers' Compensation Board.

On petitioners' petition for reconsideration filed March 27, 1991, and on respondent's motion for reconsideration filed May 17, 1991. Opinion filed December 26, 1990, 105 Or App 67, 803 P2d 1203.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General, Salem, for petition.

Thomas Cary, and Coons, Cole & Cary, P.C., Eugene, for motion.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

DEITS, J.

Reconsideration allowed; opinion modified and adhered to as modified. Motion for reconsideration denied.

*Joseph, C.J., vice Newman, J., retired.

Employer has petitioned for review of our decision, 105 Or App 67, 803 P2d 1203 (1990), arguing that we erred in concluding that the Workers' Compensation Board had authority to award attorney fees under ORS 656.382(1) for services rendered in a vocational assistance proceeding before the Director of the Department of Insurance and Finance. We treat the petition as a petition for reconsideration, modify our opinion and adhere to it as modified. ORAP 9.15.

Employer correctly asserts that we erred in stating that whether to award attorney fees is a "matter concerning a claim." 105 Or App at 71. "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). Attorney fees are not compensation. *Harrington v. Board of Trustees*, 100 Or App 733, 738, 788 P2d 1019, rev den 310 Or 133 (1990); *Saxton v. SAIF*, 80 Or App 631, 723 P2d 355, rev den 302 Or 159 (1986).

Employer contends that, because entitlement to attorney fees is not a matter concerning a claim and because the Director has no statutory authority to award attorney fees in a vocational assistance matter, the Board lacks authority to award attorney fees for such claims. We disagree. After seeking review of her claim for vocational assistance through the administrative review process, as required by the statute, claimant was authorized to appeal the Director's decision, which she did. ORS 656.283(2) limits the Board's authority to modify the Director's decision. However, it does not limit the Board's authority to act on ancillary issues, such as attorney fees, that are outside the Director's authority and for which the Board has separate authority. As discussed in our earlier opinion, ORS 656.382(1) gives the Board authority to award attorney fees in this type of case.

Claimant has moved for reconsideration. We deny the motion.

Reconsideration allowed; opinion modified and adhered to as modified. Motion for reconsideration denied.

Cite as 109 Or App 169 (1991)

October 9, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Daniel P. Roam, Claimant.

SAIF CORPORATION and CAPE ARAGO LUMBER CO., Petitioners,

v.

DANIEL P. ROAM, Respondent.

(89-03055; CA A66917)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 26, 1991.

Arden J. Olson, 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.

Donald M. Hooton, Eugene, argued the cause for respondent. On the brief were Jon C. Correll and Malagon, Moore & Johnson, Eugene.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P.J.

Affirmed.

Employer seeks review of an order of the Workers' Compensation Board holding that it is responsible for payment of certain medical expenses necessary for the treatment of claimant's noncompensable psychiatric problem.

Claimant, who has a pre-existing psychiatric problem, including drug dependency, sustained a compensable elbow injury in 1977, requiring several surgeries over a period of years. In 1987, he claimed that those surgeries had worsened his psychiatric condition. He and employer entered into a disputed claim settlement by which claimant agreed that his psychiatric condition was not compensable. As part of the settlement, employer paid claimant \$7,000. One year later, claimant's treating physician recommended further surgery on his elbow but stated that claimant must first be treated for his psychiatric problem. Although employer concedes that the surgery would be compensable, it denied the claim for treatment of the psychiatric condition, contending that the disputed claim settlement had absolved it of all responsibility for that problem. The referee held that employer must pay for the treatment, and the Board affirmed.

Claimant is entitled to treatment reasonably necessary to permit treatment of the compensable elbow condition. ORS 656.245; *Van Blokland v. Oregon Health Sciences University*, 87 Or App 694, 743 P2d 1136 (1987); see also *Williams v. Gates, McDonald & Co.*, 300 Or 278, 709 Or 712 (1985). The evidence is uncontroverted that treatment of the non-compensable psychiatric condition is necessary as a prelude to treatment of the compensable elbow injury. Accordingly, the Board correctly held that employer must pay for the necessary psychiatric treatment.

Affirmed.

Cite as 109 Or App 182 (1991)

October 9, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

INSURANCE COMPANY OF NORTH AMERICA, a foreign corporation, Appellant,
v.

SCHWABE, WILLIAMSON & WYATT, an Oregon corporation, Respondent.
(A8905-02599; CA A65657)

Appeal from Circuit Court, Multnomah County.

Gerald R. Pullen, Judge pro tempore.

Argued and submitted May 20, 1991.

Thomas M. Christ, Portland, argued the cause for appellant. With him on the briefs was Mitchell, Lang & Smith, Portland.

Deborah L. Sather, Portland, argued the cause for respondent. With her on the brief were Frank A. Moscato and Cooney, Moscato & Crew, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Reversed and remanded for proceedings not inconsistent with this opinion.

Buttler, P.J., dissenting.

This legal malpractice action arises out of a workers' compensation case in which defendant represented plaintiff insurer. The workers' compensation dispute concerned which insurer, plaintiff or American International Adjustment Company, Inc. (AIAC), owed compensation to the injured worker. The referee held that plaintiff was responsible. Plaintiff asked defendant to appeal the referee's order to the Board, but defendant failed to do so in time. In this action, plaintiff claims that, if defendant had made a timely appeal to the Board, plaintiff would have prevailed, and it seeks damages equal to the compensation that it now owes the injured worker.

Pursuant to a stipulation of the parties, the trial court assigned the case to a reference panel. The stipulation provides that the panel's findings and conclusions are to be non-binding, except that they are to have the "same effect as a jury verdict." ORCP 65E(3).¹ The panel found that plaintiff's appeal to the Board would not have succeeded and filed its report with the trial court. Plaintiff objected to the report, pursuant to ORCP 65E(3), but the court denied the objections.

In its order, the trial court first noted that, under ORCP 65E(3)(a), it had broad discretion to affirm or set aside the reference report. It said that it found "no basis to set aside the report in whole or part." The court then pointed out that the "panel was similar to an arbitration" and cited decisions holding that review of an arbitration decision is limited. See, e.g., *Brewer v. Allstate Insurance Co.*, 248 Or 558, 436 P2d 547 (1968). It adopted the panel's

¹ ORCP 65E(3)(a) provides:

"Unless the parties stipulate to the contrary, the referee's findings of fact shall have the same effect as a jury verdict. Within 10 days after being served notice of the filing of the report, any party may serve written objections thereto upon the other parties. Application to the court for action upon the report and upon objections to the report shall be by motion. The court after hearing may affirm or set aside the report, in whole or in part."

report and entered judgment for defendant. Plaintiff seeks reversal on the ground that the panel and the trial court misallocated what would have been the burden of proof in the underlying workers' compensation proceeding.

In determining liability for malpractice, the question is whether, if defendant had timely appealed the underlying workers' compensation case to the Board, plaintiff would have succeeded in establishing that AIAC, and not plaintiff, was responsible for insuring the claim. See *Jackson v. Olson*, 77 Or App 41, 44, 712 P2d 128 (1985), rev den 300 Or 605 (1986). Because the panel's findings have the effect of a jury verdict, we review them to determine whether they are supported by the evidence, but we review the legal conclusions for errors of law. We conclude that the panel made an error of law in assuming that plaintiff had the burden of proof in the underlying workers' compensation case and that, therefore, the trial court erred in adopting the panel's report.

The worker suffered a compensable injury to his neck in July, 1985, when AIAC was the employer's insurer. AIAC accepted that claim, and it was closed in December, 1986, with an award of benefits for permanent partial disability. The worker had returned to work in November, 1986, and had performed his job without difficulty until July 23, 1987, when he again experienced pain in his neck while attempting to lift a carton. By that time, plaintiff was the responsible insurer. The worker left work and filed a claim against AIAC, seeking benefits for an aggravation of the 1985 injury; he also filed a claim against plaintiff for a new injury. Each insurer denied responsibility. Plaintiff retained defendant to represent it. The only issue before the referee was whether the worker had sustained a new injury or an aggravation. The referee placed responsibility for the claim on plaintiff and affirmed AIAC's denial.

It is apparent from the reference panel's opinion that it understood the issue before it. It also correctly stated the legal test for determining responsibility:

"In successive injury cases where there are a series of work-related injuries and there is a dispute over responsibility for a period of disability during or after later employment, once a later incident is accepted as a compensable injury, there is a rebuttable presumption that responsibility lies with the last employer/insurer at the time of the last work-related injury, *Boise Cascade v. Starbuck*, 296 Or 238 [675 P2d 1044 (1983)]; *Industrial Indemnity v. Kearns*, 70 Or App 583, [690 P2d 1068 (1984)]. However, the subsequent employment and/or injuries must contribute to the underlying or pathological condition and it is inadequate to show merely that subsequent employment and/or injuries contributed only to the symptoms of the compensable condition, *Hensel Phelps Construction v. Mirich*, 81 Or App 290 [724 P2d 919 (1986)]; *Mission Insurance Co. v. Dundon*, 86 Or App 470, [739 P2d 1069] (1987)."

The panel then found that plaintiff had not overcome a presumption that the 1987 incident had independently contributed to the worker's underlying condition.

As the panel said, the presumption applies to the last "employer/insurer" to accept an injury. There could have been no such presumption as to plaintiff, unless plaintiff had accepted the 1987 claim. *Stevens Equipment Co. v. American Fabricators*, 106 Or App 354, 807 P2d 334 (1991); *Delta/McLean Trucking v. Wyncoop*, 106 Or 319, 807 P2d 336 (1991). It had not; it had denied the claim.²

² We know of no support for the dissent's view that "acceptance of compensability," as opposed to acceptance of the claim, is sufficient to give rise to the presumption.

Accordingly, the panel erred in concluding that there was a presumption that plaintiff was responsible. In fact, as the last insurer with an accepted claim, AIAC is presumed to be responsible for the injury, unless it proved that the 1987 incident contributed independently to the worker's condition. The court erred in adopting the reference panel's report, which misallocated the burden of proof to plaintiff.

Reversed and remanded for proceedings not inconsistent with this opinion.

BUTTLER, P.J., dissenting.

The majority says that the reference panel correctly stated the legal test for determining responsibility. I agree. The key to the panel's opinion is that "once a later incident is accepted as a compensable injury, there is a rebuttable presumption that responsibility lies with the last employer/insurer at the time of the last work-related injury * * *." 109 Or App at 185.

However, the majority then says that there could have been no such presumption as to plaintiff, unless it had accepted the July, 1987, claim. What the majority appears to have overlooked is that both plaintiff and AIAC had agreed that the claim was compensable, that is, they had accepted compensability, but each of them had denied that it was the responsible insurer. Under the test, which the majority agrees is correct, there is a rebuttable presumption that the last insurer is responsible. However, the majority says that the rebuttable presumption does not apply unless the last employer had accepted the claim. Obviously, if plaintiff had accepted the claim unconditionally, that would be the end of the case; there would be no reason for the presumption. Plaintiff did accept the fact that the incident that occurred on July 23, 1987, occurred while it was on the risk, but it denied responsibility for claimant's present disability. That is precisely the circumstance in which the rebuttable presumption operates.

As the Supreme Court said in *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244-45, 675 P2d 1044 (1984):

"In a procedural context, if a worker presents substantial evidence of successive work-related injuries causing disability, a prima facie case for recovery from the last employer is made out. Either or any employer against whom a claim is made still can present evidence to prove that the cause of the worker's disability is another employment or a cause unrelated to the employment. In such a case, the trier of fact decides the case on the basis of the evidence presented. If the trier of fact is convinced that the disability was caused by successive work-related injuries but is unconvinced that any one employment is the more likely cause of the disability, the finding is for the worker against the last employer whose employment may have caused the disability. On the other hand, if the trier of fact is convinced that the disability was caused by an earlier injury, or was not work related, such a finding may be made."

Concededly, the court in *Starbuck* said a great deal more, which has led to a great deal of confusion, as evidenced by the cases on which the majority relies. However, the quoted language is an accurate statement of the law.

I would affirm and, therefore, dissent.

Cite as 109 Or App 204 (1991)

October 9, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Barry Dunn, Claimant,
and, In the Matter of the Complying Status of Frank Stanley Wood and Mike
Hermeling, dba Herwood, Noncomplying Employer.

FRANK STANLEY WOOD and MIKE HERMELING, dba Herwood, Petitioners,

v.

BARRY DUNN, SAIF CORPORATION, and STAN'S WOOD PRODUCTS, Respondents.

(WCB Nos. 89-05827, 89-05826, 89-03292 & 89-16769; CA A66933)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 11, 1991.

James L. Edmunson, Eugene, argued the cause for petitioners. On the brief was
Carl W. Hopp, Jr., Bend.

Dan Steelhammer, Bend, waived appearance for respondent Barry Dunn.

Jerald P. Keene, Portland, argued the cause for respondent Stan's Wood
Products. With him on the brief was Roberts, Reinisch, Mackenzie, Healey &
Wilson, P.C., Portland.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and
John Reuling, Assistant Atty. Gen., Salem, filed the brief for respondent SAIF.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Reversed.

Herwood, a partnership of Mike Hermeling and Frank Stanley Wood, seeks re-
view of an order of the Workers' Compensation Board holding that it is a noncom-
plying employer and that claimant is entitled to benefits for a compensable
injury.¹

Herwood contracted with claimant to do several jobs on buildings that it
owned. Claimant hired several workers to assist him in the Herwood job and paid
them on an hourly basis. He gave a statement to Herwood accepting responsibil-
ity for his workers in the event of an accident. He had no workers' compensa-
tion insurance, and neither did Herwood.

In the course of his work, claimant injured his hand and filed a claim
listing Herwood as his employer. Following an investigation, the Department of
Insurance and Finance issued an order of noncompliance to Herwood and sent the
claim to SAIF for processing.

SAIF sent Herwood a letter advising it that SAIF had accepted the claim
and that it had the right to request a hearing regarding compensability.
Herwood requested a hearing, challenging the order of noncompliance on the
ground that claimant was an independent contractor and denying the compensabil-
ity of the claim on the same ground.

The referee rejected claimant's argument that, after SAIF's acceptance of
the claim, Herwood was barred from denying the claim by the rule against back-up
denials. *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983). He found that
Herwood's request for hearing and denial of compensability were timely. He
found that claimant was an independent contractor but held, nonetheless, that
Herwood is liable for claimant's injury by operation of ORS 656.029.

¹ Claimant filed a claim against Stan's Wood Products which Stan's denied.
That denial is not challenged on review.

The Board found that Herwood had failed to request a hearing on compensability within 60 days after the date of SAIF's knowledge of the claim and held, therefore, that Herwood had not timely requested a hearing and that it could not avoid SAIF's acceptance of the claim without a showing of one of the circumstances described in *Bauman v. SAIF, supra*.

We do not understand the Board's rationale. Certainly, Herwood needed notice of SAIF's acceptance of the claim before it could be expected to request a hearing on that issue. In any event, under our holdings in *Blain v. Owen*, 106 Or App 285, 807 P2d 313, rev den 312 Or 80 (1991), and *Clark v. Linn*, 98 Or App 393, 779 P2d 203 (1989), we conclude that the request was timely.

The Board also held, apparently in the alternative, that, although claimant was an independent contractor and, accordingly, was not a subject worker under the workers' compensation laws, he was entitled to coverage under ORS 656.029, as one who had performed labor under a contract and for whom workers' compensation coverage was not otherwise available. The Board held, further, that claimant was not otherwise excluded from coverage by operation of ORS 656.027,² as a sole proprietor, because he had hired workers and, therefore, did not perform labor "without the assistance of others," as required by ORS 656.029(4)(b).

Under ORS 656.017 and ORS 656.027, only subject workers are entitled to benefits under the Workers' Compensation Law. ORS 656.027 provides that "[a]ll workers are subject to [the workers' compensation laws]." ORS 656.005(27) defines a "worker" as

"any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *."

If claimant is an independent contractor, he is not subject to the direction and control of an employer and is not a worker entitled to coverage. *Bisbey v. Thedford*, 68 Or App 200, 202 n 1, 680 P2d 1003 (1984); see *Woody v. Waibel*, 276 Or 189, 554 P2d 492 (1976); *Castle Homes, Inc. v. Whaite*, 95 Or App 269, 769 P2d 215 (1989).

Despite that rule, the Board concluded that claimant was a subject worker as a matter of law by virtue of ORS 656.029. Until 1985, that statute provided:

"(1) If any person engaged in a business and subject to this chapter as an employer lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let, with assistance of others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract unless the person to whom the contract is let has qualified either as a carrier-insured employer or a self-insured employer.

"(2) If the person to whom the contract is let performs the work

² ORS 656.027 provides, in part:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(7) Sole proprietors. When labor or services are performed under contract, the sole proprietor must qualify as an independent contractor."

without the assistance of others, that person is subject to this chapter as a subject worker of the person letting the contract unless that person and the person letting the contract jointly file with the insurer or self-insured employer a declaration stating that the services rendered under the contract are rendered as those of an independent contractor.

"(3) A person who files the declaration of status as an independent contractor is not eligible to receive benefits under this chapter unless the individual has obtained coverage for such benefits pursuant to ORS 656.128.

"(4) The filing of a declaration of status pursuant to this section creates a rebuttable presumption that the person is an independent contractor."

We held in *Kistner v. BLT Enterprises*, 74 Or App 131, 135, 700 P2d 1047 (1985), that, in the absence of a joint notice of independent contractor status, a worker engaged in the performance of labor under a contract is deemed to be the subject worker of the person letting the contract, and the statute eliminated the need to decide in each case whether the worker is a subject worker or an independent contractor. See also *EBI Companies v. Erzen*, 73 Or App 256, 698 P2d 534, rev den 299 Or 583 (1985); *Love v. Northwest Exploration Co.*, 67 Or App 413, 678 P2d 754 (1984).

In 1985, the legislature rewrote the statute. Or Laws 1985, ch 706, 1. At the time relevant to this case, ORS 656.029 provided, in part:

"(1) 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 ORS 656.001 to 656.794 for the payment of benefits to the worker of a noncomplying employer.

"(2) If a person to whom the contract is awarded is exempt from coverage under ORS 656.027, and that person engages individuals who are not exempt under ORS 656.027 in the performance of the contract, that person shall provide workers' compensation insurance coverage for all such individuals. 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 to whom the contract is awarded, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in ORS 656.001 to 656.794 for the payment of benefits to the worker of a noncomplying employer.

"(3) A person, other than a partnership engaged in work performed in direct connection with the construction, alteration,

repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto, who submits proof of compliance with section 3, chapter 895, Oregon Laws 1981, as amended by section 1, chapter 579, Oregon Laws 1983, [regarding certification of construction businesses] is conclusively presumed to be an independent contractor and is not eligible to receive benefits under this chapter unless the person has obtained coverage for such benefits pursuant to ORS 656.128.

"(4) As used in this section:

"(a) 'Person' includes partnerships, joint ventures, associations, corporations, governmental agencies and sole proprietorships.

"(b) 'Sole proprietorship' means a business entity or individual who performs labor without the assistance of others."

That version of the statute requires that the person awarding the contract obtain coverage for all individuals who perform labor under the contract, other than those exempt from coverage under ORS 656.027, unless the person to whom the contract is awarded provides such coverage before labor begins. If the person awarding the contract does not provide such coverage, it will be treated as a noncomplying employer. The burden, thus, is on the person awarding the contract either to provide coverage or to make sure that the person to whom the contract is awarded provides coverage for those who are to perform labor under the contract. ORS 656.029(1).

If the person to whom the contract is awarded is not a subject worker under the provisions of ORS 656.027, that person is not eligible for coverage under any statute. If, however, that ineligible person hires individuals who are subject workers in the performance of the contract, that person is required to provide coverage for those workers. ORS 656.029(2).

ORS 656.029(2) does not expressly state that independent contractors are excluded from its coverage. Subsection (3) of the statute provides, however, that, if the person to whom the contract is awarded is a certified construction business, the person is presumed to be an independent contractor and is not entitled to benefits under the statute. That provision appears to be based on the unstated premise that independent contractors are not entitled to coverage.

Additionally, ORS 656.029(1) provides that a person awarding a contract need not provide coverage for individuals "exempt" from coverage under ORS 656.027. As we have said, an independent contractor is not subject to the direction and control of the employer and, therefore, is not a subject worker entitled to coverage; accordingly, an independent contractor is not included within the general provision of ORS 656.027 that requires coverage for "all workers."

We conclude that, as between Herwood and claimant, the provisions of ORS 656.029 have no application, and this case is indistinguishable from any other claim by an independent contractor. As an independent contractor, claimant is not a subject worker under ORS 656.027 entitled to benefits under the workers' compensation laws; accordingly, he is not entitled to coverage under ORS 656.029. The Board erred in concluding that claimant is entitled to benefits as a subject worker and that Herwood is a noncomplying employer.

Reversed.

Cite as 109 Or App 292 (1991)October 23, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Margaret I. Boehr, Claimant.

MARGARET I. BOEHR, Petitioner,

v.

MID-WILLAMETTE VALLEY FOOD and SAIF CORPORATION, Respondents.
(89-21774; CA A67319)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 17, 1991.

Brad G. Garber, Salem, argued the cause for petitioner. With him on the brief was Law Office of Michael B. Dye, Salem.

Katherine H. Waldo, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Joseph, Chief Judge, and Richardson* and Deits, Judges.

DEITS, J.

Reversed and remanded for reconsideration.

*Richardson, J., vice Newman, J., retired.

Claimant challenges an order of the Workers' Compensation Board denying her request for attorney fees. She argues that she is entitled to the fees because of employer's failure to provide discovery within fifteen days after her request. We remand for reconsideration.

The parties stipulated to these facts, which were incorporated in the Board's order:

"1. On July 21, 1989, claimant's attorney requested records from the above-captioned claim file. The request was received by SAIF on July 24, 1989.

"2. By letter dated August 29, 1989, SAIF provided the requested documents to claimant's attorney.

"3. The length of time between the attorney's request for discovery and SAIF's response was 35 days."

The Board held that, because a request for hearing had not been filed at the time of the request for discovery, discovery was not governed by OAR 438-07-015(2),¹ which requires compliance with discovery requests within 15 days, but by OAR 436-10-030(10),² which does not specify a time for compliance. It concluded that,

"even if SAIF's production of the documents was unreasonable, there has been no delay or resistance to the payment of compensation; there is no evidence that the delay in production of documents delayed acceptance of the claim. Without such a finding, there is no basis for an assessed attorney fee."

Claimant first contends that the Board erred in holding that it is without authority to regulate pre-hearing discovery. However, the Board did not hold that. It simply held that OAR 438-07-015(2) does not apply here.

Claimant also argues that the Board's conclusion that OAR 438-07-015(2) does not apply is wrong. We agree with the Board. The rule does not apply,

because the discovery request was made before a request for a hearing was filed. *O'Leary v. Valley View Cutting*, 107 Or App 103, 106, 810 P2d 1324 (1991).

However, we do not agree with the Board's conclusion that it could not award attorney fees. As the Board held, the applicable rule is OAR 436-10-030(10). Although that rule does not include any express time limit for responding to discovery requests, the Board has interpreted it to require that documents be produced in a reasonable time under the circumstances surrounding the discovery request. *Lawrence A. Durette*, 42 Van Natta 413 (1990). The Board did not decide whether employer's delay was unreasonable. It concluded that, even if the delay was unreasonable, there was no basis for awarding an attorney fee, because there was no delay or resistance to the payment of compensation.³ We have held that failure to comply with discovery requirements may be unreasonable resistance to the payment of compensation and may justify attorney fees under ORS 656.382(1), even when there is no evidence that the noncompliance delayed acceptance of the claim. *Aetna Casualty Co. v. Jackson*, 108 Or App 253, 815 P2d 713 (1991). However, we have also held that, in order for unreasonable resistance to compensation to be found, the claim must have been compensable. *Randall v. Liberty Northwest Ins. Corp.*, *supra* n 3. Accordingly, we remand to the Board to determine if the underlying claim was compensable and, if so, whether employer's delay was unreasonable and whether attorney fees should be awarded.

Reversed and remanded for reconsideration.

¹ The pertinent part of former OAR 438-07-015(2) and the amended version both provide:

"Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing or a written demand accompanied by an attorney retention agreement or medical information release, to the insurer or self-insured employer. Within fifteen (15) days of said mailing, the insurer or self-insured employer shall furnish the claimant and other insurers, without cost, originals or legible copies * * *."

² OAR 436-10-030(10), now renumbered OAR 436-10-030(15), provides, in part:

"Injured workers, or their representatives, are entitled to copies of all relevant medical information. This information should ordinarily be available from the insurers, but may be obtained from physicians upon the payment of an appropriate charge for copies."

³ The Board analyzed the case under ORS 656.262(10). However, as established in *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599, 813 P2d 1120 (1991), the applicable statute for awards of attorney fees is ORS 656.382(1).

Cite as 109 Or App 296 (1991)October 23, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

POWER MASTER, INC., Respondent,

v.

The filings of the NATIONAL COUNCIL ON COMPENSATION INSURANCE and the OREGON COUNCIL ON COMPENSATION INSURANCE, Respondents,
and SAIF CORPORATION, Petitioner.
(88-02-14; CA A62510)

Judicial Review from Department of Insurance and Finance.

Argued and submitted February 4, 1991.

David L. Runner, Assistant Attorney General, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

David J. Sweeney, Portland, argued the cause for respondent Power Master, Inc. On the brief were Raymond M. Rask, Paul G. Dodds, Suzanne C. Ritter, Certified Law Student, and Brownstein, Rask, Sweeney, Kerr, Grim & DeSylvia, Portland.

No appearance for respondents National Council on Compensation Insurance and the Oregon Council on Compensation Insurance.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

DEITS, J.

Reversed and remanded for determination of assessment as to employee Blanchard; otherwise affirmed.

*Joseph, C.J., vice Newman, J., retired.

This is a workers' compensation premium audit proceeding. SAIF seeks reversal of the part of the order of the Department of Insurance and Finance (DIF) that relieved Power Master, Inc. (PMI), of any premium obligation for its former Portland branch employees as of September 1, 1986. We reverse in part and otherwise affirm.

PMI is a corporation principally engaged in the business of industrial cleaning and maintenance. It is incorporated in Oregon, with its main office in Portland and branch offices in five other states. On September 1, 1986, PMI permanently moved its only Oregon branch office to Vancouver, Washington. The purpose of the move was to obtain better facilities in a safer location; to gain economic advantages such as lower costs, proximity to potential work sites and lower workers' compensation rates; and to further its increasing emphasis on Washington job opportunities.

Each PMI branch office maintains autonomy over its operations and employees. The Vancouver branch keeps its own employee records and is responsible for personnel management. The branch manager supervises the hiring and firing of employees, issuance of paychecks, training of employees, administration of grievances and assignment of employees to work sites. Generally, employees working outside Washington report directly to their work site except when they need tools or other equipment from the branch. PMI presented evidence that, since the move to Vancouver, most of the branch's work involved repeat industrial and commercial cleaning jobs and that the majority of those were in Washington. The branch also had two major asbestos removal jobs in Oregon and a few smaller asbestos jobs in Idaho and Washington. The evidence did not include a detailed breakdown of employee work hours in each state where work was done. On September 1, 1986, PMI stopped paying Oregon workers' compensation premiums for its former Portland branch employees and began paying premiums to the State of Washington.

In November, 1987, SAIF retroactively assessed PMI an additional premium of approximately \$175,000, for the period of September 1, 1986, to March 31, 1987, on the basis of SAIF's conclusion that PMI's former Portland branch employees were Oregon workers rather than Washington workers. PMI appealed the assessment to DIF, which concluded that the employees were permanent Washington workers for workers' compensation purposes. It explained:

"The basic test to determine jurisdictional situs of an employee, for workers' compensation purposes is the permanency of the employment relation. *Kolar v. B & C Contractors*, 36 Or App 65, 583 P2d 562 (1978). This permanency test appears to look at both the intent of the employer and the understanding of the employee to determine the situs of the employment [sic] relationship. The Court of Appeals looks to the employment relationship itself as opposed to the temporal place of a given job to determine jurisdiction."

SAIF assigns error to DIF's conclusion that the former Portland branch employees were not Oregon workers. With one exception, we agree with DIF's conclusion. Subject workers are defined under Oregon law as "[a]ll workers," with certain exceptions not pertinent to this case. ORS 656.005(25); ORS 656.027. Subject workers who temporarily work outside Oregon remain entitled to benefits under Oregon's Workers' Compensation Law. ORS 656.126(1). Out-of-state workers and their employers are exempt from Oregon's Workers' Compensation Law when they are temporarily working in Oregon, provided that certain requirements for coverage in another state are met. ORS 656.126(2).

SAIF first contends that, in applying the permanent employment relation test, DIF applied the wrong test for deciding if the workers in question were Oregon or Washington subject workers. It argues that, under an agreement between Oregon and Washington regarding jurisdiction for workers' compensation, executed pursuant to ORS 656.126(5),¹ DIF is only required to consider the location of the employee's work. According to that agreement,

"a Washington workman is a person *hired to work* in the State of Washington, and an Oregon workman is a person *hired to work* in Oregon." *Agreement Between the Department of Labor and Industries of the State of Washington and the Workmen's compensation Board of the State of Oregon Regarding Extraterritorial Reciprocity*, February 4, 1966." (Emphasis supplied.)

However, there is no indication in the language of ORS 656.126, or in the case law interpreting the statute, that the interstate agreement was intended to change the test for determining a worker's principal place of employment. Rather, the purpose of the interstate agreement appears to be to protect employ-

¹ ORS 656.126(5) provides:

"The director shall have authority to enter into agreements with the workers' compensation agencies of other states relating to conflicts of jurisdiction where the contract of employment is in one state and the injuries are received in the other state, or where there is a dispute as to the boundaries or jurisdiction of the states and when such agreements have been executed and made public by the respective state agencies, the rights of workers hired in such other state and injured while temporarily in Oregon, or hired in Oregon and injured while temporarily in another state, or where the jurisdiction is otherwise uncertain, shall be determined pursuant to such agreements and confined to the jurisdiction provided in such agreements."

ers from having to pay dual premiums and to protect workers by ensuring that an on-the-job injury or disease is compensable in at least one state.

SAIF's principal authority for its contention that the interstate agreement changed the test is *House v. State Industrial Accident Commission*, 167 Or 257, 268, 177 P2d 611 (1941). The Supreme Court construed the expression "employed to work in this state" in OCLA 102-1731,² the precursor of ORS 656.126(1),³ to mean the "location of the [worker's] work" rather than the location of the "employment relation." House is not controlling. It did not directly concern the language at issue here. The cases decided since the interstate agreement was executed have consistently applied the "permanent employee relation test" articulated in *Kolar v. B & C Contractors, supra*, 36 Or App at 70. See *Power Master, Inc. v. Blanchard*, 103 Or App 467, 471, 798 P2d 691 (1990); *Phelan v. H.S.C. Logging, Inc.*, 84 Or App 632, 735 P2d 22, rev den 303 Or 590 (1987).

SAIF also argues that, even if the permanent employment relation test applies, DIF did not apply it correctly. SAIF lists certain factors that it contends must be addressed in applying the permanent employment relation test and argues that DIF is required to make specific findings on each factor. It also asserts that a determination of the location of the work sites is essential. However, finding that the employees were transient and worked out of many locations, DIF decided that it was inappropriate "to simply look at the sequence of temporary assignments." Instead, it focused on other factors, such as the location of various supervisory and administrative activities as well as the intent of the parties, to determine the permanency of the employment relation.

There was evidence that PMI supervised and controlled the employees out of the Vancouver office. It hired, fired and trained employees and administered grievances there. It also assigned work sites and distributed equipment and supplies from that office. Unless it was inconvenient, the employees reported there daily and to receive their paychecks. There was evidence that most of the jobs were in Washington. DIF's order stated that "[a]ll parties, both employees and employer, who testified, stated that the Vancouver branch office was the new location of their job-employer as of September 1, 1986." Although many of the workers were hired in Oregon, that is not controlling. As we have held,

"that [an employee] was hired in Oregon, drove out of this state on his way to Virginia, and continues to believe he is Oregon-based

² That statute, OCLA 102-1731, provided:

"If a workman employed to work in this state and subject to this act temporarily leaves the state incidental to such employment and receives an accidental injury arising out of and in the course of his employment, he shall be entitled to the benefits of this act as though he were injured within this state * * *." (Emphasis supplied.)

³ 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." (Emphasis supplied.)

does not establish that he was permanently in Oregon." *Jackson v. Tillamook Growers Co-Op*, 39 Or App 247, 250, 592 P2d 235 (1979).

Neither does the location of the corporate headquarters control. Even though company-wide policy may have been formulated in Portland, the branches had administrative and supervisory control of their employees. We conclude that DIF applied the appropriate factors and that its findings are supported by substantial evidence. It was not necessary, as SAIF asserts, that DIF make detailed findings on each factor that it considered.

SAIF also argues that our decision in *Power Master, Inc. v. Blanchard, supra*, precludes reconsideration of the status of a former Portland branch employee in this case. We held that Blanchard was a subject Oregon worker when he was injured in November, 1986. Under the doctrine of issue preclusion, future litigation is precluded between the parties on any issue of fact or law that was actually litigated and determined in a setting where its determination was essential to the final decision reached. *Drews v. EBI Companies*, 310 Or 134, 139, 795 P2d 531 (1990).

SAIF and PMI were parties to the litigation in both cases. The critical question is whether any issue of fact or law essential to the first decision also arose in the second. In *Blanchard*, the issue was "whether claimant is a 'worker employed in this state' within the meaning of ORS 656.126(1) or is, instead, an out-of-state employee who is not covered by the Oregon Workers' Compensation Law." 103 Or App at 469. The record in that case showed that claimant had worked out of the Portland office and only on Oregon jobs until the move on September 1. After the move, he reported to the Vancouver office each morning and afternoon but continued to work on Oregon jobs. In October, he began working in Idaho, where he was injured in November. The Board order set aside the denial of the Oregon claim. We affirmed, holding that "the move of the office had no significant effect on claimant's job. * * * Claimant remained an Oregon employee for purposes of ORS 656.126(1)." 103 Or App at 472.

We conclude that Blanchard's status as of the time of his November, 1986, injury was decided in *Power Master, Inc. v. Blanchard, supra*. DIF, therefore, was precluded from making a different determination regarding him for the same period.

SAIF asserts that *Blanchard*

"provides the best legal authority imaginable for the conclusion that Mr. Blanchard and all other similarly situated workers continued to be Oregon workers after the branch relocation."

We do not agree that that conclusion automatically follows. The decision and record in *Blanchard* involved only the status of one claimant at the time of an injury that occurred less than three months after PMI changed the location of its branch office. The decision and record in this case involves all former Portland branch employees for a six-month period. In summary, we conclude that, except for the precluded issue concerning *Blanchard*, there were no errors of law and there was substantial evidence to support DIF's findings.

Reversed and remanded for determination of assessment as to employee Blanchard; otherwise affirmed.

Cite as 109 Or App 349 (1991)October 30, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gilbert Archer, Jr., Claimant.

SOUTHWEST FOREST INDUSTRIES, Petitioner,

v.

GILBERT ARCHER, HARRY & DAVID, INC., and SAIF CORPORATION, Respondents.
(86-10377, 86-16025; CA A63020)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 21, 1990.

H. Scott Plouse, Medford, argued the cause for petitioner. On the brief were Kimberly D. Wallan and Cowling & Heysell, Medford.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents Harry & David, Inc. and SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

No appearance by respondent Gilbert Archer.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

JOSEPH, C.J.

Reversed and remanded for reconsideration.

*Joseph, C.J., vice Newman, J., deceased.

Petitioner seeks review of a Workers' Compensation Board order that reversed the referee and awarded claimant compensation for aggravation of his condition. We reverse.

In April, 1984, claimant experienced back pain after lifting a motor while working for petitioner. A chiropractor diagnosed dorsal lumbar back strain. He and an osteopath also recommended that claimant seek psychological counseling for preexisting emotional problems. In July, 1984, petitioner accepted the injury claim.¹ Claimant returned to work but still experienced back pain. Petitioner denied that the pain was compensable. In April, 1985, the referee approved a settlement stipulation and issued a disputed claim settlement order. ORS 656.289(4).

The settlement order provides:

"The parties stipulate as follows:

"(1) That on or about April 19, 1984, Claimant filed a Form 801 Report of Occupational Injury or Disease alleging that he injured his upper, mid and low back during the course of employment on April 10, 1984. The Employer accepted the claim in accordance with the applicable statutes and regulations. Subsequently, Claimant complained of continuing problems to his upper, mid and low back. These problems were diagnosed as having a psychiatric or psychological origin. The Carrier denied the compensability of the present problems and psychiatric origin of them on July 12, 1984. The Claimant requested a hearing.

¹ Petitioner denied any liability for the psychiatric condition. Claimant did not appeal that denial.

"(2) The parties each have substantial evidence to support their contentions:

"(a) The Claimant contends that his present problems with his upper, mid and low back are a continuing result of industrial injury.

"(b) The Employer contends that Claimant's problems with his upper, mid and low back have no physical etiology but are due to psychiatric and psychological problems. That these problems are unrelated to and did not arise out of or during the course of Claimant's employment with the Employer or were they caused, aggravated, worsened, or contributed to by the industrial injury. That the psychiatric problem is pre-existing and unrelated to the industrial injury. * * *

"(3) That it appears to the parties that a bona fide dispute exists as to the compensability of Claimant's claim that his present problems are a result of industrial injury and that the matter should be settled by a lump sum payment of \$3,000.00 to Claimant by the Carrier under the provisions of ORS 656.289(4). That Claimant fully understands that said compromise is in full and final settlement of any contention that his present problems and need for care is [sic] compensable.

"(4) Claimant's request for Hearing shall be dismissed with prejudice and *the Employer's denial and Employer's contentions contained in this stipulation shall be affirmed.*" (Emphasis supplied.)

Subsequently, claimant worked for different employers and received treatment for back pain. In November, 1985, petitioner issued a notice of closure. In December, 1986, a determination order awarded claimant additional temporary disability benefits and closed the claim for the back injury.

In March, 1986, claimant experienced back pain after moving boxes while working at Harry & David, Inc. An orthopedic surgeon concluded that claimant had not suffered a new injury but had an ongoing back condition that had been aggravated. Claimant filed a new injury claim with Harry & David, Inc., whose insurer, SAIF, paid interim compensation and then denied the claim. Claimant requested a hearing on SAIF's denial and also notified petitioner that he was claiming an aggravation of the 1984 injury. Petitioner denied the aggravation claim.

The referee found that claimant had suffered neither an aggravation of the back injury while in petitioner's employment nor a new injury at Harry & David, Inc. He affirmed both denials. The Board reversed. It found that claimant had suffered an aggravation of the 1984 injury.

Petitioner² assigns errors to the Board's finding that claimant had suffered an aggravation and to its failure correctly to interpret the disputed claim settlement order. It argues that claimant could not claim an aggravation, because the settlement order accepted petitioner's contentions that the condition had no physical etiology and did not arise in the course of employment.

² Curiously, claimant has not appeared in this judicial review. Harry & David, Inc., and SAIF, its insurer, filed a brief that effectively agrees with petitioner in all respects.

Therefore, it effectively eliminated the possibility of establishing a causal relationship between the 1984 injury and the purported aggravation.

The Board erred as a matter of law when it did not correctly read and apply the settlement order. The Board's order says that the settlement order "affirmed [petitioner's] acceptance [in 1984] of claimant's back injury and upheld [its] denial of claimant's psychiatric claim." The settlement order, however, does much more than that. It also "affirmed" petitioner's contentions that claimant's upper, middle and low back problems were unrelated to his employment, had no physical origin and were due to psychiatric and psychological problems.

The Board made no findings about whether claimant's physical problems when he filed the aggravation claim in April, 1986, were medically any different from those he had in March, 1985, when the settlement order issued.³ The referee had found that they were the same. If they were, the settlement order establishes that they are unrelated to his employment by petitioner. We remand to the Board for those findings to be made. If it finds that the 1986 problems were different, then it must decide, under a correct reading, whether the settlement order bars him from asserting an aggravation.

Petitioner also assigns error to the Board's award of fees to claimant's attorney for prevailing on Board review. That award fails with the rest of the Board's order.

Reversed and remanded for reconsideration.

³ The Board relied exclusively on the opinion of a doctor who first saw claimant in October, 1985, seven months after the settlement order was issued.

Cite as 109 Or App 387 (1991)

October 30, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John H. Bement, Claimant.

SAIF CORPORATION and **PACIFIC WEST BUILDING MAINTENANCE**, Petitioners,
v.

JOHN H. BEMENT, Respondent.
(WCB No. 88-13391; CA A67097)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 17, 1991.

Katherine H. Waldo, Assistant Attorney General, Salem, argued the cause for petitioners.

Quintin B. Estell, Salem, argued the cause and filed the brief for respondent.

Before Joseph, Chief Judge, and Richardson* and Deits, Judges.

JOSEPH, C.J.

Reversed and remanded for reconsideration.

*Richardson, J., vice Newman, J., deceased.

Employer seeks review of a Workers' Compensation Board order that reversed the referee and awarded claimant permanent partial disability (PPD) benefits. We reverse and remand for reconsideration.

In 1987, claimant sustained a compensable back injury but received only temporary disability benefits. His work later exacerbated that injury, and he again received temporary disability benefits in January, 1989. However, he did not receive a permanent partial disability award. He requested a hearing. The referee found that, because claimant had suffered no "measurable impairment," he was not entitled to PPD.¹

Claimant conceded before the Board that he had suffered no measurable impairment and was not entitled to PPD under the standards. Nevertheless, the Board reversed the referee and awarded claimant 10% PPD. To support its order, it relied on *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987), and *International Paper Co. v. Turner*, 91 Or App 91, 754 P2d 589, rev den 307 Or 101 (1988).

In *Gwynn*, the court held that a claimant who files an aggravation claim cannot recover for periods of temporary disability if those disabilities are not more than was anticipated at the time of the previous arrangement of compensation. In *International Paper Co.*, we said that we will assume "that all relevant evidence concerning [a] claimant's anticipated permanent disability [that] was before the referee was considered in making the award * * *." 91 Or App at 93. The Board found that claimant's injury will inevitably cause periods of temporary disability. Relying on *International Paper Co.*, it concluded that, in view of the evidence that claimant would experience future periods of temporary disability, the award would be deemed to have anticipated those periods. Then, relying on *Gwynn*, it concluded that claimant could not be compensated for those periods of temporary disability on the basis of an aggravation claim, unless the disability were worse than was anticipated at the time of the previous arrangement of compensation. Therefore, it reasoned, the present award has to compensate claimant for future disabilities, even in the absence of measurable impairment and that claimant had sufficiently established that he "has suffered a greater permanent loss of earning capacity than is indicated by the standards." ORS 656.283(7) (since amended by Or Laws 1990 (Spec. Sess.), ch 2, 20).²

The Board reads *International Paper Co.* too literally. We will not assume that an award was based on anticipated periods of temporary disability if, as a matter of law, the claimant was precluded from receiving benefits on the basis of that evidence. The standards provided that "[i]f there is no measurable impairment[,], no award of unscheduled permanent partial disability shall be allowed." Former OAR 436-35-320. Therefore, claimant's concession that he suffered no measurable impairment precluded the referee (and the Board) from awarding PPD, no matter what the evidence showed concerning future periods of disability.

Reversed and remanded for reconsideration.

¹ Under ORS 656.283(7) (since amended by Or Laws 1990 (Spec. Sess.), ch 2, 20), a referee, in determining PPD, was required to apply the standards for the evaluation of disabilities adopted pursuant to ORS 656.726. The standards provided that "[i]f there is no measurable impairment no award of unscheduled permanent partial disability shall be allowed." Former OAR 436-35-320.

² ORS 656.283(7) (since amended by Or Laws 1990 (Spec. Sess.), ch 2, 20) provided, in part:

"Nothing in this section shall be construed to prevent or limit the right of a worker * * * to present evidence at hearing and to establish by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more * * * than the entitlement indicated by the standards adopted by the director under ORS 656.726."

Cite as 109 Or App 391 (1991)

October 30, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Steven E. Jones, Claimant.

CAMERON LOGGING/LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners,
v.
STEVEN E. JONES and **DOUGHERTY LOGGING/LIBERTY NORTHWEST INSURANCE CORPORATION**,
Respondents.
(WCB No. 89-08974; CA A67238)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 17, 1991.

David O. Wilson, Employers Defense Counsel, Eugene, argued the cause and filed the brief for petitioners.

No appearance for respondent Steven E. Jones.

Darrell E. Bewley, Salem, argued the cause and filed the cause for respondent Dougherty Logging.

Before Joseph, Chief Judge, and Richardson* and Deits, Judges.

JOSEPH, C.J.

Reversed and remanded for reconsideration.

*Richardson, J., vice Newman, J., deceased.

Cameron Logging Company (Cameron) seeks review of a Workers' Compensation Board order assigning responsibility to it for claimant's back condition. We reverse and remand for reconsideration.

Claimant suffered a series of compensable back injuries beginning in 1978. His last accepted claim was for an injury on December 10, 1986, while he was working for respondent Dougherty Logging (Dougherty). On August 3, 1988, while working for Cameron, he began experiencing severe back pain. However, there had been no specific injurious incident. The next day, claimant's chiropractor took him off work.

Cameron and Dougherty contested responsibility for claimant's current condition and sought a hearing. ORS 656.289.¹ The referee applied the last injurious exposure rule and found Cameron responsible for claimant's condition. The Board adopted the referee's opinion and order.

We review for substantial evidence and errors of law. ORS 183.482(7),(8). However, as a preliminary matter,

"[i]n order for us to conduct that kind of review, we must be able to know what the Board found as fact and why it believes that its findings led to the conclusions that it reached. That requires a reasoned opinion based on explicit findings of fact." *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988).

Although the order contains explicit findings of fact, it does not explain why they lead to the Board's conclusions. We cannot determine whether the Board properly applied the last injurious exposure rule. More specifically, we cannot determine whether the Board properly allocated the burden of proof or whether it found that claimant suffered a new injury. Therefore, the Board's order is insufficient for review.

¹ For reasons not apparent to us, this case has not come to us by way of the arbitration procedure described in ORS 656.307(2).

Under the last injurious exposure rule, the last employer with an accepted claim relating to a specific body part bears the burden of proving that a new injury at the subsequent employment independently contributed to a worsening of the claimant's underlying condition. *Stevens Equipment Co. v. American Fabricators*, 106 Or App 354, 807 P2d 334, rev den 311 Or 482 (1991). The party who bears that burden has 2 distinct obligations. *Hansen v. Oregon-Wash. R. & N. Co.*, 97 Or 190, 210, 188 P 963 (1920). First, it must produce evidence of the facts in issue, which is a burden of production. See ORS 183.450(2). Second, the party "must in the end establish a given proposition in order to succeed," which is a burden of persuasion. 97 Or at 210.

Misallocation of the burden of proof is a procedural error, *Harris v. SAIF*, 292 Or 683, 689-90, 642 P2d 1147 (1982), for which we will remand only if the error can be seen to have impaired the fairness of the proceeding or the correctness of the action. ORS 183.482(7). Misallocation of the burden of production tends to impair fairness or correctness by permitting the party who should have had the burden to prevail without producing necessary evidence. Misallocation of the burden of persuasion tends to impair fairness or correctness by permitting the party to prevail when the evidence is in equipoise. See, generally, *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 394, 737 P2d 595 (1987).

Dougherty, as the last employer with an accepted claim concerning claimant's back, should have had the burden of proof. In its order, the Board said:

"Resolution of the [sic] responsibility in this case is controlled by the last injurious exposure rule which places full responsibility on the last employer unless the last employer can provide sufficient proof of a lack of independent contribution to a worsening of the claimant's underlying condition."

That language suggests that the Board placed the burden of proof on Cameron--the last employer--instead of Dougherty--the last employer with an accepted claim, where it belonged. However, the Board also said:

"Claimant's increased symptoms required significant medical care and treatment and significant time loss with the concomitant worsening of his underlying condition sufficient enough [sic] to transfer responsibility from Dougherty Logging to Cameron Logging."

That language suggests that the Board initially assumed that Dougherty was responsible and had the burden of proof. The Board's order lacks a reasoned analysis, and we cannot determine whether it properly allocated the burden of proof.

The Board also found that claimant's condition had worsened while he was working at Cameron. Nevertheless, under the last injurious exposure rule, responsibility would shift to Cameron only if there was "evidence of a second injury that materially contributed to the claimant's disability." *Stevens Equipment Co. v. American Fabricators*, supra, 106 Or App at 358. "Injury" means a new injury, not the exacerbation or aggravation of an old injury.

The order reads:

"While claimant in the instant case did not sustain a specific traumatic injury, it is clear that as a result of his work activity at Cameron Logging in general and, specifically, on August 3, 1988, his preexisting underlying condition worsened to the point where he required significant medical care and treatment and time loss from work."

If that means that the Board found that claimant's previous injury was merely aggravated but responsibility still shifted to Cameron, that would be an error of law. Conversely, if the Board really meant to say that claimant had suffered a new injury, even in the absence of a specific injurious incident, we would uphold that determination, if it is supported by substantial evidence. See *Hensel Phelps Const. v. Mirich*, 81 Or App 290, 293, 724 P2d 919 (1986). Because the Board's order lacks a reasoned analysis in this respect, too, we cannot determine whether the Board found a new injury or merely an aggravation.

Reversed and remanded for reconsideration.

Cite as 109 Or App 452 (1991)

October 30, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jeannie S. Hubbard, Claimant.

INTERNATIONAL PAPER COMPANY, Petitioner,
v.

JEANNIE S. HUBBARD, Respondent.
(88-05829; CA A65248)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 14, 1991.

Paul L. Roess, Portland, argued the cause for petitioner. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Malcolm J. Corrigan, Coos Bay, argued the cause for respondent. With him on the brief was Ormsbee & Corrigan, Coos Bay.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

DEITS, J.

Affirmed.

*Joseph, C.J., vice Newman, J., deceased.

Employer seeks review of an order of the Workers' Compensation Board that held that claimant has a compensable aggravation claim. The issue presented is whether claimant is entitled to temporary disability benefits for the period when she was laid off and was receiving unemployment benefits. We affirm.

Claimant compensably injured her back while working in employer's wood products mill in April, 1983. After the injury, she continued working at the mill, but in less strenuous jobs. Her claim was closed in July, 1987, pursuant to a determination order that awarded five percent unscheduled permanent disability. Claimant appealed the determination order and, after a hearing, the referee affirmed the award on December 11, 1987. Claimant was laid off, along with many other workers at the mill, on December 18, 1987. The mill closed soon thereafter. She then applied for and received unemployment benefits, until she began working for the purchaser of the mill in June, 1988. On January 22, 1988, she sought treatment from her physician. She reported that her back had been feeling worse for about two weeks. On February 19, 1988, her physician wrote to the insurer, stating that her back and neck pain had worsened and that she needed further therapy. The physician later explained that claimant was not physically able to work and that she would be undergoing physical therapy and be off work for a period of approximately two to four weeks.

On March 7, 1988, the insurer issued a written denial of the aggravation claim. Claimant requested a hearing. The referee held that claimant had a

valid aggravation claim, disallowed employer's denial and remanded the case for the payment of benefits. On review, the Board correctly stated:

"In order to prove a claim for aggravation of an unscheduled condition under ORS 656.273, claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity."

It then affirmed the referee's order, concluding that

"(1) claimant sustained a symptomatic exacerbation of her neck condition; (2) which resulted in diminishing earning capacity; and (3) as a result of the increased symptoms, claimant became totally disabled for more than 14 days. Therefore, we hold that claimant has met her burden of proof and established a compensable aggravation case."

Employer does not dispute that claimant proved an aggravation, but argues that the Board erred in ordering the payment of temporary disability benefits. Employer contends that, because claimant had been laid off and because she was receiving unemployment compensation, she could not prove that she had lost wages as a result of the worsened condition. It argues that, if there was no work to be done, there were no wages to be lost and, therefore, the worsening of claimant's condition made no difference in her earning capacity.

We do not agree with employer that claimant must prove an actual loss of wages due to the aggravation to be entitled to benefits. If claimant proves that, because of the worsening, she was less able to work to such an extent that she was temporarily incapacitated from regularly performing work at a gainful and suitable occupation, *Smith v. SAIF*, 302 Or 396, 401, 730 P2d 30 (1986), and that she was otherwise willing to seek work, *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 300, 702 P2d 403 (1985), the fact that she was laid off from one job makes no difference.

Employer also argues that claimant has not lost wages, because she received unemployment benefits for the same time period that she is seeking temporary disability benefits. However, claimant's receipt of unemployment benefits does not disqualify her from receiving temporary disability benefits because, as discussed above, it is not necessary that claimant prove actual loss of wages to be entitled to temporary disability benefits.¹ Payment of concurrent unemployment and disability benefits might result in an offset of benefits. See *Wells v. Pete Walker's Auto Body*, 86 Or App 739, 740 P2d 245, rev den 304 Or 406 (1987).

Affirmed.

¹ It is important to note that employer here does not challenge the validity of the aggravation claim. Although we have held that receipt of unemployment benefits does not disqualify a claimant with a compensable aggravation from receiving temporary disability benefits, evidence of receipt of unemployment compensation and the representations made by a claimant in seeking it may be relevant as to whether or not there was an aggravation.

Cite as 109 Or App 464 (1991)

October 30, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James R. Lasiter, Claimant.

JAMES R. LASITER, Petitioner,
v.
SAIF CORPORATION and WELCH TRUCKING, Respondents.
(88-10337; CA A64095)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 11, 1991.

Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were Robert F. Webber, and Black, Chapman & Webber, Medford.

David L. Runner, 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 Joseph, Chief Judge,* and Deits, Judge.

DEITS, J.

Affirmed.

*Joseph, C.J., vice Newman, J., deceased.

Claimant seeks review of a final order of the Workers' Compensation Board that dismissed his claim for compensation because, in an earlier compliance proceeding, his alleged employer was found not to be a subject employer under the Workers' Compensation Law. We affirm.

On December 8, 1987, claimant filed an occupational disease claim against Patricia Sue Welch, dba Welch Trucking. Claimant drove a truck owned by Welch that had been leased to Lynn Transportation, Co., Inc. The Compliance Section of the Workers' Compensation Division issued an order on February 24, 1988, that declared Welch to be a noncomplying employer. ORS 656.005(18). Welch contested that order, and a hearing was scheduled for June 14, 1988. Notice of the hearing was sent to claimant and his attorney, captioned:

"In the Matter of the Compensation of JAMES R. LASITER, Claimant,
and in the matter of the Complying Status of PATRICIA SUE WELCH, dba
WELCH TRUCKING, Employer."

Neither claimant nor his attorney appeared at that hearing. The referee determined that Welch was not a subject employer under the Workers' Compensation Law, and copies of the order were sent to claimant and his attorney.

On April 22, 1988, SAIF issued a denial of claimant's occupational disease claim on the basis that the disease was not sufficiently work-related. On June 20, six days after the hearing on Welch's complying status, claimant filed a request for hearing on SAIF's denial. In response, SAIF filed a motion to dismiss claimant's request on the basis that Welch had already been found to be a non-subject employer and, therefore, claimant could not be a subject worker. The referee granted the motion on the basis that the holding in the compliance proceeding that claimant was not a subject worker was the "law of the case." The Board affirmed, explaining:

"The result of [the Referee's] order is to negate the claim as there is no longer a subject employer against which to file a claim. The Referee [in this case] referred to this as the law of the

case[;] we disagree with that terminology, but we do agree with the ultimate result of the Referee."

The parties argue the case in terms of issue preclusion. However, we agree with the Board's characterization. It is not really a matter of claimant's being precluded from litigating the compensability of his claim. Technically, he is not precluded from doing that. The problem is that, because of the holding in the earlier compliance proceeding, there is not a subject employer against which claimant can claim. Although claimant had notice of that proceeding and could have participated in it or have had that proceeding consolidated with the compensability proceeding, ORS 656.740, his failure to participate does not affect the validity of the compliance holding. The Board's order dismissing the request for hearing on SAIF's denial was correct.

Affirmed.

Cite as 109 Or App 499 (1991)

November 13, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donald J. Taylor, Claimant.

DONALD J. TAYLOR, Petitioner,

v.

MULTNOMAH COUNTY SCHOOL DISTRICT NUMBER 1, Respondent.

(WCB No. 88-09071; CA A65698)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 17, 1991.

David C. Force, Portland, argued the cause for petitioner. With him on the brief were Glen J. Lasken and Vick & Gutzler, Portland.

Craig A. Staples, Portland, argued the cause for respondent. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

JOSEPH, C.J.

Affirmed.

*Joseph, C.J., vice Newman, J., deceased.

Claimant seeks review of an order of the Workers' Compensation Board that adopted the order of the referee holding that he had suffered no compensable injury. We affirm.

Claimant had worked for 13 years as a custodian for employer. He was treated for back pain unrelated to his work in 1970 and in 1980. He was injured in a car accident in 1986 and has had sacroiliac back pain since then. In December, 1987, he developed lower left back and left leg pain. In January, 1988, that pain increased after he had moved school gym bleachers. On February 9, it also increased after he lifted a wrestling mat at work. On February 11, he filed an injury claim stemming from the mat incident. On April 12, he underwent surgery to correct a herniated disc.

The Board specifically found that claimant is not credible. It concluded that his work activities were not a material contributing cause of his back condition or the need for treatment. Claimant assigns as error the finding that he is not credible. He also asserts that, even if he is not credible, he proved by a preponderance of the evidence that he suffered a compensable injury.¹

The Board based its credibility finding on inconsistencies in claimant's testimony and in the information that he supplied on the claim form and on an earlier medical form.² There is sufficient evidence to support the finding that

¹ Claimant argues that he was compensably injured in January when he moved the bleachers and again in February when he lifted the mat. However, he filed a claim only for the mat incident. The Board did not, and we do not, address the bleacher incident.

² Claimant initially testified that he had never received back treatment before December, 1987, but, on cross-examination, he acknowledged that he had been treated in 1970 and 1986. In December, 1987, he saw Dr. Welck, a chiropractor, and wrote on a form that he had experienced lower left back pain and leg pain for the past year. On the injury report form in this case, he said that he had hurt his left lower back only 2 months earlier. He also reported to Welck that he had not had "this or similar [back pain] in the past," although he had been treated for back pain before at least 3 times.

he is not credible. However, it does not necessarily follow that he did not prove his claim. The issue for us is whether there is substantial evidence to support the conclusion that he had not suffered a compensable injury. ORS 656.005(7)(a); see *Mashadda v. Western Employers Insurance*, 75 Or App 93, 95, 705 P2d 234 (1985).

In *Wausau Insurance Company v. Huhnholz*, 85 Or App 199, 735 P2d 1292 (1987), we held that the claimant did not suffer a compensable injury when he lifted objects at work and preexisting osteoarthritis in his back became more painful. We explained that he was not injured within the meaning of ORS 656.005(7)(a), because

"there was no sudden onset of pain over a discrete period. Although claimant testified that after lifting the racks of Teflon his back hurt 'real bad,' he also testified, and the medical evidence showed, that his back had hurt periodically before the June incident. * * * [A]t most, claimant's work made his preexisting condition symptomatic." 85 Or App at 202.

Claimant has suffered continuous low back pain since 1986. He had suffered lower left back and left leg pain for at least a month before he lifted the mat. Compare *Valtinson v. SAIF*, 56 Or App 184, 188, 641 P2d 598 (1982). He had previously sought treatment for pain in precisely the same area. Dr. Silver, the neurosurgeon who operated on claimant's disc, concluded that the mat incident did not independently contribute to the herniation. There is substantial evidence to support the Board's finding that claimant's preexisting condition, rather than the February 9 incident, caused him to need medical services.

Affirmed.

Cite as 109 Or App 509 (1991)

November 13, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Debbie L. Brown, Claimant.

DEBBIE L. BROWN, Petitioner,
v.

GOLD BEACH DAIRY QUEEN and SAIF CORPORATION, Respondents.
(WCB No. 88-19187; CA A65857)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 17, 1991.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Jon C. Correll and Malagon, Moore & Johnson, Eugene.

Thomas E. Ewing, 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 Joseph, Chief Judge, and Richardson* and Deits, Judges.

JOSEPH, C.J.

Reversed and remanded for reconsideration.

*Richardson, J., vice Newman, J., deceased.

Claimant seeks review of an order of the Workers' Compensation Board denying her request for an increase in benefits over a previous award that was based on 30 percent scheduled disability for an injury to her left knee. She based her request on increased pain. The referee found that, at her last medical examination, claimant had a full range of motion with "mild patellofemoral crepi-

tus on longitudinal motion of the patella in the femoral groove at about 30 degrees of flexion"; that she had failed to return to her doctor for a re-check after her last treatment; and that she had not been taking any medication for pain. He reasoned that the evidence, as a whole, did not establish entitlement to an increase under the applicable standards. He also explained that claimant's testimony that her knee was bothering her more than it had earlier did not provide a basis for quantifying her increased pain and that she had, therefore, not shown clear and convincing evidence of entitlement to an award outside the applicable standards.

The Board adopted the referee's findings and also found that "[f]lexion in claimant's knee was to 143 degrees" and "[c]laimant suffers disabling pain due to her compensable knee injury." It calculated claimant's current disability, concluding that she is entitled to an award of 1.7 percent under the standards, because she has 143 degrees of retained flexion. Its discussion of her disability for pain reads, in its entirety:

"Additionally, we conclude that claimant is entitled to an award of 10 percent disability for disabling pain. See *Daniel Alire*, 41 Van Natta 752 (1989)."

It then combined the 1.7 percent with the 10 percent and concluded that she had not met her burden to show by clear and convincing evidence that she has lost more than the 30 percent use and function of her left knee recognized in the original award. It affirmed the determination order.

Claimant argues that the Board erred in that it did not provide an ordered set of findings and a reasoned explanation of why her disabling pain causes only a 10 percent loss of use and function. See *Matthies v. Tillamook County Creamery Assoc.*, 101 Or App 44, 47, 788 P2d 1032 (1990). SAIF concedes that that was error.

In *Daniel Alire*, *supra*, the claimant established that pain limited his ability to lift, work while on his knees, sit and stand, which in turn limited his ability to perform his usual work. The Board concluded that his inability to perform such tasks constituted an impairment of 10 percent. 41 Van Natta 752. We find nothing in that case, or any other, that would justify the Board's failure to explain why claimant's pain causes only a 10 percent disability.

Reversed and remanded for reconsideration.

Cite as 109 Or App 545 (1991)

November 13, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

KILHAM STATIONERY AND PRINTING, Petitioner,

v.

NATIONAL COUNCIL ON COMPENSATION INSURANCE and the OREGON COUNCIL ON
 COMPENSATION INSURANCE, SAFECO INSURANCE COMPANY and DEPARTMENT OF INSURANCE AND
 FINANCE, Respondents.
 (88-09-20; CA A61120)

Judicial Review from Department of Insurance and Finance.

Argued and submitted October 26, 1990.

Paul G. Dodds, Portland, argued the cause for petitioner. With him on the
 briefs was Brownstein, Rask, Sweeney, Kerr, Grim & DeSylvia, Portland.

Jacqueline Weber, Lake Oswego, argued the cause and filed the brief for
 respondent SAFECO Insurance Company.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for
 respondent Department of Insurance and Finance. With him on the brief were Dave
 Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Peter A. Ozanne, Portland, waived appearance for respondents National Council
 on Compensation Insurance and Oregon Council on Compensation Insurance.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P.J.

Affirmed.

Petitioner is an Oregon corporation engaged in the business of supplying
 stationery and delivering documents. From January 1, 1986, through January 1,
 1988, it obtained worker's compensation coverage from SAFECO. SAFECO reclassi-
 fied some of petitioner's employees for 1986 and 1987, resulting in a retroac-
 tive assessment of premiums on May 21, 1987, and on July 7, 1988.

In 1987, the legislature enacted ORS 737.318, which established a premium
 audit program for workers' compensation insurance. It provides, in pertinent
 part:

"(1) A workers' compensation insurer shall maintain a premium
 audit program to aid in achieving equitable premium charges to Ore-
 gon employers and for the collection of credible state-wide data for
 ratemaking.

"(2) The director shall prescribe by rule a premium audit pro-
 gram system for workers' compensation insurance.

"(3) The premium audit system shall include provisions for:

"* * * * *

"(d) An appeal process pursuant to ORS 737.505 for employers to
 question the results of a premium audit; * * *

"(e) * * *

"(4) Notwithstanding ORS 737.505, the provisions of this section
 apply to all premium audit disputes between employers and insurers
 in existence on July 20, 1987, regardless of the policy year in-
 volved or the date of the final audit billing." (Emphasis sup-
 plied.)

The first of the billings in this case was sent to and received by petitioner before the effective date of ORS 737.318, and there is a dispute whether it is subject to the statute's provisions. It is agreed that the second billing, sent after the effective date of the statute, is subject to it.

In 1987, the legislature also amended ORS 737.505 by adding subsections (4) and (5), which provide procedures for appeal of a final premium audit billing. As amended, ORS 737.505 provides:

"(1) Every rating organization and every insurer which makes its own rates, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, shall furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

"(2) Every rating organization and every insurer which makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by the authorized representative, on written request by the person or authorized representative, to review the manner in which such rating system has been applied in connection with the insurance afforded the person. If the rating organization or insurer fails to grant or reject such request within 30 days after it is made, the applicant may proceed in the same manner as if the application had been rejected.

"(3) Any party affected by the action of such rating organization or such insurer on such request, within 30 days after written notice of such action, may appeal to the director, who, after a hearing held at a place designated by the director upon not less than 10 days' written notice to the appellant and to such rating organization or insurer, shall affirm or reverse such action.

"(4) Appeals to the director pursuant to ORS 737.318 with regard to a final premium audit billing must be made within 60 days after receipt of the billing.

"(5) The director may, upon a showing of good cause, stay any workers' compensation insurer's collection effort on a final premium audit billing during the pendency of an appeal authorized by subsection (4) of this section." (Emphasis supplied.)

Subsection (4) became effective after the first billing in this case but before the second.

Petitioner appealed both billings to the Director of the Department of Insurance and Finance (DIF) on September 13, 1988, more than one year after the May, 1987, billing, and more than 60 days after the July, 1988, billing. SAFECO moved to dismiss the appeal as untimely. On May 22, 1989, DIF issued an order dismissing the appeal, and petitioner submitted exceptions. DIF responded by letter, stating that the May 22, 1989, order was final and was subject to review by the Court of Appeals. Petitioner filed its petition for judicial review in this court on June 20, 1989. It contended, *inter alia*, that DIF had failed to follow the procedures set forth in ORS 183.460, which provides:

"Whenever in a contested case a majority of the officials of the agency who are to render the final order have not heard the case or considered the record, the order, if adverse to a party other than

the agency itself, shall not be made until a proposed order, including findings of fact and conclusions of law, has been served upon the parties and an opportunity has been afforded to each party adversely affected to file exceptions and present argument to the officials who are to render the decision."

On October 26, 1989, DIF withdrew its May 22, 1989, order for reconsideration. On October 30, 1989, we suspended our review pending issuance of a new order by DIF. On January 3, 1990, DIF issued a proposed order, to which petitioner and SAFECO filed responses. In February, 1990, DIF issued an amended final order dismissing the appeal as untimely, without taking evidence.

Petitioner filed an amended petition for judicial review and a supplemental brief. It now contends that it is entitled to recover its costs incurred in bringing the initial petition for judicial review, pursuant to ORS 183.482(6), which provides:

"If an agency withdraws an order for purposes of reconsideration and modifies or reverses the order in favor of the petitioner, the court shall allow the petitioner costs, but not attorney fees, to be paid from funds available to the agency."

Petitioner argues that DIF's decision to withdraw its order was made in response to petitioner's contention on review that it had not complied with ORS 183.460 and that, by withdrawing its original order and allowing petitioner to submit exceptions, DIF acted favorably to petitioner, entitling it to costs. However, it is not the withdrawal of the agency's order that triggers the right to costs under ORS 183.482(6), but the modification or reversal of that order in the petitioner's favor. DIF's final order after reconsideration adhered to its original proposed order, which was not favorable to petitioner. Petitioner is not entitled to its costs.

The first issue on the merits is whether the provisions of ORS 737.318 and ORS 737.505(4) are applicable to the May, 1987, billing. Petitioner contends that, before the 1987 amendment of ORS 737.505 added subsection (4), there was no time limit on an employer's right to appeal a retroactive assessment and that that statute should not be applied "retroactively" to cut off petitioner's right to appeal the May, 1987, billing. SAFECO contends that, before the 1987 amendment to ORS 737.505 and the enactment of ORS 737.318, there was no right to appeal the results of a premium audit and that, unless the provisions of those two statutes apply, petitioner has no right to appeal the May, 1987, billing.

ORS 737.318 states that its provisions, which incorporate by reference the provisions for appeal contained in ORS 737.505, apply to all premium audit disputes in existence on July 20, 1987, regardless of the date of the final audit billing. The legislature has, accordingly, expressed its intention that, even if the final audit billing occurred before the effective date of the statute, the procedures of ORS 737.318 apply, if the dispute was in existence on July 20, 1987. Although, on July 20, 1987, petitioner had not yet appealed the May, 1987, billing, we conclude that the retroactive billing itself initiated the dispute and that the dispute was in existence on July 20, 1987. Accordingly, the provisions of ORS 737.318 and ORS 737.505(4) are applicable to the May, 1987, billing.¹

Petitioner also contends that DIF erred in dismissing its appeal with

¹ We express no opinion as to what petitioner's appeal rights, if any, might have been before the 1987 changes.

regard to the July, 1988, billing, because the record does not reflect whether SAFECO gave it notice of its right to appeal, as required by OAR 836-43-110(2), which became effective January 20, 1988. It provides:

"An insurer, when adjusting a premium for an employer based on a premium audit, shall notify the employer of the right to appeal to the Director, as allowed by ORS 737.505, within 60 days of receiving the results of the audit."²

Petitioner urges that, read together, ORS 737.505(4) and OAR 836-43-110(a) provide an employer 60 days from the date of receipt of the billing *and the notice of its right to appeal* within which to file the appeal, i.e., that the time within which it must appeal does not start to run until the employer has received notice of its right to do so.

DIF is not free to amend or extend the terms of the statute. *U. of O. Co-Oper. v. Dept. of Rev.*, 273 Or 539, 542 P2d 900 (1975) *Oreg. Fire/Police Retire. v. PERB*, 62 Or App 777, 662 P2d 729, *mod* 65 Or App 465, 671 P2d 729 (1983), *rev'd* 296 Or 464, 296 Or 486 (1984). The language of ORS 737.505(4) unambiguously states that the 60-day appeal period runs from the date that the insured receives the billing. Whatever the consequence of an insurer's failure to comply with the notice provision of OAR 836-43-110(2),³ the rule cannot contradict the statute or create a different time limit for appeal. DIF correctly dismissed the appeal as untimely.

Affirmed.

² The rule was not in effect when petitioner received its first billing, so the rule could not have applied to it. On July 27, 1988, after petitioner received its second billing, the rule was amended to require that the notice be included in the billing.

³ The Director may order compliance with the rules, and a failure to comply may be a ground for sanctions under ORS 737.545. Additionally, an insurer is subject to civil penalties under ORS 731.988 for violations of the standards of the premium audit system. ORS 737.318.

Cite as 109 Or App 566 (1991)

November 13, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rita R. Spurgeon, Claimant.

LIBERTY NORTHWEST INSURANCE CORP. and SACRED HEART GENERAL HOSPITAL,
Petitioners,

v.

RITA A. SPURGEON, Respondent.
(WCB No. 86-02697; CA A67035)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 24, 1991.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.

W. Daniel Bates, Jr., argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P.J.

Reversed and remanded for reconsideration.

Riggs, J., dissenting.

Employer seeks review of a Workers' Compensation Board order that held that claimant's carpal tunnel syndrome is compensable as an occupational disease. We reverse.

Employer does not challenge the Board's findings, which it adopted from the referee's order. Claimant worked in employer's food service for eight years. Her job required significant repetitive motions with both hands. Claimant's off-the-job activities included crocheting and bowling. The Board found that "idiopathic"¹ factors, such as claimant's age, gender and borderline diabetes, were either a predisposition to or the major cause of her carpal tunnel syndrome. It also found that her work activities materially contributed to the condition, and that, as between activities off the job and on the job, work activities contributed more.

The Board concluded that the claim was compensable. It held that claimant's predisposition or idiopathic causes should not be considered and compared only her activities on and off the job to decide which of those activities were the major cause of the onset of her condition. Employer asserts that, in determining the major contributing cause, all factors that contributed to cause the disease must be considered, including idiopathic causes.

At the time relevant to this claim, an occupational disease was defined as

"[a]ny disease or infection which arises out of and in the scope of the employment, and to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein." ORS 656.802(1)(a).

A disease is compensable if work activities are the major contributing cause of the disease or an aggravation or exacerbation of it. *Dethlefs v. Hyster Co.*, 295 Or 298, 310, 667 P2d 487 (1983); *SAIF v. Gygi*, 55 Or App 570, 573, 639 P2d 655, rev den 292 Or 825 (1982).

The Board concluded that causes of a disease that are personal to a claimant and independent of anything that happens off the job or on the job should not be considered in deciding whether work is the major contributing cause of the claimant's disease, relying in part on the principle that an employer takes the employee as it finds her. That analysis fails to take into consideration the difference between a susceptibility or predisposition to a disease and a disease that is actually caused by idiopathic factors, independently of a claimant's activities or exposures anywhere. An employer is responsible for a disease that a claimant who has a particular susceptibility or predisposition develops due in major part to conditions at work. The predisposition to disease is not a bar to compensability, if work causes the disease. In that sense, the employer takes the employee as it finds her. If, in contrast, a claimant develops a disease in major part because of factors personal to her that are independent of any activities or exposures either off or on the job, the claim is not compensable, even if work contributed to some degree to causing the disease.

¹ The Board made it clear that, by "idiopathic," it meant "peculiar to the individual," rather than "unexplained."

All causes of a disease, as opposed merely to a susceptibility or predisposition, must be considered in determining which, if any, was the major contributing cause.

Dethlefs v. Hyster Co., supra, and *SAIF v. Gygi, supra*, do not compel or suggest a contrary result. In both of those cases, the claimants had a disease that was caused both by exposures on the job and off the job. The question was which of those exposures was the major contributing cause of the disease. Neither case involved either a predisposition or idiopathic causes that combined with work-related activities or exposures to cause the disease.

The Board's order, adopted from the referee, says, in part:

"This case turns on what causative agents are being compared in applying the major cause test. If one is comparing on the job factors with all other causative factors, then the claim is not compensable. If one is comparing only on the job factors with off the job factors without considering claimant's *predisposition*, then the claim is compensable.

"The clear weight of the medical evidence is that claimant's work is a material cause of her carpal tunnel syndrome. The clear weight of the evidence is also that the work exposure is a greater cause than any of claimant's off the job activities. Finally, the clear weight of the evidence is that *claimant's idiopathic factors* including her age, gender and borderline diabetes are a greater factor than either her on the job or off the job activities." (Emphasis supplied.)

The Board did not distinguish between a predisposition and idiopathic causes. We cannot tell whether it found that the idiopathic factors were causes of claimant's carpal tunnel syndrome or whether they merely existed as conditions that made her *susceptible* to carpal tunnel syndrome. Accordingly, we remand to the Board to make that determination and to enter an appropriate order in the light of this decision.

Reversed and remanded for reconsideration.

RIGGS, J., dissenting.

Even if claimant's idiopathic condition, in comparison with the workplace condition, would be considered the major factor in her resulting carpal tunnel syndrome, it seems to me that her workplace activities were the major contributing cause, as contemplated in former ORS 656.802(1)(a). Only if non-work conditions, other than idiopathic propensities, outweigh workplace conditions can we say that the workplace conditions did not constitute a major contributing cause of her disease. The referee and the Board did not err in comparing only activities on and off the job to decide whether the workplace activities were the major contributing cause of claimant's carpal tunnel syndrome.

The majority appears to conclude that idiopathic conditions can be non-work conditions to which a claimant is ordinarily subjected or exposed. That conclusion is contrary to the statutory definition of occupational disease, which uses language that contemplates external causative forces, and to the spirit of the Workers' Compensation Law.

For this case, an occupational disease is:

"Any disease or infection which arises out of and in the scope of the employment, and to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein." *Former ORS 656.802(1)(a)*.

To prove an occupational disease, a claimant first must show that the disease "arises out of and in the scope of the employment." We have previously compared that language to similar language in the definition of "compensable injury" in ORS 656.005(8)(a) and determined that the unitary work-connection analysis for compensable injuries also applies to occupational diseases. *SAIF v. Noffsinger*, 80 Or App 640, 645, 723 P2d 358, rev den 302 Or 342 (1986). "If the relationship between the disease and the employment is sufficient, then the disease arises out of and in the scope of employment." 80 Or App at 645. When a compensable injury is involved, work-connection is established if the work activity is a material contributing cause of the injury.

However, under *former ORS 656.802(1)(a)*, a second requirement must be satisfied to prove an occupational disease. A claimant must also prove that the disease is one "to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein." In other words, a claimant also must prove that work conditions or exposures, when compared with non-work conditions or exposures, were a major contributing cause of the disease. *Dethlefs v. Hyster Co.*, 295 Or 298, 310, 667 P2d 487 (1983); *SAIF v. Noffsinger*, *supra*, 80 Or App at 645-646. The language of the second requirement--that an employee not be *subjected or exposed*--contemplates external forces that cause the disease, not internal forces peculiar to the individual. Once work-connection is proved, on the job conditions and exposures must be compared with off the job conditions and exposures to determine the major contributing cause. That is what the referee and the Board correctly did.

The referee and the Board also correctly stated well-settled principles that the employer takes the worker as it finds her and that the Workers' Compensation Act is to be liberally construed in favor of injured workers. Under those principles, an employer is liable for disability, even if the worker has a preexisting condition, if the workplace injury contributes to the disability. The Workers' Compensation Law "prescribes no standard of physical fitness to which the employee must conform, and compensation is not based on any implied warranty of perfect health." *Keefer v. State Ind. Acc. Commission*, 171 Or 405, 412, 135 P2d 806 (1943).¹ The majority's conclusion that idiopathic conditions must be taken into consideration in determining the major contributing cause effectively eliminates that principle in the occupational disease context. Workers whose idiopathic conditions, such as age and sex, may render them more vulnerable to work conditions that cause disease will be at a great disadvantage in showing persuasively that work conditions or exposures were a more important causative factor than the idiopathic conditions. The majority, in effect, is requiring a warranty of health, and that is not required under the Workers' Compensation Law.

For these reasons, the majority is wrong, and I dissent.

¹ The court in *Keefer* also noted that "[t]he great weight of authority is to the effect that the existence of a * * * disease which does not impair the employee's ability to work will not prevent his recovery of compensation if an accident accelerates the disease to a degree of disability[.]" 171 Or at 412. That should also be true when work conditions or exposures accelerate a disease to a disability.

Cite as 110 Or App 10 (1991)November 27, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rickey J. Jackson, Claimant.

RICKEY J. JACKSON, Petitioner,
v.
BOGART CONSTRUCTION and SAIF CORPORATION, Respondents.
(WCB 88-16192; CA A65360)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 17, 1991.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Christopher D. Moore and Malagon, Moore & Johnson, Eugene.

John T. Bagg, 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 Joseph, Chief Judge,* and Deits, Judge.

RICHARDSON, P.J.

Affirmed.

*Joseph, C.J., vice Newman, J., deceased.

Claimant seeks review of an order of the Workers' Compensation Board denying him benefits for his wife and youngest son. We affirm.

Claimant was injured in an industrial accident on October 18, 1977, when he was unmarried and had two children. He married in December, 1978, and had a third child in March, 1979. On June 13, 1987, a determination order awarded him benefits for permanent total disability. ORS 656.206(2)(b) provides that, in determining the rate of permanent total disability, the claimant shall receive wage based benefits and "[i]n addition * * * \$5 per week for each additional beneficiary not to exceed five." The referee ruled that his benefits should be calculated by taking into account his wife and all three children. The Board reversed, granting benefits only on the basis of the two children who were alive at the time of claimant's injury.

Both parties agree that "[t]he date of injury is the date on which a worker's status conclusively determines his rate of compensation." *SAIF v. Brannon*, 62 Or App 768, 771, 662 P2d 11 (1983); see also *SAIF v. Calkins*, 80 Or App 369, 722 P2d 43, rev den 302 Or 158 (1986); ORS 656.202(2).¹ Claimant argues that only the rate of compensation, not the number of members of a claimant's family is determined as of the date of injury. This is a case about the rate of compensation, not the eligibility of beneficiaries. It is the injured worker who receives the benefits, not his family, although the calculation of the rate depends on the number of dependents that the claimant has at the time the injury occurred.

¹ ORS 656.202(2) provides:

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

The precedents are mixed. In *State v. State Industrial Acc. Com.*, 115 Or 484, 487, 237 P 680 (1925), the Supreme Court held that "[t]he dependents of the injured workman must be determined as of the date of the injury." In *Rosell v. State Ind. Acc. Com.*, 164 Or 173, 185, 95 P2d 726 (1940), on the other hand, the court allowed a widow who had married her husband after his compensable injury to recover death benefits. In *SAIF v. Brannon, supra*, we held that a child born after his father's occupational accident was not entitled to death benefits when his father later died from his injury.

The workers' compensation statutory scheme suggests the results in *State v. State Industrial Acc. Com.*, *supra*, and *SAIF v. Brannon, supra*. ORS 656.005(2) defines "beneficiary" as "an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under this chapter." ORS 656.005(5) states that "child" includes

"a posthumous child, a child *legally adopted prior to the injury*, a child toward whom the worker stands in loco parentis, an illegitimate child and a stepchild, if such stepchild was, *at the time of the injury*, a member of the worker's family and substantially dependent upon the worker for support." (Emphasis supplied.)

The latter statute strongly suggests that, in order for a child to be counted in determining the rate of compensation, the child must have been a member of the worker's family at the time of injury. Under Oregon law, adopted children are treated the same as biological children. See ORS 109.041; ORS 112.175. It would be illogical for biological children born after a parent's injury to be part of the calculation of benefits while children adopted after an injury or stepchildren would not. Claimant's youngest child was not a member of his family at the time of his injury and therefore cannot be considered a dependent in the rate calculation.

The same reasoning applies to claimant's wife. *Rosell v. State Ind. Acc. Com, supra*, is not apposite. That case involved death benefits, and the court distinguished the status of a widow from other beneficiaries. We hold that, at least for calculation of permanent total disability benefits, claimant and his spouse had to be married at time of the injury in order for the calculation to include the spouse.

Affirmed.

Cite as 110 Or App 62 (1991)

December 4, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lyle K. Vance, Claimant.

BARNEY'S KARTS, INC. and **ROYAL INSURANCE COMPANY OF AMERICA**, Petitioners,
v.

LYLE K. VANCE, SAIF CORPORATION and EBI COMPANIES, Respondents.
(88-04451, 88-08693, 88-09002, 88-13152; CA A67686)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 31, 1991.

Jerald P. Keene, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.

Max Rae, Salem, argued the cause and filed the brief for respondent Lyle K. Vance.

Jas. Adams, Assistant Attorney General, Salem, waived appearance for respondent SAIF.

Mark P. Bronstein, Portland, waived appearance for respondent EBI Companies. Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P.J.

Affirmed.

Barney's Karts, Inc. (Barney's) and Royal Insurance Company (Royal) seek judicial review of an order of the Workers' Compensation Board holding Royal responsible for claimant's low back condition.

The facts are not disputed. Claimant has operated Barney's, a small amusement park and go-cart rental business, since 1970. Over the years, he has had various ownership interests in the corporation. There is no dispute but that, at the relevant times, he was covered by workers' compensation insurance. His primary employee responsibilities have included maintaining go-carts, supervising other workers and keeping the business books. In December, 1981, he fell out of a chair at work and injured his low back. He was treated by Dr. Strom through January, 1982. At that time, SAIF was Barney's worker's compensation insurer, but Barney's did not give it notice of the claim; instead, it paid for claimant's treatment.

In March, 1984, claimant bent over to lift a bumper car motor and experienced low back pain. Later that evening, he experienced a "pop" in his back while walking on the beach. He sought treatment from Strom and filed a claim for workers' compensation benefits with Barney's insurance carrier at the time, Fire and Casualty Insurance Company of Connecticut (FCICC). FCICC deferred acceptance or denial of the claim.

On April 13, 1986, claimant experienced low back pain while opening a safe at work. At that time, Barney's insurer was Royal. Claimant reported the incident to his fellow shareholder, Bernard, but did not give notice to Royal, although he was the person responsible for processing claims against Barney's and was also a part owner and the manager of the business at that time. He testified that he believed then that the pain was merely a continuation of the 1984 problem.

In October, 1986, FCICC denied the 1984 claim on the ground that claimant's March, 1984, disability was an aggravation of the 1981 injury. Claimant's request for a hearing was dismissed after he entered into a disputed claim

settlement with FCICC. Then, in February, 1988, claimant filed a claim with SAIF for the 1981 injury; SAIF denied responsibility. In May, 1988, claimant filed this claim for the 1986 incident, which Royal denied in July, 1988. Claimant sought a hearing on each denial.

Barney's and Royal seek review of the Board's order affirming the referee's determination that claimant had done all that was required of him, that the 1986 incident was a "discreet injurious event" that contributed independently to claimant's current back condition and that Royal, as Barney's insurer at the time of the injury, is responsible.

ORS 656.265 provides, in part:

"(1) Notice of an accident resulting in an injury or death shall be given immediately by the worker or a dependant of the worker to the employer, but not later than 30 days after the accident.

"* * * * *

"(4) Failure to give notice as required by this section bars a claim * * *."

There is no dispute but that Barney's had timely notice of the injury and that the injury was job-related.

ORS 656.262(3) requires an employer to notify the insurer of a claim:

"Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. * * * Failure to so report subjects the offending employer to a charge for reimbursing the insurer for any penalty the insurer is required to pay under subsection (10) of this section because of such failure."

Although claimant was a stockholder in Barney's and managed the business, the corporation was his employer and was the insured. Under the statutory scheme, claimant's only obligation was to notify Barney's of the claim, see *Priest v. City of Hermiston*, 106 Or App 732, 736, 809 P2d 1370 (1991), and he did that.

Barney's was responsible for giving notice of the claim to Royal and, failing that, Royal was entitled to be reimbursed by Barney's for any penalties assessed for late processing. Barney's failure, as the employer, to notify Royal is a matter between Royal and Barney's; it does not concern claimant or his entitlement to benefits. We find no authority in Workers' Compensation Law to support Royal's contention that claimant should be treated as the employer or that he is equitably estopped from seeking benefits because, as part owner and manager of Barney's, he failed to carry out his responsibility to Barney's to notify Royal of the claim.¹

Affirmed.

¹ Contrary to Royal's statements in its brief, the record contains no evidence that, in failing to report the claim to Royal, claimant acted deliberately to delay and compromise Royal's rights.

Cite as 110 Or App 72 (1991)

December 4, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of William J. Wilson, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,

v.

WILLIAM J. WILSON, Respondent.

(WCB 89-09198; CA A68590)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 14, 1991.

Adam T. Stamper, Medford, argued the cause for petitioner. With him on the brief were H. Scott Plouse and Cowling & Heysell, Medford.

Jim L. Scavera, North Bend, argued the cause and filed the brief for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P.J.

Reversed and remanded for reconsideration.

Employer seeks judicial review of a Workers' Compensation Board order that reversed the referee and required employer to pay claimant temporary total disability (TTD) benefits. We reverse and remand for reconsideration.

In September, 1988, claimant sustained a compensable injury. He was taken off work and began receiving TTD benefits. In March, 1989, employer offered claimant physician approved modified work. When claimant arrived at the designated job site, he encountered a labor dispute and refused to cross the picket line. Relying on former OAR 436-60-030(5), employer considered claimant's failure to report for work to be a refusal of wage earning employment and terminated TTD benefits.¹ Claimant sought a hearing, and the referee upheld employer's termination. The Board reversed. We review its order for errors of law and substantial evidence. ORS 183.482(7), (8).

Former OAR 436-60-030(5) provided:

"An insurer shall cease paying temporary total disability compensation and start making payment of such temporary partial disability compensation as would be due in section (1) when an injured worker refuses wage earning employment prior to claim determination under the following circumstances:

"(a) the attending physician has been notified by the employer or insurer of the specific duties to be performed by the injured worker and the physical requirements thereof;

"(b) the attending physician agrees that the offered employment appears to be within the worker's capabilities; and

"(c) the employer has provided the injured worker with a written offer of the employment which states the beginning time, date and place; the duration of the job if known; the wage rate payable; an

¹ Because employer offered modified work at claimant's pre-injury rate of pay, employer did not pay any temporary partial disability benefits after terminating claimant's TTD. If employer had properly terminated TTD, that action was also proper. See former OAR 436-60-030(2).

accurate description of the job duties and that the attending physician has said the offered employment appears to be within the worker's capabilities."

An employer seeking to rely on that rule to justify a termination of TTD benefits must fully comply with its procedural requirements. *Eastman v. Georgia Pacific Corp.*, 79 Or App 610, 613, 719 P2d 1310 (1986). The Board found such compliance, and that finding is supported by substantial evidence.² Therefore, the issue here is whether claimant impermissibly refused wage earning employment.

Claimant argues that he did not impermissibly refuse wage earning employment, because it would have been unreasonable for him to cross the picket line.³ He also argues that he could not be penalized with a loss of TTD benefits, because his refusal to report for work resulted from his participation in a labor dispute. Employer argues that it is irrelevant why claimant refused to work. It contends that, if approved work was available, claimant had to accept that work, unless his refusal was legally justified. We agree.

The legislature intended temporary disability benefits to provide replacement for wages lost because of a compensable injury. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296, 702 P2d 403 (1985). In the absence of a legislative direction to the contrary, TTD benefits are not available if the loss results from other than the compensable injury. When a claimant refuses physician approved modified work under former OAR 436-60-030(5), resulting wage loss is not caused by the compensable injury. Therefore, unless the legislature authorized that refusal, wage loss benefits are not available.

ORS 656.268(9) (since amended by Or Laws 1990 (Special Session), ch 2, 16)⁴ provided:

"If the attending physician has approved the worker's return to work and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of reemployment rights or any vocational assistance provided by this chapter."

That statute expressly declares that workers who participate in labor disputes will not lose reemployment rights or vocational assistance benefits. It does not expressly protect a worker's right to TTD benefits for wage replacement.

The legislature's failure to include TTD benefits within the protection of ORS 656.268(9) indicates that it did not intend those benefits to be available to claimants who lose wages due to an election to participate in a labor dispute. The inclusion of specific matters in a statute implies a legislative intent to exclude related matters not mentioned. *Gantenbein v. PERB*, 33 Or App 309, 319, 576 P2d 1257, rev den 282 Or 537 (1978). Therefore, we hold that claimant's participation in a labor dispute did not justify his refusal of work.

Reversed and remanded for reconsideration.

² The record contains employer's written offer of employment. That offer letter, with enclosures, supports the Board's finding that employer fully complied with the procedural requirements of former OAR 436-60-030(5).

³ Claimant contends that, if he had crossed the picket line, he would have lost \$10 per month of union benefits and would have been shunned by his fellow workers, and his supervisor would not have had coffee with him.

⁴ That amendment renumbered ORS 656.268(9) as ORS 656.268(12) but did not otherwise alter its substance. We refer to the previous version.

Cite as 110 Or App 103 (1991)December 4, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ACCIDENT PREVENTION DIVISION, Petitioner,

v.

ED ASANA, dba American Sewer and Pipe, Respondent.
(SH-88-825; SH-88-826; SH-88-827; SH-88-828; CA A62876)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 10, 1990.

Meg Reeves, Assistant Attorney General, Salem, argued the cause for petitioner. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

No appearance for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Reversed and remanded for reconsideration.

Accident Prevention Division (APD) seeks review of a Workers' Compensation Board order that modified penalties and dismissed citations that APD issued to employer for violations of various safety rules. ORS 654.290; ORS 183.482. We reverse.¹

Employer is engaged in the repair and installation of sewer pipes and related activities. APD issued him citations for violations of numerous safety rules that allegedly occurred in September, October, and November, 1988. Employer requested a hearing. ORS 654.290(2)(a). The referee dismissed some of the citations and, for the remaining ones, reduced APD's recommended penalties below the amounts established by OAR 437-01-145. APD first assigns error to the reduction of the assessed penalties.

ORS 654.086(1) authorizes APD's director to assess various civil penalties for violation of any occupational safety or health statute, rule, standard or order. Pursuant to that statute, the agency adopted OAR 437-01-145 and OAR 437-01-165, which establish a schedule for assessing penalties.² Under the rules, the severity and probability ratings for any violation are determined by an on-site inspection. OAR 437-01-135; OAR 437-01-140; OAR 437-01-015(41). Once the ratings are determined, the penalty is calculated by using the table in OAR 437-01-145. If the penalty is for a repeated violation, it is increased in accordance with OAR 437-01-165(1).³ When the citations in this case were issued, OAR 437-01-165(2) authorized the penalty to be adjusted.⁴

APD argues that, under the rules, the referee's reduction of penalties must be within the confines of OAR 437-01-145 and OAR 437-01-165. Specifically, it contends that

"the Referee's task in assessing a penalty is to find facts on the evidence before him, and from these facts to (1) determine whether the facts support the probability and severity rating assigned to each violation; and (2) determine the number of previous violations. Having done that, the Referee must identify the applicable penalty from Table 1 [of OAR 437-01-145] for the current offense. If it is a first or second repeat violation, the Referee must apply to the current penalty the percentages found in OAR 437-01-165(1) -- as adjusted, if appropriate, by the factors listed in OAR 437-01-165(2). If it is a third repeat violation, the Referee reviews the

penalty set by the Administrator for abuse of discretion, keeping in mind that the penalty assessed must be reasonable. OAR 438-85-820."

We agree that the referee had no authority to impose penalties less than those mandated by the rules. An agency's action must be consistent with its rules. *Moore v. OSP*, 16 Or App 536, 537, 519 P2d 389 (1974). OAR 437-01-145(1) provides that "a penalty shall be assessed" in accordance with the penalty schedule in table 1 of the rule. OAR 437-01-145(2) provides that penalty "[a]djustments shall not reduce the penalty to less than the mandatory minimum penalty which has been established by rule." Moreover, OAR 437-01-165(1) states that the penalties for repeated violations "shall be increased[.]" Although OAR 437-01-165(2) permitted a referee to "adjust" recommended penalties, it did not authorize the reduction of penalties below the mandatory minimums provided in OAR 437-01-145(1).

The September citation involved two violations that the referee concluded created a high probability of serious bodily harm. Under OAR 437-01-145(1), the minimum penalty for each violation is \$1,200. The referee's \$1,000 penalty for both violations was too small. The October and November citations concern two violations that APD assessed as creating a medium risk of serious bodily harm and a medium probability of moderate bodily harm, respectively. The referee assessed penalties of \$100 and \$250. Neither penalty corresponds with any prescribed by OAR 437-01-145(1).

APD also assigns error to the referee's dismissal of allegations of safety violations regarding work in a trench. The referee dismissed the citation, because employer had told his employees to stay out of the unsafe trench until he had returned and, consequently, the referee did not hold employer responsible for their failure to follow his instructions. APD argues that, under ORS 183.470(2),⁵ the referee was required to make findings on its contention that employer knew or should have known that his employees would disregard his instruction and work in the trench. ORS 183.470(2) requires the referee to make findings on contested issues of fact and on every ultimate fact that is necessary to the conclusion. The referee's dismissal is predicated on an implicit finding that employer believed that his instructions would be followed. His knowledge, if any, regarding the likelihood that his employees would disregard his instructions bears on that issue and is necessary to the conclusion. The referee should have addressed APD's argument in its findings and explained the relationship between those findings and the conclusion. *Dan McCormack Agency v. Employment Division*, 99 Or App 47, 50, 781 P2d 370 (1989).

Reversed and remanded for reconsideration.

¹ After this case was submitted and argued, it was abated pursuant to ORAP 8.20(7). The bankruptcy stay was lifted on September 11, 1991.

² OAR 437-01-145 provides, in part:

"(1) A penalty shall be assessed for any serious violation and may be assessed for any general violation by considering the penalty established by the intersection of the probability rating and severity rating on the penalty schedule (Table 1). In a case where probability and severity are not appropriate considerations, a penalty may be assessed by considering the facts of the violation.

"(2) Penalty adjustments may be made based upon the employer's current lost workday cases incidence rate, if available, and efforts made during the inspection to correct violations. Penalty adjustments shall not be applied to repeat, willful or failure to correct violations or to any violation which contributed to an injury, illness or death of an employee. Adjustments shall not reduce the penalty to less than the mandatory minimum penalty which has been established by rule. * * *:

"* * * * *

"TABLE 1 - PENALTY SCHEDULE

"Probability		Severity		
		"General Violation	Serious Violation	
		"Low Moderate	"Serious Physical Harm	Death
"Low	0	75	150	1,000
"Medium	0	300	500	1,500
"High	75	500	1,200	2,500

³ OAR 437-01-165(1) provides:

"The penalty for a repeat violation shall be computed by *increasing* the penalty for the current violation by the following applicable percentage:

	"General	Serious
"1st repeat	+50%	+100%
"2nd repeat	+100%	+200%
"3rd repeat	Discretion of Administrator	

(Emphasis supplied.)

⁴ OAR 437-01-165(2) provided:

"(2) The penalty determined under subsection (1) of this rule may be adjusted by considering the following:

- "(a) The time between violations;
- "(b) Whether identical or similar machinery is involved;
- "(c) Whether the same supervision, crew or locations are involved;
- "(d) The proximity to the prior violation; and
- "(e) Other extenuating or aggravating circumstances."

Subsection (2) was deleted in 1989, by APD Admin. Order 10-1989. Subsection (3) provided that "[t]he total penalty for a repeat violation shall be not less than \$50 nor more than \$10,000."

⁵ ORS 183.470(2) provides:

"A final order shall be accompanied by findings of fact and conclusions of law. The findings of fact shall consist of a concise statement of the underlying facts supporting the findings as to each contested issue of fact and as to each ultimate fact required to support the agency's order."

Cite as 110 Or App 126 (1991)

December 4, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Darrel K. Rickman, Claimant.

DARREL K. RICKMAN, Petitioner,
v.

SAIF CORPORATION and SURE-GRO, INC., Respondents.
(89-25573; CA A68991)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 18, 1991.

Charles D. Maier and Gatti, Gatti, Maier & Associates, Salem, filed the brief for petitioner.

Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM

Reversed and remanded for reconsideration of attorney fees; otherwise affirmed.

Claimant seeks review of an order of the Workers' Compensation Board denying him a penalty and attorney fees for SAIF's alleged unreasonable denial of his claim for "future" medical benefits. Even if the denial was unreasonable, there is no amount due against which a penalty could be assessed. However, we remand the case to the Board for an award of attorney fees under ORS 656.386(1) for SAIF's withdrawal of its denial after claimant's request for hearing had been filed but before the hearing was held. *Jones v. OSCI*, 108 Or App 230, 814 P2d 558 (1991); Or Laws 1991, ch 312, 1.

Reversed and remanded for reconsideration of attorney fees; otherwise affirmed.

Cite as 312 Or 106 (1991)

September 19, 1991

IN THE SUPREME COURT OF THE STATE OF OREGON

DEE DIKA, dba Northwest Record Service, and OREGON MEDICAL RECORDS ASSOCIATION,
Petitioners on Review,

v.

DEPARTMENT OF INSURANCE AND FINANCE, Respondent on Review.
(DIF WCD 1-1990; CA A64719; SC S37964)

In Banc

On review from the Court of Appeals.*.

Argued and submitted August 28, 1991.

James M. Brown of Enfield, Guimond & Brown, Salem, argued the cause for
petitioner on review Oregon Medical Records Association.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for
respondent on review. With him on the response to the petition were Dave
Frohnmayr, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

FADELEY, J.

The decision of the Court of Appeals is reversed. The rule is declared
invalid.

*Judicial review from Department of Insurance and Finance. 105 Or App 635,
805 P2d 758 (1991).

The issue in this administrative law case is whether respondent Department
of Insurance and Finance complied with a statute requiring that a fiscal impact
statement, containing information described in the statute, be included in a
government agency's notice of proposed rulemaking. ORS 183.335 in part pro-
vides:

"(1) Prior to the adoption, amendment or repeal of any rule, the
agency shall give notice of its intended action:

"* * * * *

"(2)(b) The agency shall include with the notice of intended
action * * *:

"* * * * *

"(D) A statement of fiscal impact identifying state agencies,
units of local government and the public which may be economically
affected by the adoption, amendment or repeal of the rule and an
estimate of that economic impact on state agencies, units of local
government and the public. In considering the economic effect of
the proposed action on the public, the agency shall utilize avail-
able information to project any significant economic effect of that
action on businesses which shall include a cost of compliance effect
on small businesses affected."

ORS 183.315 confirms that the provisions of ORS 183.335 apply to rulemaking by
respondent.

Petitioners, an association of persons who maintain medical records and an
individual in the business of supplying copies of medical documents for use
within the workers' compensation system, challenged the rule in question by

petition for judicial review, claiming, *inter alia*, that the rule was adopted in violation of the requirements for a fiscal impact statement. The Court of Appeals affirmed the validity of the rule, OAR 436-10-090(30), without written opinion. *Dika v. Dept. of Ins. and Finance*, 105 Or App 635, 805 P2d 758 (1991). Because respondent did not comply with ORS 183.335(2)(b)(D), we declare the rule invalid and reverse.

Respondent proposed to amend its rules providing maximum allowable fees for copies of various materials. One portion of the proposed amendment added a new subsection covering charges for copies of "office progress notes" of various providers of medical services. The proposed rule permitted a maximum fee of 15 cents per page for copying progress notes.¹

The notice of intent to adopt the proposed rule contained the following:

"*Fiscal and Economic Impact.* The following entities are economically affected: (a) workers' compensation insurers and (b) medical vendors."

It is this "fiscal and economic impact" statement that petitioners challenge as insufficient to comply with ORS 183.335(2)(b)(D), quoted above. Petitioners contend that the rule is invalid because the statute was not followed. They argue that a simple declaration in the fiscal impact statement that insurers and medical vendors are "economically affected" falls "far short" of the statutory requirement.

Analyzing that claim, we first consider whether compliance with ORS 183.335(2)(b)(D) is mandatory. On its face, there can be little doubt. The statute uses the word "shall."

The provisions of the statute are protections against arbitrary and inadequately informed governmental conduct. To construe the word "shall" as anything other than mandatory would thwart the intention of the legislature, rather than pursuing it. That would be contrary to the judicial role in construction of a legislative act. See ORS 174.020 ("In the construction of a statute the intention of the legislature is to be pursued if possible").

The requirement for a fiscal impact statement was created by Oregon Laws 1979, chapter 593, section 11, and Oregon Laws 1981, chapter 755, section 2 (House Bill 2497 of the 1979 session and House Bill 3274 of the 1981 session, respectively). The 1987 Legislative Assembly added to the definition section of ORS 183.310(3) a more extensive definition of "economic effect" to include the economic impact on businesses affected by a proposed rule. Or Laws 1987, ch 861, Section 1.

Section 3 of that 1987 act also amended ORS 183.400 in a manner relevant to our inquiry. ORS 183.400 provides the procedure for challenging the validity of a rule through a petition for judicial review filed with the Court of Appeals. Before the 1987 amendment, subsection (7) stated: "The court shall not declare a rule invalid because the fiscal impact statement required by ORS 183.335 is insufficient or inadequate." ORS 183.400 (1985); see Frohnmayer, *The Oregon Administrative Procedure Act: An Essay on State Administrative Rulemaking Procedure Reform*, 58 Or L Rev 411, 466 (1980) (indicating that author's view of

¹ The analogous charge under the then-existing rule, to which the new rate of reimbursement was proposed to be added by amendment, was \$3.50 for the first page and 50 cents per page thereafter for various medical reports. OAR 436-10-090(25) (1989).

the reason for the former provision limiting reviewability of the fiscal impact statement). The 1987 act deleted that proscription and did not substitute an alternative in its place. After the 1987 act, no impediment to review of the sufficiency of an impact statement exists.

We next consider whether the fiscal impact statement included by the agency in its notice of proposed rulemaking complied with the statutory description of the contents that "shall" be included in such statements. ORS 183.335(2)(b)(D) requires that a fiscal impact statement provide "an estimate of [the] economic impact" upon the public, as well as on governmental units, that will be caused if the rule is adopted. Here, the agency's notice indicates that there will be such an impact. However, its statement of anticipated impact does not provide any quantitative estimate of economic impact on anyone. In that regard, the statute requires that the agency "shall utilize available information to project any significant economic effect" on businesses, should the rule be adopted. The statement does not attempt to do that, nor does it provide any explanation for failing to do so, such as those that might be related to inadequacy of "available information" or that would be appropriate where there will be no fiscal impact. The statement falls short of meeting the mandatory requirements of the statute.

A fiscal impact statement must be included in the notice of planned adoption of a proposed rule or amendment. The statement must comply with the provisions of the statute. In this case, a purported impact statement was included in the notice, but it did not comply with the statute. Accordingly, respondent failed to meet a statutory precondition for the valid adoption of the changes in the rule involving fees for copying office progress notes. ORS 183.400(4) provides that the reviewing court "shall declare the rule invalid" where the rule was "adopted without compliance with applicable rulemaking procedures." That subsection describes this case. Oregon Laws 1987, chapter 861, section 3, by deleting the former restriction against declaring a rule invalid because of a defective fiscal impact statement, erased the impediment to a judicial declaration of invalidity of a rule on that ground. As a result, the rule (which is embodied within OAR 436-10-090(30)) that is the subject of this case is not a valid rule of respondent.²

The decision of the Court of Appeals is reversed. The rule is declared invalid.

² Because we hold that the rule was not validly adopted, we do not reach the remainder of the grounds for petitioners' challenge.

Cite as 312 Or 132 (1991)September 19, 1991

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Marvin C. Wright, Claimant.

SAIF CORPORATION, Petitioner on Review,
v.

MARVIN C. WRIGHT, Respondent on Review.
(WCB TP-88016; CA A51030; SC S37533)

In Banc

On review from the Court of Appeals.*

Argued and submitted March 6, 1991.

John Reuling, Assistant Attorney General, Salem, argued the cause for petitioner on review. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

David C. Force, of Vick & Gutzler, Salem, argued the cause and filed the response to the petition for respondent on review.

GRABER, J.

The decision of the Court of Appeals is reversed, and the case is remanded to the Court of Appeals for reconsideration.

*Judicial review from the Workers' Compensation Board. 102 Or App 598, 795 P2d 604 (1990).

The issue in this workers' compensation case is whether ORS 656.593(3)¹ gave the Workers' Compensation Board (the Board) the authority to determine whether SAIF Corporation (SAIF) was a "paying agency" within the meaning of that statute. We hold that the Board had the authority to make that determination. Accordingly, we reverse the decision of the Court of Appeals, which held to the contrary.

Claimant suffered injuries in a two-car accident in 1984. He filed claims with four employers, contending that he was injured in the course and scope of employment and that at least one of the four was his employer. SAIF received and processed three of the claims, because they involved noncomplying employers. ORS 656.054(1).² In June 1985, SAIF denied all three claims, on the ground that

¹ ORS 656.593(3) provides:

"A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

² ORS 656.054(1) provides:

"A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with ORS 656.001 to 656.794. The director shall refer the claim for such an injury to the State Accident Insurance Fund Corporation within 60 days of the date the director has notice of the claim. A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first instalment of compensation is to be paid, pursuant to ORS 656.652(4), shall not begin to run until the director has referred the claim to the State Accident Insurance Fund Corporation."

claimant was not a subject worker of any of the employers. The fourth purported employer denied the claim on the same ground.

Also in 1985, claimant filed an action against the other driver who had been involved in the accident. His case against the other driver was settled on January 20, 1986, for \$81,960.75. Claimant did not inform SAIF of the settlement, and SAIF was not otherwise aware of the litigation or of the settlement. Thus, SAIF did not consent to the settlement. See ORS 656.587 (settlement between worker and third party must have written approval of paying agency); ORS 656.593(3) (claimant may settle third party case with approval of paying agency). The settlement was distributed as follows: \$29,869.72 to claimant; \$27,243.18 to claimant's lawyers; \$24,616.65 for medical expenses; and \$231.20 for costs.

Meanwhile, claimant had appealed the denials of his four claims. After a hearing on January 30, 1986, the referee upheld the denials, on the ground that no employer-employee relationship existed with any of the four purported employers. Claimant appealed to the Board, which found that claimant was a subject worker of one of the three noncomplying employers whose claim had been referred to SAIF for processing. The Board set aside SAIF's denial as to that employer and remanded the claim to SAIF for processing.³ Thereafter, SAIF paid claims costs of \$43,418.82, comprised of temporary total disability compensation (\$39,693.35), a permanent disability award (\$2,359.45), and medical expenses (\$1,366.02).

SAIF first learned of claimant's settlement with the other driver in April 1988, when claimant sought reimbursement for the \$24,616.65 in medical bills that had been paid directly to the providers from the settlement. On June 23, 1988, SAIF filed a "Petition for Distribution" asking the Board for an order that would require claimant to distribute to SAIF \$36,324.23 as its "statutory share" of the third-party settlement, pursuant to ORS 656.593(3). The Board denied the petition on the ground that SAIF was not a "paying agency"⁴ entitled to share in the settlement under ORS 656.593(3), because SAIF had denied the underlying claim. SAIF sought judicial review of the Board's order.

The Court of Appeals held that, although the Board had jurisdiction over SAIF's petition, it had no authority to grant the specific relief sought. There was a dispute between SAIF and claimant, not about what amount claimant would owe under ORS 656.593(3), but about whether SAIF was entitled to any distribution at all. The Court of Appeals reasoned:

"In the settlement of a third-party action and the distribution of the proceeds, the Board has authority to do only two things. First, it may order written approval of the settlement by the paying agency, if there is a dispute between the parties regarding it. ORS 656.587. Second, if the settlement is approved,

'the paying agency is authorized to accept such a share of the proceeds as may be just and proper * * *. Any conflict as to what may be a just and proper distribution shall be resolved by the board.' ORS 656.593(3)."

³ The employer sought judicial review of the Board's order. The Court of Appeals affirmed that order. *Bernards v. Wright*, 93 Or App 192, 760 P2d 1388 (1988).

⁴ ORS 656.576 defines "paying agency" as "the self-insured employer or insurer paying benefits to the worker or beneficiaries."

SAIF v. Wright, 102 Or App 598, 601, 795 P2d 604 (1990). We allowed SAIF's petition for review.

We note at the outset that "matters concerning a claim under ORS 656.001 to 656.794" are generally within the Board's jurisdiction. ORS 656.704(1). This dispute involves a matter concerning a claim, because the amount of compensation to which claimant is entitled is directly in issue. See ORS 656.704(3) (providing definition).⁵ The more that a paying agency is entitled to receive, the less that the claimant is entitled to retain. A paying agency's right to a share of third-party recoveries derives from its responsibility for compensation. The amount that the paying agency is entitled to recover is determined, in part, by the amount of compensation that it paid. See generally ORS 656.576 to 656.595 (providing procedures for paying agency to recover from third persons and noncomplying employers).⁶ Moreover, ORS 656.593 gives the Board jurisdiction over the parties of a worker and a paying agency and over the subject matter of a worker's recovery from a direct third-party action.

The question here is: Did the Board have the authority under ORS 656.593 to decide that SAIF was not a "paying agency" and thus was not entitled to any share of the third-party settlement? Or, as the Court of Appeals concluded, does ORS 656.593(3) limit the Board's authority to deciding only how much is owed, and not whether it is owed at all? We do not read the statute as narrowly as did the Court of Appeals.

The measure of an agency's authority to administer a statutory remedy is found in the statute creating the procedure. *Board of Medical Examiners v. Buck*, 192 Or 66, 82, 232 P2d 791 (1951). A statute can confer authority either expressly or by necessary implication. *Ibid.* See also *Warren v. Marion County*, 222 Or 307, 320, 353 P2d 257 (1960) (agency has such implied powers as are necessary to carry out the powers expressly granted).

The key words of ORS 656.593(3) are: "[T]he paying agency is authorized to accept such a share of the proceeds as may be just and proper * * *. Any conflict as to what may be a just and proper distribution shall be resolved by the board." (Emphasis added.) That statute expressly grants authority to the Board to decide the question presented to it in this case. The wording of ORS 656.593(3) is broad. "Any conflict," given its natural, plain, and obvious meaning, encompasses the gamut of disputes about distribution of the proceeds. See *Perez v. State Farm Mutual Auto. Ins. Co.*, 289 Or 295, 299, 613 P2d 32 (1980) (in construing a statute, words of common usage are to be given their natural, plain, and obvious meaning). "Any conflict" includes a dispute about entitlement to a distribution. The words "a just and proper distribution" are similarly broad. In some cases, "a just and proper distribution" may be no distribution at all, as the Board decided in this case.

⁵ ORS 656.704(3) provides in part:

"[M]atters 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."

⁶ In *Schlecht v. SAIF*, 60 Or App 449, 455, 653 P2d 1284 (1982), the Court of Appeals also came to the conclusion that this type of proceeding is a matter concerning a claim.

Finally, we note that the Board is the most appropriate tribunal to determine what a "paying agency" is in the first instance.⁷ The legislature designed the workers' compensation law as an integrated body of statutes, with the Board generally charged with matters relating to the adjudication of claims.

We hold that the Board had the authority to determine whether SAIF was a "paying agency" under ORS 656.593(3). Because the Court of Appeals concluded to the contrary, it did not examine the merits of the Board's decision. We, therefore, remand this case to the Court of Appeals to consider the merits of SAIF's petition for judicial review.

The decision of the Court of Appeals is reversed, and the case is remanded to the Court of Appeals for reconsideration.

⁷ "As a matter of common law, a court having jurisdiction to decide a question ordinarily refrains from doing so until the question has first been decided by the specialized agency that has jurisdiction to decide it, but the court may still decide the question in reviewing the agency's decision." 4 Davis, Administrative Law Treatise 119, 22:11 (2d ed 1983).

See also *Tracy v. Lane County*, 305 Or 378, 382, 752 P2d 300 (1988) (Employment Relations Board's jurisdiction under ORS 243.752(1) is primary, even if not exclusive).

Cite as 312 Or 147 (1991)

September 19, 1991

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Robert T. Walther, Claimant.

ROBERT T. WALTHER, Petitioner on Review,

v.

SAIF CORPORATION and JACKSON COUNTY EDUCATION SERVICES, Respondents on Review.
(WCB 86-02176; CA A64494; SC S37311)

In Banc

On review from the Court of Appeals.*

Argued and submitted October 11, 1990; reassigned August 14, 1991.

Roger Ousey, of Bischoff & Strooband, P. C., Eugene, filed the petition and argued the cause for petitioner on review.

Jas. Adams, Assistant Attorney General, Salem, filed a response and argued the cause for respondents on review. With him on the response were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

PER CURIAM

The order of the Court of Appeals dismissing the petition for judicial review is affirmed.

* Judicial review of an order on reconsideration of the Workers' Compensation Board. Court of Appeals' order dismissing appeal filed June 6, 1990.

Claimant petitions for review of the Court of Appeals' order that dismissed his petition for judicial review because of lack of proof of timely filing.

The Court of Appeals received claimant's petition for judicial review after the 30-day time period allowed by ORS 656.295(8). The date of mailing serves as the date of filing if a notice of appeal is "mailed by registered or certified mail and the party filing the notice has proof from the post office of such mailing date." ORS 19.028(1).¹ ORS 19.028(3) provides that ORS 19.028(1) applies to petitions for judicial review. This case presents the question of what type of proof is necessary in order to prove the time of mailing under ORS 19.028.

Claimant conceded at oral argument that there is no contemporaneous proof of mailing in this case. In *Southwest Forest Industries v. Anders*, 299 Or 205, 213, 701 P2d 432 (1985), this court held that ORS 19.028 requires that a "litigant obtain proof at the time of mailing in order to satisfy the statutory requirement that the litigant 'has' proof." Claimant asks this court to reconsider its holding on this point. Claimant does not present, and our investigation does not reveal, any compelling reason to do so. More importantly, statutory interpretation particularly implicates the rule of stare decisis. When this court interprets a statute, that interpretation becomes a part of the statute as if written into it at the time of its enactment. *State v. Clevenger*, 297 Or 234, 244, 683 P2d 1360 (1984). Accordingly, we will not reconsider our holding.

We hold that the petition for judicial review in this case was not timely filed. Therefore, the order of the Court of Appeals dismissing the petition for judicial review is affirmed.

¹ ORS 19.028(1) provides:

"Filing a notice of appeal in the Court of Appeals or the Supreme Court may be accomplished by mail. The date of filing such notice shall be the date of mailing, provided it is mailed by registered or certified mail and the party filing the notice has proof from the post office of such mailing date. Proof of mailing shall be certified by the party filing the notice and filed thereafter with the court to which the appeal is taken. If the notice is received by the court on or before the date by which such notice is required to be filed, the party filing the notice is not required to file proof of mailing."

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